



THE PRACTICE OF PATIENT EDUCATION BY ATTENDING PHYSICIANS IN SOUTHWEST NIGERIA

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Cite this article:

Tobih J., Oyewole A., Tobih D., Olajide A., Esan T. (2023), The Practice of Patient Education by Attending Physicians in Southwest Nigeria. African Journal of Biology and Medical Research 6(1), 9-23. DOI: 10.52589/AJBMR-KALBT5IJ

Manuscript History

Received: 23 Nov 2022

Accepted: 20 Dec 2022

Published: 3 Jan 2023

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ABSTRACT: Background: The value of patient education involves an improved understanding of their medical conditions, diagnosis, disease, or disability. However, the challenge of educating patients is multi-faceted, considering the complexity of many diseases, limited health literacy and a limited number of available doctors to tend to the long awaiting patient queue. **Objective:** This study aimed to assess the practice of patients' education of their illnesses by the treating physician in different practice settings, specialties, contact, duration of admission, the eventuality of death and post-mortem. **Method:** The study was a cross-sectional descriptive design conducted among 449 medical doctors. A self-administered semi-structured pretested questionnaire was administered to all cadres of physicians in four health centres selected randomly in the southwest, Nigeria. The data collected were analysed using SPSS version 25 and results were presented in descriptive statistics and inferential statistics with the level of significance set at $p = < 0.05$. **Result:** The majority (57.0%) of the respondents were within the age range of 25-40. The highest respondent cadres were registrars and medical officers 224 (49.9%). Of the total participants, 140 reported seeing over 40 patients per week. It was observed that 95.9% did explain to the patients the impressions of their symptoms at first contact. However, the percentage of respondents reduced markedly when giving the next appointment, 58.8%. Also, 86.6% always explain the need for hospital admission, 76.4% explained options of surgery while only 28.3% discussed mistakes/complications from the procedures. **Conclusion:** There were a lot of gaps in the patient's understanding of their illnesses as imparted by the attending physicians. The gap increases after the first contact both in knowledge and understanding on the part of the patient which may be one of the major factors responsible for poor compliance and cooperation on the part of the patient which ultimately hinders the optimum delivery of effective and efficient health care. This in effect affects the overall health status of the community and society.

KEYWORDS: Assessment, Physicians, Patients education, Illness, South-West Nigeria.



INTRODUCTION

Patients' perception of healthcare delivery has been accepted as an important indicator for measuring the quality of healthcare and a critical component of performance improvement and clinical effectiveness. Patients' satisfaction has been defined as the degree of congruency between patients' expectations of ideal care and their perception of real care received. Higher levels of satisfaction indicate higher levels of patient empowerment, commitment to care, increased health service utilization, and compliance to recommended management, all of which result in better health outcomes.¹⁻³

Patient education can be defined as the process of influencing patient behavior and producing the changes in knowledge, attitudes and skills necessary to maintain or improve health. The Latin origin of the word doctor, "docere," means "to teach," involving the education of patients and their families, as well as communities. Providing patients with complete and current information helps create an atmosphere of trust, enhances the doctor-patient relationship and empowers patients to participate in their own health care. Effective patient education also ensures that patients have sufficient information and understanding to make informed decisions regarding their care.⁴

The proper diagnosis of a disease and effective treatments are essential to an individual's prognosis and quality of life. But beyond the accuracy of diagnosis, there is also compelling evidence about the value of being sufficiently informed since the more clearly a disease is understood, the more likely it is that an individual will be comfortable with their care and adhere to necessary regimens.⁵⁻⁷ For instance, cancer treatments can be extremely intimidating and adequate knowledge about what can be expected during and after chemotherapy and other procedures is critical. It has been established that patients with cancer benefit from proper patient education in terms of enhanced self-care, reduced anxiety, enhanced self-concept and self-esteem, increased satisfaction with care, improved pain control, improved oral status, and reduced disruption in daily functioning.^{5,6}

However, the challenge of educating patients is multi-faceted, especially when you consider the complexity of many diseases and limited health literacy. The patient education modality should be easily understandable with efficient methods of dissemination. Resources need to be presented in laymen's terms to communicate in a way that is impactful for all patients and materials could be authored at various reading levels and in different languages.⁷

Factors influencing patient satisfaction have been broadly classified into three: patient-related factors, such as age, gender, level of education, race, socioeconomic status, physical, psychological, and illness experience; medical personnel-related factors, such as technical skills of the health-care provider, time spent during visits, communication, and interpersonal relationship; and system-related factors, such as accessibility, facilities, appointments, referrals, and continuity of care.⁸⁻¹¹ Patient satisfaction is multifaceted and is an internationally accepted factor that needs to be assessed continually to ensure the quality of care. Due to the need for better quality of health services in developing countries, patient satisfaction has become a major concern among researchers.¹²

Most studies carried out in Nigeria assessing patient satisfaction in various hospital settings using different methods reported overall moderate to high patient satisfaction.¹³⁻¹⁵ However, due to the paucity of data on this area of study, this work aimed to assess the practice of patients' education of their illnesses by the treating physician in different practice settings,



specialties, contact, duration of admission, the eventuality of death and post-mortem. This study is significant in providing a baseline of assessment of patient education by attending physicians crucial for optimum doctor-patient relationship and improved care and quality of life of the patients.

