https://dspace.org/

The experiences of adult patients involved in clinical teaching sessions conducted by health professionals in an academic hospital

Nxumalo, Mercedes Zanele

2014-03-20
http://hdl.handle.net10539/14242

Downloaded from a DSpace repository. https://dspace.org/

THE EXPERIENCES OF ADULT PATIENTS INVOLVED IN CLINICAL TEACHING SESSIONS CONDUCTED BY HEALTH PROFESSIONALS IN AN ACADEMIC HOSPITAL.

Mercedes Zanele Nxumalo

A research report submitted to the Faculty of Health Sciences, University of the Witwatersrand, in partial fulfilment of the requirements for the degree

of

Master of Science in Nursing

Johannesburg, 2000

Declaration

I, Mercedes Zanele Nxumalo declare that this research report is my own work. It is being submitted for the degree of Master of Science in Nursing in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other University.

.....MZNxumalo.....

.....26.....day of .....Nov....., 2000

Abstract

The purpose of this study was to describe the experiences and perceptions of adult patients in relation to their rights and their involvement in clinical teaching sessions in an academic hospital. A descriptive survey design was used. A structured questionnaire with both open and closed-ended questions was used to interview a systematic random sample of 218 hospitalised patients. Several strategies including a pilot study were implemented to ensure reliability and validity. Percentages and chi-square analysis were obtained by use of a Statistical Analysis System (SAS) Software Programme. Qualitative data was sorted into descriptive categories, to which numerical codes were assigned. A narrative text was written.

The majority of patients had knowledge of their rights except for their right to autonomy. They reported that their rights were observed during clinical teaching except for their right to respect, health care and education and communication. Patients' knowledge of their rights, especially their right to autonomy and education depended on their educational status. Similarly the extent to which patients perceived whether or not their rights were observed depended on their knowledge of their rights.

Although patients had both positive and negative experiences during clinical teaching, they were generally positive about their involvement in health professional education. Patients also suggested strategies to increase their comfort during clinical teaching sessions.

Acknowledgements

I would like to thank the Lord All Mighty for giving me the opportunity, intellect and strength to conduct this research. My deepest gratitude goes to my supervisor, Mrs Judith Bruce for her valuable constant support, guidance and encouragement.

In a special way, I would like to thank my family- my husband Mxolisi and the children Sifiso, Mlungisi and Menelisi for the support, encouragement, time and money I have taken away from them during this study. I cannot forget my parents and siblings for their continued support and encouragement. I also give thanks to my special friends and colleagues in particular Ms D. Gershater and Dr T. T. Ziqubu-Page for their support.

I am equally grateful to Prof. H.F. Schoeman and Dr. J.F. Levin for their statistical guidance and support. I am also grateful to Mr J.P. Kelly for the editing he has done and Mrs M.J. Oosthuizen for the technical support.

Table of Contents

		Pages
DECLARATION		ii
ABSTRACT		iii
ACKNOWLEDGEMENTS		iv
TABLE OF CONTENT		v
LIST OF TABLES		x
LIST OF FIGURES		xi

Chapter 1:

1.0	Introduction	1
1.1	Identification of the problem	4
1.2	Research question	5
1.3	Aims and objectives	5
1.3.1	Aim	5
1.3.2	Objectives	6
1.4	Operational definitions	6
1.5	Significance of the study	7
1.6	Summary	8

Chapter 2: Literature review

2.0	Introduction	9
2.1	Clinical teaching and learning	9
2.2	Human rights	13
2.3	Patients' rights	15
2.3.1	Patient's rights charter	17
2.3.2	Patients' rights in clinical teaching	21
2.3.2.1	Human dignity and respect	21
2.3.2.2	Quality health care and comfort	22
2.3.2.3	Information and education	24
2.3.2.4	Freedom and autonomy	26
2.3.2.5	Privacy and confidentiality	33
2.4	Patients' perceptions and experience about clinical teaching	37
2.5	Summary	40

Chapter 3: Research methodology

3.0	Introduction	42
3.1	Research design	42
3.2	Research setting	43
3.3	Population and sample	44
3.4	Data collection	45
3.4.1	Data collection procedure	45

3.4.2 Data collection tool 46

3.4.3 The research assistant 46

3.5 Validity and reliability 47

3.5.1 Reliability 47

3.5.2 Validity 48

3.6 Pilot study 50

3.7 Ethical considerations 51

3.8 Summary 53

Chapter 4: Findings and discussion of findings

4.0 Introduction 54

4.1 Data analysis 54

4.2 Presentation and discussion of results 55

4.2.1 Section A- Personal information and background knowledge of participants 56

4.2.1.1 Age of respondents 55

4.2.1.2 Employment status of respondents 56

4.2.1.3 Educational status of respondents and patients' knowledge of their rights 57

4.2.2 Section B- Clinical teaching sessions 60

4.2.2.1 Health professionals involved in clinical teaching 60

4.2.2.2 Patients assessment of whether their rights were observed or not 61

4.2.2.3 Human dignity and respect 64

4.2.2.4 Health care and comfort 67

4.2.2.5 Privacy and confidentiality 73

4.2.2.6 Freedom and autonomy 75

4.2.2.7 Communication and interaction 84

4.3. Section C- Patients' experiences and perceptions during clinical teaching 91

4.3.1 Patients' positive experiences 91

4.3.2 Patients' negative experiences 95

4.3.3 Patients' perceptions 101

4.4 Summary 107

Chapter 5: Summary, main findings, limitations, recommendations and conclusion

5.0 Introduction 109

5.1 Summary 109

5.2 Main findings 110

5.2.1 Background 110

5.2.2 Patients' knowledge of their rights 110

5.2.3 The extent to which patients' rights were observed during clinical teaching 111

5.2.4 Patients' experiences in relation to observance of their rights 112

5.2.5 Patients' perceptions of clinical teaching session 114

5.3 Limitations 115

5.4 Recommendations 116

5.4.1 Health Professional Education 116

5.4.2 Research 119

5.5 Conclusion 119

References 122

Appendix A *Questionnaire* 127

Appendix B Letter of permission Research on Human Subjects (Medical) Committee (University of the Witwatersand) 135

Appendix C Letter of permission from the Post Graduate Committee (University of Witwatersrand) 136

Appendix D Letter of permission from Ga-Rankuwa Academic Hospital Superintendent 137

Appendix E *Patients' information letter* 138

Appendix F Consent form 140

List of Tables

2.1	Patients' Bill of Rights of the American Hospital Association (1992)	18
2.2	Patients' Rights Charter of the Department of Health in South Africa (1999)	19
2.3	Health Rights Charter according to the National Progressive Primary Health Care Network (NPPHCN)	20
4.1	Age of respondents	56
4.2	Employment status of respondents	56
4.3	Educational status of respondents	57
4.4	Health professionals involved in clinical teaching sessions	61
4.5	Ways used by clinical teaching groups to address patients	67
4.6	Frequency of clinical teaching sessions	69
4.7	Duration of clinical teaching sessions	70
4.8	Extent to which physical needs of patients were met during clinical teaching sessions	71
4.9	Number of participants in the most recent clinical teaching session	74
4.10	Specific ways of explaining the procedure	78
4.11	Involvement of patients during clinical teaching sessions	78
4.12	Options given to participate in clinical teaching sessions	82
4.13	Reasons for participation in clinical teaching sessions	83
4.14	Messages not communicated by patients during clinical teaching sessions	90

List of Figures

2.1	Clinical learning model	10
4.1	Patients' knowledge of their rights	59
4.2	Observance of patients' rights during clinical teaching	63
4.3	Introduction of clinical teaching group members during clinical teaching sessions	65
4.4	Consideration of spiritual and cultural beliefs and needs during clinical teaching sessions	72
4.5	Explanation of the procedure to patients before the commencement of clinical teaching sessions	77
4.6	Informed consent and permission asked to participate in clinical teaching	81
4.7	Communication and interaction between patients and clinical teaching groups	85
4.8	Feedback sessions conducted during and after clinical teaching sessions	88
4.9	Patients' responses related to comfort during clinical teaching sessions	92
4.10	Patients' responses related to discomfort during clinical teaching sessions	100
4.11	Patients' perceptions about clinical teaching	102
4.12	Patients' reasons for involvement in clinical teaching	104
4.13	Patients' views on how they should be treated during clinical teaching sessions.	106

Chapter 1

1.0 Introduction

The White Paper for the Transformation of the Health System in South Africa, later referred to as the White Paper (DOH, 1997:15) aimed at promoting the optimal use of the skills, experience and expertise of all health personnel. The primary objective is to develop education and training programmes aimed at recruiting and developing personnel who are competent to respond appropriately to the needs of the people they serve. It is envisaged, according to the White Paper (DOH, 1997), that Academic Health Service Complexes will meet this primary objective. Academic Health Service Complexes are essential national resources which play an important role in the education and training of health professionals, caring for the ill and creating new knowledge through research.

Clinical teaching is one of the facets of the health professional education programme that addresses the cognitive, psychomotor and affective skills of health professional neophytes. Clinical teaching should be conducted in a manner that displays caring, commitment, conscience, confidence and compassion, as these are the core qualities of all health professionals. In the process of clinical teaching sessions, the experience of patients should be that of caring and compassion. This would be in line with the goal and philosophy of "humanisation of care" as proposed by the World Health Organisation (WHO) in 1977 (in Diederick and Latengan, 1994). One way of attaining the WHO's goal and philosophy is through the identification, recognition

and protection of patients' rights during clinical teaching. It can thus be seen that the humanisation of care and enunciation of patients' rights are intertwined. Hence, the promotion of patients' rights is to be seen as the vehicle for promoting the values of humanisation of care.

Diedericks and Lategan (1994) suggest that generally economic, technical, psychosocial and political reasons prevent fundamental rights from being recognised and protected. This state of affairs prevents the realisation of ethical values and hence the protection of human rights in practice. In the past, many factors contributed to the unavailability of a Charter of Patient's Rights in South Africa. One of the main reasons was the apartheid system that destroyed the possibility of a human rights culture in the country for six decades and undermined the dignity of the black majority. Human rights were not entrenched in the Constitution of the country, hence their transgression in many areas such as the workplace, health care settings and social institutions. The White Paper (DOH, 1997) has proposed the development of the Patients' Bill of Rights with full consultation with health service providers, users and other stakeholders in support of the continuing democratisation of society.

In the health services, patients' rights were violated in several ways. Major problems of inequity and inefficiency existed. Socio-economic conditions, racial divisions and geographical location were isolated as the main determinants of inequality in the provision, allocation and distribution of health care (Fourie and Van Rensburg, 1994).

Quality care and standards of education and training varied widely as evidenced by unequal and poor distribution of services, human and physical resources (Diedericks and Lategan, 1994). Violations of patients' rights have occurred in the context of a deliberate policy of discriminatory health care, favouring the white minority over the black majority. Consequently, there was vast disparity in the standards and quality of care between white and black hospitals. Black hospitals generally had fewer resources hence an inferior quality of patient care was rendered.

Institutions of learnir' were racially divided imposing inferior primary and secondary school education on black students; medical and nursing schools included because of apartheid policies. Black health professionals were trained in separate medical and nursing schools where their training and education tended to be of inferior quality. Consequently, there were few adequately qualified black health professionals who could effectively meet the health needs of black South Africans. The culture of insensitivity towards human rights seems to have undermined patients' confidence to express their feelings and defend their rights during clinical interactions including clinical teaching.

Since the inception of the Government of National Unity in 1994, human rights are entrenched in the Constitution, hence a culture of human rights is slowly emerging, as people are being re-educated. Due to persistent education and sensitisation, people are starting to exert their rights in many situations even in the health care setting. The

importance given to the need for community participation in recent national policy is a revealing indicator of the strength of democracy in South African society. Communities and patients have a say in health care matters and how they would like to be treated. Patients are now expecting health professionals to respect and observe their rights during their treatment and care. It is therefore more likely that patients' rights will not be merely formulated but truly observed in daily practice (Bewley, 1992).

The challenge posed by this new reality of patient care concerns balancing the future generation's need for hands-on training and experience against the right of patients to receive the highest quality of care. The dilemma is a reflection of the flawed medical model, which is both inapposite to the patient-health professional relationship and ineffectual in reshaping it. The problem may also be attributed to medicine's highly autonomous professional culture, which undervalues patient involvement and reinforces benign paternalism (Silverman, 1996).

1.1 Identification of the problem

The researcher was involved in clinical teaching and accompaniment of Bachelor of Curationis (B. Cur) undergraduate students at the Medical University of Southern Africa (Medunsa). These students gained their clinical experiences from Ga-Rankuwa Hospital and other neighbouring health care services. After clinical teaching and accompaniment sessions patients were informally interviewed about their experiences

during clinical teaching. Some of the patients were uncomfortable and visibly distressed and most expressed mixed feelings while a few valued and enjoyed their involvement in clinical teaching. It became apparent from discussions with health professionals and students that, in some cases, patients' rights were transgressed resulting in their resenting clinical teaching sessions. If patients resent such sessions and exercise their right to refuse, clinical teaching opportunities would be diminished. This poses a problem because clinical teaching is the cornerstone in the education of health professionals especially in Academic Health Service Complexes.

1.2 Research questions

It is through these experiences that the researcher gained an interest in investigating this problem in order to address the following questions:

- How do patients experience clinical teaching sessions?
- How do patients perceive their involvement in clinical teaching?
- To what extent are patients' rights observed during clinical teaching?

1.3 Aim and objectives

1.3.1 Aim

Through a descriptive survey design, the study aimed at describing the experiences and perceptions of adult patients in relation to their rights and their involvement in clinical teaching sessions in an academic hospital.

1.3.2 Objectives

The objectives of the study were to:

- Identify and describe patients' positive and negative experiences associated with their involvement in clinical teaching.
- Determine the perceptions of patients pertaining to their involvement in clinical teaching
- Determine the extent to which patients' rights are observed during clinical teaching.

