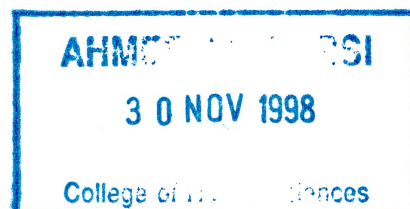


***The Perceptions and Satisfaction of Children and Mothers about
their Gps: A comparative study of the British and Bahraini
societies***

Aysha Al-Shaikh

1996

***Msc in Medical Social Anthropology
Keele University***



Acknowledgment

My grateful thanks to:

My family, especially to my understanding husband, children, and my mother who was a great help to me throughout my study in Britain.

To Dr. Alan Prout, Dr. Jeanette Edwards, Judith Monks, and to my supervisor, Dr. Jane Parish. And to all the tutors on the course who patiently helped me to acquire this valuable knowledge in the field of Anthropology.

To my colleagues, who provided me with their help and emotional support.

To all the families and friends, who patiently and willingly provided me with all the information I needed, without whose support this study would not have been possible.

Abstract

This research aims to explore and compare the perceptions and satisfactions of children and their mothers about their general practitioners, in two cultural settings, Bahrain and Britain.

In order to identify the above perceptions and satisfactions an ethnographic approach is used as one of the methodological techniques, utilising semi-structured (tape-recorded) interview methods. Interviews were conducted in a variety of social and cultural settings e.g. offices, clinics and homes, over a six month period.

One of the main themes of this research, is to focus on the children's interpretations of the process of their health and illness, their roles in this process, and their communication with their general practitioners during the health consultation.

In contrast to previous studies investigating children's roles in the process of health and illness which project children as active social actors, this fieldwork explores how children hesitate to express or to communicate their view points to authorities including mothers and general practitioners. However, those children still see themselves as active actors in the process of their health and illness which was contradictory to their mothers' view points.

Although mothers generally seemed initially satisfied with the way general practitioners dealt with their children's sickness, and/or with the doctors' professional competence, they were, however, not satisfied with the way doctors dealt with their personal health matters or with the way doctors acted towards them as parents of sick children.

Contents

	Page
<u>Chapter One</u> <i>Introduction and Theoretical Considerations</i>	
Why Investigate Patient's Perception?	2
'The Foucauldian Perspective on Power'	5
The Pole of Power Between Patients and their Practitioners	
Children's Position in the Health Setting	10
Why are Children's Accounts not Considered?	10
The Role of Mother in the Process of Children Illness	13
Interaction Between General Practitioner, Mother, and Child	14
<u>Chapter Two</u> <i>Research Methodology</i>	
A Matter of Definition and Subject Selection	21
Face to Face with Children	26
Focusing on Two Cultural Settings:	29
'Methodological Consideration'	
<u>Chapter Three</u> <i>Reporting of the Result & Analysis of the Data</i>	
Doctor should only Ask Mothers Questions	39
It is not Confirmed Yet	42
Mum is a Gatekeeper	45

Children's Access to Medicine	46
It Depends on the Doctor	50
Moral Aspects of Doctor's Care	51
Some Doctors are Keen to Answer Your Questions	52
The children's Account of their General Practitioners	52
Female Prefer Female	54
The Contradiction between Mothers & Children's	56
Points of View	
Children's Passivity, Yes but!	57
Children's Right to Speak	57
Mothers' Overall Satisfaction	59

Chapter Four ***Discussion of the Final Thoughts***

Comparing the Two Settings	62
Mothers' & Child's Opposition	63
The Role of the Social Network	66

Chapter Five ***Some other Related Findings & the Conclusion***

Time & Nursing Team	69
Appendix 1	
Appendix 2	

Chapter One

Introduction and Theoretical Considerations

This chapter describes the most related contemporary literature addressing the questions of patients' perceptions and satisfactions, especially those related to children's accounts in different health settings. A full interpretation of these studies is dealt with in Chapters Three and Four.

““ Illness is something that happens between the doctor and patient’ (Valabrege). He means by this that illness is not an autonomous entity, but a result of the confrontation of two individuals, the first contributing the mystery of his illness and the second proposing an explanation and fitting the subjective realm into the objectivity of a theoretical system...” (Bastide, R 1972. cited in Robinson 1973: 65)

In this account Robinson (1973) agreed with Bastide's explanations and has also stressed the importance of considering the context within which that relationship is set. In this case, if we are to explore people's behaviour when faced with illness we must consider the social relation between the patients and their doctors, the meaning of illness from the view point of the actors involved, the social context of that relation, different conceptions of illness from the patients and the doctors perspectives, as well as the different expectations of both mentioned actors (patient-doctor). Doing so would enable us to use those findings to make adequate predictions about the use of medical facilities, and to consider the nature of the illness that brought them to the professional's attention.

According to the literature review there is a great difficulty among researchers determining the definition of “patients' satisfaction” since this is usually affected by

the patient's perception, the way the patient views, feels, and evaluates the health care system; this includes the services provided and the providers of those services. One reason for this difficulty is that scientists interested in studying that element of health care began to use different dimensions to identify and measure this indicator. In return, this has led to a greater widening of the conceptualization of patient's satisfaction.

Why Investigate Patient's Perception?

For a very considerable time a patient's social experiences of his/her disease has been neglected by the medical professionals. The standpoint of patients was the last to be considered. As discussed by Porter (1985), even in the historical documentation of illness, the contemporary aspects of illness or disease experience were rarely mentioned. The main emphasis was on documenting the discoveries of "the great men" of biomedical science, which means only considering the health professionals' accounts. Despite this neglect, a lot of contemporary anthropological researchers have presented the ideas of sufferers. One of the reasons for considering patient's narrative accounts of disease and illness, as presented by Frankenberg (1990), is that such accounts could provide insights into the ways in which illness is experienced. That in return can help health professionals to get more understanding of their patients in order to avoid future suffering of those patients.

As the awareness of patient satisfaction has drawn increasing attention among scientists from different disciplines, they (scientists) attach greater importance to considering patients' perception and satisfaction about the health care services

provided to those patients. According to Guebaly and his colleagues (1983), there has been a shift in emphasis from a complete reliance on professional opinion in the evaluation of health care services, to considering the opinion of those who are being served or the “users” of those services. The researchers have emphasised that this does not underestimate the information provided by the users, but links it to the process of ‘consumerism’ with its focus on the consumer’s evaluation and satisfaction.

Like Guebaly (1983), Elston (1991) in her discussion of Steven’s (1986) idea of consumerism, notes that the past decade has witnessed tremendous changes, not only that of the end of optimism scientific knowledge but it also witnessed the end of ‘patient’s passivity’ and lead to the reconsideration of the patient as an active ‘consumer’. In this account the changes in the economic system have modified the pole of power, in which the medical dominance of practitioners is replaced by more dominance of power by the client. The Patient is no longer seen as a passive, subordinate, and a follower object, instead, he/she is perceived as an important and active user who has a point of view which should be both heard and carefully considered.

As a result, this satisfaction has been seen as an important element in the evaluation of the quality and the utilization of the health care system. However, scientists from different disciplines, especially the social and anthropological ones should consider the widening conceptualization of the patient’s satisfaction as mentioned earlier.

Keeping in mind the factors affecting a patient's perception about health services, including patient's beliefs system and his or her explanatory model.

The intention of this work is not to look at the validity and reliability of this concept; (patient's satisfaction) it focuses on the general use of this concept in relation to the practitioner's personal and professional competencies.

The interest in consumerism is not the only reason for the shift of attention to consider the patients' view points. More important, is the increased awareness about the importance of listening to the patients voice, as mentioned above, 'the patient's narrative', which involves thematic analysis of patient's inner life story (Monks 1995), about the suffering with an illness and the personal account of this suffering, from the patient's point of view.

Investigating parents' and children's perspectives, their perceptions and satisfactions is no exception. According to Clarke and Hewison (1991), parents are continually having to make complex decisions about their children's health (Wyke and Hewison 1991 p:75). In this case both children and parents' perception, especially that of the mother should be investigated. Again children's view points, have been recently introduced as an important element in the process of evaluation of health care benefits and services provided to this category of patients (children). However, it is worth mentioning at this stage that, up to 90% of minor illness episodes are diagnosed and treated at home by the parents of those children (Wyke and Hewison 1991).

Keeping all of that in mind, there is much more to the health setting or the medical consultation than just the immediate interaction between doctors and parents concerning the child's health. Another factor in this regard, perhaps is the shift of the power relationship from the health professionals to their patients, as simply explained by some of the Foucauldian scholars such as David Armstrong (1982), and Fisher (1991) who do not see the power relationships between the two main actors (patient and doctor) as a sovereign power practiced by a medical professional within a medical encounter. They see it as no more than a 'strategic relation which is diffuse and invisible' (Lupton, 1994: 111).

That shift in doctor-patient relationship operates with the central distinction of control and has recently allowed patients more negotiation of relationships within the health care system. These ideologies of power may to some extent be influenced by a person's financial status, the professional position, and most importantly, by the authority level or/and the social power associated with that position.

The Pole of Power Between Patients and Their Practitioners

The Foucauldian Perspective on Power

It is essential to consider the Foucauldian account of power when discussing any system of power relationship. With regard to the doctor-patient relationship, the Foucauldian approach develops with an assumption that power within the medical encounter 'is not a unitary entity, but a strategic relation' used by both actors. In this

account 'power is not necessarily a subjugating force aimed at domination which itself is vulnerable to resistance' (cited in Lupton, 1994:111). The contemporary theory of medical encounter based on Foucault's insights is also discussed by some Foucauldian scholars such as Armstrong (1987). This scholar criticises the simplicity of the Marxist analysis of the power relationship which takes place in the medical encounter, between the patients and their doctors. This analysis (Marxist) conceives doctors as having sovereign power and control over their patients' bodies, and it examines only some elements of the visible medical power; for example it does not consider the moment in which patient and doctor collude to solve the illness problem (Lupton 1994).

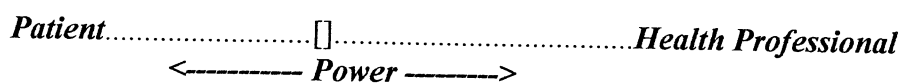
That strong critique which is directed at the idea of medical dominance, is considered by Fisher (1991), Smart (1985), and Armstrong (1987), as inappropriate because it is neither possible nor desirable to specify who is subjecting or dominating whom (Fisher 1991 :77-8, cited in Lupton 1994).

Looking historically at the position of medical professionals, Lupton (1994) stresses that while healing powers are valued in most societies, medical professionals in Western societies, did not gain that position until recently. Before the Enlightenment, they were ranked in a low position because surgeons were associated with blood and other dangerous substances of the human body. These substances were believed to be dangerous, poisonous, and polluted, and the same was believed about those who dealt with such substances.

Although Lupton's analyses could be very general and perhaps, are not documented in other studies, however, I find it important to reflect at least the lay beliefs about

those health professionals who had, according to Lupton, much lower social and economic status, and less prestige than they do now. As also pointed out by the researcher, the status of the patient in that historical period was higher than that of his or her doctor. Lupton stresses that the sick person's account of his or her illness was highly considered, and the role of the medical practitioner was to interpret the signs of illness. This was mainly based on the patient's bodily experience and subjectively defined sensations and feelings.

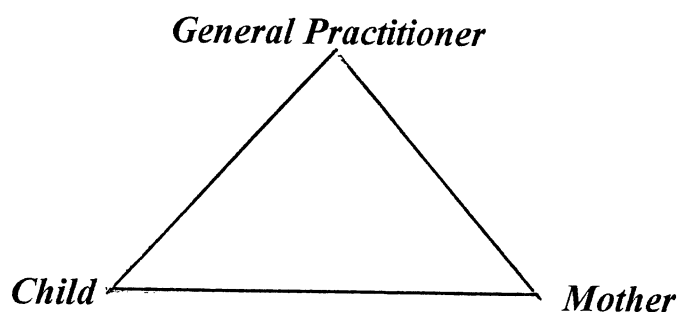
It was not until the development of the biomedical model of illness and disease, that the importance of the patient's interpretation of his or her illness began to 'diminish', (Lupton 1994). From the historical review and from the following diagram, I propose that, the criterion of the power relationship between the main actors of health care (patient and doctor) is not fixed. It is dynamic, since in some historical periods doctors and health professionals have more domination of power whereas in some other historical periods it is the other way round.



(Diagram no. 1)

Keeping all of this in mind, one should not assume a complete passivity of one actor against a complete powerfulness of the other actor within the health setting. Another issue which should be considered in this regard is the powerful influence of medical professionals even with the apparent increase of interest in patients' perception and satisfaction.