METHODOLOGY

Study Design

A descriptive cross-sectional design was used for the study.

Study Population

The study involved four hundred and forty-nine medical doctors selected randomly from different health facilities, such as teaching hospitals, specialist hospitals, state hospitals, mission hospitals, private clinics and primary health centers involving all cadres of doctors ranging from Professors, Readers, Senior Lecturers, Senior Registrars, Registrars, Medical Directors, Principal Medical Officers, Senior Medical Officers and Medical Officers.

Study Technique

The selection of respondents covered four states in southwest regions of Nigeria using a multi-stage sampling procedure. A self-administered semi-structured pretested questionnaire consisting of 37 items eliciting relevant information regarding the study was used to collect data. The questionnaires were distributed across the hospitals through various representatives. Selection and participation were voluntary across all cadres of doctors and those who consented to take part were given a questionnaire to fill.

Data Analysis

The data collected were analyzed using SPSS version 25 and results were presented in descriptive statistics (frequency counts, percentages, mean, standard deviations) and inferential statistics (Chi-square) was used to test the hypothesis with a level of significance set at $p < 0.05$.

Ethical approval

Ethical approval was obtained from the Research and Ethics Committee of UNIOSUN Teaching Hospital, Oshogbo before the commencement of the research while informed consent was obtained from all the respondents.

RESULT

Five hundred questionnaires were distributed for the study, four hundred and forty-nine were suitable for analysis following data clearing.

Table 1: Age range 25-40 was in the majority with 256 (57.0%) while those under 25 were very few (5.6%) and those over 40 years had about 142 (31.6%). The highest percentage of



respondents were registrars and medical officers 224 (49.9%). All specialties were involved such as Medicine 43 (9.6%), Surgery 93 (20.7%), Paediatrics 48 (10.7%), Obstetric & Gynaecology 77 (17.1%), Family Medicine 54 (12.0%) and others 105 (23.4%). Years of practice reveal over 6-20 were in the majority 284 (63.2%).

Table 1: Socio-Economic and Demographic Characteristics

| Variable | Frequency | Percentage | |
|-------------------------------|--------------------------------|--------------|------|
| Age Group (In Years) | Under 25 years | 25 | 5.6 |
| | 25-40 | 256 | 57.0 |
| | Above 40 | 142 | 31.6 |
| | No response | 26 | 5.8 |
| Status a | Consultant | 59 | 13.1 |
| | Senior registrar | 84 | 18.7 |
| | Registrar | 145 | 32.3 |
| | No response | 161 | 35.9 |
| Status b | CMO | 11 | 2.4 |
| | PMO | 15 | 3.3 |
| | SMO | 27 | 6.0 |
| | MO | 79 | 17.6 |
| | No response | 317 | 70.6 |
| Specialty | Medicine | 43 | 9.6 |
| | Surgery | 93 | 20.7 |
| | Paediatrics | 48 | 10.7 |
| Gynaecology | Obstetrics & | 77 | 17.1 |
| | Family Physician | 54 | 12.0 |
| | Others | 105 | 23.4 |
| | No response | 29 | 6.5 |
| Year of practice (yrs) | <2 | 40 | 8.9 |
| | 2-5 | 78 | 17.4 |
| | 6-10 | 121 | 26.9 |
| | 11-20 | 163 | 36.3 |
| | >20 | 15 | 3.3 |
| | No response | 32 | 7.1 |
| Place of practice | Health centre | 2 | 0.4 |
| | Private Clinic/Hospital | 18 | 4.0 |
| | State Hospital | 40 | 8.9 |
| | Mission hospital | 8 | 1.8 |
| | Special Hospital | 10 | 2.2 |
| | Teaching Hospital | 343 | 76.4 |
| | No response | 28 | 6.2 |
| Total | 449 | 100.0 | |

Figure 1: 140 respondents reported seeing over 40 patients per week. The least 6(x) seeing under 10 patients.

