

PATIENTS' AWARENESS OF THEIR RIGHTS IN RELATION TO
HEALTH CARE

BY

CHRISTINE CHISENGANTAMBU

DEDICATION
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This study is dedicated to my beloved parents

Mr. R. Chisengantambu and Mrs. J. Chisengantambu

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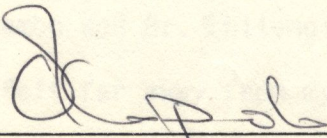
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APPROVED BY:



SUPERVISING LECTURER



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DEDICATION

This study is dedicated to my beloved parents
Mr. R. Chisengantambu and Mrs. J. Chisengantambu
for their unfailing love, prayers and support
throughout my two years of study.

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(v)

DECLARATION

I hereby declare that the work presented in this study for the diploma in Nursing Education has not been presented either wholly or in part for any other Diploma and is not being currently submitted for any other Diploma.

SIGNED BY:

Abu
CANDIDATE

STUDY APPROVED BY:

[Signature]
SUPERVISING LECTURER

ABSTRACT

This study was conducted at the University Teaching Hospital in Lusaka, Zambia. the aim of the study was to assess whether patients are aware of their rights and whether this awareness does influence the type of health care given to patients.

Literature reviewed from other countries had shown that patients who are not aware of their rights are excluded from participating in their own care and as a result patients are maltreated and dehumanised. Literature also revealed the rights patients are supposed to be aware of and how lack of such awareness contributes to maltreatment and dehumanisation of clients by health professionals.

The study was descriptive in nature. Data were collected in December 1985 from fifty(50) respondents who had been purposively selected from those admitted to UTH in medical and surgical, male and female wards. Subjects selected had stayed in the ward for 48 hours or more and were not below the age of 15 years.

The instrument used for data collection was a self devised interview schedule. It was chosen as the most appropriate tool for collecting data from subjects with diversified educational background and tribes, since the country as a whole has a high rate of semi-literate and illiterate nationals. Data collected were analysed manually.

Findings of the study revealed that patients are not given enough information concerning different procedures and treatment which they are subjected to. The patients' accounts of their experiences in hospital as revealed by the study are similar to those encountered by

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patients in other countries. Factors identified which prove patients' ignorance of their health rights are for instance that patients do not seek for information related to their care. Among the 68% respondents who had no information regarding procedures and treatments, only 8% sought for this information. Therefore since patients do not seek for information, this contributes in most cases to patients being excluded from participating in their own care. The study further revealed that 58% of the respondent, when asked what they would do if an injury was caused on them by health personnel due to carelessness, will not take any legal action against the health personnel. However, even those who were aware of their rights (36%), the study revealed that none of these respondents had taken legal action against the health personnel in situations where they could have done so. In addition, the study revealed that 2% of the respondents would ask for treatment if they had an injury caused by health professionals while 4% of the respondents would complain to higher authority with no implications of taking legal action.

As a result of the findings in the study, the investigator has recommended that health administrators and educators encourage the implementation of the use of the problem solving process in the wards so as to encourage patients to participate in their own care. Another recommendation made for health authorities was that they encourage health personnel to research into problems associated with patients' awareness of their rights and how lack of this awareness contributes to the decline in the standards of health care delivery.

The hypothesis which stated that, "patients' lack of awareness of their rights to be treated with respect and dignity leads to maltreatment and dehumanisation", was supported.

Furthermore, the assumption which stated that patients' lack of awareness of their rights while in hospital contributes to patients' poor satisfaction with the care they receive was also supported. The other hypothesis and assumptions were however not supported.

As information obtained makes the study important to health professionals, suggested readings are indicated in the bibliography. It is hoped that the findings will provide the health professionals with an insight into the inadequacies of the present health care delivery so as to identify ways of improving the poor and substandard care that results from patients' lack of awareness about their rights. The results also reveal that due to societal changes, patients are becoming aware of their rights so that the health professionals will no longer hide behind public ignorance in case of negligence and other inadequacies.

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CHAPTER I

INTRODUCTION AND OPERATIONAL DEFINITIONS

INTRODUCTION

Patients lack of awareness of their rights to health care is a situation that has been and which is still existing in many of the health institutions in the country. Many patients nursed in various health institutions are ignorant and unaware of their health rights. Awareness of the patients right is just a root which is springing up now due to educational and technological developments in the country.

Ganong and Ganong (1980) state that changes in the medical profession occurring over the last two decades are significant features of external environment. These changes ultimately affect each medical practitioner in every type of medical setting. As a result credentialing has become a topic for investigation and not only within the medical profession but also by groups outside the profession due to public accountability and social protection. The public wants to know whether the multiple, elaborate, inconsistent and expensive mechanism in credentialing does protect the public.

Lack of awareness of patients rights can contribute to patients receiving poor health care. In many cases a patient who is ignorant of his rights is usually abused, maltreated and dehumanised (Servellen, 1983). This is because the patient in most cases is unaware that the health professionals must treat him/her as an individual with respect and dignity irrespective of the nature of the health problem he has (Tate, 1977). However, since the patient is unaware of his medical rights he is not respected by the health professionals.

It has been observed that the patients who ask any member of the health team in relation to his treatment or what the doctor said during rounds is usually commanded not to act as a boss. Later on the patient is labelled as a "trouble-some patient".

Many times because the patient is unaware of the right to having proper explanation concerning the measure of treatment, ends up getting treatment which he could otherwise not consent to. For example a patient can be wheeled to a procedure room for a procedure like lumbar puncture or liver biopsy without the knowledge of what is exactly happening to him. He is merely told to "sign here". It has been observed that the patient will interpret the procedure as an operation which would cause the patient to refuse to consent to the real measure of treatment should the need arise.

Tate (1977) relates a story where a patient who had cancer of the ovary and was not told the real diagnosis received treatment for tuberculosis instead of cytotoxic drugs because it was feared that the patient will know the truth even though the patient has the right to know his diagnosis no matter how dreadful it is. Knowledge of the real diagnosis helps the patient to understand his situation and make proper arrangements pertaining to his life. This is especially true when the patient knows he would not live for a long time.

Patients lack of awareness of their rights has contributed to the patients' being neglected. Tate (1977), relates a case caused by doctors negligence which resulted in the death of the baby and total hysterectomy for the patient. A patient admitted to a maternity ward who has had five (5) previous abortions due to cervical incompetence had a shirodikor stich at sixteen weeks.

During her fifty pregnancy, the patient was admitted with labour pains at thirty two weeks, however, the doctors did not remove the shirodikor stich even when he was fully aware of the patient's condition. Labour continued to progress, as a result, the patient had a longitudinal tear from the cervix to the fundus of the uterus making it impossible to preserve the uterus but to have a total hysterectomy done. If the patient was aware of her rights, she was going to sue the hospital or the doctor for negligence.

Patients' lack of awareness of their rights contributes to the giving of improper explanation and it hinders the patient from participating in their own care. The patient who has the right to participate in his own care is usually excluded from doing so when it comes to practical terms (Long, 1980). since patients are not aware of their rights, the medical professionals tend to develop nonverbal cues which hinder the patients' involvement and participation in his own care. The medical professionals by their own nonverbal actions tell the patient indirectly to have no ties for interpersonal relationships with the patient. They display the message that, " I am only here to give you medication, check the intervenous fluids, administer treatment, teach you breathing etc" (Servellen, 1983). The patient is not awakened to the fact that he is entitled to have a say in his health care and treatment.

There is difference between patients in developed countries and those in developing countries like Zambia. Most patients in developed countries know their rights and they know exactly what is expected of the doctor, nurse and other medical personnel. This knowledge and awareness makes a new trend in the delivery of health care services because the health care is delivered with all concern and precautions as the medical personnel

are fully aware that they are held responsible for any poor health care. This clearly indicates the differences there are with the medical personnel in developing countries where patients are ignorant and are not aware of their rights. Patients in developing countries view the medical services offered to them by the government as a view the medical services offered to them by the government as a privilege and not a right since health care means different things to different people (Hafford, 1976).

With this kind of perception, the patient accepts the medical and nursing care without questioning because the patients thinks he does not deserve the care. Because of this, medical professionals look at this ignorance and lack of awareness as a blinding fold to giving poor health care. As a result the medical professionals develop an "I don't care attitude," and they are less concerned with what happens to the patients. The patients therefore are not given the care they are entitled to while in hospital. Lanora (1976) states that the medical care given most times is dehumanising. As a result there are many reports^{of} increasing depersonalization in hospitals and other agencies from recipients of health care both in hospitals and the community because the health care given does not satisfy the deep needs of people for care, security understanding recognition, comfort and care. The health care however must be rooted in the need of humanity founded on the ideal professional health services. One can ask whether the medical professionals can grasp the opportunity to rehumanise patient care.

Patients lack of awareness about their rights can contribute to the decline of good health care. Patients' awareness of their rights is therefore a key to maintenance of humane individualistic concern for people and their health problems.

In recent years, it has been observed that patients are becoming aware of their rights. Yura and Walsh (1973) state that awareness in technology, computer and changes in education have had an overwhelming impact on the forward momentum of advances and changes in the society which have made the public to be more knowledgeable and wanting to learn more about their individual health, illness and rights thus presenting new challenges to the health professionals so as to create new appearances to health care and thereby emphasizing the need for preventive medicine as well as health care during hospitalization. A clear indication of this is demonstrated in Sunday Times (1985), where the public is rejecting the idea of being treated by clinical officers. The article defends the point that a person's life is very important and for it to be entrusted in unexperienced hands is a crucial matter of life and death. Hence the rejection. This response from the public indicates the growth of awareness in relation to medical rights. Ganong and Ganong (1980) assert that the awareness of the public about their health rights has a great impact on the health care today because health consumers are more aware of what they should get and if wronged or neglected are often prepared to take legal actions against the medical professionals. Patients rights therefore constitute an important component of the health framework. Thus the health professionals must know how patients rights influence levels of practice and performance.

Awareness of health rights is in itself not a bad thing because a professional like medicine and nursing should not shelter behind public ignorance to remain free from legal penalties since this awareness instills a sense of professional duty towards the patient (Finch, 1980).

The significant change of people being aware of their rights can bring with it many changes and differences in health care standards since it has been observed that the present health care system does not meet all the needs of people and there is need for change (Fowkes, 1973). Patients awareness of their rights can contribute to bringing about this change and unless this does occur, the health care standards will continue to decline.

Medical services are a right to all patients and clients. But from the researcher's past experience, it has been observed that the rights and dignity of patients have been abused. The health personnel have taken it upon themselves to decide the care they give to different patients and withhold patients' information on their conditions, treatment and expected outcomes; where as it is a right for the patient to decide on their care, treatment and to have full information of the expected outcomes.

It has been thought necessary to assess the knowledge patients possess on their rights while seeking for health care services and how lack of such knowledge has contributed to poor health care in the field of health.

Barrent (1968), asserts that patients who are not aware of their rights do not receive the care they are entitled to. The health professionals do not view the patients as an important individual who should receive good health care regardless of his/her physical or mental condition, race, colour or creed. The patient does not know that the health professionals caring for him must show interest in him as a person and not as an example of a disease condition. Patients who are not aware of their health rights do not know that they must be respected, called and referred to by name as an individual and not by bed number.

Patients lack awareness of their rights contributes to patients being treated with no understanding of their personal feelings and views about the health care they are receiving and that they have a right to expect their treatment, health care and other health care activities to be given in a manner which must produce desired results, safe-guard him and cause him minimal discomfort.

Many times however, the health activities mentioned are forfeited by most of the health professionals in many of the health institutions in the country. These poor health standards can be attributed to many contributing factors of which one of the many factors can be patients' lack of awareness of their rights in relation to health care.

OPERATIONS DEFINITIONS

1. NURSE: A person who has completed a programme of basic health education and is qualified and authorised by the government to provide responsible and competent

professional service for promotion of health prevention of disease, the care of the sick and rehabilitation (Ganong and Ganong, 1980).

2. **PATIENT:** Is any person either well or sick who receives specialised changes in usual health process or who requires assistance in the maintenance of health or the management of illness, injury or infirmity.

3. **HEALTH CARE:**
The process of maintaining optimal functioning of the body with freedom from disease and abnormality as an objective description of returning to normal health conditions. It is descriptive persons or agencies devoted to others in maintenance or returning to normal health condition (Ganong and Ganong 1980). This includes medical and nursing care and the right to information.

4. **STANDARD OF CARE:**
Clearly defines measures of comfort, technique, clinical observations, perception, interpretation and judgements used in initiating medical actions and evaluating therapeutic results (Ganong and Ganong, 1980).

LAW: These are rules which are supported by the power of the government which governs the behaviour and professional standards of health personnel (Creighton, 1975).

RIGHT: Patients right to health care is when the patient has the right to obtain from the medical professionals complete current information concerning his diagnosis, investigation treatment nursing care and prognosis in terms of his health (Divincent, 1977)

CHAPTER II

STATEMENT OF THE PROBLEM

The major problem in the health services is poor substandard care given to patients and other health consumer as a result of ignorance on the side of the consumer as to what their rights and privileges are while seeking ^{for} health care.