Since this fieldwork is focusing on three actors, mother , practitioner, and child; then the child's account of his or her illness, treatment, and attitudes about the practitioner should be investigated. In order to explore the triangulation of power shown in diagram no.2, it is important to study the role of each actor and the social power assigned to it.



(Diagram no. 2)

It is certainly the case that the direction of the power relationship depends on the setting, and on the actor's social position. In regard to setting, it has been noticed that a child acts differently in different places. Children seem to be active communicators in their schools, in public places, but they seem to be very passive when they are placed in certain settings such as health consultations. Even within these familiar settings children act differently as studied by Mayall (1996), who argues that 'children's identities, knowledge, permitted behaviours, their negotiating power, and their interactions vary according to social context' (1996:40). More importantly, the children's point of view is also considered differently accordingly.

As indicated by Mayall's study (1996), which aimed to explore children's negotiating ability as regards daily health-related decisions at home and school, children seem to be perceived as 'active participants' at home, being themselves and acting as negotiators of their social world; however, they are perceived to be passive at school. Mayall explains that children's activities within the latter are restricted by the bureaucratized and standardized school system which is rigid, institutionalized, and organized by the adult authority.

The question now is whether the way of approaching the children is responsible for the above differences in children's reactions and satisfactions. The results of many studies demonstrate the importance of patients-professional interaction. These studies have also stressed the need for accurate training directed to health professionals in order to ensure better communication with the health care users and to improve the level of patient's satisfaction with those services. For example, Wissow, Roter and Wilson's study (1994) in relation to patient-physician communication, suggests that there are certain aspects of pediatrician interview style, in regard to referral of children with mental health problems which are considered to have a greater level of importance to patient's satisfaction than others, and that this is believed to increase the disclosure of sensitive information by the parents. These communication elements include things such as physician's concerns about psychological issues, making supportive statements and reassurance; and sympathetic and attentive listening.

Children's Position in the Health Setting

According to Pantell, Stewart et al. (1982), most studies investigating doctor-patient communications focused on adults. When children have been the patients, physicians directed the impacts of their interactions to the children's parents. However, studies discussed by the above researchers documented that parents' satisfaction is somehow linked to the amount of time physicians interacted, were friendly, and discussed nonmedical, social subjects with their children. This finding shows that doctors' manner is an important element in parents' satisfaction; even though parents some times do not explicitly express that need (treating a child in an acceptable manner).

Why are Children's Accounts not Considered?

The statement "Children should be seen and not heard" is used by Pantell, Stewart et al. (1982) to refer to the way children are perceived in the health setting interaction. Children's right to speak and to express their point of view often gets abused by the adults, either parents, teachers, or/and health providers. Children must often petition adults for the right to speak and to enter a conversation. However, allowing children to speak is not only important so that their point of view is heard, it is also seen as a therapeutic lever. The researchers explain that experimental studies have documented a reduction in the number of surgical complications when experimenters talked directly to children before surgery (Pantell and Stewart's 1982:p 396).

Although communicating with children has such a level of importance, according to Pantell and Stewart's study (1982), parents received 4.4 times as much information as their children about the nature and prognosis of a child's condition.

Through the analysis of videotaped interviews between child, health practitioners, and parents, Pantell and Stewart (1982) have documented that doctors had different patterns of communication with parents and their children. Although physicians gathered more information from children about their health ailments than from parents, they directed less communication towards those children. The study has also shown that a physician's experience did not lead to extensive communication with children. Among possible reasons for that phenomenon are that physicians are affected by their previous perception and underestimation of the information provided by children.

It is very essential at this stage to trace the reason(s) responsible for children's social position in order to understand their roles in the process of health and illness with special focus on the wider social and cultural context of that position. A review of the literature on the social position of children within the field of anthropology and sociology reveals that children can be understood as social actors with their own perspectives on the social world (Prout and James 1990, cited in Prout and Christensen 1996 p:32).

However, Prout and Christensen (1996), stressed that adults are simply perceived as being in charge, as well as, responsible for children. This feeling of responsibility obscured children's own role and contribution. The above researchers argue that, this doesn't only affect the wider social perception of childhood illness, but it extends to influence the general beliefs of most researchers investigating the world of children.

Children are perceived differently in the medical setting by doctors, parents and by the researchers. For example, according to Almarsdottir, Aramburuzabala, et al (1996), some researchers working in the study of children, viewed them as passive, incompetent, and asocial actors in relation to medicine used. However, and in contrast to these claims and perceptions, some contemporary studies documented that children are believed to have some attitudes, beliefs, and that they do have some expectations about medicine. These researchers go further, to stress that children have some autonomy over their medicine used even without their parents knowledge, among them Bush, Iannotti, Prout (1996, mentioned earlier) and some other researchers interested in this field. Bush, for example, sees children as active social actors, while Green and Bird (1986) point out that children seem to perceive self-care as the most important determinant of health. Furthermore, preadolescents participate actively in the treatment of their minor injuries and health complaints (Iannotti et al 1990).

Other studies have similar findings regarding children's tendency to create values, feelings, and behaviour towards the treatment they get from the health providers or the care givers. The studies have also shown that these attitudes of children are usually affected by the children's environment or the surrounding culture in which they are socialized.

In this case the meaning of illness and treatment may vary from culture to culture, as emphasised by Almarsdottir and his colleagues (1996) who state that the meaning of sickness and treatment varies across cultures and that nation and culture are responsible for creating some degrees of stoicism of illness and disease, which

according to him, in return can influence a person's tendency to seek treatment. This has also explained why some people tend to seek health treatment more than others (Zborowski 1952 and Zola 1973, cited in Almasdottir 1996).

The Role of the Mother in the Process of a Child's Illness

Looking to the wide social context of health and illness, mothers are expected to provide care and emotional support to their children, to care for the sick as well as the healthy; to young as well as older family members. Caring is one of the main social female functions. As stressed by Almarsdottir, Aramburuzabala, et al (1996), the mother seemed to be the primary caregiver to sick children in most instances (1996 p:129). She (mother) is involved in all the processes of a children's sickness and illness, starting from the time of recognizing that something was wrong until the stage of deciding to see a doctor.

Gelder and Prout (1996) in their study explain that in the process of illness reporting and negotiation of symptoms of an illness, children often tend to tell their mothers not any other person(s), and that mothers always decided the next step to be taken, e.g. for a child to stay at home, or to see a doctor.

According to Cunningham-Burley and Maclean (1991), most of the health care activities taking place outside the professional arena are mostly done by mothers who are at the front line of primary health care. These activities included, monitoring children's health and illness in order to recognize any sign(s) of sickness;

involvement and responsibility for nursing and caring for their children. The researchers have also stressed that health and illness then, are embedded in the everyday life of those mothers.

Therefore, I think, it is very important for any research that is investigating children's welfare, to consider the unique abilities of mothers in the process of child's health and illness, since they have such a major role(s) in this process.

Mothers' accounts of their children's illness then, can be one of the important sources in the process of assessing health care benefits, as well as the evaluation of the professional and personal quality of the health providers. It is worth mentioning that studies of mothers' accounts should cover the social context of the home then extend to the medical consultation.

Interaction Between General Practitioner, Mother and the Child

The way physicians communicate with patients has a direct effect on the latter's level of satisfaction with medical care. According to a review of the literature, satisfaction is highly related to the affective quality of the provider's manner, the information conveyed by the provider, the provider's technical and interpersonal skill, and the length of medical visit (Hall & Dornan 1990). This study aims to explore the perceived satisfaction of both mother and their children with the GP (general practitioner) care they received, in order to identify the personal and situational characteristics that influenced the extent of communication taking place between three main actors: the GP as a health care provider, the mother as the child's

representative, and the child as a health care user, focusing on the triangular power relationship between those three actors.

Sloper and Turner (1993) in a similar study, stress that parents were more likely to be satisfied if they felt that the health professionals carrying out the disclosure showed understanding, sympathy, and used an approachable manner; and if they were direct and had communicated well, if they released sufficient information and they had been given opportunities to ask questions. However, factors such as time provided for that were not significantly related to satisfaction.

Meeting patients' expectations is primarily a very important aspect influencing the level of patients' perception and satisfaction as shown in another study done by Kristjansdttir (1995) investigating needs expressed by parents in a pediatric hospital, in regard to health care facilities provided to their hospitalized children in Scandinavia. The study has shown that parents' perception of satisfaction was significantly and positively correlated with their perception of how their needs were being met and with their request for help from the hospital to fulfil them.

Patients' expectations are usually affected by numerous factors including patients' cultural surroundings, education, age, and previous experiences with similar illness. These above mentioned factors can possibly interact with each other to establish patients' perception and expectation. According to Iannotti and Kapor (1996), in cross-sectional studies of preschool and school children in the USA, factors predicting patients' expectations in response to health and illness include 'age, family

composition, health locus of control, autonomy, concern about illness, perceived severity of illness, and the perceived benefits of the health action (Bush and Iannotti 1985, 1988, 1990; Bush, Iannotti, and Davidason 1985; Iannotti and Bush 1992; cited in Iannotti and Kapor 1996:255). In some cases these factors are responsible for the differences and conflict taking place between the lay concept of the patient and the knowledge of the health professional.

Robinson (1973) points out that it is not surprising that both doctors and patients come into the consultation holding somewhat different conceptions of illness. Both of these actors are influenced by their knowledge and backgrounds which may differ in emphasis, detail, or ordering of priorities.

Patients need to understand what the health practitioner is talking about. Studies have proved that understanding, has a major role in the level of patient's satisfaction. Patients are not always able to understand their doctors; Lay (1993) emphasises that it is likely that patients do not understand or misinterpret much of the information released by doctors.

As mentioned by Mazzullo, Lasagna and Griner (1974, cited in Lay, 1993) even simple everyday words can be ambiguous in a medical context. Lay has also argued that there are two reasons for that failure, the first is that doctors use a difficult level of information presented to their patients. The second is that patients themselves have their own knowledge, information, and theories about illnesses which may be different from that of clinicians.

It is probably worth noting that, according to the above study's results, it is not enough to tell patients about the various aspects of their conditions. More importantly, they have to be told in ways that they can understand the level of information communicated by their clinicians. The researchers of this study have also suggested that more explanations should be given to the patients by the health professionals. Perhaps, this could improve patients' understandings and satisfaction.

The degree of patient's understanding of the concepts of health and illness can be responsible for determining the treatment selection and the appropriate method(s) for dealing with health problems. In a recent study done by Iannotti and his colleagues (1993) investigating the elementary school children aged 6-10 years, understandings of certain diseases ranging from common cold to AIDS, the researchers reported that children's understanding of health and illness is linked to the developmental mental progression but they also identified within children differences depending on the illness.

In another related study investigators have documented that children's understanding of health and illness was not related to the recent family incidents of illness; rather it was related to children's health attitudes and to their positive coping with common health problems (Iannotti et al 1990).

The linkage between a child's cognitive development and his or her understanding of an illness, is similar to Social Cognitive Theory (Bandura 1986), and the Cognitive Development Theory of Inhelder and Piaget (1958). It is worth citing the different

influences that help to determine the child's perception and understanding. According to the Swiss psychologist Piaget (1958), the above theory emphasises the stages of a child's causal thinking which develop and operate within his/her environment.

Piaget goes further to assume the 'naturalness and universality of childhood'. In Bandura's (1986) theory, social cognition is a result of the interaction and interrelation of three factors: firstly, the personal factors, including 'the child's own value system, expectations deriving from observation and experience'. Secondly, the behavioural factors, including 'skills in performing the behaviors', and thirdly, the environmental factors which include, 'peer, family, and media (Almarsdottir, et al 1996).

The Process of deciding on the kind of health care needed, which doctor to consult, and which medicine or treatment to use, is influenced by patients' previous experience with similar illness or disease, as well as the previous experience with specific doctor(s). Stimson and Webb (1975) argue that 'patients quickly learn the manner and the techniques of individual doctors and based on that, patients tend to select a certain doctor, if they are given a choice (1975: 29).

As in all interactions, negotiation between two main extremes of that communication always occur. According to Stimson and Webb (1975), this process may be presented consciously or unconsciously by both actors in an attempt to persuade each other. This argument may overlap with the Foucauldian perspective of power discussed earlier, power as a strategic relation. However, in the medical consultation there is the problem of the outcome that is desired by both patient and doctor. Therefore both use the negotiation process as one of the strategies to influence

each other to obtain a better outcome, either regarding the diagnosis, or the treatment.

In their study Strong and Davis (1972), explain how parents come to a doctor's consultation holding their own definition of their child's problem. During the consultation, both doctor and patients may accept or reject each other's categorization of health ailments. Nevertheless, the doctors usually use various techniques to reinforce his status as an expert, especially, when he or she comes across parents 'loss of faith' in his or her competence.