1.4 Operational definitions

For the purpose of the study the following definitions will apply:

- **Experience**

  Experience can be described as the individual's physical, social and psychological perceptions of an event. This may include emotions, thoughts, preferences, values and perceptions. In this study the "event" is clinical teaching.

- **Clinical teaching**

  Clinical teaching is an event in the health care service that involves the applied teaching of students about the care and treatment of patients under the supervision of a health professional. This involves any procedure or activity conducted by the health professional on a patient.

- **Health professional**

  Health professional is a person qualified and licensed to be involved in the promotion of health, prevention of ill health, treatment of disease and rehabilitation. Health professionals that were involved in this study include medical practitioners, registered nurses and physiotherapists.

- **Adult patient**

  An adult patient is an individual who is 18 years of age and older and is hospitalised to receive health care under the supervision of a health professional.

- **Right**

  It refers to an action, behaviour and/or principle that is considered morally, socially and legally correct, just and acceptable.

- **Academic Health Service Complex**

  It is a tertiary level health institution involved in the management of health problems, health related research, education and training of health science students.

1.5 Significance of the study

It is envisaged that the study will advance knowledge, increase awareness and sensitise health professionals about patients' experiences during clinical teaching especially in relation to the observance and protection of their rights. Recommendations will be made on patient management and care during clinical

teaching. If it is known what patients experience, whether positive or negative, this could make health professionals more caring and empathetic towards them. A culture of patients' rights during clinical teaching could be promoted and enhanced.

1.6 Summary

The objective of the White Paper (DOH, 1997) is to promote optimal use of the experience, expertise and skills of health professionals and to develop education and training programmes. This objective will be accomplished by Academic Health Service Complexes primarily through clinical teaching. Because clinical teaching is the vehicle of health professional education, the caring attribute must be emphasised. The identification, acknowledgement and protection of human and patients' rights, which include promotion of the humanisation of care, could do this. The main aim of the study was to elicit information and describe the experiences and perceptions of adult patients in relation to their rights and their involvement in clinical teaching sessions in an academic hospital.

This chapter served to introduce the study, the research questions, aims and objectives. Concepts were operationally defined and the significance of the study was highlighted.

Chapter 2

Literature review

2.0 Introduction

This chapter describes the components of clinical teaching and learning and the concept of human rights. It covers the definition, settings, participants and model of clinical teaching and briefly describes its challenges. Patients' rights are described, with reference to specific rights relevant to clinical teaching. The perceptions and views of patients involved in clinical teaching will also be highlighted.

2.1 Clinical teaching and learning

Clinical teaching is defined as an event in the health service that involves the teaching of students about the care and treatment of patients, in the presence of a patient, under the supervision of a registered health professional. This involves any procedure or activity conducted by the health professional. It can be formal or informal, direct or indirect, planned or unplanned. Clinical teaching is regarded as a vehicle that provides students with the opportunity to translate basic theoretical knowledge into the learning of a variety of skills. These are affective, intellectual and psychomotor skills needed to provide patient-centred quality care (Schweer in White and Ewan, 1994). Clinical teaching and learning assist students to acquire all performance-oriented skills and competencies associated with patient diagnosis, treatment and

care. These are not only psychomotor in nature but include professional and personal skills, attitudes and behaviours essential for quality patient care.

White and Ewan (1994) call it clinical learning and have adopted a cyclical model which comprises five steps as indicated in Figure 2.1.

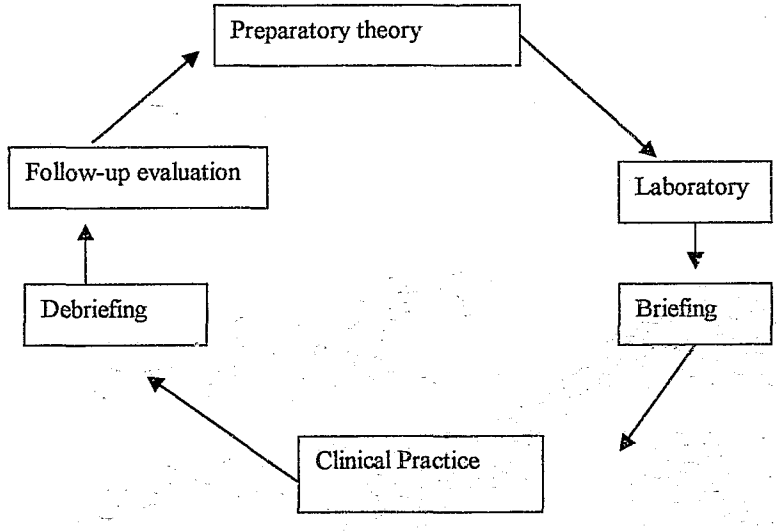


Figure 2.1. Clinical learning model

According to the above cyclical model, the progression of clinical learning begins with the theoretical component of the programme and proceeds to a laboratory where principles and concepts from the theoretical component are applied and practiced. After students have practised in a laboratory, they then proceed to a briefing or pre-

conference session before going for clinical practice. A debriefing or post-conference session is conducted after students have gone for clinical practice in a health setting. The emphasis of this study is on the clinical practice step. During this step, students are actively involved in a health care service setting, learning and practising the clinical skills on patients.

As indicated, clinical teaching and hence learning could be conducted in a laboratory setting (simulated practice setting) and in the real clinical area (non-simulated practice setting). Without doubt, the presence of the patient makes clinical teaching a powerful tool for learning as compared to the laboratory situation. Bruce (1992) states that the laboratory offers a well-controlled, relaxed and static learning environment. In this environment the students can practise and attain proficiency in psychomotor skills with less emotional and ethical stress. The patient care setting on the other hand, is dynamic with uncontrolled factors and constraints that may influence skill learning. Patient care settings are patient-centred rather than student-centred hence the priority in atient settings is service and the priority of a learning laboratory is learning (Bruce, 1992). This could mean that patients' needs, feelings and rights could become subordinate to the students' needs to learn during clinical teaching sessions. When using the patient care setting for clinical teaching, service may be provided in the process but the client's needs and the quality of service rendered may be compromised. Although a shift of emphasis onto the student does exist,

preservation of patients' rights must be entrenched in the ethical and philosophical foundations of health care and health professional education.

There are three role players in clinical teaching- student(s), clinical teacher(s) or preceptor(s) and patient(s). All the participants have different roles during clinical teaching. The clinical teacher's role is to teach the students and to care for the patient in the process. Learning and caring for the patient are the student's role. The role of the patient is to receive care and to "teach" or inform the student and the clinical teacher about his/her disease process and needs. Because all these people are participants, their specific roles should be acknowledged. In most instances the roles of the student and the clinical teacher are emphasised and clearly articulated. Very little emphasis is placed on the role of the patient during clinical teaching. This practice gives an impression that the presence of the patient is ignored, his/her role is devalued and consequently his/her rights are undermined.

Newble and Cannon (1994) are of the opinion that clinical teaching is the most neglected of all areas of teaching. Hence, many deficiencies have been found in this area. The conclusion of one extensive study was that many clinical teaching sessions were haphazard, mediocre and lacking in intellectual excitement (Newble and Cannon, 1994).

Presently there are many challenges facing clinical teaching, mainly resulting from changes in the educational, health care and socio-political systems. These changes are interrelated and interdependent. For example, changes in the socio-political system demand changes in the educational and health systems. In response to this, clinical teachers must be sensitive to the needs of the patients/ clients they are dealing with. This calls for changes in patient care approach. Therefore in caring for the patient, the patient's physical, spiritual and psychological needs must be met. In showing caring attitudes, the patient's basic comfort, needs and rights must be considered during clinical teaching.

2.2 Human rights

The Online Ethics Centre (1999) refers to rights as claims that have some justification. There are normally two broad distinctions of rights i.e. moral and legal rights. Moral rights are determined by moral norms and the law determines legal rights. The use of the word "right" without specifying the nature of justification normally refers to a moral right. Rights specify the acts that are permitted, forbidden or required. If they specify acts that the holder of rights may perform (such as voting), they are called licenses. If they specify what others may not perform (as the right to life obliges one not to kill), they are called liberties or negative rights. If they specify what the holder of a right should receive, they are called rights of entitlement or positive rights.

Other classifications of rights are alienable or inalienable, human or special, absolute or prima-facie rights (Online Ethics Centre, 1999). The descriptions are as follows:

- *Alienable* rights and *inalienable* rights - Alienable rights may be taken or given away. For an example the right to informed consent can be outweighed in emergency situations. Inalienable rights cannot be taken or given away. The right to respect and dignity cannot be taken away because it is a fundamental human right.
- *Human* rights and *special* rights - Human rights belong to all people or all people who are competent to exercise them. In contrast, a right that only belongs to some people is termed a "special" right e.g. children's rights or patients' rights.
- *Absolute* rights and *prima-facie* rights - Absolute rights cannot be outweighed by other considerations. The right to life and health care cannot be outweighed by other considerations. Prima-facie rights can be outweighed by other considerations. For example, the law can in some circumstances outweigh the right to autonomy of patients suffering from tuberculosis where the patient does not comply with medical treatment. This could be done for the sake of the public's needs and their right to health.

It is important to note that all these rights are interrelated and interdependent. An effect on one right has a consequence or ripple effect on others. For an example, if one respects a patient's right to privacy, chances are that that individual will also

protect a patient's rights to confidentiality and autonomy. The opposite is also true if the patient's right to privacy is not respected.

This study and the following text will concentrate on human rights with specific emphasis on patients' rights.

2.3 Patients' rights

Effective health care requires collaboration between patients and health care professionals. Health care services must provide a foundation for understanding and respecting the rights and responsibilities of patients and their families. Health care services must ensure a health care ethic that respects personal and professional values and the role of patients in decision-making about treatment choices and other aspects of care. This urges these services to be sensitive to the general and special needs and rights of patients.

As previously discussed, human rights belong to all people including those who are not competent to exercise them. Patients' rights can be described as follows:

- They are special rights because they belong to a special group of people. These people are patients, clients or health care consumers.
- They are both legal and moral. They are considered legal because they are enforced by the law i.e. the law that governs different health professions and the law of the land. There is a link or a relationship between human rights and

patients' rights. Patients' rights are part of human rights. They are also considered moral rights because they are justified by moral and ethical norms.

- They are rights of entitlement or positive rights because they specify what the patient should receive from health professionals and others.
- They are inalienable rights because they cannot be taken or given away.
- They are prima-facie because they can be outweighed by other considerations and situations e.g. emergency situations, considerations of health and social laws. Hence patients' rights are limited to a certain extent, depending on full consideration to the patients' and public's interests and needs.

For the first time in the history of South Africa, human fundamental rights are protected in the Constitution Act (Act no 108 of 1996). These rights include among others the right to equality, life, human dignity, freedom, security, privacy, healthy environment, and the right to own language and culture. According to the Standards for Nursing Practice [South African Nursing Council (SANC), 1992:03], the patient has the right to privacy, confidentiality, respect and autonomy which encompasses the right to be involved or refuse to be involved in hospital routines, procedures and clinical teaching.

2.3.1 Patients' Rights Charter

Worldwide, charters or bills of patients' rights are used as a definitive plan to operationalise patients' rights. South Africa through the Department of Health (DOH) has recently developed a Patients' Charter as was suggested in the White Paper (DOH, 1997). The ultimate aim is to contribute to effective patient care and to be supported by the different health institutions, the health care professionals, health care workers and the patients.

The tables that follow are examples of Patients' Bill of Rights as published by different organisations i.e. American Hospital Association (AHA), the Department of Health in South Africa and the National Progressive Primary Health Care Network (NPPHCN) (DOH Talk, 1998) respectively.

Table 2.1 Patients' Bill of Rights of the American Hospital Association (1992)

The patient has the right to:
1. Considerate and respectful care
2. Obtain complete information from the physician about the nature of disease, treatment, and prognosis
3. Make decisions about the plan of care prior to and during the course of treatment and to refuse a recommended treatment or plan of care to the extent permitted by law and hospital policy
4. Have an advance directive (such as a living will, health care proxy or durable power of attorney of health care) concerning treatment
5. Every consideration of privacy
6. All communications and records pertaining to his care and to be treated as confidential
7. Review the records pertaining to his/her medical care
8. Expect that within its capacity and policies, a hospital will make reasonable response to the request of a patient for approximate and medically indicated care and services
9.Ask and be informed of the existence of the business relationship among the hospitals, educational institutions, other health care providers or payers that may influence the patients' treatment and care.
10. Consent or decline to participate in proposed research studies or human experimentation affecting care and treatment or requiring direct patient involvement
11. Be informed of hospital policies and practices that relate to patient care, treatment, and responsibilities

Table 2.2 Patients' Rights Charter of the Department of Health in South Africa (1999)

Every patient has the right to:
1. A healthy and safe environment
2. Participation in decision making
3. Access to health care
4. Knowledge of one's health insurance/medical aid scheme
5. Choice of health services
6. Be treated by a named health care provider
7. Confidentiality and privacy
8. Informed consent
9. Refuse treatment
10. A second opinion
11. Continuity of care
12. Complain about health services

Table 2.3 Health Rights Charter according to the NPPHCN

Every patient has the right to:
1. Access to health services
2. Exercise his/her choice
3. Simplified communication
4. Express complaints
5. Confidentiality
6. Courteous care
7. Dignity, privacy and confidentiality
8. Non discrimination
9. Access a doctor, dentist and other health specialists
10. Appropriate drugs and medicine
11. Discuss fees and related medical costs
12. Information regarding health
13. Informed choice and consent
14. Palliative care
15. Safety and security
16. Admission and stay in hospital
17. Provision of ambulance and transport
18. Appropriate and emergency medical treatment
19. Adequate water supplies, sanitation and waste disposal
20. Free health services

From the analysis of the above-mentioned Patients' Bills of Rights, there seem to be unique and common rights. This study will concentrate on common rights as identified above and includes the rights to:

- Human dignity and respect
- Quality health care and comfort
- Information and education
- Freedom and autonomy (informed consent)
- Privacy and confidentiality

2.3.2 Patients' rights in clinical teaching

2.3.2.1 Human dignity and respect

Every patient is entitled to respect for their person, human dignity and privacy, without unfair discrimination on one or more grounds such as race, gender, ethnic or social origin, colour, sex, sexual orientation, age, disability, health status, pregnancy, marital status, religion, conscience, belief, culture, language, birth. (DOH, 1999). The patient's person, physique and properties must be respected. Should the patient find the manner in which he/she is treated unacceptable, he/she has a right to complain, have the complaints investigated and receive a full and prompt response.