Patients' rights to health care is when the patient has the right to obtain from medical professionals complete current information concerning his diagnosis, investigations, treatment, nursing and medical care and prognosis in terms of health (Divincent, 1977).

It has been observed that most patients in many of the hospitals in the country are not aware of their rights while in hospital. The patient does not know many times that he is entitled to know the type of treatment he is being given and how it works. In most cases, the patient is not aware about procedures being carried out on him. The patient does not know that he has the right to receive from the doctors, the nurses and other health professionals the necessary information before he can consent to any procedure and treatment and that he has the right to refuse treatment, nursing and medical care with the knowledge that he is personally responsible and accountable for the consequences of denied treatment, medical and nursing care (Divincent, 1977). Servellen (1983) states that patients' ignorance of their rights has contributed to the medical professionals ^{to have} "I don't care attitude", lazy on duty, lack of vigilance and lack of sense of caring for their patients.

The patient is mishandled and mistreated because the health professionals look at the state of ignorance as a blinding fold to giving improper health care. It has been thought necessary to assess patients' awareness of their rights and whether this contributes to better health care as patients will be able to participate in their own care and the right information, in relation to their health care, will not be denied of them when patients are aware of their rights.

When patients are not aware of their rights, they are usually excluded from participating in their own care which denies the modern concept of health care supported by Long (1980), that time has come for patients to participate in their own care.

Patients who are aware of their rights are to understand and identify their problems and participate intelligently in meeting their health needs. Patients awareness of their rights also helps the health professionals who are the care givers to see the importance of informing patients about their own conditions. Within such limits, the health professionals are motivated to be well abreast with knowledge and develop competence in different skills so as to give health consumers effective quality health care because the health professionals are aware that they are accountable for any poor health care they render to the patients. Alexander (1978), asserts that health professionals are motivated to undergo continuing education as a means of ensuring quality care due to societal pressure of accountability for the type of care delivered to health consumers.

Servellen (1983), states that patients who are unaware of their rights are usually maltreated and dehumanised. This contributes to patients seeking care from traditional healers where they are given consideration and sympathy that is often lacking among hospital staff. Nchanga (1977) asserts that the traditional practitioner not only treats and counsels using therapeutic practices of the people, but also speaks with authority using dialect idiom of the people. Thus to the people traditional medicine fulfills the four criteria of accessibility, availability, acceptability and dependability. This contributes to under utilization^{health services which attributes to high morbidity} and morbidity rates because clients seek traditional medicines first and are brought to the hospital in advanced stages of the disease. Narrow (1980) confirms under utilization of medical services being due to rural population distrust of conventional health services and the local culture.

Lack of awareness of patients' rights contributes to non-explanation of the health care measures being given. this contributes to patients refusing to consent to investigations that need to be carried out on them. Furthermore, this causes unnecessary prolonged stay in hospital because patients are not discharged in time making it expensive for the hospital to keep a patient who is undecided before he gives consent to receive the necessary measure of health care. The prolonged stay of one patient hinders the hospitalization of other patients who need medical care because the patient is occupying the bed. The patients themselves are psychologically affected resulting into depression since they are unable to continue with their normal social activities and functions.

It is of great importance that while the patient is in hospital he must be given complete information concerning his health care. The patient has the moral right to determine what will be done to him as a person and to be given the information which is necessary so as to make correct judgements. He must also be told of the possible side effects of either care or treatment since the patient has the right to accept, refuse or terminate the treatment (Tate 1977). This can only be achieved wholly by giving proper explanation to the patient. The patient must know what is happening to him before he can participate intelligently in his own care. Patients who do not know that they have a right to participate in their own care do not seek for information about their conditions, as a result they are unable to make correct judgement and decisions.

Patients' awareness of their rights will therefore contribute greatly to the way health care services are organised and delivered. This awareness will contribute to a significant difference both in the quality outcome and humanistic delivery of care (Servellen, 1973). It will also help the medical professionals to detach from apathy, lack of self respect and acquire a humble spirit. The health care given will therefore be aimed to remove patients' anxiety, fear, frustration and involve the patient in his own care. These factors if removed will instil confidence and a sense of belonging thus creating an atmosphere where the patient can feel free to participate and make decisions concerning his care.

In Zambia and all other countries in the world, the aim is to achieve health for all by the year, 2,000 through the implementation of primary health care made universally accessible to individuals in the community by measures acceptable to them through their full participation at a cost

which the community or country can afford (WHO/UNICEF Almar Alta Joint Report, 1978). However the goal of achieving health for all by the year 2,000 cannot be possible if patients and clients who are not aware of their rights while in hospital setting are expected to participate fully in their health care activities in their own communities.

PURPOSE OF THE STUDY

the purpose of the study is to assess the knowledge patients possess on their rights while seeking health care services. Inference on how lack of such knowledge contributes to poor health services in the health care field will be made. If the research findings reveal lack of patients awareness of their rights, efforts will be made to encourage health personnel disseminate information on patients' rights. However, if the research findings reveal awareness of the patients' rights, health personnel will be urged through research recommendations to encourage patients to exercise their rights. The research findings therefore are hoped to benefit the patient who is the receiver of health care services and the health professionals who are deliverers of health care. The research question is: "Are patients aware of their rights?".

HYPOTHESIS

The following hypotheses have been proposed:-

- 1) Patients lack awareness of their rights while in hospital contributes to patients' poor satisfaction with the health care they receive.
- 2) Patients lack of awareness of their rights to information related to their health care leads to refusal of treatment.

ASSUMPTIONS

- 1) Lack of patients' awareness of their rights to be treated with respect and dignity by health professionals contributes to patients' maltreatment and dehumanisation.

- 2) Patients who are aware of their rights will seek information concerning their health care.

CHAPTER IIILITERATURE REVIEW

Many articles have been written which clearly indicate the importance of patients awareness of their rights. When patients are not aware of their rights, it is a common practice for health professionals to impose certain sick role expectations upon them during hospitalization. Patients are told in an indirect way to confirm to certain social hospital expectations if they are to seek treatment from doctors, nurses and other health personnel; and unless they abide to the hospital expectations imposed on them, health professional do not deliver their responsibilities effectively. The medical personnel expects a patient to behave in a certain way. These expectations sometimes deprive the patients of their rights to participate in their own care (Blishen, 1969).

Blishen continues to say that there are social changes occurring in our society and these changes affect the various arrangements through which health care is practiced. These changes give an underlying order to many of the daily health activities and they reveal how a patient is treated.

As knowledge has increased among the health consumer, they have realised that there is no relationship existing between the patients' social factors and rights. (Blishen, 1969). As a result of this awakening, Blishen says that hospitals especially in the western countries have taken on the patients' insurance policies due to the belief that all persons have the right to

adequate standard of health care services regardless of income and social status. Within such units patients' rights can only be properly protected if patients themselves are aware of their rights. This awareness contributes to improving the national welfare of every citizen, so that no injustice is practiced.

Davis and Aroskar (1978) assert that the awakening in the health services has brought about two sets of major problems related to optimal health care. One of these problems is the danger of becoming so infatuated with the technological dimensions of health care that health personnel cease to question its limitations. This means that the health professionals can un-intentionally lose sight of the axiomatic foundations of health care which say that human beings must not only be understood in mechanistic terms. This realisation has led to the improvement on the demands of abilities and special training. In spite of these improvements, emphasis is still being placed on professional behaviour to be guided by moral considerations.

Davis and Aroskar (1978) continue to say that patients awareness of their rights does not only promote a particular moral style but its role is defined as functional because of two reasons:-

- (1) It sensitizes or raises the consciousness of health professionals and the public concerning issues found in health care settings.
- (2) To structure the issues so that ethically complex situations can be drawn out clearly to which health personnel adhere when giving care.

However, for patients who are not aware of their rights, the opposite of what is mentioned above happens. There is no sensitized consciousness of duty among the health professionals and there is no consideration of the professional ethics. This contributes to the giving of poor health care.

Divincenti (1977) outlines the patients' bill of rights which patients are expected to know during their hospitalization. Patients' awareness of these rights can influence the delivery of health care.

The patients' bill of rights are as follows:-

- (1) The patient has the right to considerate and respectful care.
- (2) The patient has the right to obtain from his physicians complete current information concerning treatment, diagnosis and prognosis in terms of which the patient can understand. And if it is not medically advisable to give such information to the patient, the information should be made available to the appropriate person on their behalf.
- (3) The patient has the right to receive from his physicians necessary information before he can consent to the starting of any procedure or treatment.
- (4) The patient has the right to refuse treatment to the extent permitted by law and to be informed of the medical consequences of his actions.
- (5) The patient has the right to every consideration of his privacy concerning his care programmes, case discussions, consultations and treatment.
- (6) The patient has the right to expect that all communications and records pertaining to his care should be treated in confidence.
- (7) The patient has the right to be advised if the hospital proposes to engage in or perform human experimentation of his care and treatment. The patient has the right to refuse in such research projects.

- (8) The patient has the right to know hospital rules and regulations which apply to his conduct as a patient.

In many cases, the patient is not aware of his right to receive proper treatment. Davis and Aroskar (1978), give a proper example where a lawyer argues that patients when admitted to hospital are usually committed for treatment purposes and they have unquestionably a constitutional right to receive such individual health care as will give each of them a realistic opportunity to be cured or to improve his condition. The argument continues on to say that to deprive any citizen of his or her liberty upon the altruistic theory that confinement is for humane therapeutic reasons and fail to provide adequate treatment violates the patients' right to treatment. Most of the patients are not aware of this right, therefore they are discharged even when they are not completely cured from their ailment. Patients do not pursue their rights to receive proper treatment.

Davis and Aroskar (1978) continue to argue that the patients' right to know the type of treatment being given is an excellent overview of the many areas in which health personnel have an ethical obligation to patients because treatment can only be carried out effectively if it involves human consent.

Davis and Aroskar say that this statement is supported by the moral principal which has a demand on health personnel to treat patients as valuable being and not as instruments. The right of an individual in any society to dignity, self respect and freedom of self determination supports the right of the patient to have a

say in their health care because these attributes involve humanitarian values which have to do with the respect of sanctity of human life, to safe guard and to protect the patient from physical and emotional pain. On the other hand, the scientific values of patients include the right to know anything that need to be known in relation to the health care being given. The doctors, nurses and other health professionals must be aware of perceiving any measure of treatment different from the patient's perception because what the health professionals consider to be good in their eyes may not be necessary^{it} right for the patient. For instance euthenasia by some way may be considered good as a virtue in a particular situation but not considered right as a duty to autonomy and health.

The violation of patient's autonomy becomes justified by decision to with hold information because it is considered in the interest of the patient. Davis and Aroskar (1978), state a case where an adult patient had a right on religious grounds to refuse blood transfusion. Since medical opinion was for blood transfusion, this decision from the doctors' point of view amounted to patient taking his own life. In any case, the court determined that the patient was mentally competent with the decision he made even though doctors did give the patient blood. The conclusion of this case was that the individual patient must have a final say in his health care. This rule has been imposed in the ^{health} system and it gives the greatest possible protection to the individual in the furtherance of his decision.

Patients who are not aware of their right consent to measures of

health care which include treatment and different procedures ignorantly even when no explanation has been given. Maclean (1977), says that the patient yearns to know what is happening to him as an individual. Unfortunately, most patients are not aware that they have the right to refuse treatment if it is unsatisfactory or not to their personal safety.

In most cases, because the health professionals are aware of the patients' ignorance about their rights, give improper care. Nevertheless, the health professionals have no excuse for any wrongful act or maltreatment because the care they must give should not be influenced or based on parent's awareness of their rights. Martin (1977) asserts that simply because the patient appears to be backward is not a genuine reason to give improper health care or dehumanise the patient. Health personnel in relation with human rights must know the roles expected of them. This helps them to be duty conscious and be obliged to give proper health care. On the other hand, the patient must still be in a position of knowing what is expected of the health professionals.

The code of health professionals as prescribed by Tate (1977), are as follows:-

- (1) Health professionals must provide services with respect for human dignity and uniqueness of the client. The services should be un-restricted by considerable or social economic status, personal attributes or the nature of health problems.
- (2) Health professionals must guide to safe guard the rights of the clients.
- (3) Health professionals assume responsibility and accountability for individualised judgements and actions.

- (4) Health professionals must exercise informed judgements and must use individual competence and qualifications as a criteria in seeking consultation and accepting responsibility.
- (5) Health professionals must participate in the professionals effect to protect the public from misinformation and misinterpretation, and to maintain intergrity of health care services.
- (6) Health professionals must participate in the health professional effect to implant and improve the standards of health care.

Health professionals who know what is expected of them will treat the patient differently and the health care given will be aimed at the patients' needs. Most patients however are not aware of what is expected of the health professionals. If patients were aware of their rights and the rules expected of health professionals, there would be a different trend in the delivery of health care as the patient would be given chance to participate in his own care. Tate (1977) continues to say that each health consumer has the moral right of participating in his care whenever possible. Health consumers should be fully involved in planning and implementing their own health care.