Patients' beliefs influence their perceptions of health and illness. Weston and Brown (1989), have examined the concept of patients' beliefs which they define as, patients' 'thoughts, ideas, convictions, opinions, and values about illness and health care'. They stress that all of these beliefs are learned from a patient's social group. However, the voice of medical professionals and the voice of the lifeworld of patients may clash with each other (Mishler, 1984).

In regard to children's health beliefs or the locus of control, a number of studies have attempted to explore children's perceptions of the benefits of medicines, treatment, and the services provided by the health professionals. Other studies focused on children's expectations, value system, and the influence of environmental factors affecting the shaping of these elements of children's perceptions. Examples of these studies are mentioned above.

Patient's responsibility for health and maintenance of care have recently started to become an issue in most health prevention programmes. However, Maiman, Becker and Kattic (1985, 1986,) and Iannotti and Kapor (1996) assert that issues related to patient's responsibility of health maintenance have not received enough attention, especially the role of children in that process (care taking) in which they suggest further studies are needed and more consideration must be given to this aspect of health.

Chapter Two

Research Methodology

A matter of Definition and Subject Selection

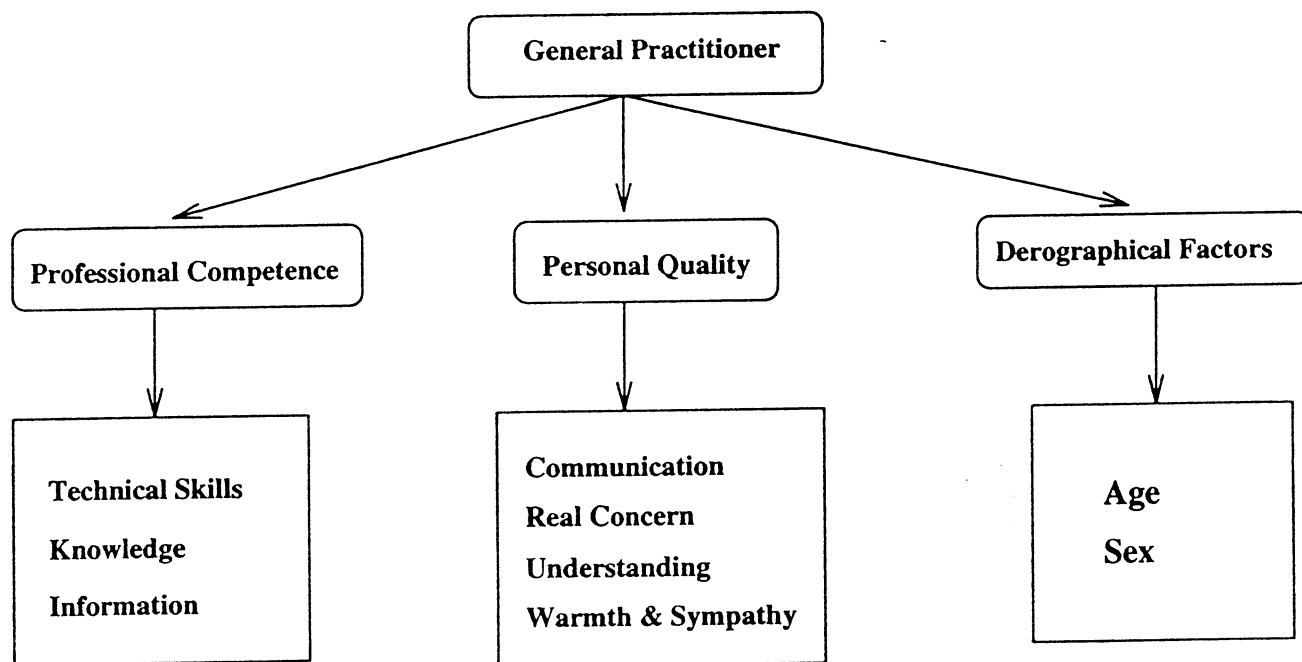
As emphasised by Stimson and Webb (1974), no research project can avoid the problem of bias in the selection of research area and method(s) of investigation. The area which I selected to explore has just one aspect of health care (patient). As stressed by the above researchers, investigating the patient's view point about his or her practitioner, is reflecting one side of the medical interaction, and I think it is like focusing on one side of the coin; the patient at the expense of the other actor(s), the doctor.

In the process of selecting my research subjects, I was very motivated by my experience in the field of psychology which usually stresses the importance of communication; especially the effective interaction which occurs between two persons or more. The psychological theories are also concerned with people's perception of what they see and with whom they are interacting. I found that in investigating the health care systems from the perspective of the patient, especially, children I would gain new practical skills which would probably enrich my previous knowledge and experience. In regard to my training in the field of social and medical anthropology, I chose to focus on two different cultural settings (Britain and Bahrain), in order to apply the cross-cultural method appropriate for the investigation of the different meanings attached to the concepts of health and illness.

Ley (1993) explains that focusing on patients' levels of satisfaction with various aspects of health care is essential for two reasons. On one hand, it is a desirable goal in its own right, and on the other hand, it is an important indicator determining patients' compliance with medical advice. Ley refers in his book to the inherent contradictions in defining and measuring patients' satisfaction. For example, Ley (1993), stressed that investigations of patients' satisfaction have used a range of interview techniques measuring the concept, differing tremendously in the level of methodological sophistication.

As seen from the literature review, deciding to define a concept such as patient's satisfaction is not an easy task. I had great difficulty finding and deciding on the right explanations of patient's satisfaction. Keeping in mind the different dimension(s) of that satisfaction, I became confused about what I should examine due to the wide availability of different dimensions measuring that satisfaction. This lead to considerable tensions emerging early in my fieldwork. This resulted in the dilemma, should I focus on all the dimensions used to measure patients satisfaction including factors related to health provider's characteristics which was one of my interests, or should I be selective and focus on the main elements of patient's satisfaction used commonly by the majority of researchers studying that factor, including socio-cultural dimensions Such as patient's demographical factors, e.g. sex, age and educational level?

I managed to free myself from that confusion by focusing my attention on some selective factors affecting patient's satisfaction, including factors related to the patient him or herself, such as patient's health beliefs, understanding, expectations. Factors related to the general health practitioner were also selectively determined, such as professional competence, personal qualities and socio-demographical factors. As detailed in the following table:



Based on both my previous academic background in the field of psychology, and my experience as a mother I developed a great interest in investigating the world of

children, particularly concerning their opinion of the health services they received, and sought to discover what children themselves think about their illness and about the providers of care and treatment, rather than relying on the information collected or provided either by GPs or children's parents. In spite of the previously mentioned background and experiences of the researcher, children have often shown a high degree of suspicion and lack of trust both during the doctor's consultation, and during the interview held by the researcher. Nevertheless, there are indications that social, cultural, and psychological factors are related to children's tendency to isolate themselves from others, at least when they are questioned formally by certain authorities, such as interviewers or doctors.

Furthermore, studies show that it is a common practice that health providers namely, pediatricians do not consider and/or ignore a child's account of his/her illness; instead they direct their recommendations for treatment and prevention to parents (Pantel, et al. 1982). In this regard it seems that the information provided by children about their own illness is seen as to be of a low priority. According to Valassi-Adam, (1996), the medical history is elicited from the adult 'caregiver' who is considered a more reliable source of information.

That under-estimation of a child's ability to understand and to communicate their physical complaints or ailments is unjust because according to the observational studies mentioned in Pantell and Stewart's article (1982), these studies documented that children have shown interest in obtaining clinical knowledge and information,

and that they even seem to be rated in the level of information they have as better than adults (Spelman 1965, and MacCarthy 1974).

When designing my research instrument I tried to elicit direct questions for the above research factors, e.g., GP's personal quality, such as asking the child's mother to explain the way that the GP shows concerned interest in her child's sickness and treatment. Another example was asking the child whether he or she understands the level of information released by his or her GP, if not, why not?. I also assumed that doing so, perhaps, could enable me to have more insights into the factors responsible for the patient's perception and satisfaction.

Although this work has not attempted to re-evaluate the methodological techniques and instruments used to investigate both parent's and children's perception of the concepts of health and illness, nevertheless, it is important to discuss the other methods suggested for dealing with children, especially with regard to children's passivity. For example, Iannotti and Kapor (1996), as well as other researchers investigating the world of children, have used "Children's Drawings" to collect information about children's perceptions and the personal experiences of their health ailments. The researchers emphasise that children were happy to make the drawings and that the drawings were very impressive.

However, in my research I intentionally avoided such a technique, because I think the method has certain limitations. For example, the process of analysing children's drawings which I think needs special, perhaps, psychological, talents. I think that

analysing children's drawings is not an accurate method indicating perception and attitudes about health benefits. Perhaps, it could be used in a limited case, such as to investigate a child's perception of his or her own self-esteem or self-image.

While examining mothers and children's attitudes, two main perspectives were used to understand the perception of children about their health providers and their perceived benefits of the health care action. The first perspective, is to investigate the position of the child both in his or her home; and within the medical encounter; his or her perception and management during the process of health and illness. The second, is to investigate the power relation during the interaction taking place between the three main actors of this fieldwork: the general practitioner as a representative of professional health agencies; mother and child as representative of private agencies. The latter would probably reflect the lay perception of the services provided by the first category (the professional agencies).

Face to Face with Children

Entering the world of children needs a great deal of patience, and perhaps, special skills. I think handling fieldwork with children is not as easy as a normal interview with adult informants. My greatest difficulty in the context of children was I think, combining my previous knowledge, experiences, and training in the field of psychology, which is interested more with: the hidden motives, eye contact between people, with my recent training in the field of anthropology which focuses on what the informant says to the researcher.

As a psychologist I found it hard to resist analysing and reading between the lines. Although in some cases both sciences are interested in obtaining an individual's account of his/her experience, nevertheless, each has different methods of approaching that account (patient's).

Therefore, when interviewing children, I could not avoid analysing the eye contact between the child and his/her mother; the use of rationalization (giving acceptable reasons for certain actions), and the analysis of hidden motives of both child and mother (as they appeared to me). This resulted in my using two methodological techniques in my present fieldwork; first is the in-depth, semi-structured interview developed from my pilot study, together with covert observation.

Although I was influenced by training, in both disciplines, anthropology and psychology, the latter nevertheless helped to provide a new dimension (the psychological domain) which I think, enabled me to gather more useful information which complemented the interview material, and which affected the overall findings of my fieldwork. Although I think reporting this psychological analysis could be doing an injustice to those informants who had given information so freely to me, I nevertheless find it necessary to present all the important findings of my work.

In addition to methodological issues and technical difficulties, I also found that during the interview, children were very cautious. It seemed as if my informants were often tense and were aware that they were involved in a research study. They also

seemed very careful not to give the wrong answer and they tried to meet my expectations by providing what they considered to be the most proper answers.

Noticing that, I had to ensure that children felt more relaxed and confident about answering my questions. I also wanted to explain that their points of view were not being judged as right or wrong. In order to do that, I began my interview by making general conversation with the children, asking them about their hobbies and other interests. In some cases I asked the children to show me their colouring books. I also explained to them that there were no right or wrong answers to my questions, and that they were free to express any thing they could remember about their last consultation. I stressed that they only needed to tell me what they thought and felt about the Gps.

As explained by Cunningham-Burley and Maclean (1991), providing a non-threatening environment is very important to encourage the development of a rapport between the researcher and the researched (1991:30). To some extent, talking with the children about their hobbies was helpful with some of them, and has permitted a more relaxed atmosphere. Nevertheless, it did not work with some other children, and it wasn't effective enough to encourage them to participate more in this fieldwork.

I also tried some other techniques in order to avoid the power status, by creating a friendly setting by first introducing myself to them , and secondly asking them to write their names. I think this helped to improve communication during the interview. I started calling them by their first names in order to reinforce familiarity. This strategy has worked in very few cases, as explained earlier in my literature review.

However, Mayall (1996) states that children act differently in different settings. In some settings such as the home and playground they seemed to be perceived as active social actors, while in other settings such as the formal setting they acted passively. One of the reasons expressed by the above researcher was that the home setting is more flexible and allowed more open negotiation. In this fieldwork, it is not the setting which affected the children's passivity since all the interviews (in Britain) were conducted in the informants' homes. Children showed resistance even within their familiar setting. It seemed to me that in my fieldwork the position of authority was more significant than the settings.