To respect means to take notice of, to regard with special attention and honour, to regard as worthy of special consideration and esteem, hence to care for, to take heed.

In the same light dignity is regarded as the state of feeling and being worthy or honourable, the quality of being worthy of esteem or respect, elevation of mind or character, true worth and excellence (The Webster's Revised Unabridged Dictionary, 1998). Hence the patient must be respected for what he/she is and be accepted unconditionally.

It should be noted that the right to respect and human dignity is broad. It encompasses all patients' rights. Ensuring patients' right to respect and dignity means observing all patients' rights. One cannot ensure respect and dignity if some of the patients' rights are transgressed. It is therefore imperative that during clinical teaching the right of the patient to respect and dignity should be observed by the clinical teaching group at all times. As mentioned above the clinical teaching group cannot observe the right to respect and dignity without observing all other patients' rights.

2.3.2.2 Quality health care and comfort

Pera and Van Tonder, (1996) states that patients have two rights, the right to health and the right to health care. The right to patient care is a consequence of the right to health care (AHA, 1992). According to the theory of human rights, health care for the sick and equal access to health care services is a fundamental right not a privilege. Schmidt (1996) indicates that the consumers' right to life means quality life, not only the absence of illness. This includes the WHO's Constitution (1977) [in Diederick and Lategan, 1994] which states that "the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without

distinction of race, religion, political belief, economic or social condition." Since the health sciences encompass the spectrum of scientific and technical knowledge, quality health care should therefore be knowledgeable, competent, legally, morally and ethically based care.

The right to quality health care also encompasses the right to receive timely emergency care, treatment and rehabilitation, provision for special needs, counselling, palliative care, health information and the positive disposition of the health care workers (DOH, 1999). In so doing, total patient comfort will be attained. The Webster's Revised Unabridged Dictionary (1998) refers to comfort as a state of quite enjoyment, freedom from pain, want or anxiety; also whatever contributes to such a condition.

According to Maslow's theory (in Porter and Perry, 1999 and DOH, 1999) of needs, human beings have five basic needs of which the first three needs viz. physiological, security and social needs can be considered human rights. Quality patient care involves meeting patients' basic needs especially those considered to be human rights. Meeting patients' security needs means creating a safe and healthy environment free from physical, spiritual and psychological harm and danger. Meeting patients' basic and special physical needs ensures that the patient is homeostatically balanced. The caregiver must always bear in mind that the patient is a social being and not an object.

The clinical teacher should therefore ensure that the quality of patient care delivered during clinical teaching should not be compromised. The care offered by the student should be competent and legally, morally and ethically based. Therefore, the patient must remain comfortable with all his/her basic physical, spiritual, psychological (including cultural) needs met during clinical teaching.

2.3.2.3 Information and education

Information is the act of informing or communicating knowledge or intelligence. It also refers to news, advice, knowledge and/or intelligence obtained by personal study, observation, investigation or instruction. Education is the act or process of educating or the activities that impart knowledge acquired by learning and instruction, the result of educating as determined by the knowledge, skill or discipline of character (The Webster's Revised Unabridged Dictionary, 1998)

During clinical teaching health professionals have an obligation to inform and educate patients about the following (DOH, 1999):

- The identity and the status of health care providers in the clinical teaching group
- The patient's health status, nature and state of his/her illness/disability and the clinical teaching group's findings during and/or after the session
- Available health care services that can be consulted for further management
- Resources, the implication and the consequences of using those services and resources

- Nature of the diagnostic and therapeutic procedures intended and to what extent students will be involved in such procedures
- The range of treatment and rehabilitation options available to him/her
- The benefits, risks, side effects and consequences generally associated with each procedure.
- The conditions governing access to services. This includes hospital policies and practices that relate to patient care, treatment and responsibilities.
- Available resources for resolving disputes, grievances and conflicts such as ethics committees, patients' representatives or other mechanisms available in the institution.
- All possible immediate and long-term financial implications of treatment choices involved and the available payment methods.
- The existence of business relationships among the hospitals, educational institutions, other health care providers, or payers that may influence the patient's treatment and care.

To enhance understanding and participation of the patient during the clinical teaching session, clear information on health should be given. This could be achieved by the use of a language that can be understood by the patient and preferably should be the patient's first language. Although the patient may understand the language, medical jargon must be avoided. Where barriers such as linguistic differences, hearing impairment or visual impairment do exist, the same information should be provided

through interpreters, sign language or Braille. In addition health facilities should have visible signposts for easy access (DOH, 1999).

With reference to clinical teaching, a patient has to be informed in broad terms of the nature of the procedure that is intended. This should include all the benefits and risks i.e. the presence of the students and his level of training and the extent to which the students will be utilised. Based on the information given to the patient, he/she has to decide and give consent to the procedure intended. If the patient is deceived about the real nature and circumstances surrounding the clinical teaching procedure, the consent is invalid.

2.3.2.4 Freedom and autonomy

Every human being of adult years (over 18 years) and sound mind has a right to freedom and autonomy. According to the Webster's Revised Unabridged Dictionary (1998) autonomy is regarded as the power or right of self-government, personal and moral. It also refers to the immunity from arbitrary exercise of authority. On the other hand, freedom refers to the state of being free, exemption from power and control of another, liberty and independence. With respect to autonomy and freedom as discussed, a patient has the right to determine what shall be done with his or her own body. Any act or procedure against the will of the patient and/or without his knowledge and consent is a violation of autonomy. A health professional that touches or invades a patient without his/her consent may face charges of assault.

The patient has the right to consent or to decline to participate in any procedure that requires direct patient involvement even during clinical teaching and to have those procedures fully explained before giving consent. A patient who declines to participate in clinical teaching is entitled to the most effective care that the hospital can otherwise provide.

- **Informed consent**

Obtaining informed consent from the patient is a legal and ethical way of ensuring that procedures are not done against the will of the patient and/or without his/her knowledge. Generally health professionals touch patients and invade their bodies during surgery and other procedures. This is done for the benefit of the patient and to fulfil the duty of care by health professionals. The whole picture changes when students touch patients during clinical teaching because this is now done for the benefit of the student and future patients. Hence in this case, obtaining informed consent is crucial.

Obtaining consent is a moral duty of health professionals and serves to protect the health professional from the charge of battery. Bewley (1992) states that consent can be expressed (verbal or written) or implied. Consent can also be implied by patients' conduct or action. In most instances, consent to clinical teaching is verbal or implied. In law, three criteria must be met before consent is regarded as valid: capacity,

voluntariness and information (Bewley, 1992). As "information and education" were already discussed, emphasis in this section will be on capacity and voluntariness.

- **Capacity**

An individual's age or level of understanding defines it. Usually people 18 years and above are presumed to have the capacity to give valid consent (Bewley, 1992). Mentally ill patients, unconscious patients and minors are regarded incompetent due to associated comprehension problems. For those regarded to be incompetent, consent may be given by a parent, legal guardian or legal representatives. Normally health professionals do not consult with the significant others e.g. parents/guardian, next of kin or legal representatives to give permission to clinical teaching on behalf of the incompetent patients.

- **Voluntariness**

This term is referred to as action by choice without any payment or rewards. Some patients do not necessarily volunteer in clinical teaching. Patients may be coerced into clinical teaching. Patients normally agree because they fear the consequences of refusal, or they want to please the health professionals or they are not assertive. If the patient is rewarded in return for co-operation with the teaching of students, this is considered as applying pressure.

Flynn, Spencer and Jones (1997) and Holden and Pullon (1997) in their studies found that patients were more concerned about informed consent and confidentiality. The patients highlighted that consent was sought at the last minute making it difficult to refuse. The method used to obtain consent was unacceptable to the patients. Patients preferred their consent to be asked for in private in the absence of the student.

- **Involvement of health care teams in health professional education**

Individual health professionals and health care teams generally display different patient care approaches. This difference is influenced by the number of participants in the process of patient care and consequently affects the patient's right to freedom and autonomy. Generally, health care practice is structured around the concept of treatment by a "team" of professionals. Qualified health professionals, interns and students play a primary role in patient care as members of the health care team. In most cases the majority of attention given to and time spent with patients is by students themselves. Because the team approach is inherently confusing to patients, patients have problems differentiating between the status of qualified health professionals and students (Silverman, 1996).

When a health care team is treating a patient, implied consent may extend to all members of the team because it is presupposed that by entering the hospital premises, patients effectively agree to be treated by the health care team. It is also argued that the patient attends an academic hospital with full knowledge that students are in

training and are part of the health team. It is therefore believed that, by admission to hospital consent to be examined by the health care team including the students is implied.

In essence, the idea that when patients attend an Academic Health Service Complex, they are demonstrating implied consent to be examined by the health care team and students is invalid (Bewley, 1992). Firstly, some patients may lack the essential knowledge to differentiate between an Academic Health Service Complex and a non-teaching hospital. Some patients do not fully comprehend the role and function of the Academic Health Service Complex. Even if the patient did know, the patient has the right to refuse to participate in clinical teaching. Secondly, students only participate in health care teams for their own learning needs- hence their results and recommendations in relation to patients' conditions cannot be relied upon.

Unfortunately, patients do not have total control over the make-up of the health care team in terms of expertise and competence. To compensate for the above issue, the clinical teacher should be responsible and accountable and ensure that high quality patient care is rendered at all times. To alleviate anxiety and confusion related to clinical teaching, the functions and staffing of Academic Health Service Complexes should be clearly explained to every patient.

The patient has the right to know the identity and professional status of members of the health care team and can expect to be attended by clearly identified health providers alone. This means that name, title and professional status should positively identify every participant in the team (DOH, 1999). Applying this judgement, the national health professional community formally acknowledges that patients must be fully informed of the qualifications of all persons on the treatment team and must have a meaningful option to reject treatment by any member. In other words, a patient refusing treatment by a student retains the right to the best possible care and cannot be punished for a decision not to participate in clinical teaching. Even though a patient may consent to the clinical participation of a person who is correctly comprehended to be a student, the patient does not thereby consent to be injured as a result of the care that is rendered (Silverman, 1996).

Students who introduce themselves or are introduced by others as licensed health professionals potentially face an additional statutory liability. State laws prohibiting the illegal practice of health professions typically bar the improper use of licensed health professional titles (e.g. physician, nurse, and occupational therapist). The student becomes guilty of illegal practice if he/she gave the impression that he/she was performing as a licensed health professional. Bewley (1992) reported that other laws go even further by making the clinical teacher legally responsible for clearly indicating the student's status to patients.

Despite the enforcement of medical ethics and law, Flynn et al. (1997) discovered that patients are sometimes led to believe that students are more highly qualified or experienced than they actually are. Flynn et al. (1997) refer to a study done in 1987 which found that only 37.4% of Academic Health Service Complexes specifically informed patients about the role of students in patient care, with most institutions relying on "blanket" consent. Flynn et al. (1997) also refer to another related study, which revealed that students were reluctant to obtain patients' consent especially for invasive procedures. In the same study it was also indicated that 63.5% of the junior students "seldom" or "never" obtained patients' permission before attempting those procedures. As to the issue of deceitful student misidentification, 34% of junior students either regularly or sometimes introduced themselves to patients as licensed practitioners.

Flynn et al. (1997) found that patients' permission to have a student present during the consultation was in most cases sought at the last moment. This made it difficult for the patient to refuse. If possible, consent should be sought when the appointment is made and patients should be told that they need not decide straight away. Certainly, patients have clear views about how they would like to be informed.

2.3.2.5 Privacy and confidentiality

The Webster's Revised Unabridged Dictionary (1998) refers to privacy as the state or quality of being apart from company or observation, freedom from unauthorised intrusion. The Online Ethics Center (1999) distinguishes three categories of privacy: physical, informational and decisional. In addition, Anita Allen (in Online Ethics Center, 1999) added another category of privacy- dispositional privacy. These categories can be described as follows:

- *Physical privacy* is a restriction on the ability of others to experience a person through one or more of the five senses.
- *Informational privacy* is a restriction on facts about the person that are unknown or unknowable.
- *Decisional privacy* is the exclusion of others from decisions such as health care decisions made by the person and his group of intimates.
- Finally, *dispositional privacy* is a restriction on the ability of others to know a persons' state of mind.

Confidential information is information entrusted to another. The implication is that for some reason (from personal privacy to competitive advantage) the person entrusting the information does not wish others to know. Thus, confidential information is information to be shared only with a very limited group. This group is normally involved with furthering certain ends, which the one entrusting that information wants reserved, such as treatment of a disease. In a clinical teaching

context, confidentiality and privacy refer to the way in which all information concerning the nature of a patient's disease, treatment or stay in a health institution is dealt with. Most professions recognise some duty to keep clients' information confidential although there are limitations (page 36).

Generally, patient care activities require the invasion of privacy. During clinical teaching, patients are in most cases compelled to expose their innermost thoughts, feelings and bodies to clinical teaching groups who are strangers. For example, a patient may feel threatened if asked to expose his/her body for physical examination during clinical teaching. A patient should not be made to expose his/her body unnecessarily, only the required body part should be exposed and/or the patient's private parts should be covered. To enhance comfort and privacy, patients may be put in a private room, screened or afforded space and time of their own so that they can do what they want without any interference. To protect human dignity, health providers should limit invasion to that which is necessary to accomplish the needs of their patients above that of teaching and learning goals.