Tate (1977), continues to say that health professionals have an obligation to be knowledgeable in order to protect and support the moral and legal rights for all clients under the state law. The health personnel must be able to recognise situations in which individual rights to self determination in health care is temporarily altered for the common good. They must be aware that each case should be considered with full awareness of the need to provide informed judgements while preserving the rights of an individual. Therefore, when health professionals are aware of the appropriate

or unquestionable conduct in the provision of health care, attention is called to change in the delivery of health care thereby changing the clients health welfare. Health professionals must know that they are legally accountable and responsible for anything that will cause harm to the patient (Tate 1977).

When health professionals are aware of the legal accountability, they tend to exercise judgements over actions taken in the course of health practice. This also encourages them to evaluate the effectiveness of their performance in the health care delivery. In addition, health professional tend to maintain the professional competence since they are aware that they are concerned with the welfare of human beings and the nature of health care such as inadequacy and incompetence may harm the patient; therefore, it becomes a personal committment and responsibility of each health personnel to maintain competent practice (Tate, 1977).

The health professionals upon the knowledge of their accountability take heed of their every action and examines it before implementing the health care measures. When the patient is aware of the health professionals rules, the advantages mentioned above are taken seriously by the health professionals. This upgrades the standards of health care practice since the above means will provide a guide line in the delivery of quality health care and a means of evaluating the care given to patients because the health professionals are conscious of the responsibility they have toward the health consumer to personally implement and maintain optimal standards. Quality health care is mandated as a right to all citizens and good health care is an intergral part of quality health care. Health

professionals have an ^{obligation} to ensure that health care needs are met (Tate, 1977).

Patients' lack of awareness of their rights has contributed to health professionals being negligent while on duty. This is because health professionals are aware of the patients' ignorance not to demand for compensation or sue the hospital for any harm caused by health professionals. Finch (1980), asserts that negligence on duty seems to be a common attitude among health professionals and this kind of behaviour calls for a strong legal implication. Finch continues to say that errors affect other people who can be harmed by our mistakes and negligence. However, the law still demands of health professionals to be accountable for damages caused by carelessness. The law of negligence is one aspect of the law of Tort or civil action to be dealt with in a court of law. The health professionals are legally liable for negligence because they are breaking a contract. A contract is an agreement made by health professionals to which they adhere during their professional duration.

Finch (1980) asserts that the health professionals owe the patient a duty of care in every day terms of their attitudes which they adapt toward the patient. Such expressions seem to convey more than the simple fact that health professionals need to do their job properly, carefully and in a caring manner. A duty of care means a situation exists to which the law says there is a relationship between the health professionals and the patient. Therefore carelessness causing injury or damage to the patient demands for compensation. Therefore if health professionals and the patient

were aware of the law of negligence, the standards of health care may not only be different but every health personnel will act from time to time with a varying degree of care, efficiency and foresight and still comply with the standards of which the law requires from the health personnel (Finch, 1980).

Patients who are not aware of their rights consent to measures of treatment like liver biopsy, bone marrow aspiration or any other operation without really understanding the implications of the treatment. Most patients in many of the hospital setting who are not aware of their rights entrust their lives completely in the health professionals care. For instance a patient when asked to consent to any measure of health care usually say, "I have come here to be treated therefore the doctors can go ahead with the treatment". Patients do not know that a doctor is a human being and is liable to making mistakes. Lanora (1982), asserts that since patients feel secure in the professionals care, health care must therefore be carried out by people who feel personally responsible for their duties. Lanora continues to say that patients must know that they have the right to give personal informed consent based on the belief that an individual has the right to be informed of the possible risks and benefits of a given procedure including the potential outcome. Only by being fully informed can the patient truly consent to a procedure. A consent given in ignorance violates the individual's right to self determination. Davis and Aroskar (1978) state an example to support the statement. A patient who had laminectomy and developed paralysis after 24 hours due to falling off from the bed sued the hospital. The legal issue

was resolved based on three points:-

- (i) Informed consent
- (ii) Negligence on the part of the physician performing the surgery because patient was not told the risks involved before he consented to the operation.
- (iii) Negligence on the part of the hospital for leaving the patient unattended to.

Thus it was concluded that the physician violated the patients' right to know the risks and benefits of the operation by not performing his duty to disclose the information before patient consented to the operation. There is danger when patients are ignorant of their rights because they do not know the expected outcome of the treatment, how it works and the side effects. In case of a patient who is aware of his rights, he will always demand for an explanation no matter how small the procedure is. The patient consent to any measure of treatment with full knowledge of what is being done and what the side effects are. Martin (1977) says a consent given by a patient always justifies medical interventions in case of anything going wrong because medical action taken by the doctor will be justified.

A consent is an oral or written authorization to carry out orders. For a consent to be given, proper explanation of the treatment to be carried out must be given. Only in cases where patients' consent is withhold like unconscious patient whose relatives have been untraced will the health personnel for instance doctor have a right to administer treatment as long as he will be able to indicate that absence of the treatment could have resulted to loss of life (Martin, 1977). Martin continues to say that there is need even for patients who are not aware of their rights to have

proper explanation pertaining to their treatment before giving a consent for any measure of treatment. Simply because someone appears to be ignorant is not a strong reason to assume that one cannot be given an explanation.

Cartwright (1964) carried out a study in which he asserts that patients' dissatisfaction with information has resulted in formulating a new health law which states that the patients' need for security as far as care and treatment are concerned shall be met based on respect for the patient's personal decision and integrity, and it must promote good conduct between the patient and health personnel. The care and treatment as far as possible be formulated and carried out in consultation with the patient. The patient must be given information on his health status and the treatment that can be done. Cartwright continues to say that the need for information is the subject requirement. It is determined by the patient requesting specific information as it is specified when questioning the patient.

In the same study, Cartwright (1964) asserts that some patients' background; factors are of great importance for their satisfaction with the information given. Cartwright did find out that the patients from the professional class were more likely to ask questions while those patients in the unskilled manual group more often waited to be told. Young people were prepared to ask questions than older people. Below are the results from a study carried out by Cartwright (1964):

- a) Fifty nine percent (59) of cases were told of medical information on diagnosis, prognosis, investigation results and medicine by physician.

- 20
- b) Forty eight percent of cases were told of information on examination and investigations as why procedures were performed after care was given by registered nurses.
 - c) In 30% of cases, both the physician and the nurse were responsible for informing the patient.
 - d) For 74% of cases, nurses provided information on departmental facilities and equipment.
 - e) Sixty percent of patients felt easy to speak with nurses on every day matters than with the doctor and other health professionals.
 - f) Older patients in general had too little education status and tended to have more difficulties in communication.
 - g) Patients were dissatisfied with information on their prognosis and 38% of these cases considered not to have been given any information pertaining to their prognosis.
 - h) Half of the patients were dissatisfied with information about their prognosis. While $\frac{1}{3}$ received no information at all about their diagnosis.
 - i) Twenty six percent were dissatisfied with information on the medicines, how they function and the possible side effects.
 - j) Twenty one percent were dissatisfied with information got from the doctor.

Cartwright says that establishing what the patient knew about their medical treatment showed that 84% of patients lacked all knowledge of their medicines and side effects. Dissatisfaction with information in connection with hospitalization appeared to be a great problem which has not changed over a period of 20 years. Cartwright also concluded that patients who were dissatisfied with information on examination and investigation did not see the need to ask questions but 44% of patients saw the need to talk about their problems with other patients.

Lack of awareness of patients' rights to information does not only lead to immature signing of the consent, but it also leads to refusal of treatment. This is especially true in our hospital settings where for example patients with gangrene or cancer of

the limb will see no need to have the leg amputated, thus the refusal of treatment. Though the patient has the right to decide on the type of treatment he is to receive, yet in this case, the refusal is due to lack of adequate information.

Finch (1980) asserts that bad attitudes which consist of threat by either action or words have been seen to exist among health professionals. Lack of patients' awareness of their rights contributes to this type of unhuman attitudes. Servellen (1973) says that there are many reports and complaints of the increasing depersonalization from recipients of health care both in the community and hospital.

Health professionals have taken advantage of the patients' ignorance to give unhuman care. Many patients are therefore finding hospitals particularly large medical centres impersonal and dehumanizing because the patients' individualism and autonomy are left at the door of the hospital. (Davis and Aroskar, 1978).

Davis and Aroskar continue to say that there is need for health professionals to review the ways in which they either encourage or discourage patients autonomy. This is because many times, the patient is labelled as another "difficult patient" and not as a family member of the health team. The health professionals obligation is to help patients meet a stage where they can be able to take part in their health care. This is why a lot of emphasis is now being placed on making a significance change in the quality of health care and unhumanistic delivery of care (Swevelen, 1983). Therefore, patients' awareness of their rights hold the key to

maintainance of humane and individualisatic health care. Swevellen asserts that methods of organising health care delivery should detach from apathy and lack of respect for patients since these factors contribute to patients' fear, anxiety, frustration and a feeling of low esteem. Nevertheless, Servellen challenges the patient to be awakened to their rights and to be aware that his conduct as a patient with the health professionals consists of bad attitudes and interventions.

The fact that health professionals give poor health care has been attributed mainly to lack of equipment, drugs and shortage of staff. However, Lanora (1982) argues that it is still possible for health professionals to give professional care which constitutes of activities like communicating with the patient, reassuring the patient giving explanations and touching the patient, because these activities which constitute part of basic health care do not depend on the available technological materials but on the professionals' sense of caring and devotion to duty. The health professionals can therefore still give the best health care even if they are surrounded by a lot of technological loopholes. Lanora continues to say that no external conditions really hinder the professional effort to provide truly humane care if they choose to, since they can carry out their duties inspite of the existing obstacles and shortages. This statement clearly indicates that patients' lack of awareness of their rights contributes to poor health care standards since lack of equipment and shortage of staff is not an obstacle to the giving of good health care. Lack of patients awareness of their rights hinders patients from participating in their own care. Patients are treated in isolation

which is contrary to the modern concept of health to let the patient participate in his own care (Long, 1980). The aim of patients participation in their care is to attain good quality health care.

Traditionally, the patient relied on a dependent relationship of the provider of health care. Now the role of the patients participating in their care has been legitimised because of the patients' right movement which occurred in 1960 in U.S.A. This movement sought for a new model where the traditional physician-patient relationship becomes more of a partnership in the attainment of health. This cooperative model has the potential to make the consideration balance between duties and rights. In consideration of the patients right, there must be an advocate on behalf of the patient to make this approach effective. This includes the health consumer and the patient (Davis and Aroskar, 1978).

A report from the medical Christian Journal (1985) comments that there is need to let the patient participate in his own care and to be aware of his rights because patients can only get the best from health services if they know what is reasonable to expect of it, what their rights and responsibilities are when they have confidence and skill to exercise. The report continues to support the statement that patients need more and clear information about what services are available and how to gain access to them. Patients must know the right of having a choice in terms of the health care services offered. When examining the rights and responsibilities of the health professionals and the patient, the weight seems to be more on the health professionals. But unless the patient accepts some responsibilities of their care, the relationship between health

personnel and the patient is likely to be unsatisfactory, thereby hindering to identify the patients health problem which leads to delay in giving of treatment and recovery. Patients however can only participate in their care if they are aware of their rights (Medical Christian Journal, 1985).

Patients who are uneducated and are not aware of their rights are usually the candidates who receive poor health care because they consider the medical services offered to them by the government as a privilege and not a right since the health care is reviewed differently by different people (Hafford, 1976).

Davis and Aroskar (1978) state the concept of health care as a right rather than a privilege has gained broad acceptance because it is a benefit to health consumers. That is why attempts are being made to make this philosophical stance fit with the realities of health care delivery. Davis and Aroskar recommend the comment made by the World Health Organisation (W.H.O.) which says that the enjoyment of highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political beliefs, economy and social conditions. Even with this kind of support, the patient who is not aware of his right is unable to perceive the health services being offered as a right.

It can be concluded that patients' lack of awareness of their rights is one of the factors that contribute to the giving of poor health care. Patients' awareness of their rights can bring with it a lot of significant changes, because it has been observed by both health professional and health consumers that the health

care being given is going down and there is need for change (Fowkes, 1973).

Patients' awareness of their rights can contribute to bringing about the change in the health care delivery because patients will participate in their care and be able to make intelligent contributions. As a result, health professionals will seek to be knowledgeable and security health measures will be considered in relation to the patient's welfare thus bringing change in health care delivery. Patients' awareness of their rights contributes to improving the natural welfare of every citizen since no injustice will be practiced. The present study will therefore seek to find out if patients are aware of their rights, in relation to health care.

CHAPTER IVMETHODOLOGYRESEARCH DESIGN

The purpose of the study was to find out the extent to which patients are aware of their health rights when they are hospitalised.

A descriptive research design was thought to be more appropriate to the study. Abdellah and Levine (1977) defines descriptive study as any research that does not involve experiments but it is primarily concerned with obtaining accurate and meaningful description of the phenomena under study and it seeks to know how one or more characteristics are distributed in a population. A descriptive study was chosen for this study because the nature of data required from this study was to be in descriptive form in order to determine patients awareness of their health rights.