Focusing on Two Cultural Settings: Methodological Consideration

As a foreign student I had the chance to investigate patient perception and satisfaction in two cultural settings. In designing my fieldwork, I felt that in investigating patient's perception and satisfaction, a cross-cultural dimension would add more fruitful findings and would contribute more discussion to the research debate. Therefore, I selected two different cultural settings, my native country (Bahrain), and the British community where I am conducting my academic work. In particular I was interested in comparing and contrasting the views of people in both settings in which I assumed there were cultural differences. To investigate the similarities and diversities of both cultures, differences between the two languages were carefully considered in regard to the meaning of words. Hence I started the first set of interviews at home (Bahrain). All of the interviews were conducted in Arabic.

The second set with the British group was conducted in English. All interviews were recorded on audio-tapes and transcribed.

As is well known by anthropologists and researchers from other disciplines, conducting a comparative study may raise a number of technical problems, as emphasized by cultural relativists, such as the problem of cultural equivalence of both central theoretical and standardized concepts measures (Wirsing and Trakas 1996).

This problem was overcome as suggested by the above mentioned researchers and as followed by the researcher of this fieldwork, by simple wording of the research instrument, a structured interview. Furthermore, I consciously wrote some of my informants words, responses, and comments in English immediately after each interview to avoid the risk of losing anything. I also recorded and completely transcribed most conversations and interviews done in Bahrain.

Another problem in the process of applying a cross-cultural study, discussed by Wirsing and Trakas (1995), the 'Cross-cultural comparison, using both qualitative and quantitative data. Moving between these two type of data requires an interpretative bridge using emic [which they refer to informant's perception] and etic [refer to an outsider, or the investigator's view] categories' (1995:59-60). Following that suggestion, I used a variety of research methods: semi-structured interview, as the main source of collecting information about informants' experiences and perceptions, and observation and psychological analysis of informants' behaviour to gain access to other unforeseen information, as described by the above researchers (Wirsing & Trakas, 1995).

As a lecturer at the College of Health Sciences, I came to know a lot of health authorities either as students or as colleagues. This helped to facilitate a smooth access both to the health care system in Bahrain and to other people in the same community. Perhaps that was one advantage of conducting field work at home. Through a direct and personal communication with the health care authorities, namely some of the administrative staff at regional health clinics, I was allowed to interview mothers and their children immediately after they had been seen by their GPs in two health clinics. I chose one in a rural area (Sitra Health centre) and another in an urban setting (The National Bank Health Centre) in Arad area.

Not surprisingly, there were several differences between the informants in regard to the level of education as well as the number of children belonging to the mothers interviewed in these two centres. Although the Sitra Health centre is considered to be in a rural area, it is worth mentioning that in Bahrain, there is no clear cut separation between rural and urban areas due to the size of land which is very limited. Nevertheless, mothers in the rural clinic reported that they either attended two or three years of primary school, or had not attended school at all. However, keeping in mind the number of mothers interviewed (four mothers) at that clinic, this level of education is not an indicator of the overall level of mothers' education in this area. Regarding the number of children each reported having ten to fourteen children, which is not unusual in this area due to the social beliefs which encourage high female fertility and productivity. In contrast, four mothers in the urban clinic reported attending high school and one had a Bachelor degree, except one grandmother who

was illiterate. Again due to the limited number of mothers interviewed, this level of education does not reflect the overall educational level of people in this area. However, most mothers reported having no more than four children. Two other mothers were interviewed at their own work (in their offices). Both of these mothers were well educated, one with a Masters Degree and another has a Ph.D. level of education.

In regard to children, five children were interviewed in the Sitra Health Centre; three males and two females. Their ages ranged between 8 and 14. A similar number were interviewed at the urban clinic; three males, and two females. Their ages ranged between 10 and 14.

The Health administrative staff in both clinics were very helpful; this included nursing staff, receptionists, and GPs themselves. These staff members provided me with a GP's room to carry out my interview. For the accuracy of my fieldwork, and to avoid the confusion which my being in a GP's room may have caused my informants, I therefore explained to my informants that I was occupying that room as an MSc student and not as a GP, and that the interview I intended to conduct was part of my assessment for the MSc course.

Bearing in mind that "time" and "space" of any communication can affect the degree of the informants' trust toward the researcher, and may create a communication barrier, I also stressed that all my fieldwork was strictly confidential

and that Gps would not have access to the information provided by the research informants.

I also selected two other places in the clinic in order to test the effect the different interviews had on the level of information released by the informants. I interviewed mothers and their children in the waiting room as well as patients at the clinic pharmacy waiting to collect their medicine. Surprisingly, I did not notice any differences related to the different interviews' settings on the level of information collected. However, all the informants interviewed in the clinics were in a rush to answer my questions. For most, the time spent was approximately 10-20 minutes compared to 20-90 minutes in other settings such as interviews taking place in the informants homes or offices.

In contrast to the smooth access to the health setting in Bahrain, I faced a great problem accessing to the British health care system. One of the problems was to find a similar health setting (in the clinic) as in Bahrain, in order to compare and contrast the cultural and the medical settings. To try to convince the British health authority I wrote to and communicated with several people in different health positions, explaining to them the aim of my research and the necessity of interviewing informants within the health settings as well as in the community.

However, access could not be granted. I supposed that being a foreign student was one of the obstacles. After a long waiting period and consistent negotiations, I was advised by my department (at Keele university) to change my strategies and to try to

get in touch with mothers and children in the community rather than in the health setting. Due to these difficulties some other strategies were suggested by the department staff and by some other colleagues. For example, to contact families with children either by post, or by advertising in the school newsletter. Another way perhaps, was to get hold of addresses of families with children using certain health clinics, then to contact them personally to investigate their willingness to participate in my fieldwork. Although all of the previous steps were followed by the researcher, still access could not be achieved. Finally, through door to door postage, in the Stoke-on-Trent and Keele areas, I got only one positive response. Nevertheless, I considered this as a means of getting in contact with further informants.

After the first interview I got several names of families willing to take part in my research. Most of those families were originally white, British, middle or/and upper-middle classes, with two or three children, with a high level of education. All the British informants were living in well furnished houses in the Staffordshire area. The connection with these families was very promising. I did, however, have some anxieties that being a covered Muslim visiting British families in their own homes might raise ethnical issues such as stereotyping about fundamental Muslims. I was anxious that I might face some rejection, especially from children. However, these concerns and the fear of being rejected were unfounded and I was so amazed at how British families and especially their children accepted me for what I am. I was particularly surprised by their level of concern about my getting in touch with more informants if needed.

Furthermore, some of my informants took this matter so seriously that they started calling several of their friends and relatives, explaining to them my need for more research participants. Towards the end, when I explained to my informants that I had enough cases, some provided me with those relatives and friends names and addresses, just in case I needed further help. At times I felt like a member of these families when the children brought me some of their drawings and some of their animals. It is worth mentioning that children felt more comfortable only after they had been interviewed. Through the numbers and address lists I got, I tried to select a wide range of nearby areas from which I chose, Longport, Blurton, Newcastle, Longton, and Keele Village.

In the process of selecting my British informants among the children, a mixture of male and female child informants' with age ranges from 6 to 16, were interviewed in order to compare and contrast the perception and satisfaction of those children with their peers among the Bahrain group. The total number of children interviewed was twenty two children in both social settings. The ratio of male to female informants among the children interviewed was 13:9 which I think was remarkable in this fieldwork. As reported by both mothers and children most general practitioners were males in both cultural setting. This perhaps, could reflect the domination of males in the health care system. In regard to the number of mothers interviewed, twelve mothers in different social settings were selected. For the purpose of research confidentiality, most of the informants' names were modified.

In order to investigate children's tendency to isolate themselves from others, and to test the effect of tension created in any formal situation, I chose in some cases to interview the mother first in the presence of her children, and in other situations I chose to start with the children. However, the children showed a similar tendency to feel nervous during the interview in both cases. From this observation, I suggest several visits by the researcher studying children to create familiarity. Unfortunately in my case this was not possible due to the shortage of time and transportation difficulties.

When designing my research tool, that of a structured interview, I started with one of the ethnographic interview approaches, which means, using a "...multi-method approach that centers on participant observation; it aims at contextualized account of social life" as stressed by Almarsdottir and others. I used the "open-ended" interview technique which took more than an hour. I was aware that ethnography is supposed to be used as a predeterminer to a quantitative interview as previously suggested, however, I found that applying this methodological approach was a necessity at this stage, since I had some difficulties deciding on the appropriate level of question especially with the young informant (children). Nevertheless, following this procedure enabled me to find questions that seemed to be appropriate to my informant's level, bearing in mind the necessity of keeping the questions as easy and as direct as possible, firstly to keep them at a child's level, and secondly, to avoid translation problems as mentioned elsewhere. Surprisingly, even with this precaution I noticed that some children, especially, young ones (5-9 years) were unsure about some sample questions such as 'what do you do when you feel sick?' unless I

followed that question with some examples or other questions such as ‘Do you take any medicine?, do you seek help from your mother?, do you call your doctor?’ even when allowing enough time for the child to answer.

Finally, and based on my experience of designing research instrument, I created two levels of question within the same interview, one level specifically designed for the mother to answer and the second for the child to answer. The latter is more straightforward with shorter questions to suit the children’s level. However, with older children I sometimes extended the questions, especially when I noticed some willingness from the child to speak.

The intention of this fieldwork was not to investigate the specific definition or meanings given to the concept of health and illness, nor to trace the different usage of this term which might be different from culture to culture, and even from family to family. Patients’ perceptions and explanations were the main aims of this study. However, I think tracing these differences requires perhaps another methodological technique; and may involve numbers of variables related to patients’ social class, level of education, and the different social contexts.

When considering the words used to build up this research instrument, it is the responsibility of the researcher to ensure that his or her informants know what he/she means by certain terms. From the literature review, it seemed that terms such as G.Ps, sympathy, communication, concern, and some other terms seemed to be seen differently by different people, especially children. Therefore, and in order to find a

common ground I tended to explain in each interview what I meant by these terms. In many cases I followed the explanations with certain examples until I was sure that the children had the right meaning. In some cases I asked the children to paraphrase my term which was very helpful for the accuracy of the common meaning shared by both the researcher and the informants.

Except for a few cases amongst the British group , all the children were interviewed in the presence of their mothers, and in some cases in the presence of both parents. It was extremely difficult to ask these families to see their children individually. I had planned to meet children away from their parents, in order to get as I saw more free responses, however, after conducting the first interview, I discovered that interviewing children with their family members had several advantages. One was that the presence of the mother provided more security to her children. Secondly that the availability of the mother enabled me to observe the interaction between both, child and his or her mother. This was sometimes necessary to understand the extent of the contradiction between the perception of the child and that of the mother about the same issues such as access to medicine and the extent of a child's participation during medical consultations.

Chapter Three

Reporting of the Results and Analysis of the Data

As explained earlier, two levels of semi-structured interview technique were constructed to elicit mothers' and children's perceptions about their GPs. A few, simple, direct questions were used to suit the intellectual level of the children, especially young ones. However, during the interview, it was noticed that children had commonly responded to the interview questions, following certain patterns. When children were questioned about their feelings and perceptions, or asked to explain something, they tended to show puzzlement followed by certain prompts such as 'umm', 'ugh' then a long silence until I provided them with a check list. At the end of the interview section of my fieldwork I was able to remember all the examples I used, to list along with each question. Examples of these prompts are as follows:

I asked: what do you do when you feel sick or ill?

a child: umm, ugh, I, I, I don't know?

I: Do you take any medicine, do you tell your Mum, do you call your doctor, do you call Dad at work?

Another question, how do you see your doctor? the same prompts followed by my suggestions; Do you see him or her as, kind, rigid, assertive, aggressive, tough, understanding, friendly? Finally a child would respond to one of my examples.

Doctor Should only Ask Mothers Questions

Children take for granted that a doctor should direct his/her questions to their mothers or their parents. As reported by a twelve year old boy 'doctors should ask

parents', when I asked why, he replied, 'I don't know'. It seemed that children take the doctor's action as self-evident; since when they were asked whether they became annoyed by doctors not asking them questions about their own health, they replied; 'No'. As if the doctor's behaviour was the right one, and that children should not even discuss it or ask questions about it.

However, when children are asked if they were able to give sufficient information to their GP, they replied positively. When it comes to the actual fact of expressing their experiences with a health ailment, children showed noticeable enthusiasm to prove their knowledge and ability to speak for themselves. However, it is interesting to explore what children meant by being able to give sufficient information if asked by the Gps.

Abdulla a ten year old Bahraini, who is suffering from mild chronical allergies; as reported by his mother those allergies often cause Bronchial asthma,. I asked him: If a doctor asks you about your case, what would you say? Then, the following conversation occurred.

Abdulla: I will say I have a cough.