Patients may feel threatened or uncomfortable to respond to very personal questions. Flynn et al. (1997) reported that patients preferred not to discuss personal anxieties, family problems or sexual problems in the presence of a student. Patients were more willing to have a student present if the consultation was for a simple physical condition than for an emotional problem or if an internal examination was required.

In the study conducted by Simons, Imboden and Martel (1995), 76% of patients were reluctant to disclose personal information with the medical students whereas 24% felt comfortable to give personal information. It is therefore important that during an interview, patients must be told that some of the questions may be perceived as personal and sensitive especially when asked in the presence of the clinical teaching group. He/she has the choice to respond or to keep personal and sensitive information secret as long as it will not affect diagnosis and treatment or may divulge that required information to the clinical teacher in private. To ensure confidentiality, the clinical teaching group should not share patients' information with people who do not work directly with the patient. This should include verbal information or written information from patients' medical records. Information should only be divulged on the patient's request or after the patient's permission has been obtained. Confidentiality can only be breached when there is unwarranted access to facts about the patient or when required in terms of a law or duty.

Patients' concerns about confidentiality also challenge current practice. In the study by Flynn et al. (1997), patients did not realise that agreeing to a student's presence would usually mean that the student would see their medical notes and discuss them after they had left the room. Patients echoed dismay about this because no specific permission was given for this reason. When patients are asked for consent they should also be asked to consent or decline students seeing their notes. Openness is very essential in this regard.

Even though privacy and confidentiality must be maintained at all times, there are limitations in a hospital setting (Savulescu, Marsden and Hope, 1998) i.e:

- Patients should not be free to pursue interests that harm or interfere with others. Private behaviour should not become public in a way that offends others or incites others to break the law.
- Patients should not be free to pursue interests that cause serious harm to themselves.
- Provision of private space and time must be consistent with the proper delivery of health care and must not put an excessive burden on the available resources

Health care professionals should provide a high level of privacy for patients during clinical teaching especially those patients who spend a long time in hospital because they tend to be involved more frequently in clinical teaching. Although controversial, privacy may be one of the few freedoms patients enjoy. It is therefore important to provide privacy according to their expectations. The health professional's duty of care in this respect is limited only by the balance between the protection of personal privacy and the threat of public peril. This aspect also includes the recognition of patient autonomy i.e. respecting individuals' choices concerning their lives and, where necessary, providing an environment of privacy and confidentiality so that these choices can be pursued.

2.4 Patients' perceptions and experience about clinical teaching

Only patients can judge whether having someone else at the consultation will help or hinder them. Informed patients are quite willing to co-operate with the educational needs of Academic Health Service Complexes because the quality of care received in these services is very high. Simons et al. (1995: 253) refers to a study, which found "a consistently positive attitude towards the presence of students," and attributed it to the patient's satisfaction with students' interest in and attention to their care. Simons et al. (1995) reported that almost half of the patients in their study enjoyed their encounter with the medical students although 10.3% disliked their encounter. Studies by Flynn et al. (1997) also confirm that the majority of patients were happy to help in health professional education but were not always happy about how the student's presence and involvement was presented. Nonetheless, in a study by Seabrook and Evans (in Flynn et al., 1997), patients expressed concern about whether they would be given a choice about a student being present and reported bad experiences of hospital teaching. Lehmann, Brancati, Chen, Roter and Dobs (1997) revealed that patients preferred bedside case presentation to conference-room presentation. Cooke et al. (in Flynn et al., 1997) concluded from a questionnaire survey, that only 3% of patients had negative views about the presence of a student and approximately 11-28% thought they did not have a choice. According to Holden and Pullon (1997), 40% felt that clinical teaching had disadvantages i.e. longer waiting and appointment times and lack of experience and expertise of the student. It was recommended that changing

practice to allay these concerns is important if controversy and distrust are to be avoided. This could lead to patients being labeled as difficult and resentful.

There are many reasons for patients participating in clinical teaching. Studies by Silverman (1996) and Holden and Pullon (1997) found that patients participated because of students' interest in and attention to their care. Smith et al. (1994) surveyed patients who had been examined and interviewed by medical students. Patients indicated that they participated for various reasons. They wanted to help other patients, students and medical practitioners. They enjoyed talking to students and assisting in their own medical care. Thirty seven percent of patients who participated in the study by Simons et al. (1995) indicated that they had benefited from their interactions with medical students. In Flynn's study (1997: 1140) patients participated because they were able to "do something" for the general practitioner or the practice. This is a rather different emphasis from that of helping with health profession education (Williamson and Wilkie, 1997). In some instances, the involvement of patients in clinical teaching has been uncomfortable, presenting the possibility of patients feeling that they are indebted to health professionals in some way.

There is presently a move to update health science curricula to incorporate effective communication skills. These skills are fundamental in the establishment of partnerships with patients so that they can be active during clinical teaching sessions

in decision-making concerning the delivery of their direct care and treatment (Tope in Schmidt, 1996). A patient becomes active and joins in the clinical teaching group discussion as opposed to the traditional passive role. Williamson and Wilkie (1997) recommended that the clinical teacher could invite the patient to comment at each stage of the session. "When physicians make presentations at the bedside of less educated patients, they should be especially careful to avoid medical jargon and to explain fully their plans for in-patient care" suggested Lehmann et al. (1997: 1153). In addition, the student and/or the patient may want to discuss on their own (preferably after the clinical teaching session) whether they have achieved their purpose for the consultation. This could also enhance the students' and patients' understanding of the disease process. Furthermore, student education can improve: they could develop an understanding of patients' experiences and purposes and begin to learn how to work in partnership with them in their own practice later on. It was also confirmed that students valued the active involvement of patients. Lehmann et al (1997) reported that in one American study, patients indicated that they learnt more about their conditions when a student was present. When appropriately managed, such interactions could lead to a deeper, more mutually satisfactory relationship and could eventually reduce patients' reluctance to have students participate in clinical teaching.

2.5 Summary

Clinical teaching is the fundamental component of health professional education. It enables health professional students to acquire the relevant clinical skills that enable delivery of high quality patient care.

Generally in a non-simulated clinical situation, students and patients compete for attention. Rightfully, students' needs are subordinate to patients needs and consequently patients' rights take precedence over students' needs and rights. Changes in the socio-political, educational and health system necessitate changes in patient care approaches during clinical teaching. These changes should incorporate recognition and observation of human and patients' rights.

Unlike many countries, South Africa has never had a Patients' Bill of Rights. This has been recently developed. In this study several common patients' rights that are supposed to be observed during clinical teaching sessions were deduced and discussed. These are human dignity and respect, quality health care and comfort, information and education, privacy and confidentiality. According to previous studies (Simons et al. and 1995; Flynn et al.) patients' experiences and perceptions of clinical teaching were positive depending on the nature of the procedure conducted.

This chapter served to discuss the components of clinical teaching and the concept human rights especially patients' rights with specific reference to clinical teaching.

Patients' perceptions about their involvement in clinical teaching were also highlighted.

Chapter 3

Research methodology

3.0 Introduction

This chapter describes the research methodology used in the study. It describes the population and the sampling method used to obtain the study sample. The data collection method and instrument and the strategies to ensure reliability and validity of the study are described. The chapter also addresses the ethical issues considered during the study.

3.1 Research design

A descriptive survey design was used. A survey is a data collection research design that enables the researcher to collect information from a group of people (sample) by asking questions. The type of information that is collected consists of some characteristics such as abilities, behaviour, opinions, attitudes, expectations, self-classification, beliefs and/or knowledge (Fraenkel and Wallen, 1994 and Neuman, 1994). The survey design was chosen to fulfil the objectives of the research i.e. to elicit characteristics of the respondents, knowledge of patients about their rights, patients' opinions and experiences about clinical teaching and patients' expectations during clinical teaching. This design was implemented to gain more information about negative and positive experiences of patients involved in clinical teaching sessions and the extent to which patients' rights were observed in clinical teaching. It

also serve to identify problems with current practice with regard to the observance of patients' rights.

3.2 Research setting

Ga-Rankuwa Hospital is a historically black academic hospital about 33 kilometres north of Pretoria. It is presently administered by the Gauteng Provincial Government. It has an average bed occupancy of 1 213. It caters for the health needs of people primarily from the Northern and the North West Provinces, with a small percentage coming from Gauteng and Mpumalanga. Approximately 98% of the clients are black with a low socio-economic and educational status.

All four general wards were included in the study i.e. two female (wards 37 and 38) and two male (wards 33 and 34) general wards. Each ward has 40 beds with a bed occupancy of 100 % or more and admits an average of approximately 66 patients a week. The total number of patients hospitalised in a month in the general wards is approximately 1 056. Each ward comprises five cubicles and three side wards. The ward has an open-plan style with no noise barriers between the cubicles.

3.3 Population and sample

According to Burns and Groves (1993) a population is defined as an entire set of individuals or elements that meet the sampling criteria. The sampling criteria refer to a list of elements with characteristics essential for membership in the target population. The study population comprised approximately 1 056 patients admitted to Ga-Rankuwa hospital's general wards.

A valuable sample size of 218 patients was used which is approximately 18% of the target population and approximately 21% of the general wards monthly admissions. Burns and Groves (1993) consider a sample to be a select group of people or elements that represent the population. To obtain a representative sample, systematic random sampling was used. This was done to ensure that the individuals selected were similar to the ones who were not selected - the sample had to be as close to the original population as much as possible.

To determine a sample frame and to select qualifying patients, the researcher and the assistant observed and timed clinical teaching sessions. All patients who were involved in clinical teaching for more than 10 minutes in a selected ward were listed. The k value was calculated by dividing the population size of the ward on that specific day with the number of the patients on the sampling frame. For an example, if the total number of patients in that specific ward was 40 and the total number of patients on the sampling frame was 20, the k value was determined by dividing 40 by

20 (which is equals to two). The starting point was selected randomly, after which every second patient was selected and included in the sample (Burns and Groves, 1993). These individuals were then interviewed within 24 hours after the clinical teaching session depending on the patient's condition and other intervening factors. If the number of the sample size was inadequate for the day, a sample was selected from the next ward. The order of visits to the four general wards was randomly selected by the statistician using a table of random numbers. The order of the visits to the wards was wards 37, 34, 33 and 38. The following were excluded from the study:

- Paediatric patients due to poor verbal expression and other developmental factors
- High care wards due to the critical condition of these patients.

3.4 Data collection

3.4.1 Data collection procedure

To collect both qualitative and quantitative data, a structured questionnaire with both open- and closed-ended questions was used (Appendix A). The researcher and a research assistant administered a questionnaire in an interview to collect data. The interview was chosen as a data collection method because it catered for people's reading, writing abilities and general comprehension because most patients were not well educated. Most patients would have experienced problems if this assistance was not provided.

3.4.2 Data collection tool

A questionnaire is a printed form designed to acquire specific information that can be obtained through written responses of the subject (Burns and Groves, 1993). In this study, verbal responses were elicited and immediately written down by the researcher or the assistant. The items on the questionnaire were derived from the literature especially the Bill of Patients' Rights, the Constitution of Republic of South Africa (Act no 108 of 1996) and the researcher's experience.

The questionnaire consisted of three sections i.e. Section A, B and C. Section A aimed at gaining personal information and background knowledge of the participants. The purpose of Section B was to elicit the experiences of patients during clinical teaching and to determine the extent to which patients' rights were observed during clinical teaching sessions. The aim of Section C was to determine the perceptions of patients about their involvement in clinical teaching. Consequently, the nature of the questionnaire increased the comprehensiveness of the data and data collection became systematic for each respondent.

3.4.3 The research assistant

The research assistant was a B.Cur IV student at Medunsa who had already completed a module on Research Methodology during her training. She was fluent in English, Zulu and Tswana. To prepare her for her role, she received additional training on the research process with specific emphasis the use of the interview and

the questionnaire as a data collection method and tool respectively. She role played and practiced the collection of data on ten occasions under the guidance of the researcher.

3.5 Validity and Reliability

3.5.1 Reliability

Creswell (1994) refers to reliability as the degree of consistency with which instances are assigned to the same category by different observers or by the same observer on different occasions. It also refers to the degree of consistency by which the instrument measures the attributes it is supposed to be measuring (Fraenkel and Wallen, 1994). To reduce bias and maintain consistency during data collection, the research assistant was trained by the researcher so that the interviews were conducted in a similar manner. Fluency in English, Tswana and Zulu was a prerequisite for the research assistant to facilitate translation and interpretation of the questionnaire. Training was aimed at minimising sources of measurement error like data collector bias, situational contaminants, response set bias and administration variable.

To minimise the above sources of measurement error, the researcher and the assistant tried to standardise conditions by exhibiting similar personal attributes to all respondents e.g. friendliness and support. The physical and psychological environment where data was collected was made comfortable by ensuring privacy, confidentiality and general physical comfort. To increase patients' comfort and to

control transitory personal factors, the patient was interviewed immediately after giving consent, or a convenient time suitable for the patient was agreed upon. To ensure standardisation the reliability coefficient was calculated (page 50)

3.5.2 Validity

Validity of an instrument is the extent to which the instrument actually reflects the abstract construct being examined (Burns and Groves, 1993). Fraenkel and Wallen (1994) refer to validity as the appropriateness, meaningfulness and usefulness of specific inferences researchers make based on the data they collect. The technical preparation of the questionnaire was such that more demanding questions were asked later (e.g. Section C questions 1, 2, 3 and 4 in Appendix A). Some questions were asked in two different ways (e.g. Section B questions 4 and 5). The instrument had a combination of difficult and easy, short and long, and closed and open-ended questions.