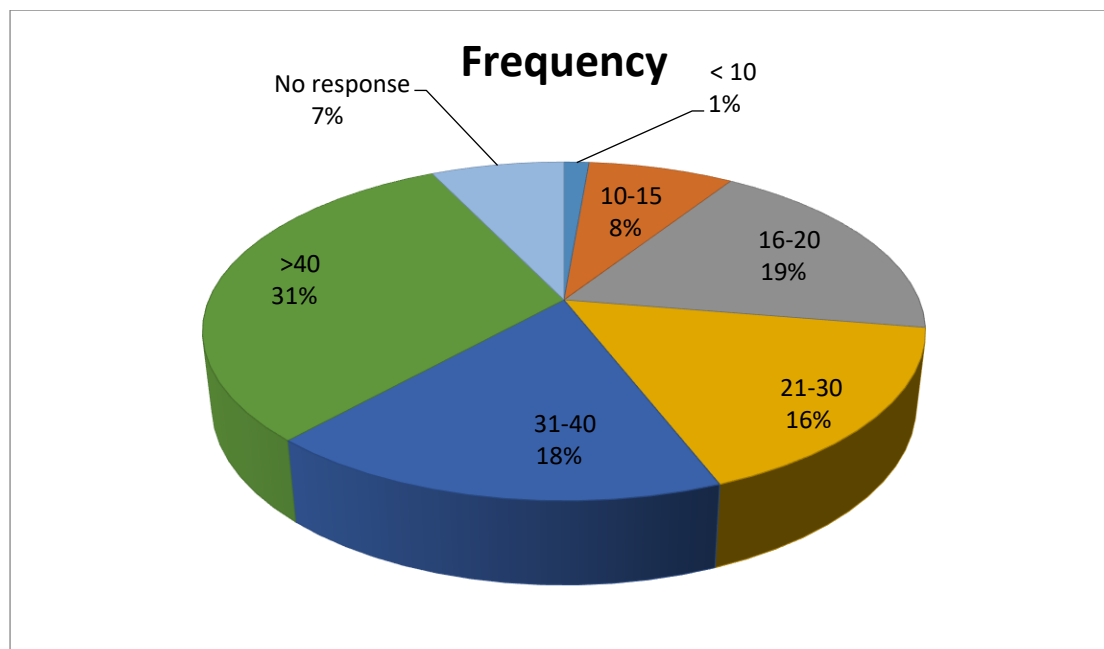


Figure 1: Volume of patient seen / week (Clinic, ward, social)

Table 2: 375 respondents (95.9%) did explain to the patients impressions of their symptoms, need for further investigation 388 (98.7%), plan of immediate treatment 384 (98.2%). However, the percentage of respondents reduced markedly when giving the next appointment 231 (58.8%), in fact 162 (41.3%) did not talk about it. On options of treatment; majority 342 (89.1%) discussed it but some 37 (10.9%) did not. At the end of first contact consultation, only 238 (61.8%) were on the same page with the attending physicians while a significant number of about 227 (38.3%) were not.

Table 2: Educating Patients at First Contact

| Variables (practice of Patient education) | | Gender | | | |
|---|-----------------------------|----------|------------------|------------------|-------------------|
| | | Male (%) | Female (%) | Total | |
| Did you explain to them what was your | Impression and basis for it | Yes | 257(65.7) | 118(30.2) | 375(95.9) |
| | | No | 5(1.3) | 3(0.8) | 8(2.0) |
| Can't remember | | No time | 6(1.5) | - | 6(1.5) |
| | | | 2(0.5) | - | 2(0.5) |
| Total | | | 270(69.1) | 121(30.9) | 391(100.0) |



| | | | | |
|--|--|------------------|------------------|-------------------|
| Need for further investigation | Yes | 270(68.7) | 118(30.0) | 388(98.7) |
| | No | - | 3(0.8) | 3(0.8) |
| Can't remember | | - | 1(0.3) | 1(0.3) |
| | No time | 1(0.3) | - | 1(0.3) |
| | Total | 271(69.0) | 122(31.0) | 393(100.0) |
| Plan of immediate treatment | Yes | 265(67.8) | 119(30.4) | 384(98.2) |
| | No | 3(0.8) | 2(0.5) | 5(1.3) |
| Can't remember | | 2(0.5) | - | 2(0.5) |
| | No time | - | - | - |
| | Total | 270(69.1) | 121(30.9) | 391(100.0) |
| Option of treatment | Yes | 234(60.9) | 108(28.1) | 342(89.1) |
| | No | 18(4.7) | 9(2.3) | 27(7.0) |
| Can't remember | | 5(1.3) | 2(0.5) | 7(1.8) |
| | No time | 6(1.6) | 2(0.5) | 8(2.1) |
| | Total | 263(68.5) | 121(31.5) | 384(100.0) |
| Next appointment | Yes | 165(42.0) | 66(16.8) | 231(58.8) |
| | No | 78(19.8) | 39(9.9) | 117(29.8) |
| Can't remember | | 23(5.9) | 16(4.1) | 39(9.9) |
| | No time | 5(1.3) | 1(0.3) | 6(1.5) |
| | Total | 271(69.0) | 122(31.0) | 393(100.0) |
| Patients understanding and response | | | | |
| | Fully understood and asked few questions | 163(42.3) | 75(19.5) | 238(61.8) |
| | Fairly understands | 63(16.4) | 22(5.7) | 85(22.1) |
| | Not understood indicated by his question | 9(2.3) | 4(1.0) | 13(3.4) |
| | Not interested in my explanation | 6(1.6) | - | 6(1.6) |
| | All he wants is to be well | 23(6.0) | 20(5.2) | 43(11.2) |
| | Total | 264(68.6) | 121(31.4) | 385(100.0) |

Figure 2 shows the effort of the attending physician in further educating the patients about their illness; 293(74.9%) repeated the explanations, only 48 (13.1%) gave books to read, 146 (39.5%) brought pictures to reinforce their explanation while 146 (39.5%) brought already treated patients with similar illness for explanations.