A descriptive design has the following advantages as described by Seaman and Verhonick (1982):-

- (1) Data is gathered from a more natural setting thereby providing a quantitative description of relationship.
- (2) A large amount of information can be gathered at a reasonably cheap labour because research is conducted in a natural setting and cooperation is easily obtained.
- (3) A descriptive design is closely related to observations, this affords the investigator a chance to observe the respondents.
- (4) The descriptive design together with stratified sampling gives a considerable degree of representative response.

The descriptive design has the following disadvantages as described by Seaman and Verhonick (1982):-

- (i) It collects self reports, this means that the respondents may not be willing to express attitudes or beliefs on sensitive issues.
- (2) The researcher if he/she uses questionnaire will not be able to observe the study subjects directly.

However, the disadvantages mentioned above were limited in the present study because the researcher carried out a structured interview personally and therefore observed the respondents and asked probing questions so that adequate information was gathered.

The descriptive study design offered most needed information which helped the researcher to know the extent to which patients were aware of their rights.

RESEARCH SETTING

The study was conducted at the University Teaching Hospital (U.T.H.) which is located in Lusaka the capital city of the country. The University Teaching Hospital is the largest hospital in the country and it offers training facilities to doctors, radiographers, physiotherapists, registered nurses and midwives and theatre nurses. It also offers post graduate training in various fields like obstetrics. The hospital in addition caters for medical research.

The University Teaching Hospital has a bed capacity of about one thousand five hundred (1,500) beds and there are 839 nurses, 346 of whom are registered nurses. The hospital has a bed capacity of 6,790 per month and admits about 236 patients per day. The wards in the hospital are arranged from A to G. The departments include paediatrics, obstetrics, gynaecology, orthopaedics, medical

and surgical wards, casualty and a new neonatal surgical department.

Many specialities are found at the hospital as it acts as the major referral centre for the country. The ward capacity for patients is about 40 per ward and there are about 18 nurses in a ward. The nurses work in split shifts of morning, afternoon and night duty. Excluding the student nurses, they are about six (6) qualified staff on the average per shift. Where as they are only two nurses on night duty. The approximate nurse patient ratio during the day shift is one nurse to seven patients. The wards are divided into bays 1, 2, 3, plus side wards. The beds within the bays are arranged in numerical order with screens around each bed. The beds are fairly well spaced.

SAMPLE AND SELECTION

Treece and Treece (1982) define a sample as that which is a representative of the total population with which the researcher is dealing with because it reflects the characteristics of the population to be studied. The two authors continue to say that a sample is part of the whole. The total population from which the sample was drawn for the study was the adult male and female, medical and surgical patients admitted to U.T.H. in December 1985. The sample consisted of 50 respondents out of the total population of 160 patients from the four wards. The number of respondents has been limited for convenience purpose because of the limited time in which the study was to be carried out, completed and submitted to the Department of Post Basic Nursing at the University of Zambia. Apart from this,

the interview technique is time consuming and as such, it would not have been possible to interview a larger sample within the given period.

Any generalisations were made with caution because the sample was not truly representative of the total population.

The identified persons of concern were the patients since the study sought to find out if patients were aware of their health rights while hospitalised. The respondents were chosen by using the stratified random sampling technique which involves taking areas into sections and then take a random sample from each section (Treece and Treece, 1977).

The criteria for the subjects who participated in the study were to meet was as follows; subjects must have been admitted to the ward for 48 hours (two days) and above as this gave them enough time to acclimatize to the ward and staff. The minimum age set was 15 years because patients at this age are able to consent to medical treatment and surgical procedures and treatments.

The medical and surgical, male and female wards were drawn from the whole hospital. Each representative ward was taken as a section then patients who were in the ward were selected randomly. That is every first and fourth patient were chosen as respondents. Twelve (12) or thirteen (13) patients were interviewed from each ward. If either the first or fourth patient was unconscious or unwilling to participate, the researcher started to count again as discussed in order to maintain the principles of random sampling. It was decided to use random sampling in order to give every patient

an equal chance of being selected so that the sample had a fair representation.

The advantages of using stratified random sampling technique as described by Treece and Treece (1977) are as follows:-

- (1) Already existing knowledge is used to divide the population into groups in such a way that the units are more alike than the units in the population
- (2) The person conducting the research can reduce the chance of obtaining non-typical sample.
- (3) It allows for efficient use of the researchers' time and it is an effective way of sampling.

INSTRUMENT USED TO COLLECT DATA

The researcher used a self devised interview schedule as a means of collecting data. The method was considered appropriate because of the nature of the sample chosen. The sample included both literate and illiterate respondents thus the interview method was chosen as the most convenient method for the study.

An interview is a method of data collection through personal or face to face contact in order to obtain facts, ideas, impressions or opinions from the study subjects (Treece and Treece, 1977).

An interview schedule which lists the questions being asked with provision of space for the recording of answers was used.

The interview method was used because of the following advantages Treece and Treece, (1977):-

- (1) It allows the investigator to know the respondents since there is a personal contact relationship.
- (2) It is flexible because it offers chances for repetitions and clarification of questions.

- (3) The interviewer maintains strict control over question sequence.
- (4) The response rate is high because of the face to face interactions.
- (5) The interviewer minimises ambiguity and confusion of questions which may lead to erroneous conclusions.
- (6) The interviewer is able to find and maintain rapport throughout the interview (Oppenheim, 1966), P. 31.
- (7) People who hate composing and writing are saved the trouble of having to do so because the interviewer does the writing and the questions are already written down.
- (8) Interviewer maintains control over the sample in that respondents are intended participates (Polit and Hungler, 1973).
- (9) Interviews also cater for people who can not read and write such as the elderly, blind, uneducated and children.
- (10) Interviews offer chance to ask probing questions whenever particular responses are encountered thereby increasing the depth of data collected.
- (11) Interviews save time for interviewer in terms of writing and returning the instrument.
- (12) Interviews provide opportunities for asking questions as well as observing (Seaman and Verhonick, 1982).
- (13) In interview technique all data is useable.
- (14) Interviews offer chance for observing emotional topics or emotions that underlie a response (Treece and Treece, 1982).

However, there are a number of disadvantage with this method of data collecting:-

- (1) It is time consuming especially in terms of dealing with a large population because the interviewer does not need to be in a hurry if adequate information is to be collected.
- (2) It does not allow the researcher to cover ^a more diverse geographical sample.
- (3) Personal and sensitive questions may not be given the correct response because of the face to face interactions (Polit and Hungler, 1983).
- (4) The face to face interaction decrease the respondents' feeling of anomynity.

- (5) Interviewer's personal characteristics may reflect his or her own opinion to the respondent.
- (6) When more than one interviewer are used, it may not be easy to achieve uniformity in terms of personal characteristics (Seaman and Verhonick, 1982).
- (7) Subjects' awareness of their response being recorded may make them nervous and bias.
- (8) Interviewer pre-occupation with the technique of an interview schedule may cause them to overlook non-verbal cues that may take place (Treece and Treece, 1982).
- (9) There is possibility of bias on the part of the interviewer because of the personal involvement with the respondent.

To ^{minimise} the disadvantages, data were collected by conducting interviews personally in order to clarify any items which could have been misunderstood. The respondent were promised that all information would be kept in confidence. Clear and simple terms were used to ensure understanding of the questions.

QUESTION SEQUENCE

The interview schedule consisted of thirty (30) questions. The first seven (7) questions sought information on demographic data such as age, sex, nationality, religion, educational standards, marital status and occupation of the respondents. This information was needed to give a background of the respondents.

The following questions from eight (8) to fourteen (14) sought to find out information from the respondents in relation with the reception patients receive when they are admitted to the ward and the impressions they first get about the nurses and other health personnel, and whether this had got any impact on the patient.

The next ten (10) questions which ranged from fifteen (15) to twenty four (24) were designed to collect data from respondents which could

reflect the type of information given to the patient in relation to the treatment and procedures. These questions sought to find out who gave the information, whether it was the doctor, nurses or other health professionals and the conditions under which patients either consented or refused treatment, and whether the respondents were aware of the possible side effects of either drugs or procedures.

The last six (6) questions from 25 to 30 sought to find out whether the education standards of the respondents affected the type of health care they received. These questions also sought to find out whether subjects were aware of any health rights and if at all they exercised these rights.

PILOT STUDY

A pilot study is defined by Seaman and Verhonick (1982) as a small scale version on trial run, done in preparation for the major duty with the aim of testing elements of the research proposal and correcting any inconsistencies. It is also used in collecting data. This kind of study designed to know if patients are aware of their rights in relation to health care has never been carried out in this country before, therefore it is considered as a pilot study in itself.

The other purposes of carrying out a pilot study are:-

- (1) To highlight practical problems related to methods of intended data collection such as communication difficulties (Treece and Treece, 1982).
- (2) To give any possible time it will take when conducting and interviewing different subjects (Seaman and Verhonic 1982).

- (3) To estimate the response rate in the research projects in which generalisation is desirable.

A pilot study was not done due to time limit in which the study was conducted, compiled and submitted to the School of Medicine, Post Basic Nursing Department. To ensure validity and reliability of the instrument used in data collection, the structure and sequence of question were checked by the supervising lecturer and colleagues before consent was reached at the final form of the interview schedule.

DATA COLLECTION PROCEDURE

Data were collected at U.T.H. from four wards; Section E which caters for male and female medical wards and Section G which caters for male and female surgical wards. Permission for data collection on the four wards was sought by writing to the Nursing Officers of the medical and surgical units. (Appendix 1). Written replies granting permission to conduct the study were received within a week (Appendix 2). In addition ward sisters and staff nurses on the wards were informed about the study by the area Nursing Officers.

On the day of data collection, personal introduction was done to the nurses in-charge of the wards at that particular time. The letter of authorization from the Nursing Officer was shown to the ^{nurse or Sister} in-charge who granted permission to conduct the interview in the ward.

Subjects were selected randomly. That is every first and fourth patient were interviewed according to the bed arrangements in the ward. Before conducting an interview, the subjects who participated in the study were approached individually. Self introduction was

was done and the purpose of the interview was explained as clearly as possible. Subjects were assured that all information would be kept in confidence. Subjects were also told that the results of the interview will be compiled in the study which will be ready in July 1986. Those who were interested in reading the study were going to find a copy of it in the school medical library. Subjects were then asked if they were willing to participate in the study. Fortunately almost all the subjects were willing to participate.

Privacy was secured by conducting the interviews in the sisters room or in an empty side ward. Where it was not possible for the subject to be out of bed, privacy was secured by screening the bed. The reason for this was explained both to the staff and the patient.

The interview schedule was used as an instrument for data collection. Data collection started on the 16th to 19th December 1985. It took four days because subjects on each ward were interviewed in a day. This was possible because the interviewer was on holiday. Each subject took approximately 30 minutes to be interviewed. Data were collected in the afternoons and evenings. These were the more suitable times for both the investigator and the respondents because there was less activity on the wards with regard to doctors' rounds, nursing and diagnostic procedures during these times.

The investigator used both English and the local languages which were commonly Nyanja and Bemba during the interview process, the staff on the wards were cooperative. This contributed to smooth running to the data collection exercise.

CHAPTER V

DATA ANALYSIS AND PRESENTATION OF FINDINGS

DATA ANALYSIS

They were fifty (50) respondents interviewed from those admitted in male and female medical and surgical wards.

It is said that data collected are not useful unless arranged in a meaningful manner (Pilot and Hungler, 1983). It is in view of this that data collected were presented in table and written form. Arrangements of data in table form offers ease to the reader in finding out relationships between variables. This arrangement also assists in summarizing findings (Sweeney and Olwieri, 1981). The data were arranged in frequency counts and percentages. Pilot and Hungler (1983) state that percentages are descriptive statistics used to describe and synthesise obtained empirical observations and measurements.

The number of tables does not correspond with the number of questions in the interviewed schedule because some of the findings are in descriptive form. The remainder of the data presented in tables are in Appendix III. The number of tables in Appendix III correspond to items in the interviewed schedule. The chapter presents findings in table form and written form.

PRESENTATION OF FINDINGS

The sex of respondents revealed equal percentage of both male and female. Out of fifty (50) respondents, 25 were male and 25 were female. See Appendix III, Item I.

The demographic data of the respondents revealed that 24 percent were aged between 24 years ^{30 years} and the same percentage were 26 - 30 years while only 14 percent were aged 60 years and above. Below is the table showing the findings.

TABLE 1: AGE OF RESPONDENTS

| AGE | NUMBER OF RESPONDENTS | PERCENT |
|----------------|-----------------------|---------|
| 15 - 25 Yrs | 12 | 24 |
| 26 - 30 Yrs | 12 | 24 |
| 31 - 40 Yrs | 9 | 18 |
| 41 - 50 Yrs | 10 | 20 |
| 60 yrs & above | 7 | 14 |
| TOTAL | 50 | 100 |

The marital status of the respondents revealed that 50 percent of the respondents were married six percent were widowed and none had been separated. The findings are tabulated below.