To achieve content validity, the items on the questionnaire were derived from the literature especially the Bill of Patients' Rights, the Constitution of Republic of South Africa (Act no 108 of 1996) and the researcher's experience. To strengthen content and face validity an expert educator and researcher critiqued the questionnaire for adequacy and representativeness of the content. The technical characteristics, presentation and clarity of the questionnaire were approved and minor modifications were suggested. The following modifications were made

- Section A question 4 did not have the first column on "no schooling"
- Section B question 7 did not have the words "during this admission"
- In Section B question 13, only the patient's feedback opportunity was explored initially. The student's feedback opportunity was explored later.
- Section A question 5 was an open-ended question and later made a closed-ended one.
- Section B question 18 was elaborated upon to include the indicated options. Initially the only options were polite and impolite.

General response rate and item response problems were minimised especially in Section C questions 1, 2, 3, and 4 by allowing the researcher and the assistant to administer the questionnaire and to set convenient appointments for the patient. Another patient was immediately selected using the same sampling method, if the selected patient could not continue with the interview due to physical discomfort and/or other intervening factors. The use of the researcher and the assistant aroused interest, encouraged participation and improved clarity, as some patients were reluctant to respond to these questions. Information from the interviews was analysed immediately after the interviews.

To achieve truthfulness, appropriateness and meaningfulness of the data, an experienced researcher moderated data analysis by co-checking 10% of the quantitative data and 50% of the qualitative data. From this, questions one and two in Section C had to be reanalysed.

3.6 Pilot study

A pilot study was conducted to determine reliability and validity. A pilot study is a smaller version of the proposed study conducted to refine methodology (Fraenkel and Wallen, 1994). The reliability coefficient was calculated to measure the accuracy, stability and consistency of the questionnaire. The two researchers pretested the questionnaire on the same respondent on different occasions based on the same clinical teaching exposure. Ten respondents were used for this exercise. The second administration was 12-24 hours after the first administration to control intervening experiences that could have influenced data collection. The two scores were compared to check if a favourable reliability coefficient was reached. By making use of Kuder-Richardson's 21 formula, a reliability coefficient of 0,89 was obtained which proved that the instrument was stable, accurate and consistent (Fraenkel and Wallen, 1994).

The pilot study also helped to determine the most favourable periods to choose patients for a sample frame and for interviews.

3.7 Ethical considerations

The conduct of research requires not only expertise and diligence, but also honesty and integrity. This is done to recognise and protect the rights of human subjects. To render the study ethical, the right to self-determination, respect, privacy, anonymity, confidentiality, fair treatment and protection from discomfort and harm were observed.

Written permission to conduct the research study was obtained from the Committee for Research on Human Subjects-Medical (Appendix B) and the Post Graduate Committee at the University of Witwatersrand (Appendix C) and Ga-Rankuwa Hospital's Superintendent (Appendix D). Verbal permission was obtained from Ga-Rankuwa Hospital Deputy Director of Nursing Services, the Head of the Internal Medicine and Family Practice and Professional nurses in charge of the four wards.

Their respective Heads of Departments or supervisors informed the health professionals about the study. The ward nurses, on admission, made all patients aware of the study and explained its purpose. Selection of respondents was done to meet the purpose of the study. After selection of the sample, the subjects were greeted and addressed in a dignified manner. They were then given the information letter to read (Appendix E). The patient's information letter explained the purpose of the study and requested patients to volunteer. Respondents who agreed to participate were

requested to give written consent (Appendix F). They were given an option to withdraw from the study without any penalty or adverse effects on their treatment.

For illiterate patients and those who could not read and understand English, a Zulu or a Tswana version of the information sheet was made available. To improve clarity, the researcher and the assistant also explained in the patient's language. Patient's questions and concerns were immediately addressed. Written consent was obtained by attaching patient's signature or thumb print on the consent form.

Anonymity was ensured by not disclosing the patient's name on the questionnaire and research reports and detaching the written consent from the questionnaire. Interviewing patients in a private room ensured privacy and confidentiality. When a private room was unavailable, screens surrounding the patient's bed were drawn and the researcher and/or the research assistant spoke audibly to patients but ensuring that other patients could not overhear the conversation. Patients' responses and transcripts were not disclosed to anyone besides the research supervisor and the statisticians. The ethical principles of beneficence and non-maleficence were applied by protecting the subjects from physical, spiritual and psychological harm and discomfort. When physical (e.g. infiltrated drip, pain/comfort) and psychological problems were encountered, the researcher and the assistant brought this to the attention of the professional nurses.

3.8 Summary

A descriptive survey design was used. To collect qualitative and quantitative data, the researcher and the assistant conducted interviews by making use of a questionnaire with both open and closed questions. A systematic random sampling method was used to draw a sample of 218 patients from four general wards at Ga-Rankuwa Hospital. The sample characteristics included adults who experienced a clinical teaching session lasting for more than 10 minutes.

Obtaining permission from patients and specific authorities in hospitals and government ensured autonomy and respect. Anonymity, privacy and confidentiality was ensured during interviews and report writing. Protecting patients from physical, spiritual and psychological harm ensured the principle of beneficence.

Training the assistant researcher and determining test- retest reliability increased the reliability of the study. The compilation of the data collection tool based on relevant literature and experience, the use of an experienced educator and researchers during the compilation of the questionnaire and data analysis improved content and face validity. Reliability and validity was further increased by use of a pilot study.

This chapter served to describe the research methodology used with specific emphasis on the population, sampling method, data collection instrument and strategies used to increase reliability, validity and ethical standards of the study.

Chapter 4

Findings and discussion of findings

4.0 Introduction

This chapter describes the data analysis methods used in this study for both qualitative and quantitative data. The research results are presented in the form of text, percentages, tables and graphs and discussed in summary.

4.1 Data analysis

Data were analysed using the Statistical Analysis System (SAS) Software Programme version 12. Closed-ended questions were codified during data collection using codes indicated on the questionnaire. After collection, data from open ended questions were sorted into descriptive categories. The total list of categories was deduced by grouping topics that relate to each other and codified by using numerical values (Cresswell, 1994). This codified data from both open and closed-ended questions were entered into the computer using the SAS Programme. Data from open-ended questions belonging to each category was assembled in one place to form a preliminary analysis. A collective qualitative text was written.

Descriptive statistics in terms of percentages were used to summarise the results. Chi-square test of association was used (without Yates continuity correction) to investigate the association between explanatory factors and the responses. In each test

the 5% significance level was used as a cut off i.e. the response was considered to be related to the explanatory factor if the significance level (p-value) was 0.05 or less. Since this was on explanatory analysis, no correction was made for multiple testing.

4.2 Presentation and discussion of results

4.2.1 Section A- Personal information and background knowledge of participants

This section describes the demography of the participants in terms of gender, age, employment and educational status. It also presents the level of patients' knowledge about their rights during clinical teaching sessions. Knowledge of their rights to privacy, confidentiality, human dignity and respect, freedom and autonomy, education and information, refusal to participate in clinical teaching sessions and withdrawal from the clinical teaching session were specifically assessed.

4.2.1.1 Age of respondents

In the study sample, there were more females (53,7%, 117) than males (46,3%, 101). Table 4.1 indicates that the majority of participants (57,4%, 125) were in their early adulthood (26- 35 years) to mid adulthood (35-55 years).

Table 4.1 Age of respondents (n = 218)

Age in years	Frequency	Percentage
16-25	53	24,3
26-40	83	38,1
41-55	42	19,3
56 and above	37	17,0
Do not know	3	1,4

4.2.1.2 Employment status of respondents

According to Table 4.2, 45,4% of the participants (99) was unemployed and 59 (27 %) were employed. This figure is compatible with South African statistics that indicate that approximately 46% of the current population is unemployed (Lestrade-Jefferif, 1997).

Table 4.2 Employment status of respondents (n = 218)

Employment status	Frequency	Percentages
Employed	50	22,9
Unemployed	99	45,4
Self-employed	9	4,1
Scholar/student	38	17,4
Pensioner	22	10,1

4.2.1.3 Educational status of respondents and patients' knowledge of their rights

Table 4.3 indicates that a small proportion (6%, 13) of patients obtained tertiary education and the majority of participants (70,6%, 154) were semi-literate (grade 10 and below) to literate (grade 11 and 12).

Table 4.3 Educational status of respondents (n = 218)

Educational status	Frequency	Percentages
No schooling	36	16,5
Grade 10 and below	118	54,1
Grade 11 and 12	50	22,9
Tertiary education	13	6,0
Other	1	0,5

On average 61,3% of patients (134) had knowledge of their rights (i.e. their right to privacy; confidentiality; human dignity and respect; freedom and autonomy; education and information). The National Progressive Primary Health Care Network (NPPHCN, 1999) had a similar finding in their post-campaign study. They indicated that there was a stronger awareness of health rights especially the basic, fundamental and essential rights that improved the quality of life. In this study the majority of patients did not have knowledge of their right to refuse to participate in clinical

teaching and to withdraw from the clinical teaching sessions i.e. 59,6% (130) and 62,2% (135) respectively (Figure 4.1).

The association between the educational status of patients and their knowledge of their rights was explored. It was discovered that there is strong evidence that patients with tertiary education are more aware of their right to education and information [chi-square (x^2) = 9,705 on 3 degrees of freedom (d.f.), probability (p) = 0,001]. In addition, respondents with higher education are more aware of their right to refuse to participate in clinical teaching sessions (x^2 = 14,702 on 3 d. f., p = 0,002). It is important to note that of the patients without tertiary education (n = 158), more than half thought that they were not allowed to refuse to participate in clinical teaching sessions.

In addition, patients with higher education (n = 13) felt they had the right to withdraw from the clinical teaching sessions (x^2 = 16,743 on 3 d.f., p = 0,001). The results have shown that knowledge of the right to privacy; confidentiality; human dignity and respect; freedom and autonomy did not depend on the educational status of patients. Yet knowledge of the right to education and information; refusal to participate or to withdraw from clinical teaching sessions did depend on the patients' educational status. Patients with higher education were assertive about their rights.

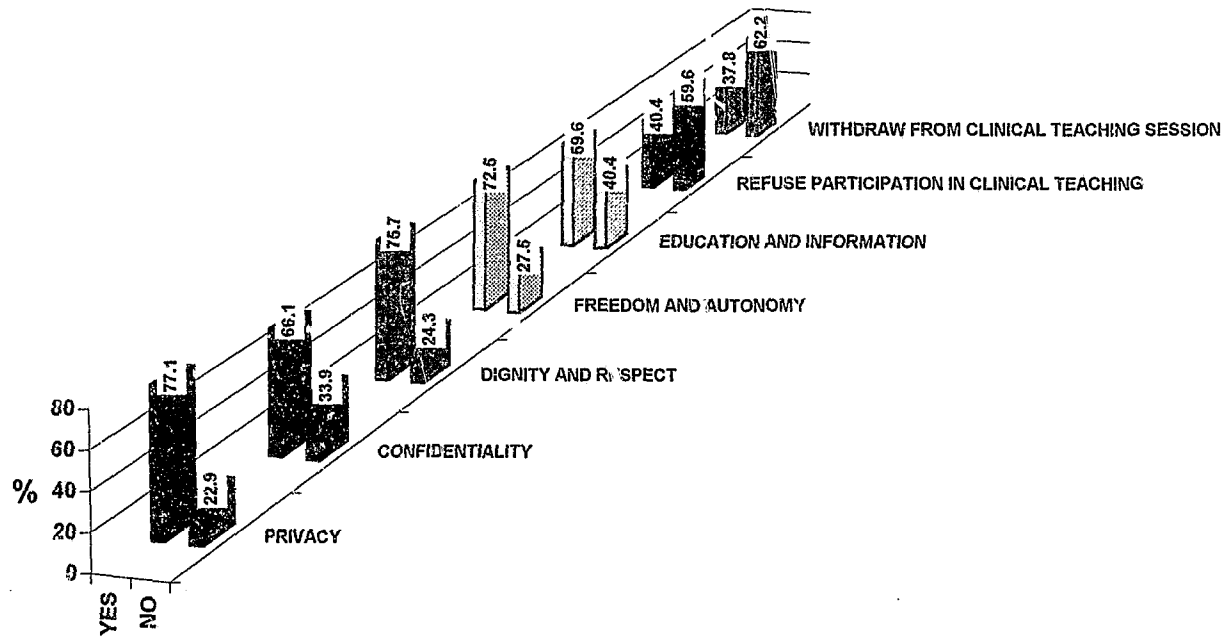


Figure 4.1 Patients' knowledge of their rights

4.2.2 Section B – Clinical teaching sessions

This section of the tool determined the nature of clinical teaching sessions and the extent to which patients' rights were observed during the most recent clinical teaching sessions. Concentrating on most recent clinical teaching sessions enabled patients to focus on one session and facilitated recall. The rights that were specifically investigated were privacy, confidentiality, human dignity and respect, freedom and autonomy, education and information. The results that follow represents the patients' own opinions and judgement.

4.2.2.1 Health professionals involved in clinical teaching

Patients were asked to identify health professionals who were conducting the most recent clinical teaching sessions. The majority of patients indicated that the clinical teaching sessions were conducted by medical practitioners (90,8%, 198) followed by nurses (8,3%, 18). Medical practitioners conducted more clinical teaching sessions because the number of medical students is greater than the number of nursing students at Ga-Rankuwa hospital. In addition, large numbers of medical students are allocated to a ward for clinical practice as compared to nursing students. The smallest percentage (1,4%, 2) of the clinical teaching sessions was conducted by physiotherapists (Table 4.4). Other health professions like occupational therapy and radiography were not mentioned by patients because clinical teaching takes place in their respective clinical departments and not in the wards.