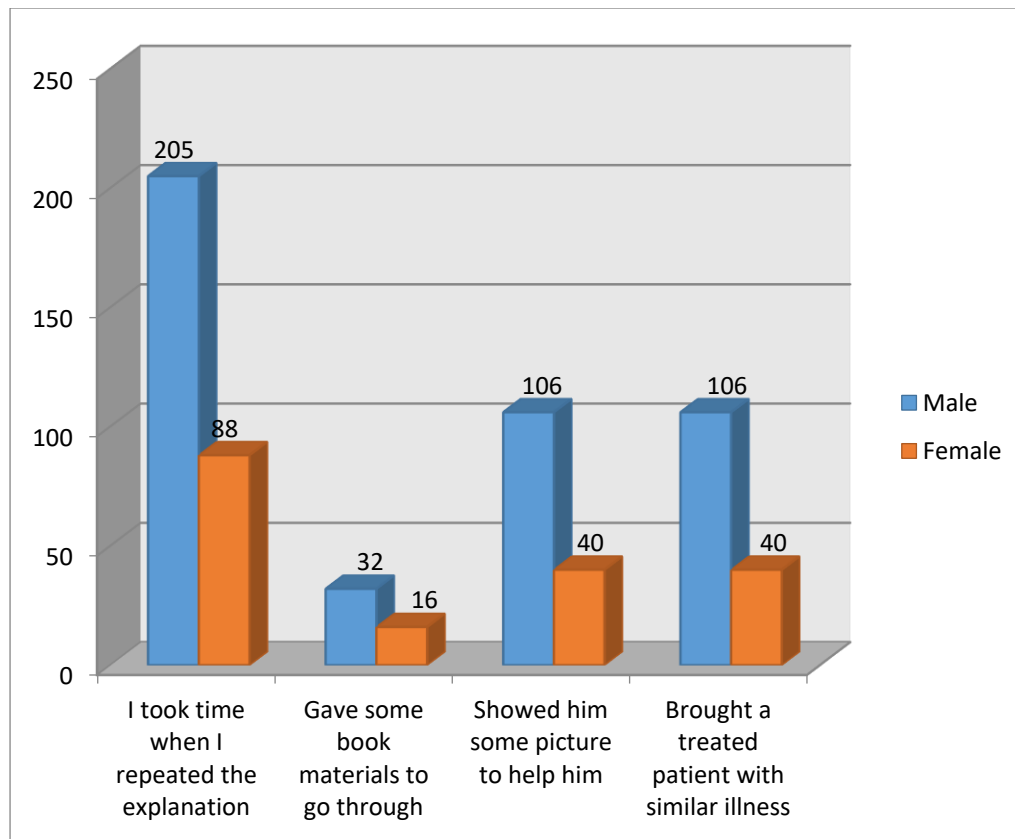


Figure 2: Effort to further educate the patient on their illness after first contact

Table 3: On subsequent contact with patient on review of results of investigations, haematological results; 338(87.6%) did explain, blood chemistry; 332(85.8%), Radiology 330(85.1%) others 252(70.4%). On the need for admissions, 325 (86.6%) gave alternative to admission, only 199 (51.6%) while only 188 (48%) explained likely period of stay in the hospital.

Table 3: Subsequent contact with patient on review of investigations results

| Variables (practice of Patient education) | Gender | | Total |
|---|------------------|------------------|-------------------|
| | Male (%) | Female (%) | |
| Did you discuss each of the following | | | |
| Haematology full blood count, platelets e.t.c | | | |
| Yes | 235(60.9) | 103(26.7) | 338(87.6) |
| No at all | 11(2.8) | 2(0.5) | 13(3.4) |
| Didn't think it necessary | 3(0.8) | 2(0.5) | 5(1.3) |
| No time | 1(0.3) | 3(0.8) | 4(1.0) |
| Scantly | 18(4.7) | 8(2.1) | 26(6.7) |
| Total | 268(69.4) | 118(30.6) | 386(100.0) |
| Blood chemistry-Electrolytes urea, creatinine etc | | | |
| Yes | 230(59.4) | 102(26.4) | 332(85.8) |
| No at all | 11(2.8) | 4(1.0) | 15(3.9) |
| Didn't think it necessary | 4(1.0) | 2(0.5) | 6(1.6) |
| No time | 3(0.8) | 2(0.5) | 5(1.3) |
| Scantly | 20(5.2) | 9(2.3) | 29(7.5) |
| Total | 268(69.3) | 119(30.7) | 387(100.0) |
| Radiology plain film, CT Scan, MRI etc | | | |
| Yes | 230(59.3) | 100(25.8) | 330(85.1) |
| No at all | 15(3.9) | 8(2.1) | 23(5.9) |
| Didn't think it necessary | 5(3) | 4(1.0) | 9(2.3) |
| No time | 3(0.8) | 2(0.5) | 5(1.3) |
| Scantly | 15(3.9) | 6(1.5) | 21(5.4) |
| Total | 268(69.1) | 120(30.9) | 388(100.0) |
| Other Investigations/ Procedure | | | |
| Yes | 172(48.0) | 80(22.3) | 252(70.4) |
| No at all | 25(7.0) | 16(4.5) | 41(11.5) |
| Didn't think it necessary | 16(4.5) | 10(2.8) | 26(7.3) |
| No time | 5(1.4) | 4(1.1) | 9(2.5) |
| Scantly | 22(6.1) | 8(2.2) | 30(8.4) |
| Total | 240(67.0) | 118(33.0) | 358(100.0) |