Interviewer: Do you know that you have allergies which can create asthma?

Abdulla: No

I asked further: Do you know what are allergies or what is asthma?

Abdulla: No

I asked: Have you ever asked your Mum or your doctor about it?

Abdulla: No. The mother interrupted my questions, saying; He (child) doesn't go through this experience (allergies) very often, its very rare. That is why he does not know how to answer.

A close look at the mother's response may enable us to have more understanding about children's passivity. I mean that from the above conversation, and as constantly documented in this fieldwork, in some ways mothers are acting like professional lawyers, side by side with their children; and that children always rely on their mothers to speak and to answer for them. Children seem to feel that if they are unable to give answer(s) to any of the GP's questions, they often get someone to explain why they can not do so. Furthermore, this person who is usually the parent(s) is in a position to justify the child's passivity or/and lack of sufficient information. Even in some cases this person can be so defensive that they may provide acceptable excuses for the child's lack of expressions. As a result the child does not bother to find out more about his/her illness, in order to answer any questions related to his/her illness, since there is always a person close by who speaks for them. In this sense the child's account about their own health ailments can get usurped by that of the accompanying adult(s).

Further evidence which should be retained from the above case (Abdulla), is that it seemed as if children are not provided with information about their health ailments, perhaps, neither by their parents, nor by the health professional(s). It has been noticed during the interview that some children are not even familiar with simple names and meanings of certain health ailments such as, Asthma, throat infections, and allergies.

It is not Confirmed Yet

Even though children may be able to provide information about their health and illness; and even though the GPs may collect information from those children, doctors do not trust the information provided by those children, including the information provided by teenagers who are supposed to be able to communicate their health problems. Nor do they show those children that their information is valuable. However, it worth mentioning that this lack of trust is not always explicitly expressed by those Gps. It is rather, embodied within the GPs behaviour, and could be easily traced or deducted from the way those GPs act with children during the medical consultation.

Doctors often double check with the mothers of those children. This behaviour by the GPs is as if they are telling the children that this information provided by you is not confirmed yet. As reported by a mother of two twelve year old children, when she was asked if the doctor directs questions to her children about the presentation of symptoms and related health problems:

Yes, he asks them questions, may be, he might look to me for confirmation, but he tends to talk to the children. (Julie-British)

A similar response was expressed by Mariem a Bahraini grandmother, accompanying her ten year old, grand-daughter who was suffering from a throat infection, to the health clinic . When the granny was questioned about whether the GP asked her grand-daughter about her health ailment she replied:

Doctors should ask the mother, or the parents. Parents are more concerned with their children, they can notice any changes in their children's health status, a child can not feel. (Mariem-Bahrain)

I will give some further comments on Mariem's explanation at the end of this section.

Muna, a Bahraini mother also expressed a doctor's ignorance of her son's account of his illness.

Doctors often ask me. I give to the GP the history of my son's case. Doctors usually ask general question, 'what's the matter?' then it is the mother's responsibility to explain the case. Doctor don't communicate with children, unless I ask them to do so. [I asked what do you mean?], for example, my son is overweight, and when I ask the doctor to give him instruction, then a doctor directs his instruction to my son and says: *Yia Baba*, (my son) you must reduce your weight. Other than that, doctors initially, direct their questions and instructions to me. (Muna-Bahrain)

Another response in this regard (children's explanations are not enough) is presented by Amal who was reflecting on her experience with a doctor in a private clinic:

When a doctor directs questions to my children that contain highly medical terms, he looks at me [mother is highly educated]; and expects that I will understand, but he is talking to the children, isn't he? However, sometimes, he simplifies the questions to my children. But when he asks me questions, he expects me to answer all of his inquiries, even in more scientific ways. May be he thinks that I'm working in health field so that I should use complicated terms. (Amal-Bahrain)

These attitudes of the health professionals are also confirmed by Pantell and Stewart et al (1982). They stress that doctors interacted differently with parents and children; that although they gathered more information from children than from their parents they tend to direct more attention and more instructions to parents.

Looking at Mariem's explanation of her grand-daughter's inability to express herself, I think she meant that a child is usually unable to express her/himself clearly.

In her response, the statement that ‘a child can not feel’, might be confusing from a Western cultural perspective, but it is not unusual for an old lady like her to say this. There are two aspects to explain this . Firstly, the lady is an illiterate who I suppose collected her knowledge from the Islamic holistic perspective of the human body. That perspective considers the integration of three main aspects of the human being, body, mind, and spirit or soul. Based on that knowledge, illiterate and old people in Bahrain use body parts freely. For example, feelings can be mixed with physical ailments such as saying, ‘my heart is hurting me’ which means that I am emotionally hurt. So feelings and awareness can be used freely as mentioned above. Secondly, according to Islam, children under fourteen are not considered as mature human beings, responsible for themselves. This is illustrated by the belief that they should be free from religious punishment if they do something wrong due to their lack of awareness and intellectual maturity. This idea can be extended into the total social context. A child is therefore seen as not mature enough to express him/herself clearly. However, while the Islamic tradition clearly influences some sections of the population in this way; this is not the case for all groups. For example, those who are educated give greater consideration to the feelings and awareness of children. (As illustrated later).

Here we can see clearly the cross-cultural differences in the way people see and experience health and illness, the meaning of body’s parts and body’s sensation, and differences in the way people in different cultural groups; age group, education and socio-economic status refer to, and express their physical and emotional problems. This holistic vision of the human body can be traced in the Islamic explanation to the

integration between body, mind, and soul. Since most of the old people in Bahrain are illiterate their knowledge and perception are based on their religious beliefs.

Mum is a Gatekeeper

Children are not only distrusted by their physicians, they are also regarded as untrustworthy in a lot of health matters by their parents, especially in regard to taking their medicine. A mother stressed her distrust:

definitely I would monitor it,... You know I trust Katy, but I don't trust her brother [who is the same age as his sister]...I could say to her get the medicine, she would; but I suppose the 'mother caring'. (Julie)

Looking further at this statement, one should not focus on the negative side of that monitoring process. From the mother's point of view, giving medicine to children, is what everyone is expecting or wanting the mother to do for her sick child. The process of supervising medicine-given by mother then, is a multi-purpose task. Firstly, it reassures the domination of the mother. Secondly, it enables the mother to show her care and concern. Thirdly, it provides social and emotional support to the children (that they are not alone with their illness). Finally, it gives the mother self-satisfaction, that they feel that they are needed, wanted, and that they do their jobs and fulfil their family's roles well. More importantly, it is a guarantee from mothers that they are available in the time of crises. Again, this has to be understood within the wider context of the position of mothers in the society.

The notion of 'mother caring' has recently become the concern of a lot of social and health professionals. Especially with the increased beliefs that only 10% of the

total health episodes are brought to the professionals' attention. Whereas the rest of those health ailments are treated in the community within the private confines of the home, and women are the main providers of this treatment (Cunningham-Burley and Maclean, 1991).

The process of caring as mentioned earlier can even provide more satisfaction to the children, as well as their mothers. As shown from Prout and Christensen's study (1996), during illness, children become the main focus of their parents, which can be appreciated by the children, especially the process of receiving sweets and/or gifts during this period. Children then get more care and attention from adult members of the family during their illness. In this case illness is an opportunity to renew the family's bonds; at the same time it provides mutual satisfaction to both the mother and her child.

Children's Access to Medicine

Going back to the process of medicine-taking by children and to the children's access to the home remedies, which ranged from rubbing or massage for the back and stomach pain, to Paracetamol and Vitamins in case of moderate illness (Gerrits, Haaijer-Ruskamp and Hardon 1994). All mothers in this study admitted that children should not have free access to medicine. When Mariem (the grandmother) was asked about the possibility of allowing her grand-daughter to take her medicine by herself, she replied:

'No' [I said, but she is ten years old] no, but if we allow her she could, but we don't. We are afraid that she might take an overdose, then something would happen to her, we can't allow her to do that.
(Mariem)

This finding is in great contrast with that of Bush and some other researchers involved in studying children's behaviours towards medicine (Bush 1985 & Bush 1992) who stressed that school age children -without determining explicitly the age of those children- perceived themselves as having independence in the access and the use of medicine, especially for the common health ailments and in some cases they could even administer the medicine to the younger or other children within the family (Bush et al 1985 cited in Bush et al 1996).

Even with older children, parents, especially the mother, regularly check the process of medicine. A fourteen year old child reporting this process:

I usually tell my parents, then they tell me what to do. That was my Hayfever the medicine, I get Antihistamine, I know what I should do...I know the right amount in the pack...it's quite easy to do it. [in another part of this interview], Usually if I'm sick, they (parents) will come often to see me, then they tell when I need to, sometimes I just do it by myself with the Hayfever medicine, I have to do that by myself, if I forget my Mum can hear me sneezing, so she tells me to get it. Quite easy with the Hayfever. (Matthew)

Surprisingly, the above child has often referred to the presence of both parents in all of his interviews' answers. However, all children interviewed focused on the role of their mothers without any referral to their fathers' roles in this process of their illness, except for Matthew. One is wondering if this is related to a shift of role from a complete reliance on the mother, and the gradual declination of this role as the child's age and maturation increased.

Mothers tended to evaluate the health status of their children, use the home remedy they had, and wait. If the symptoms did not disappear, then they sought medical help. As explained by Gelder and Prout (1996), that some acute illnesses are dealt with at home usually by mothers within the 'lay arena, lay diagnosis and medication occurs in the management of such illnesses'. However, if the cases still persist, then these cases are taken into the professional health arena, perhaps, to seek stronger medication or some antibiotics (1996 p:95).

When mothers have doubts about certain medicine or if they think that a specific medicine is not good for their children, they either say 'No', or I don't think this is a good medicine, or/and they just make a judgment of their own. This behaviour of mothers is related to the game of power shift between the mother and practitioner. As a result of this shift of power, mothers do not always follow the instructions given by their Gps.

I think if I don't agree with it, I think I will say, I don't agree with that, I don't think I will take it off him...I have changed, maybe a couple of years, maybe, before the children were born, I wouldn't do that, but I think since the children were born I am much more assertive with him. I have been able to say, yes I believe, no I don't. Maybe it is different when it comes to my own health, like the time I took my husband...the doctor doesn't believe me...I can't convince him. While I think I could put myself over with the children, because I'm speaking for them.
(Julie)

Surprisingly, a mother then, gains more power and strength to accept or to reject certain medicine suggested by a GP. This power is gained by the need to protect children from harm, keeping in mind the side-effects, chemical components, and the different body's reactions of and to modern medicine. This example then proves my assumption that the power relation is not fixed, it is dynamic. More importantly, I

claim (in the literature review) earlier that this power depends on a person's position and the social status linked to this position.

From the above example, although this mother was able to fight and to speak for her children, she wasn't strong enough to speak for herself. One question to be considered is whether it is the universal function of protecting babies even practiced by animals, that provides the mother with power, or is it something else?

It is worth mentioning that a mothers' previous experience with a GP's treatment of her health ailments, can influence her perception and satisfaction with her family physician, as shall be seen at the end of this chapter.

As I have noted above, most of the health care activities are provided outside the health professional sector; as emphasised by Cunningham-Burley and Maclean (1991), and it is the mothers who are at the front line of primary health care. However, the mother's position of power is not witnessed in the process of deciding about the medicines recommended by the GPs. More importantly, mothers have power to make decisions in all the stages of children's sickness, starting by identification of the sick role, decision to use home remedy, duration of that treatment, use of alternative medicine, and the final decision to see the doctor, either a general practitioner, a pediatrician, or/and a private doctor. A mother of two teen-boys reporting her influence in these mentioned stages.

In deciding about her children's health ailments:

I suppose, it tends much more ,me, but my husband felt that I am more competent to make that discussion. I will decide about the seriousness of it actually. (Sarah-British)

When she was questioned about the medicine recommended by a GP:

I think prescribed medicines are much better than they used to be. That is the one you buy at the pharmacy, not necessarily suit what the child needs. For example, last Weekend our diabetic's child had a very bad throat infection, that is not anything I would bother the GP about unless, I it is serious. But he had a lot of pain. Then we went to buy sugar-free 'Lozenges'. You can't buy throat Lozenges that acceptable to children. While at least you know you can get antibiotic sugar-free [I asked her, you said, it was you who decided the seriousness of your child's health problem? and that you have decided it was not serious. I intended to see how she could do that]. Yes I decided it wasn't serious, acutely, I do have a medical book which we use, it is not some relying on doctor completely. I think I sincere it, would want to call a GP umm necessarily and that the book we got, a quite good home-book which gives you all the sorts of you know , looks at the symptoms, and would help you to work out things to do. (Sarah)

It Depends on the Doctor

Not all doctors are good, friendly, patient, and helpful. Mothers in this study were very concerned about the personal qualities of their GPs. These characteristics seemed to be as important as doctors' professional competencies. In some cases they seemed even more important than the treatment and medications recommended by those GPs.