TABLE 2: MARITAL STATUS OF RESPONDENTS

| MARITAL STATUS | NUMBER OF RESPONDENTS | PERCENT |
|----------------|-----------------------|---------|
| Married | 28 | 56 |
| Single | 12 | 24 |
| Divorced | 7 | 14 |
| Widowed | 3 | 6 |
| TOTAL | 50 | 100 |

Information on the religion on the respondents revealed that 54 percent of the respondents belonged to different denominations while 4 percent belonged to Baptist. Below are the findings.

TABLE 3: RELIGION OF RESPONDENTS

| RELIGION OF RESPONDENTS | NUMBER OF RESPONDENTS | PERCENT |
|-------------------------|-----------------------|---------|
| Baptist | 2 | 4 |
| Jehovahs' Witness | 4 | 8 |
| United Church of Zambia | 6 | 12 |
| Roman Catholic Church | 11 | 22 |
| Others | 27 | 54 |
| TOTAL | 50 | 100 |

The nationality of respondents revealed that 96 percent were Zambians. (See Appendix III, Item 5).

Information of the education status of the respondents revealed that 42 percent had primary education while 6 percent had college or University education. The findings are tabulated below.

TABLE 4: EDUCATION STATUS OF RESPONDENTS

| EDUCATION LEVEL | NUMBER OF RESPONDENTS | PERCENT |
|--------------------|-----------------------|---------|
| Grade 1 - 7 | 21 | 42 |
| Grade 8 - 10 | 8 | 16 |
| Grade 11 - 12 | 8 | 16 |
| College/University | 3 | 6 |
| No Education | 10 | 20 |
| TOTAL | 50 | 100 |

The occupational status of respondents shows that majority (32 percent) were unemployed, 6 percent were business men/women.

Below are the findings.

TABLE 5: RESPONDENTS' OCCUPATION

| OCCUPATION | NUMBER OF RESPONDENTS | PERCENT |
|--------------------|-----------------------|---------|
| Students | 3 | 6 |
| Business men/women | 3 | 6 |
| Farmers | 8 | 16 |
| Professionals | 8 | 16 |
| Unskilled workers | 12 | 24 |
| Unemployed | 16 | 32 |
| TOTAL | 50 | 100 |

The duration of respondents' hospitalization revealed that 56 percent has stayed in hospital from 2 - 7 days while 4 percent stayed in hospital above a month. The findings are tabulated below.

TABLE 6: DURATION OF RESPONDENTS' STAY IN HOSPITAL

| DURATION | NUMBER OF RESPONDENTS | PERCENT |
|-----------------|-----------------------|---------|
| 2 - 7 Days | 28 | 56 |
| 8 - 14 Days | 10 | 10 |
| 15 - 21 Days | 7 | 7 |
| 22 - 28 Days | 6 | 6 |
| Above One month | 2 | 2 |
| TOTAL | 50 | 100 |

Among the respondents who were interviewed, 64 percent had been hospitalised before and 36 percent has never been hospitalised before. (See Appendix III, Item 9).

Most of the respondents (66 percent) said to have been welcomed on admission to the ward and 2 percent were not aware of the kind of reception given. The findings are tabulated below.

TABLE 7 : RESPONDENTS WHO WELCOMED ON THE WARD ON
ADMISSION

| RESPONSE | NUMBER OF RESPONDENTS | PERCENT |
|-----------------------------|-----------------------|---------|
| Those who were not welcomed | 33 | 66 |
| Those who were welcomed | 16 | 32 |
| Those who were not aware | 1 | 2 |
| TOTAL | 50 | 100 |

Respondents admitted to have been frightened on admission. 40 percent of the respondents said so while 2 percent were not aware. Below are the findings.

TABLE 8: RESPONDENTS' FEELINGS ON ADMISSION TO THE WARD

| RESPONDENTS FEELINGS | NUMBER OF RESPONDENTS | PERCENT |
|---------------------------------------|-----------------------|---------|
| Those who were not aware | 1 | 2 |
| Those who felt staff were indifferent | 6 | 12 |
| Those who felt strange and unwanted | 7 | 14 |
| Those who felt cared for | 16 | 32 |
| Those who felt frightened | 20 | 40 |
| TOTAL | 50 | 100 |

Respondents were able to reveal that they were told the reason for admission. 70 percent agreed to being told. See Appendix III Item 12a. Among those who were told, 50 percent were told by doctors and 12 percent by others. The findings are tabulated below.

TABLE 9: HEALTH PROFESSIONALS WHO INFORMED
RESPONDENTS THE REASON FOR ADMISSION

| INFORMED BY | NUMBER OF RESPONDENTS | PERCENT |
|-------------|-----------------------|---------|
| Others | 1 | 2 |
| Both | 2 | 4 |
| Nurse | 4 | 8 |
| None | 15 | 30 |
| Doctor | 28 | 56 |
| TOTAL | 50 | 100 |

Information on whether respondents related well with health personnel reveal that 56 percent of the respondents did not relate well with the health personnel. See Appendix III, Item 13.

Information on whether respondents were given chance to ask questions pertaining to their illness revealed that 60 percent of the respondents were given chance and among the 60% of the respondents 40 percent were given chance to ask questions, and only 18 percent out of the total sample were given chance by the doctor and 8 percent by both the doctor and the nurse. Respondents who did not ask questions, ^{but} asked for a chance accounted for 10 percent, See Appendix III, Item 14 A to C.

The results revealed that during the doctors' rounds, 60 percent of the respondents were not informed about the planned health care. Among those who were told (34 percent), 8 percent out of the total sample were informed by the doctor and 8 percent by both the doctor and the nurse. Respondents who were not informed of the planned care but did ask for it were 4 percent. See Appendix III, Item 15 A to C.

Respondents who did not know the type of drugs they were getting accounted for 58 percent and only 4 percent out of the total population accounted for respondents who were not informed about the type of drugs they were getting but asked for information. See Appendix III. Item 16 A to B. Many respondents (74 percent) confessed not to know how the drug worked and 10 percent out of the total sample of respondents who had no knowledge on how the drug worked asked for information. See Appendix III, Item 17 A and B.

Out of the total sample, 88 percent of the respondents suffered no side effects of the drugs they were getting. Only 12 percent suffered from the side effects of the drug and action was taken by health professionals. See Appendix III, Item 18 A and B.

Information on whether respondents would still consent to the treatment with knowledge of the side effects revealed that 90 percent would not. See Appendix III, Item 20.

More than half of the respondents (54%) were hospitalised had procedures performed on them while 40 percent had no procedures done on them. See Appendix III, Item 20. The results revealed that 68 percent of the respondents had no information regarding the procedure and among the 34 percent, 18 percent were told by the doctor and 4 percent by both the doctor and the nurse. See table 10. Only 8 percent of the respondents who had no information about the procedure did ask for the information. See Appendix III Item 21 A and C.

TABLE 10: HEALTH PROFESSIONALS WHO GAVE RESPONDENTS INFORMATION ABOUT PROCEDURES

| INFORMED BY | NUMBER OF RESPONDENTS | PERCENT |
|-------------|-----------------------|---------|
| Others | - | - |
| Both | 2 | 4 |
| Nurse | 5 | 10 |
| Doctor | 9 | 18 |
| TOTAL | 16 | 32 |

Majority of the respondents (90%) had no possible complications of the procedure explained and only 10 percent had an explanation. See Appendix III, Item 22.

The results reveal that 98 percent of the respondents persisted on refusing treatment and chance was granted on them. See Appendix III , Item 23 A to C.



During hospitalization, many respondents (68%) felt they had little to say in regard with the medical and nursing care they received. Only 4 percent claimed to have much say. Below are the findings.

TABLE II RESPONDENTS WHO FELT THEY HAD A SAY IN MEDICAL
AND NURSING CARE

| RESPONSE | NUMBER OF RESPONDENTS | PERCENT |
|------------|-----------------------|---------|
| Little say | 34 | 68 |
| No say | 14 | 28 |
| Much say | 2 | 4 |
| TOTAL | 50 | 100 |

Respondents who admitted receiving care to their satisfaction sometimes only accounted for 64 percent while 2 percent did not receive care to their satisfaction. The findings are tabulated below.

TABLE 12 RESPONDENTS RECEIVING CARE TO THEIR PERSONAL
SATISFACTION

| TIME | NUMBER OF RESPONDENTS | PERCENT |
|--------------|-----------------------|---------|
| Some time | 32 | 64 |
| All the time | 17 | 34 |
| Not at all | 1 | 2 |
| TOTAL | 50 | 100 |

Most respondents (64%) said they would do nothing to bring about satisfactory care while 2 percent would approach the staff. The findings are tabulated below.

TABLE 13 RESPONDENTS' ACTION TO BRING ABOUT SATISFACTORY CARE

| RESPONDENTS' ACTION | NUMBER OF RESPONDENTS | PERCENT |
|--|-----------------------|---------|
| Individually approach particular staff | 2 | 4 |
| Report to higher authority | 16 | 32 |
| Do nothing | 32 | 64 |
| TOTAL | 50 | 100 |

94 percent of the respondents would refuse treatment if it is not to their personal safety. Only 6 percent would risk taking the drug. See Appendix III, Item 27.

In regard to ill-treatment 36 percent of respondents will report to higher authority if they felt they were being ill-treated while 32 percent would ask for discharge or do nothing. Below are the findings.

TABLE 14 RESPONDENTS REACTION TO ILL TREATMENT

| RESPONDENTS' ACTION | NUMBER OF RESPONDENTS | PERCENT |
|----------------------------|-----------------------|---------|
| Do nothing | 16 | 32 |
| Ask for discharge | 16 | 32 |
| Report to higher authority | 18 | 36 |
| TOTAL | 50 | 100 |

Most respondents (50%) disagreed on the education status contributing to the difference in which the respondents were treated by health professionals. However 20 percent agreed on the educational status contributing to the type of treatment being given by health professional. See Appendix III, Item 29.

If there was an injury caused by accident while in hospital, 58 percent of the respondents would do nothing while 2 percent would ask for treatment. The findings are tabulated below.

TABLE 15 RESPONDENTS' ACTION TO AN INJURY CAUSED BY
AN ACCIDENT

| RESPONDENTS' ACTION | NUMBER OF RESPONDENTS | PERCENT |
|------------------------------|-----------------------|---------|
| Ask for treatment | 1 | 2 |
| Complain to higher authority | 2 | 4 |
| Sue the hospital | 18 | 36 |
| Do nothing | 29 | 58 |
| TOTAL | 50 | 100 |

CHAPTER VIDISCUSSION OF FINDINGS, CONCLUSION, IMPLICATIONS
LIMITATION OF STUDY AND RECOMMENDATIONSDISCUSSION OF FINDINGS

The results of the study were based on analysis of response from fifty (50) respondents drawn from four wards. The aim of the study was to determine if patients are aware of their rights in relation to health care.

Patients should be encouraged to exercise their health rights while they are hospitalised. Awareness of patients' rights does not only promote moral life style but it sensitizes or raises the conscious of health and the public concerning issues found in health care settings (Davis and Aroskar, 1978). Ignorance on the side of the consumer as to what their rights and privilege are, contributes to the giving of poor and sub-standard care by health professionals. It is in view of this that this chapter will discuss the findings of this study.

The sample consisted of 50 respondents, 50 percent were male and 50 percent were female (Appendix III, Item 1). The number was equalised in order to balance the findings.

Table 1, page 46 shows the age distribution of the respondents. The age ranged from 15 - above 60 years. The majority of the respondents (48%) were aged between 15 - 30 years seconded by 20 percent aged between 41 - 50 years. Only 18% of the respondents were aged between 31 - 40 years and 14% of the respondents were aged over 60

years. These figures are supportive of Cartwright's findings because clients in the range of 15 - 50 years are expected to be aware of their rights and to be able to take necessary measures or actions against health professionals or an organisation for any maltreatment. Cartwright (1964) considered the different age ranges because he did find out in his study that young and middle aged people are more likely to ask questions than older people. Most of the respondents (56%) in table 2, page 46 were married, 24% were single, 14% were divorced. It could be assumed that most of the respondents were capable of dealing with marital problems. This gives them boldness and experience in solving problems because people who are married are considered to be more mature in decision making. It can be assumed that the decisions made by clients under this age in relation to health care is based on personal mature judgement. This is especially true if proper explanation has been given.

Table 3, page 47 reveals the religions, status of respondents, 54 percent belongs to different religions, sectors like - Pentecostal, Seventh Day Adventist, Reformed Church and Apostolic. Only 12% belonged to the United Church of Zambia, 22% were Roman Catholics, 8% were Jehovahs' Witness and 4% were Baptists. The religions aspects of the respondent does affect their decision either to accept or refuse treatment and health care. For example, the Watchtower do not accept blood transfusion. Health professionals can view the patients' refusal as a way of taking their own lives. However, Davis and Aroskar (1978) state that patients have the right on religious ground to have a final say in their health care. It is in view of this that the study wants to exclude religious reasons

as to why health professionals do not give explanations to patients.