Table 4: 335 (86.6%) always explain the need for hospital admission, 199 (51.6%) discussed alternative to admission and 188 (48.7%) discussed the likely duration period of hospital stay

**Table 4: Educating patients that need hospital admission**

| Variables (practice of Patient education) | Gender | | Total |
|--|------------------|------------------|-------------------|
| | Male (%) | Female (%) | |
| In cases when your patients need hospital admission | | | |
| Do you take time to explain the necessity? | | | |
| Yes, always | 238(61.5) | 97(25.1) | 335(86.6) |
| Occasionally | 29(7.5) | 21(5.4) | 50(12.9) |
| I can't remember | 1(0.3) | 1(0.3) | 2(0.5) |
| No time | - | - | - |
| Total | 268(69.3) | 119(30.7) | 387(100.0) |
| Do you discuss alternative to admission | | | |
| Yes, always | 138(35.8) | 61(15.8) | 199(51.6) |
| Occasionally | 114(29.5) | 53(13.7) | 167(43.3) |
| I can't remember | 8(2.1) | 4(1.0) | 12(3.1) |
| No time | 7(1.8) | 1(0.3) | 8(2.1) |
| Total | 267(69.2) | 119(30.8) | 386(100.0) |
| Do discuss the likely period of stay and why | | | |
| Yes, always | 135(35.0) | 53(13.7) | 188(48.7) |
| Occasionally | 115(29.8) | 54(14.0) | 169(43.8) |
| I can't remember | 6(1.6) | 8(2.1) | 14(3.6) |
| No time | 11(2.8) | 4(1.0) | 15(3.9) |
| Total | 267(69.2) | 119(30.8) | 386(100.0) |

Table 5: 288 (76.4%) explained options of surgery available, 251 (66.8%) and 258 (69.4%) did explain the setbacks that may arise from such a surgery while only 102 (28.3%) discussed mistakes/complications from the procedures.

Table 5: Educating patients that need surgical care

| Variables (practice of Patient education) | Gender | | Total |
|---|-----------|------------|-----------|
| | Male (%) | Female (%) | |
| Have you managed patients that had surgical operations | | | |
| Did you discuss other options outside surgeries if available | | | |
| Yes, always | 206(54.6) | 82(21.8) | 288(76.4) |
| Occasionally | 48(12.7) | 29(7.7) | 77(20.4) |
| I can't remember | 5(1.3) | 6(1.6) | 11(2.9) |
| No time | 1(0.3) | - | 1(0.3) |



| | | | |
|---|------------------|------------------|-------------------|
| Total | 260(69.0) | 117(31.0) | 377(100.0) |
| You discuss the surgery type available and reason for preferred | | | |
| Yes, always | 184(48.9) | 67(17.8) | 251(66.8) |
| Occasionally | 61(16.2) | 42(11.2) | 103(27.4) |
| I can't remember | 11(2.9) | 8(2.1) | 19(5.1) |
| No time | 3(0.8) | - | 3(0.8) |
| Total | 259(68.9) | 117(31.1) | 376(100.0) |
| Likely prospects and setbacks concerning the surgery | | | |
| Yes, always | 189(50.8) | 69(18.5) | 258(69.4) |
| Occasionally | 56(15.1) | 41(11.0) | 97(26.1) |
| I can't remember | 6(1.6) | 5(1.3) | 11(3.0) |
| No time | 5(1.3) | 1(0.3) | 6(1.6) |
| Total | 256(68.8) | 116(31.2) | 372(100.0) |
| Made mistake in any of surgery and discuss with patient | | | |
| Yes, always | 75(20.8) | 27(7.5) | 102(28.3) |
| Occasionally | 82(22.8) | 47(13.1) | 129(35.8) |
| I can't remember | 74(20.6) | 29(8.1) | 103(28.6) |
| No time | 20(5.6) | 6(1.7) | 26(7.2) |
| Total | 251(69.7) | 109(30.3) | 360(100.0) |

Table 6: 284(75.1%) explained the clinical cause of death. Only 188 (49.9%) of the relations were on the same page with the physicians.