A lot of mothers describe their doctors as good professionals, but said that they (doctors) lack interest, concern, and suitable communication; either with their children or with them (mother) personally.

A mother, who has an asthmatic son, reviewing her experience:

I have met so many doctors seeking treatment for my son, I have met some doctors who were very good and friendly. They made jokes to my son and talked to him, especially, when they wanted to physically examine him, you know to make him feel more relaxed. But some of them were so serious, overall the majority of doctors were serious. (Muna)

Both the general practitioners' professional characteristics and the personal qualities, e.g. sympathy, concern, and understanding can influence the patient's perception about his/her professional competencies as seen above. Doctors demographical factors, such as age are also believed to affect parents in this study; Younger GPs seemed to be seen as better than the older GPs. This was reported by a lot of adult informants who expressed their preference for younger GPs. Those informants were described as being more modern, and up-to-date in their training, and as having a higher ability to communicate with their clients. Generally, more preference was noticed for these GPs compared to their older colleagues. As reported in the following response:

It does depend on the doctor...younger person, from what I understand, a lot of training for Gps is changing, there is more input on interpersonal skills and communication skills, whereas, my doctor is about sixty, so he is an old generation doctor. Better the Devil you know... (Julie)

Moral Aspects of Doctor's Care

These young doctors were also believed and perceived by those informants as giving high consideration to their patients. They treated them as human beings rather than medical cases. General practitioners' manners in approaching children, especially the moral aspect of doctor care, was an important aspect in mothers and children's satisfaction. This can be clearly noticed from Zahra's experience.

It depends on the doctor, some doctors are good, they carefully examine my children; but some doctors are not bothered to even to examine the patients, they just listen to what you said, then write the prescription. The doctor should examine the blood and other things. For example when you go to Salmainya [the main public medical centre in Bahrain], you can get better treatment, they give more attention to patients. She added,

There are two doctors in this clinic [Sitra Health Centre] who are very good [I asked what do you mean?], I mean the moral aspect of the treatment; It is very important. For example, if I said to him [GP] I'm in a hurry, I have a small baby at home, and you know it is Ramadan [Muslim fasting month, which requires a lot of food preparations from the housewives]; then he allowed me to see him before my time of appointment. (Zahra-Bahrain)

Some Doctors Are Keen to Answer Your Questions

Not all doctors give enough space for their patients' inquiries. Doctors who provide answers to their patients' questions are perceived by the mothers interviewed as good, keen, kind, helpful, and concerned. Several mothers especially with the Bahraini informants, expressed their preference and admiration for those doctors who have the above personal qualities.

A graduated mother of two children reflecting on her own experience.

It depends on the doctor, some doctors are very helpful. They explain in detail to you about the case of your child; about the medicine, if it is suitable or not you know, you feel comfortable talking to that kind of doctors. However, some doctors are very passive they give you the prescription, then 'Bye Bye'. I like to know every thing about the case, to be able to understand. (Ameena-Bahrain)

The Children's Account of their General Practitioners

Most children in both societies positively perceive their general practitioners. Nevertheless, the doctors' positions sometimes increased children's fear and made them feel nervous. In the process of tracing the factors relevant to children's satisfaction with their GPs each of the children interviewed focused on certain aspects of doctors' characteristics. Children's responses ranged from personal to professional aspects of a GP. The following are some of those factors which were linked to children's positive perceptions, as well as children's nervousness:

I like doctors because they reduce the pain. (Daniel)

I just see a doctor as a doctor, however, I sometimes feel scared a little bit. (Ebay)

I feel nervous when I need to see my doctor. [I asked, why?], I don't know. (Emma)

I feel nervous and sometimes shy. (Ameer)

Yes I think the doctor is an authority, but I don't feel scared. Because he will not beat me like my teacher. (Ahmed)

My doctor is very sympathetic with me. He asks me questions, he asks me to be careful; and not to fall down, because that can affect my nose (the child just had nose operation). (Abdulla)

She (her GP) is cheerful, she cares about me, she gives me the right medicine. [I asked how do you know?], she answered: I think she does. (Victoria)

Not many of the children admitted that they feel nervous or scared, and that the doctor's position of authority were amongst the reasons for their silence. However, some children were more honest as they said to me:

'When I have to see my doctor I feel scared, I'm scared of injections. I don't like injections'. Again it was very difficult to determine the factors responsible for the children's fear and nervousness. To find these factors, I tried to list all the possible reasons for those feelings, and asked the children to select the factors related to them. Sometimes I wished I had a list of GPs characteristics attached to my interview questions. As noticed from the responses above, children do not know why they experience those feelings whenever they need to see their doctors.

Studies of doctor-patient relationship emphasise the power of the former and the weakness of the latter. Then, it is not only children who usually show passivity; according to Baggott (1994), patients are somewhat afraid of doctors (1994 p:38). Amongst the reasons mentioned by the above researcher are that patients are traditionally passive, and specifically in the UK, which could be due to the long history of charitable health care. Baggott's theory may have considerable explanatory value, yet a convincing theory of power must also be able to explain the universality of patients passivity including children's hesitation to express themselves during the medical consultation. Although children in the Bahraini society have shown more ability to explain and participate in the research interviews compared to British children, nevertheless, their roles were very limited as reported by their mothers as well as by themselves .

Female Prefer Female

Although the general practitioner's sex, was not an important issue in relation to the British informants including children; except in a few cases such as the case of a little girl who said to me that she preferred a female doctor because she felt that she would possibly treat her like her mother. Looking deeper to this response, one is wondering, is it related to the idea of division of labour, that females are often placed in the positions of caring? Is it one of the female's functions to maintain security and safety? If so being examined by a female doctor perhaps, would be more relaxing to the above girl.

In regard to the Bahraini informants, the factor of GP's sex was very clear. Being an Islamic and Arabic society, one should expect that kind of preference in relation to sex, that females informants preferred female doctors, even amongst children. In this society, men should not get physically in contact with women, however, according to the Islamic religion, this can be possible during treatment or in the case of an emergency. Nevertheless, culturally, it is believed that if it is optional, or if there is a chance to choose, a patient should ask for a doctor of the same sex.

When Fatima a ten year old female was asked which does she prefer male or female doctor,

she answered: I prefer a female doctor, [I asked, why?], I don't know?

However, mothers linked that to their experience, expressing that, in relation to female matters, such as Gynecological problems, a female doctor is better.

Amongst the findings there were few surprises. Perhaps the most surprising was that gender differences were very significant amongst the Bahraini child informants. Most of the mothers emphasized that girls were able to express themselves clearly and often show more confidence in relation to their GPs or their family physicians, compared to boys who were seen as passive, and that they were less able to communicate in formal settings.

Amal, a well educated, Bahraini informant, stressed that she didn't even attend the medical consultation with her daughter because she thought that her daughter had enough knowledge and confidence to explain herself clearly to her doctor, as well as, to understand information given by the doctor.

Doctor asks my children questions. My son is sixteen, my daughter is seventeen, but I feel my daughter has more initiative to answer doctor's questions than my son. Even she doesn't allow me to answer. Sometimes my son looks at me, as if he is waiting for me to say what he suppose to answer; but my daughter does not. (Amal-Bahrain)

Zahra, an illiterate mother accompanying Najat, her ten year old daughter, expressed a similar attitude.

My daughter does not feel shy to speak. She is very talkative and sociable (*Shaibeah*), however, my son is not, but when I brought him for the school check-up; he first was scared, after a while he acted normally. (Zahra, the above statement is edited)

However, this factor was not significant amongst the British informants. Most mothers reported that both sexes act with great similarity in relationships with their GPs.

The Contradiction between Mothers and Children's Points of View

Another interesting finding was that although some children saw themselves as active participants during the medical consultation, and that they said that their GPs answered all of their questions; mothers denied that their children even asked or argued about anything with their GPs. One should ask why is there that contradiction between the way children perceived their roles in that setting; and the mothers perception about them.

A mother talking about her son who has been interviewed: 'I know he (her son) said to you that he explains to his GP everything about his health by himself, but he doesn't'. (Rose-Britain)

Children's Passivity, Yes but!

Children are believed to be irresponsible, not trustworthy, shaky, and having no desire to talk. Those impressions are held by mothers as well as general practitioners. In searching for cultural explanations for the occurrence of these impressions, mothers provided me with the following: 'It is the way we socialized our children'.

One of the respondents offered the following:

It is our the way we live, if we from the beginning taught the children to express themselves and we give them the chance to do that, they would be more able to do it. If that happens, a child could take responsibility for himself, doesn't ask his mum for medicine, that he himself knows the right dosages, especially if he is nine years of age or above. She stresses that, This should be done at all levels, in the home, encouraged by parents and relatives; by the doctors. However, we taught them (children) to rely on their mothers. Now they don't care, but I don't like a child to be dependent. [I asked do your then teach you son to be independent?], Yes, but some children don't help you, some children are very active, talkative, and expressive; and some are shy. My son is shy, he doesn't help me, I wish he could have more self-confidence. (Ameena)

Another explanation was given by Muna, who was an educated mother with a Masters Degree in Health Sciences, "I think it is the training a child gets" [I asked, where and by whom?], then she replied: In the home, by us, the mothers, maybe, the whole society. I asked: Do you think it is related to mother's educational level? She answered: No I don't think so, as I said, everybody is responsible.

Child's Right to Speak

Regardless of the above mentioned expressions about children, all mothers with no exceptions, expressed a belief that the doctors should direct questions to their children, children's voices must be heard by those health professionals, and that it is

not acceptable to ignore their children's account; either intentionally or unintentionally. In both cultural settings, mothers fight for this right; they strongly emphasised the importance of this need (to consider a child's account) in relation to their satisfaction with doctors and perhaps, the whole health care system.

Some examples of those attempts from the mothers are as follows:

I feel doctors should consider a child account, they must make an effort to make the child feel that he is an important person. They should consider his general compliance and take them seriously they should put more emphasis on children, talking to them, inquiring about their feelings, and to direct more instructions to them. (informant from Bahrain)

Some mothers explained that they sometimes, move from GP to GP, looking for the one(once) who can provide the professional as well as personal concern about their children's illness. They are (doctors) an authority figure, so if they direct instructions to the children, children would feel responsible to follow them. (another Bahraini informant)

Muna explained to me how she noticed the differences between general practitioners in the public sector and those in the private sector.

In the public clinic some GPs make quick diagnosis about the child's complaints, and start to write their prescriptions; regardless of your explanations. That way, sometimes, I don't feel sure that they take what you said seriously. While, in the private, when I go to a private clinic, I feel the difference; they often consider a child feelings. For example, when I take my son with me, they give him sweets before the medical consultation. Now when I take my son (a nine years old) to a doctor, he (her son) asks me 'do they give sweets?'. Again, it depends on the doctor, some of them don't give attention either to the child or to the mother. (Muna)

It is worth mentioning that it is common in Bahrain, in most of the private clinics to give children some sweets immediately, as they enter the doctor's surgery. One suggestion, perhaps, to ensure a more relaxing atmosphere, as well as applying a

psychological method, namely, learning attitude by association of the reinforcement technique which helps a child to like this setting (doctor surgery), and may transfer his or her like to the doctor and other professional staff. One is wondering whether the process of reinforcement of child's attitudes is relevant to the process of consumers satisfaction mentioned earlier in Chapter Two. Although I am convinced that the word 'consumers' should not be used freely within health sectors, nevertheless, there are fears that this specific technique, though favorable to children might be linked to or it can encourage the idea of "Doctor-shopping behaviour" or 'supermarket model' discussed by Baggott (1994). In this case I think doctors are acting like business or commercial actors trying to sell their health professional skills. What I mean here, is that if the children or their parents are not satisfied with a particular GP, they would merely seek treatment elsewhere. Therefore, I suppose all efforts by GPs in the above system should be directed to these young users (sick children) in order to make them satisfied, as seen from the above child's reaction to the process of the sweet-giving.