Among the subjects interviewed, only 4% were not Zambians while 96% of the subjects were Zambians. (Appendix III Item 5 page) . The nationality of the respondents could influence the findings of the study because Hafford (1976) asserts that patients in developed countries know their rights since they know exactly what is expected of the health professionals while those in developing countries are not aware of their rights. Therefore the findings in the study could have been influenced if they were more non-Zambians respondents. But in respect of these findings, this expectation has been excluded since the majority of the respondents were Zambians.

In table 4 page 48, 48% of the respondents had primary education; 20% had no education; while 16% had Junior Secondary School education. Only 6% had college or University education. It was important to find out the educational standard of respondents in the study because it has been proved that patients with little or no education tend to have more difficulties in communication and they tend to have less need for information about diagnosis while patients with higher education have more need for information on any measure of health care carried out by health professionals (Cartwright, 1964). It is in view of this that Hafford (1976) states that patients who are uneducated and are not aware of their rights are usually the candidates who receive poor health care because they consider the medical services offered to them by the government as a privilege and not a right. To some extent this should be proved to be true as it is revealed in this study that patients do not receive satisfactory care all the time because patients fear to ask anything

related to their care. As a result there is no effective communication between the patient and the health professionals, poor communication contributes to patients being excluded from participating in their own care.

It was discovered that 38% of the respondents in table 5 page 48 were unemployed, 24% were employed as unskilled workers, 16% were professionals like teachers, nurses and secretaries. This data corresponds with the level of education attained by most respondents as shown in table 4 page 48. Cartwright (1964) found out that patients in the unskilled manual group often waited to be told information while those from professional class were more likely to ask questions. This has been proved in this study because Appendix III Item 4A to C reveal that patients do not seek for information. Even when 16% of the respondents were professionals, not everybody had courage to ask questions as is expected of them than the people in the manual or unskilled group since people in this group are considered to be afraid and ignorant to ask question.

Table 6 page 49 shows the duration of the respondents stay in hospital, 56% of the respondents stayed in hospital between 2 - 7 days, 20% stayed from 8 - 14 days, 14% stayed for 15 - 21 days and only 4% stayed for a period of over a month. The period of 2 - 7 days is long enough for respondents to observe personnel's attitude and identify the type of relationships that exist between the respondents and health professionals. Therefore since 56% of the respondents stayed in hospital for 2 - 7 days their observations and judgements are based on what they really saw happen. This consolidates the findings in the study.

The findings in Appendix III Item 9, page 92 show that 64% of the respondents had been hospitalised before in U.T.H. and 36% accounted for first admissions in the hospital. This proves that the respondents were familiar with the environment. It could also be concluded that the respondents' reactions to hospitalisation is due to how they related with the health personnel than the strange environment.

Attitudes as to how respondents were welcomed to the ward is outlined in table 7 page 50. Most of the respondents 66% admitted not to have been welcomed by any member of the health team on admission to the ward. These findings reveal the type of attitudes staff have. Only 32% of the respondents were greeted by the nurses on admission. Forty percent of the respondents confessed to have been frightened or scared because they were not welcomed properly. The reasons given were, "not being greeted", "respondents waiting for a long time before a bed was given with no explanation given". Thirty-two percent of the respondents felt they were cared for because either they were greeted or an explanation was given for any inconveniences.

Findings in these two tables reveal the type of reception given to the respondents. Patients are not cared for, they are ignored and no explanations are given for any inconveniences. This type of health care given is denounced by Lanora (1982) who argues that inspite of shortages of staff and equipment, it is still possible to give professional care which constitutes of activities do not depend on the available technology but on the professionals' sense of caring and devotion to duty. Health

attitude to patients therefore accounts for no excuse of either being busy or short staffed since the problem of being short staffed is coupled with nurses spending a lot of time in the duty room than at the bed side of the patient. It could therefore be said that the health professionals' attitude to give such care are deliberate intentions coupled with the patients' ignorance that they deserve good care.

Table 9 page 51 reveal that many of the respondents (70%) were told the reason for admission. However 56% of the respondents were informed the reason for admission by the doctor, 8% were told the reason by the nurse and 4% by both the doctor and nurse and 2% by other health professionals i.e. the Clinical Officers, while 30% of the respondents were not told the reason for admission. This portrays a picture of health personnel who do not care enough as not to give explanations to the respondents.

The relationship that existed between the respondents and the health professionals is reflected in item 13 Appendix III page 93 , 44% of the respondents related well with the health professionals while 56% did not relate well with the health professionals. The reasons given were that most respondents felt they were being treated like children, others said they were not attended to, while others said they were answered rudely. The reasons given by the respondents are supported by Finch (1980) who says that bad attitudes have been seen to exist among health professionals and this consists of either bad actions or language. This leads to depersonalization because the respondent's autonomy is not considered. This type of attitude forfeits the relationship of partnership.

Davis and Aroskar (1978) state that the moral principle has a demand on health personnel to treat patients as valuable beings and not as instruments because it is the right of every individual in society to be given dignity, self respect, freedom of self and determination because these attributes involve humanitarian values. This ^{supports} the assumption that patients' lack of awareness of their rights to be treated with respect and dignity leads to maltreatment and dehumanisation.

Item 14 Appendix III page 93 reveals that only 40% of the respondents were given chance to ask questions pertaining to the health care they received. Among the 40% who were given chance to ask questions, 18% were given chance by the doctor, 14% by the nurse, 80% by both doctor and nurse. These results are shown in table 9 page 51 .

Appendix III item 13 page 93 reveals that among the 60% who were given chance, only 10% did ask questions while 50% of the respondents did not ask questions. Since clients do not seek for information, health professionals do give care without considering the patient. Martin (1977) says even if patients are ignorant of their rights to ask for explanations, they still need proper explanation pertaining to the type of treatment and procedures done on them. Martin continues to say that simply because some one appears to be ignorant is not a genuine reason to assume that the patient can not be given an explanations.

In the data analysis, Appendix III item 15 page 94 shows that 34% of the respondents are informed of the planned care. While Appendix III item 14A to C shows that among the 34 percent, 18% were informed by the nurse, 8 percent by both doctor and nurse. For the 66% who

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Lack of enthusiasm to ask questions can be attributed to the findings in table 1 page 46 where 20% of the respondents were middle aged proving Cartwright's (1964) findings. Cartwright's study reveals that patients who were dissatisfied with information upon examination and investigation did not see the need to ask questions because they were not happy with the care given of which could be said to be true in our setting because when patients do not fully understand what is going on, they fear to ask either because they are afraid to know the truth or afraid to be confused because they possess little knowledge.

Appendix III item 16A page 94 shows that, 32% of the respondents knew the type of drugs they were getting and 58% did not know the type of drugs they were getting. In item 16B among the 58%, only 14% did ask for information pertaining to the drugs they were given. Appendix 5 item 17A page 95 reveals that 26% of the respondents were knowledgeable on how the drug worked. Only 10 percent of the respondents sought for this information while 64% did not. These findings reveal that respondents took drugs ignorantly. Maclean (1977) points out that patients who are not aware of their rights consent to measures of health care even when no explanation had been given though the patients yearn to know what is happening to them as individuals. It is therefore the health professionals' responsibility to inform the patient of the care and treatment the patient is to receive even if he does not ask for it.

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had suffered from side effects and for all cases, action of either reducing the dosage of drug or stopping the drug was taken by health professionals. The majority of the respondents which accounted for 88% did not suffer from side effects. The action taken by health professionals is supported by Tate 1977 who says that health professionals who know what is expected of them will treat the patient differently because the health care given will be aimed at meeting the needs of the patient. This behaviour is only demonstrated by health professionals who are aware of the appropriate or unquestionable conduct expected of them in the provision of health care. Therefore dedication to duty must be encouraged if the health care standards are to improve.

Furthermore, item 19 Appendix III page 96 shows that 10 percent of the respondents would consent to treatment with knowledge of the side effects. The reasons given were that sometimes patients had no choice. For example in cases of tuberculosis patients cannot be treated with any type of drugs unless anti-tuberculosis drugs and being in a developing country, we do not usually have a wide choice of drugs. However, 90% of the respondents would refuse treatment if it is not to their personal safety. The reasons given were that their lives would be in danger either by getting worse or by having additional complications. This reveals that side effects of the drugs are not disclosed to the patients as to prepare them on what to expect and to be on the look out for any side effects. This type of action of not revealing the side effects is opposed by Davis and Aroskar (1978) who say that the patient has the right to know the risks and benefits of treatment. The patients have the right to know how the drug works and it's side effects. Failure to disclose this information to the patient holds the health professionals accountable

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for any faulty outcome. On the other hand, patients who are aware of their rights demand for an explanation to any measure of treatment no matter how small the procedure is. Patients must be fully be aware of what is being done and the risks involved if they are to fully participate in their care.

Item 20 Appendix III page 96 shows that the majority of the respondents (56%) had procedures performed on them and 46% of the respondents did not have any procedures done on them. In item 21 Appendix III, page 97, 32% of the respondents had information about the procedure and 68% of the respondents were not given any information. The comparison in the two tables reveals that inspite of the high percentage of the respondents who had procedures performed on them, most of the respondents however were not given any information on any procedure performed. Item 21, Appendix III, reveals that among the 32 percent who had information about the procedures, only 18% of the respondents were given information by the doctor, 10% by the nurse, 4% by the doctor and nurse while for the 68% who were not given information about procedures, 8% sought for the information while 60% did not. On the other hand, in item 22, Appendix III, page 97, among those who had procedures done, 10% of the respondents had the possible complications of the procedure explained and 90% of the respondents were not given any explanation about the possible complications to be expected.

These figures reveal that patients who are not aware of their rights consent to measures of treatment and procedures without understanding the implications involved. This brings out the picture of respondents who entrust their lives in the care of the health professionals.

Respondents are not aware that health professionals are human beings and are liable to make mistakes. Lanora (1982) supports this by saying

that patients feel secure in the professionals' care. This type of security which patients have is attributed to ignorance. Since patients are not aware that they have the right to demand for explanations on all the health care measures being carried out on them. Whereas if explanations were given, the patients will be on the look out for any mistakes in the performance of the health care activities so that if the health professionals performs an activity contrary to the explanation given, the patient would know that the activity carried out on him is not to the best of his health. Nevertheless health professionals still have a responsibility to give information to the patients based on the belief that individual patients have the right to be informed of the possible risks and benefits of procedures and treatments.

Item 23, Appendix III, page 97, shows that 2 percent of respondents who felt like refusing treatment while 98% did not. For those who were given chance to refuse, they only amounted to 2% and chance was given them. These figures reveal how little patients exercise their rights in relation to the drugs they are given. The findings also reveal that patients are not aware of their rights. They are not aware that they can insist to refuse or to demand for an alternative if treatment is not to their personal safety.

Only 4% of the respondents in table 11 page 54 had much say in medical and nursing care, the reasons given were because patients felt they were free to tell the health professionals their complaints. In other words, patients participated in their own care. Nevertheless, 68% of the respondents felt they had little say because they had to follow orders and they were not given an alternative. Fourteen percent

had no say because patients felt they were not given chance to decide but they were commanded to follow what had already been decided upon by the health professionals without questioning. These results reveal that patients do not participate in the decisions made concerning the care they received. This is contrary to what is expected because patients are supposed to be partners in the health care services.

Davis and Aroskar (1978) say that health professionals' obligation is to help patients ^{reach} a stage where they can be able to take part in their own health care. The patient is supposed to be a member of the health care team. On the whole, patients failure ~~not~~ to partake in their own care could be attributed to fear which patients have to express themselves. Servellen (1973) asserts that methods of organising health care should detach from apathy and lack of respect for patients. These ~~fact~~ors contribute to patients' fear, anxiety and frustration. It is therefore important to challenge patients to be aware of their rights so that they are free to express their views and feelings related to the care given. At the same time patients need to be aware that his conduct as a patient with health professionals consists of a passive role and as a result he is excluded from participating in his own care.

Table 12, page 55, shows that 34% of the respondents received care to their satisfaction all the time. The reasons given were because patients were attended to by health professionals. While 64% confessed to receive care to their satisfaction sometimes only. The reasons given were because health professionals did not attend to their needs. Furthermore, 2% of the respondents did not receive care to their satisfaction. Patients said they were not given good

care. These findings reveal that patients are not attended to by health personnel. Lack of patients awareness of their rights contributes to unhuman attitudes. Servellen (1973) says that there are many reports and complaints of increasing depersonalization because patient's ignorance has been taken to be an advantage. ~~These findings~~ ^{Support} the hypothesis which state that, "patient's lack of awareness of their rights while in hospital contributes to patients' poor satisfaction with the health care they receive."

Table 13 page 55 reveals 64 percent of the respondents will do nothing to bring about satisfactory care, 32 percent will report to higher authority and 4 percent will approach the staff. A report from the Christian Medical Journal (1965) comments that the patient can only get the best from the health services if he knows what is reasonable to expect of it, what their rights and responsibilities are when they have confidence and skill to exercise. And unless the patient accept some responsibilities of his care, the relationship between the health personnel and the patient is likely to be unsatisfactory.