Table 4.4 Health professionals involved in clinical teaching sessions (n = 218)

Participants	Frequency	Percentages
Medical practitioners	198	90,8
Nurses	18	8,3
Physiotherapist	2	1,4

4.2.2.2. Patients' assessment of whether their rights were observed or not

On average 71,1% of patients (155) reported that their rights had been observed during clinical teaching while 28,9 % (63) indicated that their rights had not been observed (Figure 4.2). It seemed that most of the rights other than education and information tabulated in Figure 4.2 were observed. The findings in Figure 4.1 (about the level of patients' knowledge of rights) have an impact on these findings because for patients to assess if their rights were observed or not, they needed to know and understand their rights. There is generally strong evidence that if patients have knowledge of their rights then they are more likely to assess that their rights are observed. This assumption is supported by the chi-square analysis of patients' rights to privacy, confidentiality, human dignity and respect, education and information as displayed below. I.e. For privacy: $x^2 = 10,854$ on 1 d. f. $p = 0,001$

Confidentiality: $x^2 = 16,248$ on 1 d. f. $p = 0,001$

Human dignity and respect: $x^2 = 13,659$ on 1 d. f. $p = 0,001$

Education and information: $x^2 = 38,709$ on 1 d. f. $p = 0,001$

This means that patients' opinions about the observance of their rights may be reliable because it is evident that they had a fair and clear *understanding* of their rights. This statement may not apply to patients' rights to freedom and autonomy since Figure 4.1 indicates that patients did not have knowledge of their rights to *refuse or withdraw* from a clinical teaching sessions.

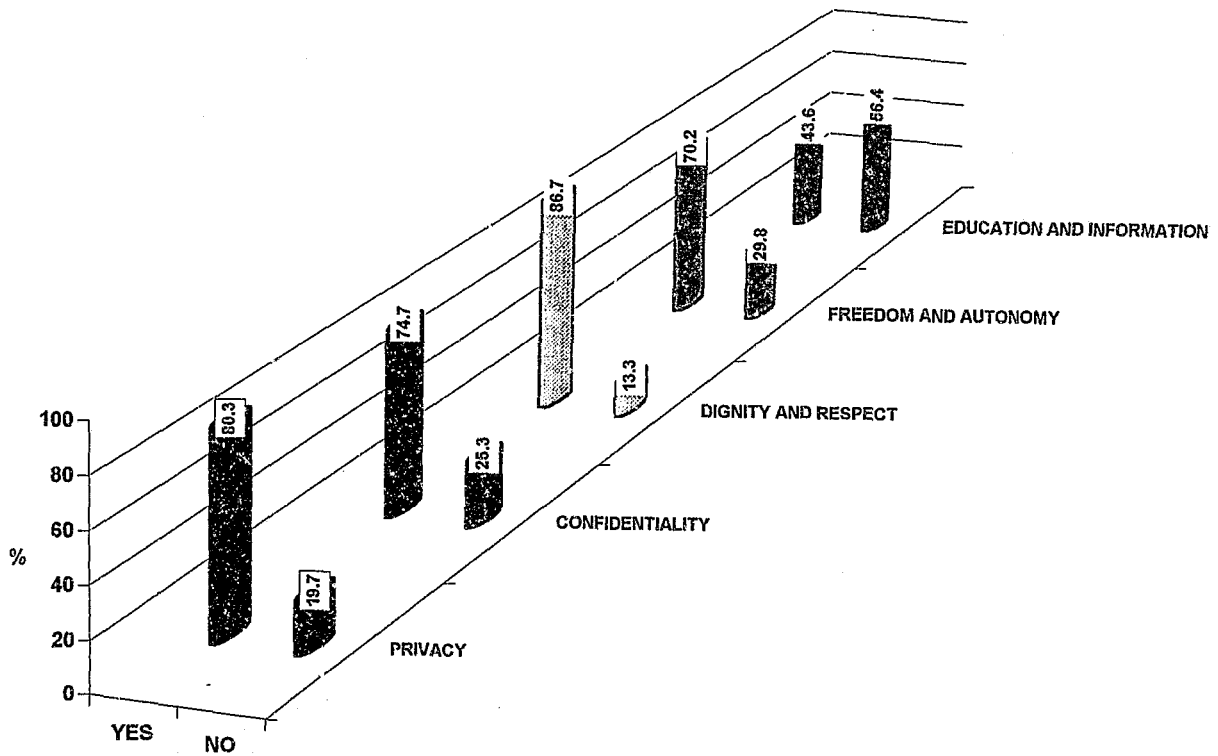


Figure 4.2 Observance of patients' rights during clinical teaching

The extent to which the specific rights (privacy; confidentiality; human dignity and respect; freedom and autonomy) were observed will be discussed in this section.

4.2.2.3 Human dignity and respect

"Do you think your right to respect was taken into consideration during clinical teaching?" was a question directed to patients. According to Figure 4.2, 189 patients (86,7%) reported that their right to respect was observed during clinical teaching sessions. However this finding is inconsistent with discussion that follows. There are many ways of demonstrating respect to patients, some of which are to introduce members of the clinical teaching group including the patient and to address patients appropriately.

The extent to which clinical teaching groups introduced themselves to patients

Figure 4.3 indicates that 53,7% of health professionals (117) did not introduce themselves to the patients. This could mean that the whole health care team, specifically the status of the individuals in the health care team, was not introduced. Although this is normal practice in many clinical situations, it could be attributed to many factors. Firstly, in most cases health professionals are hurried and the introduction of clinical teaching group members seems insignificant, impractical and time consuming. Secondly, the culture of recognition and observance of human rights is not entrenched in health care. Though there are many factors attributable to this

practise, it cannot be condoned because it could interfere with the development of the rapport between the health professionals and the patients.

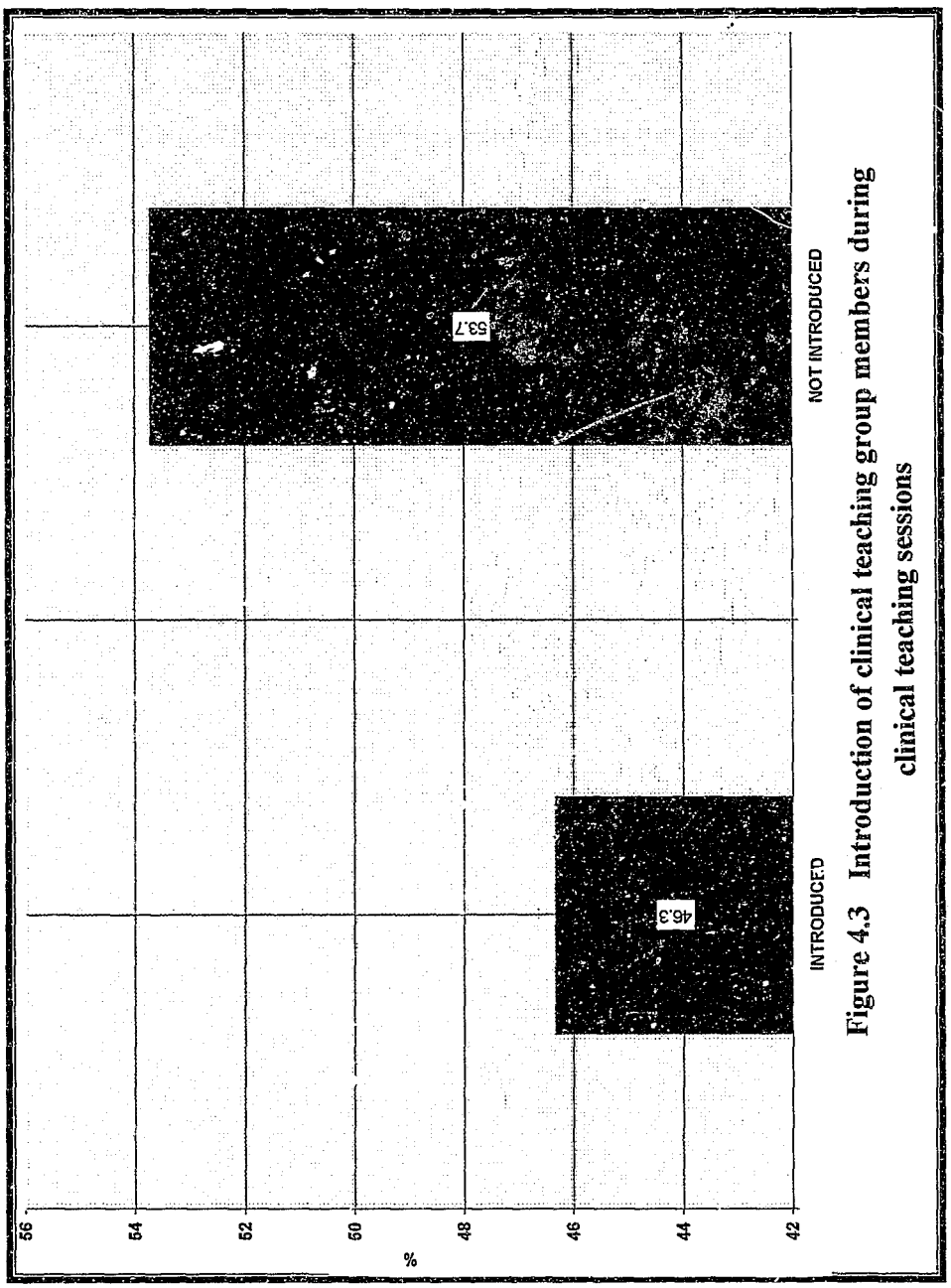


Figure 4.3 Introduction of clinical teaching group members during clinical teaching sessions

The manner in which patients were addressed during clinical teaching session

To the question "How were you addressed during clinical teaching?" 56,7% of patients (123) responded that they were addressed by name (Table 4.5). In African cultures it is often considered disrespectful and rude to address adults by name. A similar feature was also reported by NPPHCN (1999) that Africans, especially women, complained of the rude and disrespectful attitudes of health care providers towards them. The manner in which one is addressed depends on the patient's age or the age of the one addressing him/her, except for Africans who are westernised. For example if the patient is older than the student, it is regarded as disrespectful to address the patient by name. If the patient is younger than the student, it is acceptable. Table 4.1 indicated that 74,4% of patients were 26 years or older (adult years). In general the population of students in a university is young. It appeared that students were less likely to address patients respectfully according to African culture particularly the Zulu and the Tswana cultures which are predominant at Ga-Rankuwa hospital.

Since the majority felt that they were treated with dignity and respect, the two (0,9%) who were addressed as "patients" and the six (7,4%) who were not addressed directly did not feel this. Therefore no conclusion can be drawn based on only eight patients.

Table 4.5 Ways used by clinical teaching groups to address patients (n= 207)

Addressed by or as	Frequency	Percentage
Name	123	56,7
Surname	37	17,1
Title (e.g. Mr., Mrs., Ms.)	17	8,8
Aunt/ uncle etc	22	10,1
Patient	2	0,9
No address	6	7,4

[NB: Eleven patients did not respond to this question]

4.2.2.4 Health care and comfort

This section discusses the extent to which the health care and comfort needs of patients were met. This is in relation to the frequency and duration of clinical teaching sessions and the extent to which the physical, spiritual and cultural needs of the patients were met during clinical teaching session.

Health care and comfort in relation to the frequency and duration of clinical teaching sessions.

Frequency

Table 4.6 indicates that the smallest number of clinical teaching sessions that the patient was exposed to ranged between one and three whilst the biggest was more than ten per single admission. The majority of patients (72,9%, 159) were involved in

clinical teaching one to six times during the same admission period. It seems that if the frequency is above seven these sessions become uncomfortable for patients. This is especially true since the average admission period for patients in these wards is from one to three weeks. Normally the frequency of the clinical teaching sessions is determined by the condition of patients, the time of the year, the number of patients in the ward and the number of students allocated in that specific ward. For example the frequency will be higher if:

- the disease condition is rare, unique and/or more interesting to health professionals
- the number of patients in the ward is small or
- it is during examination period or
- the number of students allocated in the ward is high.

There is also the possibility that a patient could experience these sessions once or twice a day depending on the variables mentioned. In addition, if these sessions are experienced during the first week of admission when patients are normally in the acute stages of illness, the more uncomfortable these sessions are for the patients.

Table 4.6 Frequency of clinical teaching sessions (n = 218)

Number	Frequency	Percentages
1-3	103	47,2
4-6	56	25,7
7-10	22	10,1
10<	37	17,0

Duration

Patients were exposed to clinical teaching for approximately five minutes to more than three hours. Approximately 68,3% of patients (146) were involved in clinical teaching for 16 to 59 minutes (Table 4.7). A normal learning period is about 45 minutes to allow for limited concentration span. Eighty-six patients (40,3%) experienced long clinical teaching sessions of approximately 45 minutes to more than 180 minutes. This finding correlates with patients' general concerns in section 4.3.2, which indicates that the clinical teaching sessions were too long and strenuous. Patients would prefer shorter sessions so that they can have adequate time to rest and recuperate.

Table 4.7 Duration of clinical teaching sessions (n = 215)

Duration in minutes	Frequency	Percentages
0-5	12	5,6
6-15	49	22,9
16-35	68	31,8
36-59	78	36,5
60-180	4	1,9
180 <	4	1,9

[NB: Three patients did not respond to this question]

Health care and comfort in relation to physical, spiritual and cultural needs.