Another mother stressing the need to consider a children's view point:

I prefer that a doctor asks the child, doing so, would reinforce a child's self-confidence. Then when a child gets used to expressing his/her point of view; he or she would be able to explain his problem more clearly. (Fatima-Bahrain)

Mothers' Overall Satisfaction

It seemed that mothers were more appreciative of the doctor's manner in handling their children's illnesses, however, the majority were not happy with the way the

doctor dealt with them, as mentioned earlier, that mother's personal experiences can affect her overall satisfaction. Mothers expressed dissatisfaction, either with the way doctors communicated with them during the consultation, or the way doctors dealt with their health problems, especially, psycho-somatic once. As the case of Julie who took her husband with her to convince her GP that she is not feeling well. Further remarks are expressed by Sarah who has experiences with GPs of both sex:

Generally, both are very good in relation to the children. They speak to the children very nicely, but they don't always tend to reflect that back to the parents. Well the man doesn't; he speaks rough with you, but nice to the children. However, the female GP is more approachable and behaves sensitively in relation to both of us to me and to the children. (Sarah-British)

Chapter Four

Discussion of the Final Thoughts

Children certainly have beliefs, attitudes, values, and behaviour toward their health ailments, toward the treatment they received, and about the way general practitioners handle their illness and diseases. As stressed by Almarsdottir and his colleagues these factors are formed by the surrounding culture. However, most children, especially the young ones (those in the mid-childhood, 6-12 years) showed great deal of resistance and passivity to express their attitudes, experiences, and beliefs, even though those children were encouraged, motivated, and reassured by the researcher

This passivity from children may help to understand why doctors generally, spend more time communicating with the parents of sick children rather than the children themselves; as reported by Pantell and Stewart (1982). I think that children's passivity in reflecting their own feelings, suffering, and compliance discourages doctors from asking further questions or from giving further explanations to those children. Certainly, this is not to free doctors and other authorities from the responsibility of underestimating the information provided by children and does not give them an excuse to ignore children's accounts. More importantly, this study suggests directing more attention to the wider process of socializing children either in their own home or in their educational institutions; this I think needs to be a framework for further investigations.

Comparing the Two Social Settings

This study has shown some similarities as well as some diversities between the Bahraini culture and the British one, in regard to the notions of health and illness amongst both the mothers and their children. This study has also shed some light on the perception and satisfaction of the above mothers and children in both societies.

As was expected, there were more similarities than differences between Bahraini and British children reflecting a lack of autonomy in the process of medicine-taking except with the presence of an adult monitoring that action, namely mothers.

This finding is commonly documented by almost all of the studies investigating children's perceptions and autonomy in the process of medicine-taking. Examples of studies which took place in nine of the European countries are: Gelder and Prout in UK, Wirsing in Germany, Botsis and Trakas in Athens, and Almarsdottir and Bush in the USA. However, the latter has not discussed children's autonomy in regard to the medicine-given, unlike Bush's previous account (in Trakas and Sanz ed. 1996), which strongly emphasises the active role of the children in this process.

However, freedom in medicine-taking can only be applied to certain chronical cases such as asthma and diabetic problems where the children were able to consume medicine on a regular basis without the supervision of their parents as reported by both children and their parents. Children interviewed showed no autonomy in the process of medicine taking except in the case of older children (10-15) who I suppose,

were trained gradually by their parents to get the right doses at the right time and intervals.

In the same regard, however, surprisingly, British children showed more familiarity with certain medicines usually taken for chronic health ailments, such as Antihistamine, and some pain killers; which indicates cultural factors. This perhaps, needs further investigation.

Some suggestions offered to explain this familiarity are that it could be due to long exposure to these medicines, that those names of medicines were given actually by some children who suffered or who have brothers or sisters suffering from chronic illness such as asthma or allergies. Another explanation could be related to the British health educational programmes which address that factor. According to the Bahraini health education in all schools, all children are educated in the dangers of taking medicine without knowing exactly what that medicine is for ; all children are advised to consult their parents before taking any of the home remedies mentioned earlier. Again further study should be done in order to test that finding.

Mothers' and Child's Opposition

As mentioned in Chapter Four, children and their mothers had different opinions about each other's roles in the process of illness and care-given. While mothers saw their children as passive and dependent, children perceived themselves as active and independent

A great similarity between the two social settings was noticed, except for the illiterate mothers (as will be seen below). Mothers were viewed by most children as the main care-giver and the decision-makers in all the sickness processes. However, a contradiction between mothers and children about the knowledge and usage of medicine was very obvious. Eventhough children see themselves as having some roles in their own illness such as they can decide if they feel well or ill, or that they are able to know and take medicine; their mothers seemed to ignore, deny, or do not realize that their children have a sense of responsibility about themselves. This contradiction has also been noticed in the study of Aramburuzabala et al (1996), 'Most parents in the three samples (the mentioned places in the following paragraphs) did not seem to realize that children perceive themselves as decision makers and active participants in this process (the process of treatment), (1996 p:164).

One suggested explanation for this is perhaps, and as explained earlier by one of the mothers interviewed, that mothers have an internal motive to feel that they are the main care-givers and that their children are always in need of their attention and care, which psychology can consider as a self-satisfaction to mothers. However, some Bahraini children as reported by their mothers, especially, illiterate ones, just need to be reminded of their (children) medication by their mothers who then leave it to them to take it.

However, not all mothers denied their children's autonomy in the above process (medicine-taking). This was generally, the case of some illiterate mothers in the Bahraini group, as noticed from the field notes, and from the tone of interaction

typed; this could be because those mothers lack confidence in knowing the right doses, and remembering the right time(s) for the children's medicine. Therefore, and as a result of this, the children felt more competent to use their medicines. An important question can be raised in relation to this matter. Is it the level of mother's education which is responsible for the children's lack of confidence and the other way-round; or is it something else? As I suggested earlier, further study needs to be addressed to this interesting finding.

As with medicine use and participation during consultation children's self-caring is perceived differently by both the children and their mothers. In the case of minor injuries as discussed by Green and Bird (1986) and Iannotti (1990) the recent study shows that children and mothers have different perceptions about children's self-caring. This means that while some children perceived themselves as independent in self-caring and claimed that they have some degrees of autonomy, their mothers rejected that independence; instead they strongly stressed child-reliance and dependence. Again this kind of contradiction between the mothers and children should not be taken as self-evidence. Future research should address this contradiction in order to elicit greater understanding and more explanations.

In relation to the child's health and medicine giving in the Bahraini society, it is worth mentioning the new life-style (the sudden wealth), which involves the Asian house-maid in all the family's activities; including the children's illness, medicine-given. However, surprisingly, none of the children mentioned anything about the

involvement of the house-maid. This means, that during a child's illness the mother feels responsible for her child's well-being.

Regarding the question related to who decided about visiting a GP, and about the seriousness of an illness, a majority of children and mothers admit that it is the mother who decides on these two factors,. However, according to Iannotti and Kapor's (1996) study of pre-school and school children into who decides what should be done in the case of illness, some differences are shown which were related to the factor of age; that 'the older the children, the less influence the mother has in deciding which medicine should be taken.

The Role of the Social Network

One of the major differences noticed between the two cultural settings, was the availability of the grandparents in all the stages of a child's illness. This started early in the first stage of deciding to see a doctor until the final stage when that child is fully recovered and he or she can return to normal activities, either going to school or joining the play activities with other brothers and sisters.

A similar finding is also reported by Aramburuzabala et al (1996) in their comparative study in the treatment of childhood illness in Madrid, Tenerife, and Chapel Hill. Their study indicates that more grandparents and other relatives were involved in the process of decision-making of child's illness amongst Spanish than other studied groups. They related this to the role of the extended family, as well as the influence of the family social support network. A great similarity can be addressed

to the role of grand-parents with the Bahraini informants; adding that most mothers are working these days.

A final point to mention here, is that regardless of the above contradiction, it seemed from the responses of the children and the mothers interviewed, that both groups of informants enjoyed participating and being interviewed in an academic work. It was the first time anybody had considered their perceptions, feelings, and experiences about and with their general practitioners. Informants, specifically, children seemed so involved in expressing their point of views even with the shortcoming of the results as mentioned earlier. Some of those children were very serious in the process of answering the interviews' questions.

In summary, a prospective and multi-disciplinary study is urgently needed to investigate the role of the socialization process in the children's passivity. Perhaps, a new educational programme needs to be introduced to the teaching curriculum in order to orient our children to have a more active role in the process of decision-making.

Chapter Five

Some other Related Findings and the Conclusion

Some other interesting findings which I would like the reader(s) of my work to share with me, are that men seem to feel annoyed by me omitting them from my account about their GPs, their roles in handling their children's illness, and my appearing to ignore their role in the context of health and illness within the household. My justification was that I was focusing on the children's account of their illnesses and their perception about the Gps; I also stressed the importance of interviewing mothers along with the children. All of that, however, didn't satisfy men. On two occasions men insisted on being interviewed and that their voices must be heard; I therefore did interview them and recorded their view points.

In order not to miss the information provided by them, I tended to project their opinions as an adult's account of health services, their perception of their Gps, and their experiences with their children's illness, and the overall perception about their own children in relation to health and illness. It is worth mentioning that although their account is presented in this section, it wasn't considered as part of the main analysis of this fieldwork.

One of the men I dealt with was very keen to listen to every member of his family answering my questions, and sometimes he showed interest in interpreting my questions to his wife and children. It seemed to me that he was trying to help and that he felt very involved with my research. He also suggested providing me with a number of his friends addresses and telephone numbers.

Surprisingly, when he was asked if he trusted his children to have their medicine alone, he answered: Yes, [mother in the background, 'now only'] 'when they were younger, no' (Betty British mother).

When he was asked about his over all point of view about his GP.

Doctors are very professional, very cold, competent, he knows his limitations, [he refers to his GP]...he is very black or white, I don't see him as friend. While he is talking to you, he turns away, starts typing on his computer, by the time you finish telling him what's wrong. (Paul)

In regard to his view about his children's actions at the time of surgery, or medical consultation about his children, he responded:

'...if it is me, and that I don't understand something I would ask again. I don't think children have got that sort of confidence.' (Paul)

Time and Nursing Team

Time, either waiting time or visiting time, was amongst the factors that did not show a strong relation in regard to patient's satisfaction, except for a few cases. One of the mothers expressing her view:

What is annoying with Gps is opening time, which is simply not helpful for someone who is working, or to children. If a child to see a doctor, or if I'm to see a doctor, they have to take time off school. The doctors only operating during school time, to his convenience, I suppose...you know we have got one of our children has Asthma and allergies, it is not a reason to take time off work or school. (Saraha)

Although I did not include nursing staff or other health professionals as part of my investigation into patient's satisfaction, one of the mothers strongly stressed that

nursing staff should be considered when a full picture of health care services is to be studied. She expresses that as follows:

I don't think anybody has thought about doing some training with the nurses, to make them reassure the patients, helpful, friendly. They treat people in a very off hand, and very hostile sometimes way. My husband felt that more then I do. I think they could do a lot in training. They dealt with people, just people who need to be helped. [I asked: do you think it is related to work pressure?], it's habits, they are in of being like that with people...on private health care as well as the National Health Care the differences are fairly marked. (Sarah)

Conclusion

The major purpose for undertaking this study was to explore and concentrate upon the children and their mothers' perceptions and satisfaction with their general practitioners, and sought to show how any understanding and evaluation of health care benefit is impossible without a consideration of this relationship and to the context of the relation which takes place between the doctors and their patients. This main aim was achieved by the in-depth interview as the main methodological tool. Indirect observation was also a very helpful instrument used to collect further information; especially these related to children.

This study to an extent, I believe has successfully illustrated some of the similarities as well as diversities between the two main social settings selected in this fieldwork. Among the similarities, the children's lack of autonomy in the process of medicine-taking. Most importantly, the apparent contradiction between the way children perceived themselves as active actors and the way they were perceived by their mothers. I suggest further investigation should be directed to this important aspect of the mother-child relationship.

Certain aspects of mothers' and children's perception and satisfaction with their practitioners' characteristics in the process of child sickness were highlighted, such as the importance of the moral aspect of care e.g. sympathy, concern, and effective communication with children.

Generally, substantial numbers of informants in both societies felt satisfied with their practitioners' professional competence. However, the British group seems more satisfied with the way doctors handle and approach their children but were

dissatisfied with the ways those doctors either dealt with them or handled their personal complaints. In regard to the Bahraini group, it seems mothers were more concerned with doctors' personal characteristics, such as giving certain consideration e.g. listening with sympathy, giving time for questions, and showing more involvement with both the mothers and their children.

In the future I would wish to focus on the factors responsible for children's passivity especially those related to the socialization process. Through the application of other methods, perhaps, to invent new affective ones to study children in a more relaxing atmosphere, in order to explore this group view point with the least resistance from them.