Fortunately 94 percent of the respondents in item 27, Appendix III, page 98, would refuse treatment if it is not to their personal safety because it would delay recovery, bring additional or unwanted complications. Only 6 percent of the respondents would consent to treatment with the knowledge of the side effects of the drugs because the side effects may be minimal compared to the good effects of the drug. Davis and Aroskar (1978) state that patients' right to know the type of treatment being given is an excellent overview of the many areas in which health personnel have an ethical obligation because treatment can only be effective if it involves human consent. The

findings however reveal that treatment is sometimes given without human consent.

The findings in table 14, page 55, show that 36 percent of respondents would report to higher authority if the respondents felt they were being illtreated, 32 percent would ask for discharge, adding to a total of 64 percent of respondents who did not know exactly what to do. The reasons given were; patients can do do anything because they were seeking help while others said they did not know what to do. These reasons are supported by Tate (1977), who said that patients are not aware of what is expected of them nor the health professionals. On the other hand patients who are aware of their rights contribute to bringing a different trend in the delivery of health care. When the health personnel are aware of the appropriate or unquestionable contact in the provision of health care, attention is called to the possible change in the deliver of health care. These findings are also supported by Servellen (1983) who states that patients' ignorance of their rights has contributed to medical professionals having an 'I dont care attitude, being lazy on duty, unvigilant and to having no sense of caring for the patient'. As a result, patients are mistreated, in the health care settings.

Item 29, Appendix III page 98, reveals that 20% of the respondents felt that the educational status does influence the kind of treatment and care given since some felt that more attention was given to those who were educated because the health personnel spend more time with these types of patients. Nevertheless, 80% felt that the educational status did not affect the type of health care given because patients felt they were treated in the same way. They saw

no communication barriers since most of the nurses were able to speak in the local languages like Tonga, Nyanja, Bemba and Lozi etc. Although the results do not reveal that patients' education does influence the individual patient to participate in his care intelligently, it still can be argued because Cartwright (1964) did find out in his study that patients with higher education had more need for information on health measures being done than did patients with lower education status. The investigator supports Cartwright's findings because from the investigator's past experience the investigator did observe that patients with low education standards did not question any of the health care measures being done on the patient, while those with good education background were always eager to find out what the health personnel were doing and why.

More than half (58%) of the respondents in table 15 page 56 reveal that they can do nothing if there was an injury caused by an accident. Among the 58%, most respondents felt that they would not be in a position to know when an injury was caused by health personnel. On the other hand 36% said they would sue the hospital. However these same patients admitted not to know the channels of how to sue a health personnel. As a result, such action was never taken. Only 2% of the respondents said they would ask for treatment in cases where they were injured by a health personnel. These findings do reveal that many patients are not aware that health personnel are liable to legal implications for any injury caused as a result of negligence.

Finch (1980) asserts that negligence on duty is a common attitude

among health professionals, nevertheless, this kind of behaviour still calls for strong legal implication because errors do affect other people, who can be injured by our mistakes and negligence. The law still demands of health professionals to be accountable for any damages caused by carelessness. This legal demand calls for dedication from health professionals to do their job carefully, properly and in a caring manner. Negligence on part of the health professionals is no exception for legal implications.

The findings in this discussion reveal that patients are not aware of their rights.

CONCLUSION

In conclusion, the findings of the study reveal that patients are not aware of their rights in relation to health care. This probably accounts for the many reasons why health care standards are going down contributing to the giving of poor and substandard care to patients.

It appears from the results that there exists a problem on what is expected of a patient while he is hospitalised since the results reveal that patients do not know that they are expected to participate in their own care and that they are a member of the health care team. The study portrays a picture of patients being commanded to follow instructions without questioning. There also exists a problem of patients being ignorant of the right to seek for information about the disease and treatment. As a result, many patients take a passive role in their own care and this contributes to the delivery of substandard care by health professionals. The results in the study reveal that 36% of the respondents interviewed were aware of their

rights though they did not exercise these rights even when opportunities did arise.

In addition, the study reveals that health professionals treat patients with little care and consideration because not only are patients given inadequate information about the health care but decisions are made for the patient and not with the patient.

All these factors contribute to the reasons why patients are complaining of deperonaalization in big hospitals because the results reveal that patients feel left out in their own care as information is not given to them on the health care measures taken to enable them to participate in their own care. The study does reveal that patients' lack of awareness of their health rights greatly influences the type of health care they receive.

IMPLICATIONS

The study has shown that the majority of the patients are not aware of their health rights while hopsitalised in U.T.H. Only 36% of the respondents were aware of their right but even then they did not exercise these rights when opportunities arose. This ignorance about health rights does contribute to many of the short falls in providing satisfactory care, and unless measures are drawn to avert this ignorance, there would still exist the problem of giving sub-standard health care. It is in view of this that the following measures must be taken to correct and upgrade the health care given.

The first implication is that health professionals must encourage patients' participation in their own care by the use of the problem solving process as there is provision within this process to give

information and explanation on all the health care measures being ^{concerned} on the patient and to encourage patients to participate in their own care. These measures encourage the patient to be a member of the health care team. The health professionals therefore have a responsibility to educate the patient on the importance of participating in his own care and **by** the counsel of the health professionals be able to make personal decisions on individual bases. Patients must be educated on the role they are to play in promoting health care as a means of upgrading health care standards.

Secondly, the health professionals should shoulder the responsibility of discussing with the patient the different procedures and treatments the patient is to receive while at the same time providing opportunities for the patient to ask questions and make personal decisions.

Another implication is that of poor communication between the health personnel and the patient. The results in the study have shown that the staff client interaction is minimal as a result of which patients do not feel secure to ask questions pertaining to their care. In addition, explanations that are given are unsatisfactory which should not be the case since health professionals have expertise and knowledge in different fields of health specialities. Health professionals therefore have a responsibility to share their knowledge by giving explanations to the patient who do not understand the disease process, the treatment given including the procedures done and why these need to be done. By giving explanations, it helps the patient to understand the role he can play in the delivery of health care activities which contribute to the promotion of quick recovery. Giving explanations therefore contributes to achieve ^{ment of} quality patient

care. Patients participation in his own care is based on the knowledge and understanding of the disease and treatment given.

Teachers in the health profession must intergrate and lay more emphasis on the importance of using the problem solving process. This is so because to increase accountability on the part of the health professionals, the modern trend offers the use of problem solving process and within this process, there is provision for patients to participate in their own care. This encourages the giving of individualised care thereby promoting staff patient relationship which make it possible for the patient to feel comfortable and be able to claim his rights. Introduction of the problem solving process maximises patients participation in his own care. However, this does not imply that patients can no be involved in their own care in the absence of this process. The problem solving process can be reinforced among leaners by giving adequate supervision to students in clinical areas. This gives the students an insight or the importance of using the problem solving process.

Another implication is on staff development which is one the methods to increase accountability on the part of the health professionals. Because due to societal and scientific changes, clients are becoming aware and are putting more challenges to the health professionals, hence the need for staff development which can be attained through inservice education activities like seminars, workshops, and conferences. Through staff development, health professionals are abreast with knowledge on how societal and scientific changes influence the delivery of health care. This knowledge instills a sense of, duty, caring and accountability among health personnel.

LIMITATIONS.

Even though efforts were made to limit the limitations in the study, there still were some problems.

The time within which the study had to be conducted was limited. This affected the size of the sample to only 50 subjects. The study was also limited to only four wards therefore the results can not be generalised to the total population of clients in U.T.H.

Due also to the time limit in which the study was to be conducted, the instrument used in the study was not pretested, as a result, the problems encountered during the actual interview could have been identified earlier.

Language posed a slight problem because the sample consisted of both literate and illiterate subjects. Many of the English terms had no equivalents in vernacular as a result they had to be rephrased for easy understanding and this was time consuming.

Insecurity was observed among patients inspite of the subjects being assured by the interviewer that all information would be kept in confidence. Subjects were still not free to express themselves for fear of being exposed and possibly being victimised.

There was also a problem due to inadequate reference since a study like this has never been done before in the country, therefore comparisons and references were not easily done. Most of the references were based on literature and research done in other countries.

RECOMMENDATIONS

1. A study of this kind should be conducted on a larger scale

include other designated wards that cater for different cases and a similar study can be done in other hospitals in the country to allow for generalisation of findings.

2. A study of this kind should be carried out on a larger scale but clients can be interviewed after discharge so that they can be free to answer questions.
3. Emphasis should be made by health administrators and educators on the importance of using the problem solving process in different schools and health institutions to prepare personnel to interact with patients effectively and to enhance patients' participation in their care.
4. Health administrators and educators must encourage the implementation of the problem solving process in the wards to encourage patients to participate in their own care and to be able to make intelligent personal decisions with the help of health personnel.
5. In service education department must encourage the holding of more workshops, conferences and seminars so as to instill awareness among health professionals on the importance of using the problem solving process.
6. Health professionals should be encouraged to conduct group and individual research to investigate into problems associated with how lack of patients' awareness of their rights contributes to decline in the standard of care and what efforts can be done to encourage patients to demand for their rights.
7. A summary of findings of the study will be sent to the areas where samples were drawn so as to enlighten and motivate health personnel

to research into existing problems regarding clients awareness of their rights in relation to health.

. Another study should be conducted to reveal whether or not health professionals' are aware of patients being aware of their rights and how this awareness by health professionals can contribute to a different trend in the delivery of health care.

. Group discussions must be held by health personnel in different modes of mass media such as television and radio on how patients can exercise their health rights while they are hospitalised and at the same time educating the public.

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APPENDICES

APPENDIX I

LETTERS REQUESTING PERMISSION TO COLLECT DATA

The University of Zambia
School of Medicine
Department of Post Basic Nursing
P. O. Box 50110
LUSAKA

25 November 1985

The Principal Nursing Officer
University Teaching Hospital
P. O. Box 50001,
LUSAKA

u.f.s. The Head
Department of Post Basic Nursing
P. O. Box RW 50110
LUSAKA

FOR THE ATTENTION OF: NURSING OFFICER SURGICAL UNIT

Dear Madam,

RE: RESEARCH PROJECT

I am a student at the above named school currently studying for a Diploma in Nursing Education. In partial fulfilment of the requirements for my studies, I am required to conduct a research study. The title of the study is "Patients' Awareness of their Health Rights".

In order to complete the study, I need to conduct a scheduled interview on patients in adult male and female surgical wards.

I will be very grateful if you could kindly allow me to use the named wards to carry out the interviews. I intend to interview 25 patients from the Surgical Unit between December 1985 to January 1986.

The study will be complete in July, 1986 and those interested in reading it can find a copy in the Department of Post Basic Nursing.

Your favourable reply will be greatly appreciated.

Yours faithfully,

Miss Christine Chisengantambu

The University of Zambia
School of Medicine
Department of Post Basic Nursing
P. O. Box 50110,
LUSAKA

25 November 1985

The Principal Nursing Officer
University Teaching Hospital
P. O. Box 50001
LUSAKA

u.f.s. The Head
Department of Post Basic Nursing
P. O. Box RW 50110
LUSAKA

FOR THE ATTENTION OF: NURSING OFFICER MEDICAL UNIT

Dear Madam

Re: RESEARCH PROJECT

I am a student at the above named school currently studying for a Diploma in Nursing Education. In partial fulfilment of the requirements for my studies, I am required to conduct a research study. The title of the study is "Patients' awareness of their Health Rights".

In order to complete the study, I need to conduct a scheduled interview on patients in adult male and female medical wards.

I will be very grateful if you could kindly allow me to use the named wards to carry out the interviews. I intend to interview 25 patients from the Medical Unit between December 1985 to January 1986.

The study will be complete in July 1986 and those interested in reading it can find a copy in the Department of Post Basic Nursing.

Your favourable reply will be greatly appreciated.

Yours faithfully

Miss Christine Chisengantambu

APPENDIX II

LETTERS GRANTING PERMISSION TO COLLECT DATA

The University Teaching Hospital
Board of Management
Department of Medicine
P.O. Box 50110
LUSAKA

3rd November 1985

Miss Chisengantambu C.
University of Zambia
School of Medicine
Department of Post Basic
P. O. Box 50110
LUSAKA

Dear Miss Chisengantambu,

RE: RESEARCH PROJECT

Thank you for your letter of November 25th 1985 in which you were requesting to conduct a research study in this Unit. You are most welcome and I hope you will be able to get all the cooperation from the patients to be interviewed.

Yours sincerely

Mrs. G. Zulu
ACTING NURSING OFFICER

The University Teaching Hospital
Board of Management
Department of Surgery
P.O. Box 50001
LUSAKA

24th January, 1986

Miss Christine Chenga'ntambu
School of Medicine
Department of Post Basic Nursing
P.O. Box 50110
LUSAKA

Dear Madam,

RE: RESEARCH PROJECT

With reference to your letter dated 25th November 1985 concerning the above mentioned subject, I have no objection for you to carry out the research as scheduled.