Table 6: Educating patient relations on cause of death

| Variables (Relation education) | Gender | | Total |
|---|------------------|------------------|-------------------|
| | Male (%) | Female (%) | |
| In case of death of patient | | | |
| Did you explain to relation the clinical cause of death | | | |
| Yes, fully | 198(52.4) | 86(22.8) | 284(75.1) |
| Partially | 57(15.1) | 29(7.7) | 86(22.8) |
| Did you understand at all | 3(0.8) | 1(0.3) | 4(1.1) |
| Did you not agree with my explanations | 3(0.8) | 1(0.3) | 4(1.1) |
| Total | 261(69.0) | 117(31.0) | 378(100.0) |
| Did the relation understand and agree with your explanation | | | |



| | | | |
|--|------------------|------------------|-------------------|
| Yes, fully | 126(33.4) | 62(16.4) | 188(49.9) |
| Partially | 117(31.0) | 53(14.1) | 170(45.1) |
| Did you understand at all | 6(1.6) | 1(0.3) | 7(1.9) |
| Did you not agree with my explanations | 10(2.7) | 2(0.5) | 12(3.2) |
| Total | 259(68.7) | 118(31.3) | 377(100.0) |

Table 7: Only 44 (13.1%) requests for post-mortem, and 176 (52.2%) does occasionally. 216 (62.1%) did explain the importance of post-mortem and 226 (67.3%) discussed the benefits of the cause of death to the family.

Table 7: Patient relation education in the case of postmortem

| In case of Post Mortems | Gender | | Total |
|--|------------------|------------------|-------------------|
| | Male (%) | Female (%) | |
| Have you reason to request for you dead patient postmortem | | | |
| Yes, on very few occasion | 129(38.3) | 47(13.9) | 176(52.2) |
| Yes on many occasion | 35(10.4) | 9(2.7) | 44(13.1) |
| None at all | 68(20.2) | 49(14.5) | 117(34.7) |
| Total | 232(68.8) | 105(31.2) | 337(100.0) |
| Did you explain the importance of postmortem | | | |
| Yes, in detail | 161(46.3) | 55(15.8) | 216(62.1) |
| No | 41(11.8) | 23(6.6) | 64(18.4) |
| No time | 9(2.6) | 1(0.3) | 10(2.9) |
| Our environment is hostile to this | 32(9.2) | 26(7.5) | 58(16.7) |
| Total | 243(69.8) | 105(30.2) | 348(100.0) |
| It is coroner (legal) case | | | |
| Yes, in detail | 120(38.3) | 44(14.1) | 164(52.4) |
| No | 60(19.2) | 30(9.6) | 90(28.8) |
| No time | 9(2.9) | - | 9(2.9) |
| Our environment is hostile to this | 24(7.7) | 26(8.3) | 50(16.0) |
| Total | 213(68.1) | 100(31.9) | 313(100.0) |
| Discovery of cause of death may help the family | | | |
| Yes, in detail | 169(50.3) | 57(17.0) | 226(67.3) |
| No | 21(6.2) | 11(3.3) | 32(9.5) |
| No time | 10(3.0) | - | 10(3.0) |
| Our environment is hostile to this | 34(10.1) | 34(10.1) | 68(20.2) |
| Total | 234(69.6) | 102(30.4) | 336(100.0) |



| | | | | |
|--|----------------------------|-----------|-----------|------------|
| It clear issue of suspicion | | | | |
| | Yes, in detail | 95(39.7) | 34(14.2) | 129(54.0) |
| | No | 25(10.5) | 10(4.2) | 35(14.6) |
| | No time | 1(0.4) | - | 1(0.4) |
| to this | Our environment is hostile | 38(15.9) | 36(15.1) | 74(31.0) |
| | Total | 159(66.5) | 80(33.5) | 239(100.0) |
| The body will not be dismembered | | | | |
| | Yes, in detail | 102(40.3) | 35(13.8) | 137(54.2) |
| | No | 28(11.1) | 14(5.5) | 42(16.6) |
| | No time | 8(3.2) | - | 8(3.2) |
| to this | Our environment is hostile | 34(13.4) | 32(12.6) | 66(26.1) |
| | Total | 172(68.0) | 81(32.0) | 253(100.0) |
| No part of the body will be taken away | | | | |
| | Yes, in detail | 133(40.3) | 43(13.0) | 176(53.3) |
| | No | 44(13.3) | 15(4.5) | 59(17.9) |
| | No time | 7(2.1) | - | 7(2.1) |
| to this | Our environment is hostile | 46(13.9) | 42(12.7) | 88(26.7) |
| | Total | 230(69.7) | 100(30.3) | 330(100.0) |

DISCUSSION

This study involved four hundred and forty-nine medical doctors of all cadres. The majority of the respondents were above the age of 25 years. About 57% were between 25-40 years of age. The registrars and the medical officers accounted for a majority of the respondents. This is because they are still undergoing much training in their career and the outcome of this new emphasis will be handled by them for a much longer period than the other cadres. Also, the highest bulk of the patients in all facilities passes through them in one way or the other. All the specialties were well represented with surgery leading followed by obstetrics and gynaecology, and family medicines. All categories of health facilities were also involved from primary health centres, mission hospitals, state hospitals, and specialty centres with the teaching hospitals having the highest number of respondents. This is because teaching hospitals are the citadel of training medical personnels, hence this platform is an appropriate one to establish this concept of one page between the patient and the attending physician.