References

- Almarsdottir, A. and Aramburuzabala, P. et al. (1996) Children's Perceived Benefit of Medicine in Chapel Hill, Madrid, and Tenerife in Children, Medicine, and Culture USA: Pharmaceutical Products Press.
- Armstrong, D. (1987) Bodies of Knowledge: Foucault and the problem of human anatomy. In Scambler, G., (ed.) Sociological Theory and Medical Sociology. London: Tavistock.
- Armstrong, D. (1982) The doctor-patient relationship: 1930-80. In Wright, P. and Treacher, A Lupton, D. (1994), (ed.) Medicine as Culture: Illness, disease, and the body in Western societies London: Sage.
- Baggott, R. (1994) Health and Health Care in Britain Great Britain: Mackays of Chatham PLC.
- Bandura, A. (1986) Social Foundations of Thought and Action: A social cognitive theory Englewood Cliffs, NJ: Prentice-Hall.
- Bush, P. and Trakas, D. et al (1996) Children, Medicine, and Culture USA: Pharmaceutical Products Press.
- Bush, P., Iannotti, R. & Davidson, F. (1985) A Longitudinal study of children and medicine, in Topics in Pharmaceutical Sciences, Breimer, Speiser & Elsevier (ed.) pp 391-403.

Bush, P. & Iannotti, R (1992) The socialization of children into medicine use, Studying Childhood and Medicine Use Trakas & Sanz (ed.) Athens: ZHTA Medical Publication.

Clark, J. and Mishler, E. (1992) Attending to Patients' Stories: Reframing the clinical task Sociology of Health and Illness vol 14 no 3 pp 344-372

Clarke, A. and Hewison, J (1991) Whether or not to consult a general practitioner: decision making by parents in a multi-ethnic inner-city area, in Wyke, S. and Hewison, J. (ed) Child Health Matters Great Britain: Open University Press.

Cuebaly, N. and Toews, J. at el (1983) On Evaluating Patient Satisfaction Methodological Issues Can. J. Psychiatry vol 28 pp 24-29

Cunningham-Burley, S. and Maclean, U (1991) Dealing with children's illness: mothers' dilemmas, in Wyke, S. and Hewison, J. (ed.) Child Health Matters Great Britain: Open University Press.

Elston, M.A. (1991) The politics of professional power: medicine in a changing health service in Jonathan, G. and Calnan, M. and Bury, M. (ed.) The Sociology of Health Service London: Routledge.

Fisher, S. (1991) A discourse of the social: medical talk/oppositional? Discourse and Society, 2 (2), 157-82. in Lupton, D. (ed.), (1994) Medicine as Culture: Illness, disease, and the body in Western societies London: Sage.

Frankenberg, R.(1990) Disease, literature and the body in the era of AIDS-a preliminary exploration. Sociology of Health and Illness Vol 12 No 3 pp 351-360

Foucault, M. (1973) The Birth of the Clinic: An archaeology of medical perception USA: Tavistock Publications.

Gallagher, E. B. (1976) Lines of reconstruction and extension in the Parsonian sociology of illness. Social Science and Medicine, 10, 207-18 in Lupton, D. (1994), (ed.), (1994) Medicine as Culture: Illness, disease, and the body in Western societies London: Sage.

Gelder, L and Prout, A (1996) The Danish participation in the COMAC medicines and childhood project in Trakas, D. J. and Sanz, E. (ed.) Childhood and Medicine Use in a Cross-Cultural Perspective: A European concerted action Luxembourg: Office for Official Publications of the European Communities.

Green, K. and Bird, J (1986) The structure of children's beliefs about health and illness Journal of School Health 56 pp 325-328

Hall, J. and Dornan, M. (1990) Patient Sociodemographic characteristics as predictors of satisfaction with medical care: A meta-analysis Social Sciences and Medicine vol 30 No 7 pp 811-818

Ham, C. (1992) Health Policy in Britain: The politics and organisation of the national health service 3rd edn. London: Macmillan Press Ltd.

Iannotti, R. and Kapor, N. (1996) Children's Perspectives on Illness and Medicines: Yugoslavia in Children, Medicine, and Culture USA: Pharmaceutical Products Press.

Iannotti, R. et al (1990) Understanding and response to minor injury and illness among pre-adolescents Presented Conference on Human Development, Richmond.

Iannotti, R. and O'Brien, R. (1993) A cognitive-developmental approach to children's and parent's understanding of AIDS, Presented Annual Meeting Society for Research in Child Development, New Orleans.

Inhelder, b. and Piaget, J. (1958) The Growth of Logical Thinking from Childhood to Adolescence New York: Basic Books.

James, A. and Prout, A. (1990) Constructing and Reconstructing Chidhood: Contemporary issues in the sociological study of childhood U.K & USA: The Falmer Press.

Kristjansdottir, G (1995) Perceived importance of needs expressed by parents of hospitalized 2-year-olds to 6-year-olds Scandinavian Journal of Caring Sciences Vo 19 No 2 pp95-103

Lawernce, S . at el (1984) Consumer values and subsequent satisfaction ratings of physician behavior Medical Care Vol 22 No 9 pp804-813.

Ley, P. Communicating with Patients: Improving communication, satisfaction and compliance London: Chapman & Hall.

Lupton, D. (1994) Medicine as Culture: Illness, disease, and the body in Western societies London: Sage.

MacCarthy, D. (1974) Communication between children and doctors Developmental Medicine and Children Neurology Vol 16 p:279

Mazzullo, J., Lasagna, L. & Griner, P (1974) Variations in interpretation of prescription instructions Journal of the American Medical Association Vol 227 pp 929-931

Maiman, L., Becker, M. & Katlic, A. (1985) How mothers treat their children's physical symptoms Journal of Community Health Vol 10 pp 136-155

Maiman, L., Becker, M. & Katlic, A. (1986) Correlations of mothers' use of medications for their children Social Sciences and Medicine Vol 22 pp 41-51

Mayall, B (1996) Access to Health Maintenance: Intergenerational issues in children's daily lives, in Trakas, D. J. and Sanz, E. (ed) Children and Medicine Use in a Cross-Cultural Perspective: A European concerted action Luxembourg: Office for Official Publications of the European Communities.

Mishler, E. (1984) The Discourse of Medicine: Dialectics of medical interviews Norwood: Ablex.

Monks, J (1995) Life stories and sickness experience: A performance perspective Culture, Medicine and Psychiatry Vol 19 pp 453-478

Pantell, R. and Stewart, T. and Dias, J. (1982) Physician Communication with Children and Parents Pediatrics vol 70 No 3 pp:396-402

Porter, R. (1985) Introduction. In Porter, R. (ed.) Patients and Practitioners: Lay perceptions of medicine in pre-industrial society Cambridge: Cambridge University Press.

Prout, A and Christensen, P. (1996) Hierarchies, boundaries, and symbols: Medicine use and the culture performance of childhood sickness, in Bush, P. and Trakas, D. et al (ed.) Children, Medicine, and Culture USA: Pharmaceutical Products Press.

Rabinow, P. (1984) The Foucault Reader: An introduction to Foucault's thought England: Penguin Group.

Robinson, D. (1973) Patients Practitioners & Medical Care: Aspect of Medical Sociology London: William Heinemann Medical Book LTD.

Silverman, D. (1987) Communication and Medical Practice: Social relations in the clinic Great Britain: Sage.

Sloper, P. and Turner, S. (1993) Determinants of parental satisfaction with disclosure of disability Developmental Medicine and Children Neurology Vol 35 No 9 pp 816-825

Smart, B. (1985) Michel Foucault. London: Ellis Horwood.

Spelman, L. (1965) Communication in an out-patient setting British Journal of Social and Clinical Psychology Vol 4 :114

Stevens, R. (1986) The future of medical profession, in Ginsberg, E. (ed) Physicians Shortage to Patient Shortage: The uncertain of the future of medical practice Boulder: Westview. pp 75-93.

Stewart, M. and Roter, D. (1989) Communicating with Medical Patients USA: Sage.

Stimson, G. and Webb, B. (1975) Going to See the Doctor: The consultation process in general practice London & Boston: Routledge & Kegan Paul.

Strong & Davis (1972) chapter III p: 38. In Stimson and Webb (1975), (ed.) Going to See the Doctor: The consultation process in general practice London & Boston: Routledge & Kegan Paul.

Trakas, D. and Sanz, E. (1992) Studying Childhood and Medicine Use: A multidisciplinary approach Athens: ZHTA.

Trakas, D. J. and Sanz, E. (1996) Childhood and Medicine Use in a Cross-Cultural Perspective: A European concerted action Luxembourg: Office for Official Publications of the European Communities.

Valassi-Adam, E. (1996) Implications for the Health Care Provider: View point of a Pediatrician, in Bush, P. and Trakas, D. et al (ed.) Children, Medicine, and Culture USA: Pharmaceutical Products Press.

Weston, W. and Brown, J. (1989) The importance of patients' beliefs, in Stewart, M. and Roter, D. (ed.) Communicating with Medical Patients USA: Sage.

Wirsing, R. and Trakas, D. (1996) Cross-cultural comparative research: A discourse on using qualitative and quantitative methodologies, in Bush, P. and Trakas, D. et al (ed.) Children, Medicine, and Culture USA: Pharmaceutical Products Press.

Wissow, L. and Roter, D. and Wilson, M. (1994) Pediatrician Interview style and mothers disclosure of psychosocial issues***

Wyke, S. and Hewison, J. (1991) Child Health Matters Great Britain: Open University Press.

Zastowny, D., Roghmann, P & Hengst, A. (1983) Satisfaction with medical care: Replications and theoretic reevaluation Medical Care Vol XXI No 3 pp294-322.

Zborowski, M (1952) Cultural components in response to pain Journal of Social Issues Vol 8 pp 16-30

Zola, I (1973) Pathways to the doctor-From person to patient Social Science and Medicine Vol 7 pp 677-689

Appendix 1

Interview Questions

Parent(s) Questions

- 1-What do you think are the main problem(s) that requires the attention of a G.P?
- 2-Do you discuss the problem with your child before taking him/her to a G.P?
- 3- Who makes the decision about visiting a G.P?

At the clinic

What do you think about the following factors:

Waiting time

Atmosphere/surrounding

In the G.P's room

- 1- Are you concerned about the G.P's sex? if yes why ?
- 2- How do you see his/her abilities to-communicate -level of language used
 - level of information
 - understanding
 - sympathy
 - concern
- 3 -What is your overall idea about your G.P?

In G.P's room with your child

- 1- Who does a G.P ask first about your child's problem?
- 2-Does he/she ask your child direct questions about his/her complaints?
- 3-Does a G.P ask you about the reasons for your child's problem and does the G.P explain why your child gets it?
- 4-Do you notice any differences between male and female G.P's in response to child complaints?
- 5-Do children pay attention to the G.P during the meeting?
- 6-Does a G.P explain the treatment process to you or to your child? why?

Overall comments

- 1-Do you notice any differences between boys and girls reaction to G.P questions?
- 2- Do G.P ask about aspects other than physical problems?(birth order of your child, conflict at home-school, psychological background...etc.)
- 3- How do see your G.P's personality?
- 4- Are you satisfied with the way the G.P handles your child's complaints?
- 5- Do you recommend or suggest any sort of improvement at any level ?specify
- 6- Do you allow your child to take his/her medication by him/herself? why?

Child Questions

- 1-What do you do when you don't feel well?

- 2-Do you try to get any medications to relieve your pain?
- 3- Does a G.P ask you first about your problem or asks your parent(s)? and why do you think and feel about that?
- 4- How do you see a G.P? (do you see him/her as an authority? why?
- 5- Do you feel scared when a G.P asks you questions? why?
- 6-Do you understand what a G.P's saying about your problems? if not, why?
- 7-How do you feel about your G.P?
- 8- Do you mind if your G.P's male or female/why?
- 9- What do you prefer? why?
- 10- Does the G.P explain to you about when and how to have your treatment?
- 11- How do you feel about that?

Appendix 2

March 15, 1996

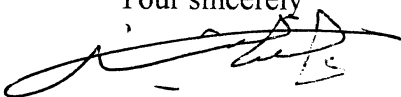
Dear family

My name is Aysha Al-Shaikh, I am an MSc student at Keele University, Department of Sociology & Social Anthropology. For the purpose of completing a dissertation for the MSc course in Medical Social Anthropology, I have been asked to carry out fieldwork in the health sector or/and in community settings (your help in this research is very much appreciated). My research focus is in the communication between doctor and patient with a particular emphasis on the perception of children and mothers about their general practitioner.

I would like to carry out interviews with families, having children age between 8-14, the interview will not exceed (an hour). Complete confidentiality of data will be guaranteed. If you fit the above sample group and willing to participate in the research, would you please contact me on the telephone numbers or address below.

Thanking you in advance for your assistance in this matter.

Your sincerely



Aysha Al-Shaikh

427 The Oaks B

Keele University

ST5 5JD

Tel: 01782-719121

Mobile: 0385-750-896