Physical needs

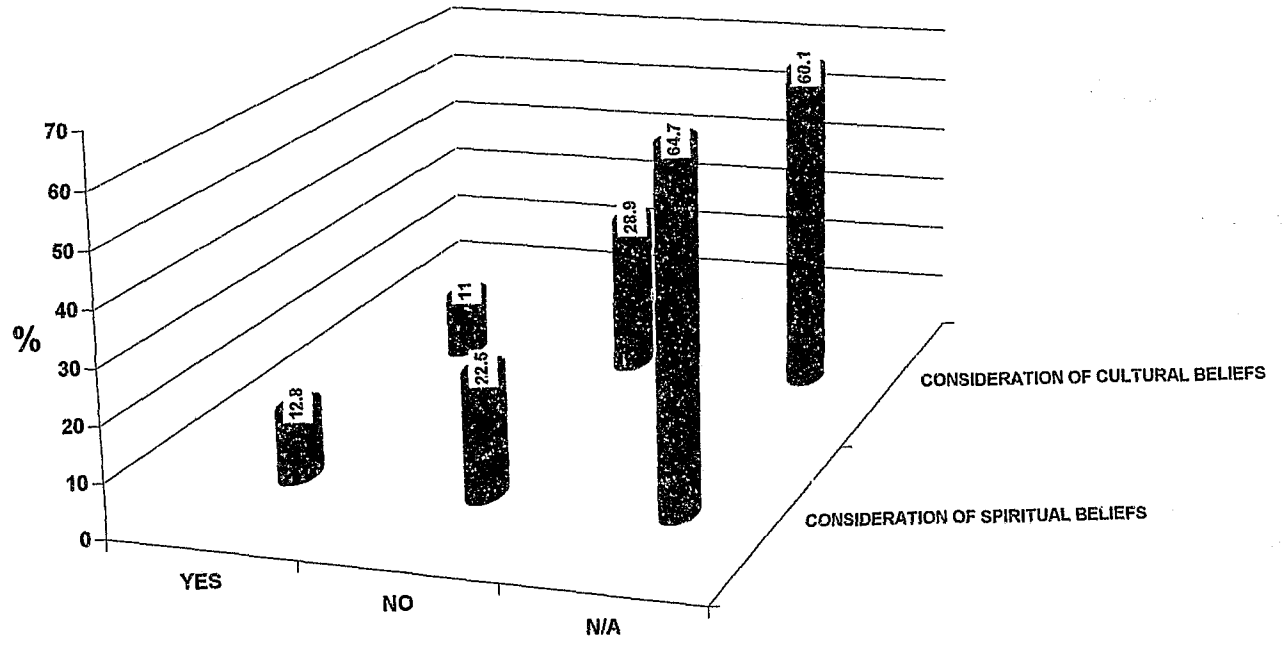
Patients were asked if their physical, spiritual and/or cultural needs were taken into consideration during clinical teaching sessions. On average 17,4% of patients (114) indicated that they had an acute physical need (e.g. need to urinate or eat) before, during and after the clinical teaching sessions (Table 4.8). Of the 17,4% (114), forty-nine patients (43%) reported that their needs were met. Of the 57% (65) whose needs were not met, fourteen patients (21,5%) were angry about their physical needs being unmet during clinical teaching sessions.

Table 4.8 Extent to which physical needs of patients were met during clinical teaching sessions (n =218)

Presence of acute physical needs		Frequency	Percentage
Before the session	Yes	35	16,1
	No	183	83,9
During the session	Yes	43	19,7
	No	175	80,3
After the session	Yes	36	16,5
	No	182	83,5

Spiritual and cultural needs

With reference to their spiritual and cultural beliefs, 49 patients (22,5%) did not have their spiritual beliefs taken into consideration. Similarly 63 patients (28,9%) did not have their cultural beliefs taken into consideration during clinical teaching sessions (Figure 4.4). These occurrences could imply that transcultural health care was not provided to these patients during clinical teaching sessions. On the other hand the majority of patients felt that the consideration of spiritual beliefs and cultural beliefs [64,7% (141) and 60,1% (131) respectively] was not applicable during clinical teaching sessions. For these patients, provision of transcultural health care might not have been an issue or it was generally regarded as observation of their right to respect and dignity.



	YES	NO	N/A
CONSIDERATION OF SPIRITUAL BELIEFS	12.8	22.5	64.7
CONSIDERATION OF CULTURAL BELIEFS	11	28.9	60.1

Figure 4.4 Consideration of spiritual and cultural beliefs and needs during clinical teaching sessions

4.2.2.5 Privacy and confidentiality

This section discusses privacy and confidentiality in relation to the size of the clinical teaching group and the place where the clinical teaching sessions were conducted.

Privacy and confidentiality in relation to the size of the clinical teaching group

In order to determine the appropriate size of clinical teaching groups, the question "How many participants were in the most recent clinical teaching group?" was directed to patients. From the responses of the patients it was concluded that the smallest clinical teaching group consisted of one to two people per group with the largest group having 16 to 25 members. Eighty-two clinical teaching groups (37,6%) were between three to five and 65 clinical teaching groups (29,8%) were between six to nine in number (Table 4.9). Approximately 19,7% (43) were more than 10. A group of about six to nine seems to be a favourable group for learning purposes in a class situation (Bruce, 1992) but not for observing a patient during clinical teaching. The majority of patients (50,4%, 110) had a comfortable number of participants in the group (i.e. one to five members) while approximately 108 patients (49,6%) had an uncomfortable number (i.e. six to twenty five members). Patients themselves expressed concern about the size of the clinical teaching groups. If these groups are big, they felt uncomfortable, frightened and shocked.

Table 4.9 Number of participants in the most recent clinical teaching session (n = 218)

No. of participants in groups	Frequency	Percentage
1-2	28	12,8
3-5	82	37,6
6-9	65	29,8
10-15	41	18,8
16-25	2	0,9

Although 49,6% of patients (108) were subjected to clinical teaching groups consisting of more than six members, 156 patients (71,6%) reported to be comfortable with the size of the groups. This implies that the observation of privacy did not depend on the size of the clinical teaching group ($x^2 = 4,155$ on 3 d. f. $p = 0,385$). Neither did it depend on whether patients were comfortable with it or not ($x^2 = 2,024$ on 1 d. f. $p = 0,155$). This could be attributed to the fact that many patients stay for long periods in the hospital and are therefore accustomed to the size of the clinical teaching group. Patients also thought that the clinical teaching group was primarily composed of differentially qualified health care professionals. These professionals were thought to be utilising their comprehensive skills and expertise in trying to deal with their health problem and ensuring a speedy recovery.

Privacy and confidentiality in relation to the place where the clinical teaching sessions were conducted.

"Where was the last clinical teaching session conducted?" was a question directed to patients. The majority of clinical teaching sessions were conducted in the ward cubicle (99,1%, 214) while very few were conducted in the side ward (0,5%, 1) and the examination room (0,5%, 1) [two patients did not respond to this question]. This trend is normal practice at Ga-Rankuwa Hospital. That clinical teaching sessions were conducted in the side ward or examination room does not necessarily imply that the right to privacy and/or confidentiality was observed. The observance of these rights can only be conclusive if the patient was alone in the side ward or examination room, screens were drawn around the patient's bed or the clinical teaching group would keep the information confidential.

4.2.2.6 Freedom and autonomy

This section discusses the extent to which patients' right to freedom and autonomy was observed in relation to the manner in which informed consent was obtained. This includes the manner in which the clinical teaching sessions were explained and permission obtained from patients.

Freedom and autonomy in relation to the manner in which the clinical teaching sessions were explained to patients.

The question "Was the procedure explained to you? If yes, what was said?" was directed to patients. Responses to this question are summarised in Figure 4.5 and Table 4.10. One hundred and twenty patients (56%) reported that clinical teaching groups explained the procedure to them (Figure 4.5). Table 4.10 tabulates different explanations used by the clinical teaching groups in proposing clinical teaching sessions. Patients were asked to be involved in history-taking (21,3%, 27), examinations (62,2%, 79), therapeutic procedures (6,3%, 8) while others were given verbal instruction only (3,2%, 4). Some clinical teaching groups gave more than one explanation.

When asked about their involvement in clinical teaching, Table 4.11 indicates that patients were involved in different ways. They were questioned (22,9%, 58), examined (51,2%, 132) and subjected to therapeutic interventions (1,9%, 5). At face value, it seems as if there is a slight relationship between the two mentioned set of data (Tables 4.10 and 4.11). This relationship presupposes that some clinical teaching groups carried out what they explained to patients before commencing with their procedure. Unfortunately this relationship cannot be statistically conclusive because it is difficult to get a measure of agreement due to the difference in the number and/or the percentage of patients involved in these instances i.e. 122 and 218 patients respectively.

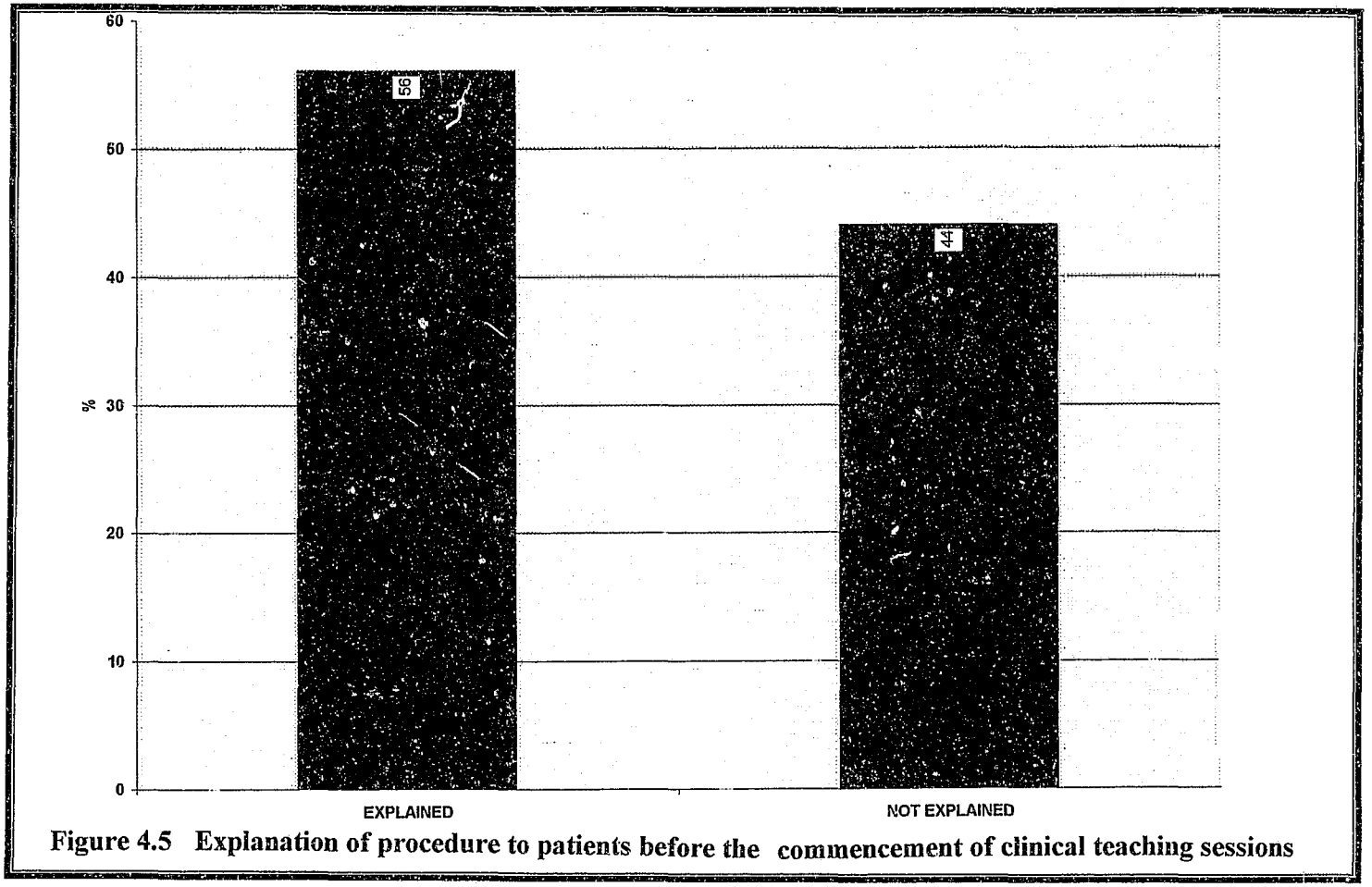


Figure 4.5 Explanation of procedure to patients before the commencement of clinical teaching sessions

Table 4.10 Specific ways of explaining the procedure (n = 122)

Explanation	Frequency	Percentage
Asked to be involved in history-taking	27	21,3
Asked to be examined	79	62,2
Asked to be helped	9	7,1
Given verbal instructions	4	3,2
Asked for therapeutic interventions to be done	8	6,3

Table 4.11 Involvement of patients during clinical teaching sessions (n = 218)

Involvement	Frequency	Percentage
Answered questions	58	22,9
Examined	132	51,2
Nothing	63	24,4
Therapeutic interventions	5	1,9

Freedom and autonomy in relation to obtaining informed consent to participate in clinical teaching

To elicit responses pertaining to informed consent, patients were asked two questions. The first question was "Did the facilitator or participants ask for your permission to be involved in clinical teaching?" and the second question was "Do you think you were given an option to participate in clinical teaching?". Responses to these questions demonstrated consistency as displayed in Figures 4.5, 4.6 and Table 4.12 between patients who were given an explanation of the procedure (56%, 122), those who were asked permission to participate in the study (62,8%, 137) and those who were given an option to participate (56,4%, 123). Similarly a relationship also exists between those who were not asked permission to participate (37,2%, 81), those who were not given an option to participate (43,6%, 95) and those who were not given an explanation of the procedure (44%, 96). Although results in Figure 4.2 indicate that right to freedom and autonomy was observed in 153 patients (70,2%), those who were asked for permission and those who were given an option to participate were proportionately lower (i.e. 59,6%, 130 and 56,4%, 123 respectively).

An association between the observation of freedom and autonomy (Figure 4.2), and the asking of permission from the patients (Figure 4.6), was determined. Statistical evidence shows that the observation of patients' rights to freedom and autonomy depended on whether patients were asked permission to be involved. The majority of patients (90,5%) felt that freedom and autonomy was observed because clinical

teaching groups asked permission to be involved in clinical teaching. Whereas 35,8% felt that freedom and autonomy was observed even if permission was not asked (x^2 = 7,806 on 1 d. f. p= 0,001). It seems that there were aspects in the behaviour of clinical teaching groups that implied that freedom and autonomy was observed.