The level of interaction regarding the patient's illness during the first contact showed that quite a good percentage of the attending physicians did educate their patients adequately regarding the clinical impression of their illness, and explained the need for further investigation and discussed the plan of immediate treatment. It was observed that only a few (12.7%) did not talk about treatment options at all. More than half of the respondents discussed the next appointment with the patient while several doctors failed to discuss it. At the end of the first contact, only 61.8% of the patients were on the same page with their physicians while 38.3% were at a loss. This is a very profound finding in that by the end of the first visit, the understanding of the patients has fallen from 98.2% to 61.8% which may be one of the reasons why patients'



compliance with our suggested options of treatment is not optimal and hence adequate health delivery is hampered. This finding is in consonant with another report.¹⁶

Regarding efforts made by the attending physician to educate their patients, the score performance here is fair because 74.9% took time to repeat the explanations, only 13.1% gave books or other material to educate their patients while only 39% brought in pictures to show their patients and 39.5% made effort to bring treated patients to educate their patients. This confirms much work and training need to be imparted to the physicians in this area of critical need of making a comprehensive effort to bring their patients on board with their illness. Moreso, on the review of investigations with the patients, most of the physicians perform creditably here as the majority took time to discuss investigation findings with their patients.

However, on the need for hospital admission most physicians discussed with their patients but about half gave alternatives to patients and only 48.7% discussed with patients the likely period their hospital admission will take. All these are findings on factors militating our effective and efficient health care delivery to the patients. It is common to find patients, especially in our environment discharging themselves against medical advice not minding the consequence, this may result from inadequate medical education to the patient of their illness. Furthermore, the study shows that 76.4% discussed options of treatment outside of surgery but the rest gave no options and only 66.8% discussed the types of surgeries available not enabling the patient to participate in the chosen option. 69.2% discussed the complications of the procedure but only 28% owned up to mistakes made during surgeries. This study also shows that despite the fact that a high percentage 89.2% do encounter cases of morbidity- staying in the hospital beyond schedule, only 71.1% regularly explain to the patient's reasons for the prolonged hospital stay.

On the education of the relations of the patient in case of eventual death, our findings show that only a very low percentage 13.1% request a post-mortem of their dead patients regularly, 34.7% do not at all while 52.2% request occasionally. This again is a big gap in our adequate healthcare delivery. The post-mortem on any patient is very necessary to tidy up the eventual cause of death. Our culture and religion are big obstacles to this necessity but until all is done to overcome this big obstacle, we may not be able to deliver the optimum health care as it is desired and we witnessed in the developed world.^{17,18}

CONCLUSION

This study has revealed that the urgent need to intensify diligent education of the patient by the attending physician has become a dire priority. There is a fair score of many physicians of all cadres trying to bring their patients on the same page with them but the gaps of not giving patients options of participating in management, and hospital admissions are uncomfortable findings. In this study, we also noted that the issue of post-mortem for dead patients which is the hallmark of diagnosis and cause of death is grossly inadequate. Therefore, there is an urgent need to reinvigorate the training curriculum of medical doctors at all levels and cadres to address these commissions and omissions otherwise our effort to attain an efficient and effective healthcare delivery in our community and society may become a mirage. The limitation of this study is that the respondents were made to assess their own practice which may require that patients and patient relatives may need to be independently investigated.



Conflict of Interest

The authors declare no conflict of interest

Source of Funding

The work received no funding aid from the government or any not-for-profit organisation.