Yours faithfully

H. Changwe
ACTING NURSING OFFICER - G-BLOCK

APPENDIX III

**THIS APPENDIX SHOWS TABLES THAT WERE ONLY BRIEFLY
DISCUSSED BUT OMITTED IN CHAPTER FIVE OF DATA
ANALYSIS AND PRESENTATION OF FINDINGS**

ITEM 1SEX OF RESPONDENTS

| SEX | NUMBER OF RESPONDENTS | PERCENT |
|--------|-----------------------|---------|
| Male | 25 | 50 |
| Female | 25 | 50 |
| TOTAL | 50 | 100 |

Item 5NATIONALITY OF RESPONDENTS

| NATIONALITY | NUMBER OF RESPONDENTS | PERCENT |
|--------------|-----------------------|---------|
| Zambians | 48 | 96 |
| None Zambian | 2 | 4 |
| TOTAL | 50 | 100 |

Item 9RESPONDENTS WHO HAD BEEN HOSPITALISED
BEFORE

| RESPONSE | NUMBER OF RESPONDENTS | PERCENT |
|----------|-----------------------|---------|
| Yes | 32 | 64 |
| No | 18 | 36 |
| TOTAL | 50 | 100 |

Item 12ARESPONDENTS WHO WERE TOLD THE REASON
FOR ADMISSION

| RESPONSE | NUMBER OF RESPONDENTS | PERCENT |
|----------|-----------------------|---------|
| Yes | 35 | 70 |
| No | 15 | 30 |
| TOTAL | 50 | 100 |

Item 13RESPONDENTS' RELATION WITH HEALTH PROFESSIONAL

| RESPONDENT REACTION | NUMBER OF RESPONDENTS | PERCENT |
|---------------------|-----------------------|---------|
| Related well | 20 | 40 |
| Did not relate well | 28 | 60 |
| TOTAL | 50 | 100 |

Item 14ARESPONDENTS WHO WERE GIVEN CHANCE TO ASK QUESTION

| RESPONSE | NUMBER OF RESPONDENTS | PERCENT |
|----------|-----------------------|---------|
| Yes | 20 | 40 |
| No | 30 | 60 |
| TOTAL | 50 | 100 |

Item 14BHEALTH PROFESSIONAL RESPONSIBLE TO GIVE CHANCE
RESPONDENTS

| INFORMED BY | NUMBER OF RESPONDENTS | PERCENT |
|-------------|-----------------------|---------|
| Doctor | 9 | 18 |
| Nurse | 7 | 14 |
| Both | 4 | 8 |
| TOTAL | 20 | 40 |

Item 14CRESPONDENTS WHO WERE NOT GIVEN CHANCE TO
ASK QUESTIONS BUT ASKED FOR THE CHANCE

| ASKED FOR CHANCE | NUMBER OF RESPONDENTS | PERCENT |
|------------------|-----------------------|---------|
| Yes | 5 | 10 |
| No | 25 | 50 |
| TOTAL | 30 | 60 |

Item 15ARESPONDENTS INFORMED OF THE PLANNED CARE

| RESPONSE | NUMBER OF RESPONDENTS | PERCENT |
|----------|-----------------------|---------|
| Yes | 17 | 34 |
| No | 33 | 66 |
| TOTAL | 50 | 100 |

Item 15CRESPONDENTS WHO WERE NOT INFORMED OF THE PLANNED
CARE BUT DID ASK FOR IT

| RESPONSE | NUMBER OF RESPONDENTS | PERCENT |
|----------|-----------------------|---------|
| Yes | 2 | 2 |
| No | 31 | 62 |
| TOTAL | 33 | 66 |

Item 16ARESPONDENTS WHO KNEW THE TYPE OF DRUGS THEY WERE
GETTING

| RESPONSE | NUMBER OF RESPONDENTS | PERCENT |
|----------|-----------------------|---------|
| Yes | 21 | 42 |
| No | 29 | 58 |
| TOTAL | 50 | 100 |

Item 16BRESPONDENTS WHO WERE NOT INFORMED ABOUT THEIR
DRUGS BUT ASKED FOR INFORMATION

| RESPONSE | NUMBER OF RESPONDENTS | PERCENT |
|----------|-----------------------|---------|
| Yes | 2 | 4 |
| No | 27 | 54 |
| TOTAL | 29 | 58 |

Item 17ARESPONDENTS WHO WERE KNOWLEDGEABLE ON HOW THE
DRUG WORKED

| RESPONSE | NUMBER OF RESPONDENTS | PERCENT |
|----------|-----------------------|---------|
| Yes | 13 | 26 |
| No | 37 | 74 |
| TOTAL | 50 | 100 |

Item 17BRESPONDENTS WHO WERE NOT KNOWLEDGEABLE ON HOW
THE DRUG WORKED BUT ASKED FOR INFORMATION

| RESPONSE | NUMBER OF RESPONDENTS | PERCENT |
|----------|-----------------------|---------|
| Yes | 5 | 10 |
| No | 32 | 64 |
| TOTAL | 37 | 74 |

Item 18A RESPONDENTS WHO HAD SUFFERED FROM SIDE EFFECTS OF THE DRUG

| RESPONSE | NUMBER OF RESPONDENTS | PERCENT |
|----------|-----------------------|---------|
| Yes | 6 | 12 |
| No | 44 | 88 |
| TOTAL | 50 | 100 |

Item 18B RESPONDENTS WHO HAD SUFFERED FROM SIDE EFFECTS BUT HAD ACTION TAKEN BY HEALTH PROFESSIONAL

| RESPONSE | NUMBER OF RESPONDENTS | PERCENT |
|----------|-----------------------|---------|
| Yes | 6 | 12 |
| No | - | - |
| TOTAL | 6 | 12 |

Item 19 RESPONDENTS WHO WOULD CONSENT TO TREATMENT WITH KNOWLEDGE OF SIDE EFFECTS

| RESPONSE | NUMBER OF RESPONDENTS | PERCENT |
|----------|-----------------------|---------|
| Yes | 5 | 10 |
| No | 45 | 90 |
| TOTAL | 50 | 100 |

Item 20 RESPONDENTS WHO HAD PROCEDURES PERFORMED ON THEM

| RESPONSE | NUMBER OF RESPONDENTS | PERCENT |
|----------|-----------------------|---------|
| Yes | 27 | 54 |
| No | 23 | 46 |
| TOTAL | 50 | 100 |

Item 21A

RESPONDENTS WHO HAD INFORMATION GIVEN ABOUT
PROCEDURE

| RESPONSE | NUMBER OF RESPONDENTS | PERCENT |
|----------|-----------------------|---------|
| Yes | 16 | 32 |
| No | 34 | 68 |
| TOTAL | 50 | 100 |

Item 21C

RESPONDENTS WHO HAD NO INFORMATION ABOUT THE
PROCEDURE BUT ASKED FOR IT

| RESPONSE | NUMBER OF RESPONDENTS | PERCENT |
|----------|-----------------------|---------|
| Yes | 4 | 8 |
| No | 30 | 60 |
| TOTAL | 34 | 68 |

Item 22

RESPONDENTS WHO HAD POSSIBLE COMPLICATIONS
EXPLAINED

| RESPONSE | NUMBER OF RESPONDENTS | PERCENT |
|----------|-----------------------|---------|
| Yes | 5 | 10 |
| No | 45 | 90 |
| TOTAL | 50 | 100 |

Item 23A

RESPONDENTS WHO FELT LIKE REFUSING TREATMENT

| RESPONSE | NUMBER OF RESPONDENTS | PERCENT |
|----------|-----------------------|---------|
| Yes | 1 | 2 |
| No | 49 | 98 |
| TOTAL | 50 | 100 |

Item 23B RESPONDENTS WHO WERE GIVEN CHANCE TO REFUSE
TREATMENT

| RESPONSE | NUMBER OF RESPONDENTS | PERCENT |
|----------|-----------------------|---------|
| Yes | 1 | 2 |
| No | 49 | 98 |
| TOTAL | 50 | 100 |

Item 23C RESPONDENTS WHO INSISTED ON BEING GIVEN A CHANCE
TO REFUSE TREATMENT

| INSISTED ON BEING GIVEN A CHANCE | NUMBER OF RESPONDENTS | PERCENT |
|----------------------------------|-----------------------|---------|
| Yes | 1 | 2 |
| No | 49 | 98 |
| TOTAL | 50 | 100 |

Item 27 RESPONDENTS WHO CAN REFUSE TREATMENT IF IT IS NOT
FOR THEIR PERSONAL SAFETY

| RESPONSE | NUMBER OF RESPONDENTS | PERCENT |
|----------|-----------------------|---------|
| Yes | 47 | 94 |
| No | 3 | 6 |
| TOTAL | 50 | 100 |

Item 29 EDUCATIONAL STATUS INFLUENCE ON RESPONDENTS
TREATMENT BY HEALTH PROFESSIONAL

| RESPONSE | NUMBER OF RESPONDENTS | PERCENT |
|----------|-----------------------|---------|
| Yes | 10 | 20 |
| No | 40 | 80 |
| TOTAL | 50 | 100 |

APPENDIX IV

INSTRUMENT USED TO COLLECT DATA

SCHEDULED INTERVIEW

For Office
Use Only

1. Sex of Patient

i) Male

| |
|--|
| |
| |

ii) Female

2) Age range

i) 15-25 yrs

| |
|--|
| |
| |
| |
| |
| |

ii) 26-30 yrs

iii) 31-40 yrs

iv) 41-50 yrs

v) 60 yrs and above

3) Marital status

i) Single

| |
|--|
| |
| |
| |
| |
| |

ii) Married

iii) Divorced

iv) Widowed

v) Separated

4) Religion

i) United Church of Zambia

| |
|--|
| |
| |
| |
| |

ii) Roman Catholic

iii) Baptist

iv) Jehovah's Witness

v) Others, specify -----

For Office
Use only

5. Nationality

i) Zambian

ii) Others Specify-----

| |
|--|
| |
|--|

6. Highest level of Education attained -----

7. What do you do for your living? -----

8. When were you admitted to the ward?-----

9. Have you been hospitalized before?---

Yes.

No.

| |
|--|
| |
| |

10. How were you welcomed in the ward during the present admission?

11. What feelings did you have when you first entered the ward?

12. Were you told the reason for your admission?

Yes.

No.

If yes, by whom?

Doctor

Nurse

Others, specify-----

| |
|--|
| |
| |
| |
| |
| |

13. Do you relate well to the health professionals who care for you?

Yes

| |
|--|
| |
| |

No

Give reasons for your answer -----

14. Were you given chance to ask questions pertaining to your illness?

Yes

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|--|
| |
| |

No

If yes, who gave you this chance?

Doctor

| |
|--|
| |
| |

Nurse

Others, specify -----

If no, did you seek this information?

Yes

| |
|--|
| |
| |

No

15. During doctors rounds, were you informed of the planned health care?

Yes

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|--|
| |
| |

No

If yes, who told you?

Doctor

| |
|--|
| |
| |

Nurse

Others, specify -----

If no, did you ask?

Yes

| |
|--|
| |
| |

No

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16. Do you know what type of drugs you are getting?

Yes

| |
|--|
| |
| |

No

If no, did you ask?

Yes

| |
|--|
| |
| |

No

17. Do you know how the drugs work?

Yes

| |
|--|
| |
| |

No

If no, did you ask?

Yes

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|--|
| |
| |

No

18. Have you suffered from any side effects of the drugs you are getting?

Yes

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|--|
| |
| |

No

If yes, did any health personnel do anything about the side effects

Yes

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| |
| |

No

If yes, what was done? -----

19. If your answer is no to question 17, would you still consent to the treatment if the side effects were explained to you before getting the treatment?

Yes

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| |
| |

No

Give reason for your answer -----

20. Have any procedures (like liver biopsy, lumbar puncture ect) been performed on you?

Yes

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| |

No

21. Was the information regarding any procedure given to you?

Yes

| |
|--|
| |
| |

No

By whom?

Doctor

| |
|--|
| |
| |

Nurse

Others, specify -----

If no, did you ask?

Yes

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|--|
| |
| |

No

22. Were there complications of any procedure explained to you?

Yes

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|--|
| |
| |

No

If yes, give reason why you consented to the treatment

23. Did you at any time felt like refusing any measure of treatment?

Yes

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|--|
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| |

No

Were you given the chance?

Yes

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| |

No

Did you insist on being given the chance?

Yes

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| |

No

24. Do you feel you have any say in regard to your medical and nursing care while in hospital?

Much say

| |
|--|
| |
| |
| |

Little say

No say

Give reason for your answer -----

25. Are you presently receiving care to your satisfaction?

All the time

| |
|--|
| |
| |
| |

Sometimes

Not at all

Explain your answer -----

26. Is there anything in your power that can help bring about satisfactory care?

27. Are you able to refuse treatment if it is not to your personal safety?

Yes

| |
|--|
| |
| |

No

Give reason for your answer -----

28. If you felt you were being ill-treated, what would you do?

Give reason for your answer -----

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Use Only

29. Does the state of being educated or uneducated make a difference in the way you are treated by health professionals?

Yes

No

| |
|--|
| |
| |

Give reason for your answer -----

30. If you had an injury caused by an accident while in hospital, what would you do?-----

THANK YOU VERY MUCH FOR ANSWERING THESE QUESTIONS.