REFERENCES

- [1]. Qadri SS, Pathak R, Singh M, Ahluwalia S, Saini S, Garg P. An Assessment of Patients Satisfaction with Services Obtained From a Tertiary Care Hospital in Rural Haryana. *Int J Collab Res Intern Med Public Health* [Internet]. 2012 [cited 2022 Nov 22];4(8):0–0. Available from: <https://www.iomcworld.org/abstract/an-assessment-of-patients-satisfaction-with-services-obtained-from-a-tertiary-care-hospital-in-rural-haryana-18751.html>
- [2]. Al-Abri R, Al-Balushi A. Patient Satisfaction Survey as a Tool Towards Quality Improvement. *Oman Med J* [Internet]. 2014 [cited 2022 Nov 22];29(1):3. Available from: [/pmc/articles/PMC3910415/](https://pubmed.ncbi.nlm.nih.gov/24710415/)
- [3]. Adhikary G, Shajedur Rahman Shawon M, Wazed Ali M, Shamsuzzaman M, Ahmed S, Shackelford KA, et al. Factors influencing patients' satisfaction at different levels of health facilities in Bangladesh: Results from patient exit interviews. *PLoS One* [Internet]. 2018 May 1 [cited 2022 Nov 22];13(5). Available from: <https://pubmed.ncbi.nlm.nih.gov/29768441/>
- [4]. Wallace LS, Lennon ES. American Academy of Family Physicians patient education materials: Can patients read them? *Fam Med*. 2004 Sep;36(8):571–4.
- [5]. Kongstvedt PR (Peter R. The managed health care handbook. 2001;1408.
- [6]. The Impact Patient Knowledge: Patient Teaching Benefits - Krames [Internet]. [cited 2022 Nov 22]. Available from: <https://www.krames.com/insights/the-impact-of-knowledge-patient-education-improves-compliance-and-outcomes>
- [7]. Fernsler JI, Cannon CA. The whys of patient education. *Semin Oncol Nurs* [Internet]. 1991 [cited 2022 Nov 22];7(2):79–86. Available from: <https://pubmed.ncbi.nlm.nih.gov/1882153/>
- [8]. Ashrafun L, Uddin MJ. Factors Determining Inpatient Satisfaction with Hospital Care in Bangladesh. *Asian Soc Sci* [Internet]. 2011 May 31 [cited 2022 Nov 22];7(6):p15. Available from: <https://ccsenet.org/journal/index.php/ass/article/view/8904>
- [9]. Peters DH, El-Saharty S, Siadat B, Janovsky K, Vujicic M. Improving Health Service Delivery in Developing Countries : From Evidence to Action. *Improving Health Service Delivery in Developing Countries* [Internet]. 2009 May 19 [cited 2022 Nov 22]; Available from: <https://openknowledge.worldbank.org/handle/10986/12335>
- [10]. Nurbaiyah SK, Hafizzudin MM. A Cross-Sectional Study on Patient Satisfaction with Universiti Kebangsaan Malaysia Medical Centre (UKMMC) Primary Care Clinic. *Med & Health*. 2012;7(1):12–23.
- [11]. Dabaghian FH, Khadem I, Ghods R. Evaluation of Patient Satisfaction with Medical Services at Traditional Iranian Medicine Clinics in Tehran. *Journal of Patient Safety & Quality Improvement* [Internet]. 2016 Jan 1 [cited 2022 Nov 22];4(1):313–9. Available from: https://psj.mums.ac.ir/article_6287.html



- [12]. A participatory approach to understanding and measuring patient satisfaction in a primary care teaching setting - PubMed [Internet]. [cited 2022 Nov 22]. Available from: <https://pubmed.ncbi.nlm.nih.gov/22616209/>
- [13]. Ofili OU. PATIENT SATISFACTION IN HEALTHCARE DELIVERY – A REVIEW OF CURRENT APPROACHES AND METHODS. *European Scientific Journal, ESJ* [Internet]. 2014 Sep 29 [cited 2022 Nov 22];10(25):1857–7881. Available from: <https://eujournal.org/index.php/esj/article/view/4261>
- [14]. Patient satisfaction with the services provided at a general outpatients' clinic, Ibadan, Oyo State, Nigeria - PubMed [Internet]. [cited 2022 Nov 22]. Available from: <https://pubmed.ncbi.nlm.nih.gov/16749337/>
- [15]. Iloh G, Njoku P, Amadi A, Godswill-Uko E, Ofoedu J, Okafor G. Satisfaction with Quality of Care Received by Patients without National Health Insurance Attending a Primary Care Clinic in a Resource-Poor Environment of a Tertiary Hospital in Eastern Nigeria in the Era of Scaling up the Nigerian Formal Sector Health Insurance Scheme. *Ann Med Health Sci Res* [Internet]. 2013 [cited 2022 Nov 22];3(1):31. Available from: <https://pubmed.ncbi.nlm.nih.gov/23634326/>
- [16]. Caldwell G. The process of clinical consultation is crucial to patient outcomes and safety: 10 quality indicators. *Clin Med (Lond)* [Internet]. 2019 [cited 2022 Nov 22];19(6):503–6. Available from: <https://pubmed.ncbi.nlm.nih.gov/31732592/>
- [17]. Okechi OS. Culture, Perception/Belief about Death and their Implication to the Awareness and Control of the Socio-Economic, Environmental and Health Factors Surrounding Lower Life Expectancy in Nigeria. *Acta Psychopathologica* [Internet]. 2017 [cited 2022 Nov 22];3(5):0–0. Available from: <https://www.primescholars.com/articles/culture-perceptionbelief-about-death-and-their-implication-to-the-awareness-and-control-of-the-socioeconomic-environment-104275.html>
- [18]. Atanda AT, Umar AB, Yusuf I, Imam MI, Sule AA. Autopsy and religion: A review of the literature. *Sahel Medical Journal* [Internet]. 2022 [cited 2022 Nov 22];19(3):119. Available from: <https://www.smjonline.org/article.asp?issn=1118-8561;year=2016;volume=19;issue=3;spage=119;epage=124;aulast=Atanda>