Similarly if they did not ask permission, freedom and autonomy was not observed for 93,5% whereas if they did ask permission freedom and autonomy was not observed for 40% (x^2 = 73,303 on d. f. p= 0,001). The fact that the concept "freedom and autonomy" is an abstract term (even if translated) that is not easy to comprehend and contextualise could also confound this finding. In addition, the fact that more than half of the patients thought that they were not allowed to refuse to participate in clinical teaching sessions undermines the legitimacy of the informed consent given by patients.

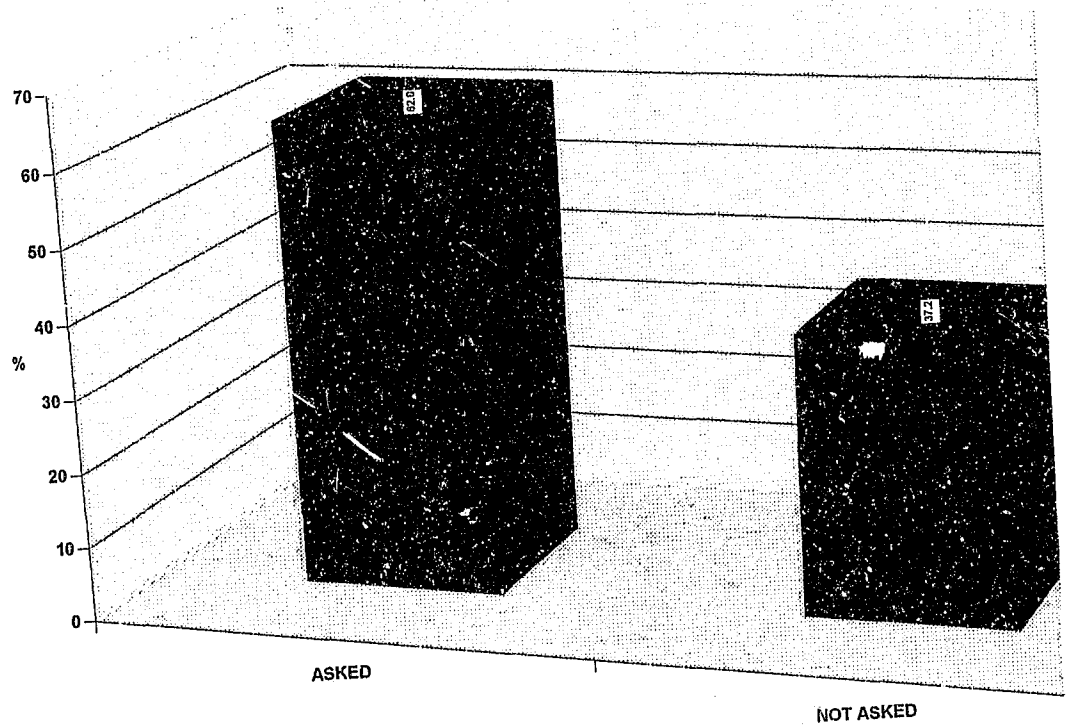


Figure 4.6 Informed consent and permission asked to participate in clinical teaching

Table 4.12 Options given to participate in clinical teaching sessions (n =218)

Option to participate	Frequency	Percentage
Given	123	56,4
Not given	95	43,6

Those patients who were given the option to participate (n = 123) were motivated for several reasons. Table 4.13 indicates that 35 patients (24%) participated because they thought that the health professionals were doing their routine clinical work. They did not know that they had an option to refuse to participate or to withdraw from the clinical teaching sessions. Some of these patients thought it was a rule and therefore did not have an option to refuse. This may mean that the clinical teaching groups did not explain the procedure to patients and/or inform them about their rights (specifically to refuse to participate or withdraw from the clinical teaching session). If the latter is true patients did not know their rights and could not exert them.

A positive response was received from 24 patients (16,4%) who participated in clinical teaching to help students in their practicals. This indicates the willingness to help students and to be involved in health professional education. Fifty-seven patients (39,4%) participated out of curiosity and interest in their disease process since they believe it is their right to know. They wanted to know more about their own disease conditions and hoped that they may be lucky and get cured in the process or understand their illness better. Twenty-seven (18,5%) participated out of politeness or

lack of assertiveness (shyness). They did not want to disappoint the health care team and felt indebted to them. They thought it was wrong to refuse and therefore conformed as most patients did. Three patients (2,1%) did not have a specific reason why they participated but found themselves participating anyway. Smith et al. (1994) also had similar results. They reported that patients participated for positive reasons i.e. to help other patients, students and medical practitioners. Besides they also enjoyed talking with students and thought the health professionals might not like it if they did not agree.

Table 4.13 Reasons for participation in clinical teaching sessions (n = 119)

Reasons	Frequency	Percentage
Doing their health professional work	35	24,0
Help with clinical practical	24	16,4
Know about illness	57	39,4
Do not know	3	2,1
Out of politeness	27	18.5

[NB: Four of the 123 patients did not respond. In this question, patients gave more than one response]

4.2.2.7 Communication and interaction

To determine whether the clinical teaching groups communicated and interacted with the patients during clinical teaching sessions, a specific question was formulated. The question was " Did the facilitator or participant interact and/or communicate with you before, during and after the clinical teaching session? If so what was communicated?". Responses to this question in Figure 4.7 indicate that on average 70,5% of clinical teaching groups (153) communicated with the patients before, during and after clinical teaching sessions. Statistical analysis showed that if there was communication before the clinical teaching session, then it is more likely that the procedure was explained to patients ($x^2 = 58{,}874$ on 1 d. f. $p = 0{,}001$) and permission was asked from patients ($x^2 = 32{,}123$ on 1 d. f. $p = 0{,}001$).

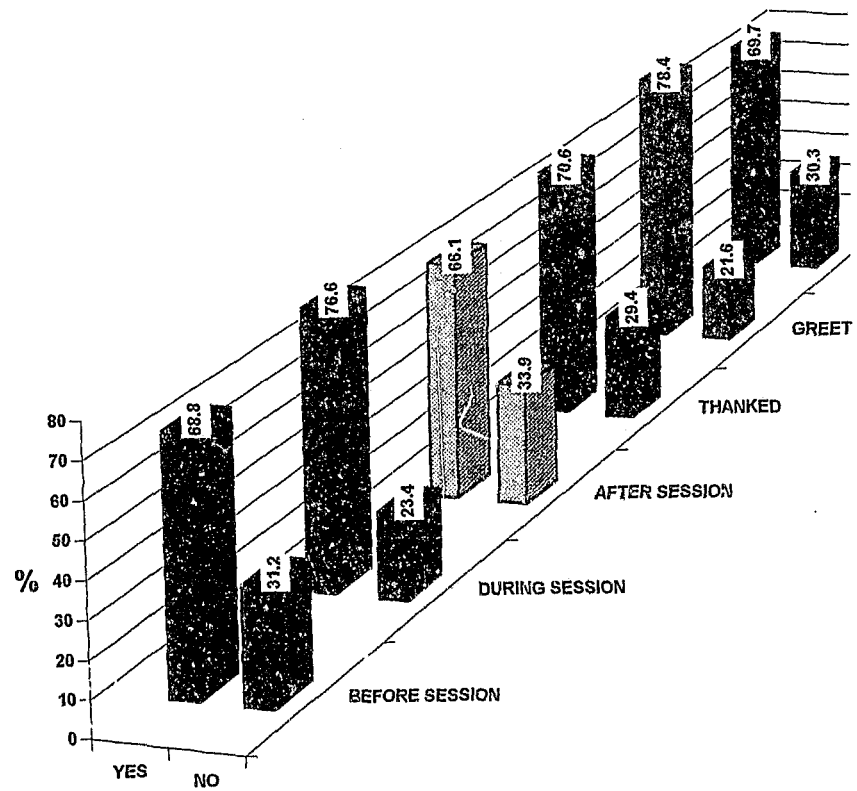


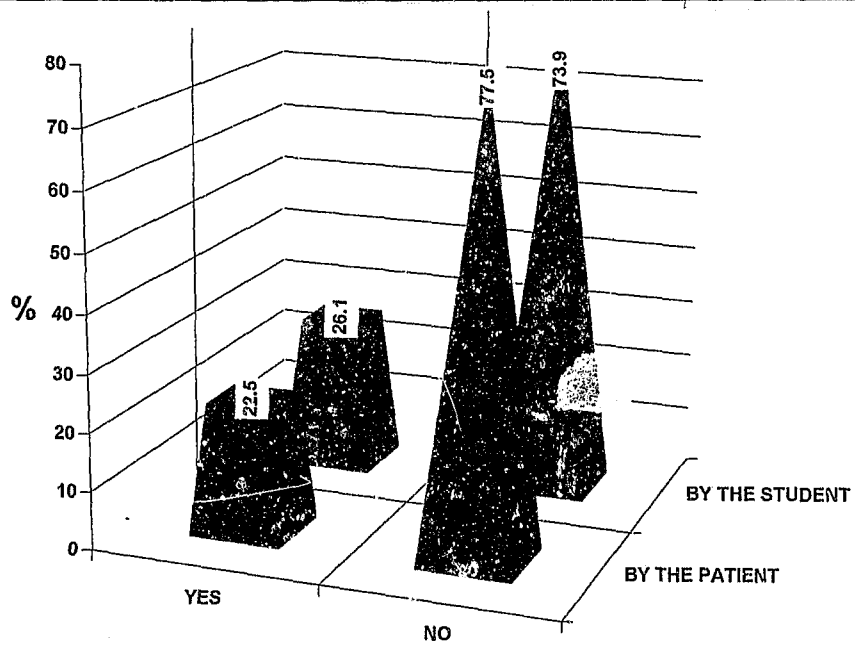
Figure 4.7 Communication and interaction between patients and clinical teaching groups

Availability of feedback sessions during and after clinical teaching sessions

"Was there an opportunity for you (patient) or the facilitator/participant to give feedback?" was a question used to ascertain if the patient(s) and the participants during or after the clinical teaching sessions conducted feedback sessions. Findings in Figure 4.7 indicate that 76 ·% (167) and 66,1% (144) of patients communicated with the clinical teaching groups during and after the sessions respectively. This finding contradicts the information displayed on the availability of feedback sessions during or after the clinical teaching sessions (Figure 4.8). It is normally recommended that feedback sessions must be conducted where both the patient and the students can comment on the proceedings of the session. In this case this did not happen. One hundred and sixty-nine patients (77,5%) were not given a chance to give feedback to the clinical teaching group during and after the clinical teaching sessions. Similarly 161 clinical teaching groups (73,9%) did not give feedback to patients. It implies that on average 75,7% of clinical teaching groups (165) did not have feedback sessions during and after the clinical teaching sessions.

In addition findings in page 84 revealed that 32% of those clinical teaching groups who communicated during clinical teaching sessions had feedback by students whereas eight percent of those clinical teaching groups who did not communicate during clinical teaching sessions also had feedback from students. Similarly 29% of the clinical teaching groups who communicated during clinical teaching sessions had no feedback by the patient whereas only two percent of those who did not

communicate during clinical teaching sessions had no feedback by the patient. There is also overwhelming evidence that if there was communication during and/or after the clinical teaching session, then it is more likely that feedback was done by the patients ($x^2 = 16,573$ on 2 d. f. $p = 0,001$) and/or the students ($x^2 = 11.500$ on 1 d. f. $p = 0,001$). This implies that communication between the clinical teaching groups and patients was minimal during the clinical teaching sessions.



	YES	NO
BY THE PATIENT	22.5	77.5
BY THE STUDENT	26.1	73.9

Figure 4.8 Feedback sessions conducted during and after clinical teaching sessions

The manner in which clinical teaching groups departed from patient

There is consistency in these findings in that 66,1% of clinical teaching groups (144) communicated with patients after clinical teaching sessions and on average 72,9% of patients (159) were thanked, greeted and made comfortable after the clinical teaching sessions (Figure 4.7). In addition, if there was communication after clinical teaching sessions, the clinical teaching groups were more likely to have thanked [(85,41% versus 41,9% patients), $x^2 = 45,138$ on 2 d. f. $p = 0,001$], greeted [(90% versus 56,8% patients), $x^2 = 31,611$ on 2 d. f. $p = 0,001$]; and made patient comfortable [(83,3% versus 43,24% patients), $x^2 = 37,815$ on 2 d. f. $p = 0,001$]. It can be concluded that the majority of clinical teaching groups interacted with patients after clinical teaching sessions and departed in a polite and respectful manner.

Information not communicated by the patients to the clinical teaching group

Those patients (n = 99) who did not give feedback to the clinical teaching group, reported interesting information that they would have liked to communicate (Table 4.14). One hundred and three patients (57,2%) wanted to know more about their disease process. This figure refers to patients who needed to know about their health problems or illness. Twelve patients (6,7%) wanted to know about the performance of students to check if they met their objectives and whether the patients were of help. One patient (0,5%) wanted to thank the clinical teaching group for having done a good job. Two patients (1,1%) explicitly indicated that they wanted only qualified health professionals to manage them.

Table 4.14 Messages not communicated by patients during clinical teaching sessions (n = 99)

Messages not communicated	Frequency	Percentage
Needed to know their health problem	81	45,0
Needed more information about illness	13	7,2
Investigations done	9	5,0
Needed help	9	5,0
Wanted to know about students' performance	12	6,7
Want professionals not students	2	1,1
Thank you	1	0,5
Do not know	9	5,0
Nothing	44	22,4

[NB: Patients gave more than one response]

4.3 Section C - Patients' experiences and perceptions during clinical teaching

Patients' experiences and their perceptions concerning clinical teaching will be discussed in this section. According to the definition in section 1.4, experiences would be what the patients felt and thought according to their own judgement and opinion. Patients' responses about their experiences were categorised into positive and negative experiences although these categories are not mutually exclusive. It is because some patients had both positive and negative experiences during the same clinical teaching session. Patients' positive and negative experiences will be discussed in the text that follows.

4.3.1 Patients' positive experiences

The question "What is it the facilitator or the participants did that you were comfortable with during the clinical teaching?" was directed to patients. The main categories of responses are presented in Figure 4.9.

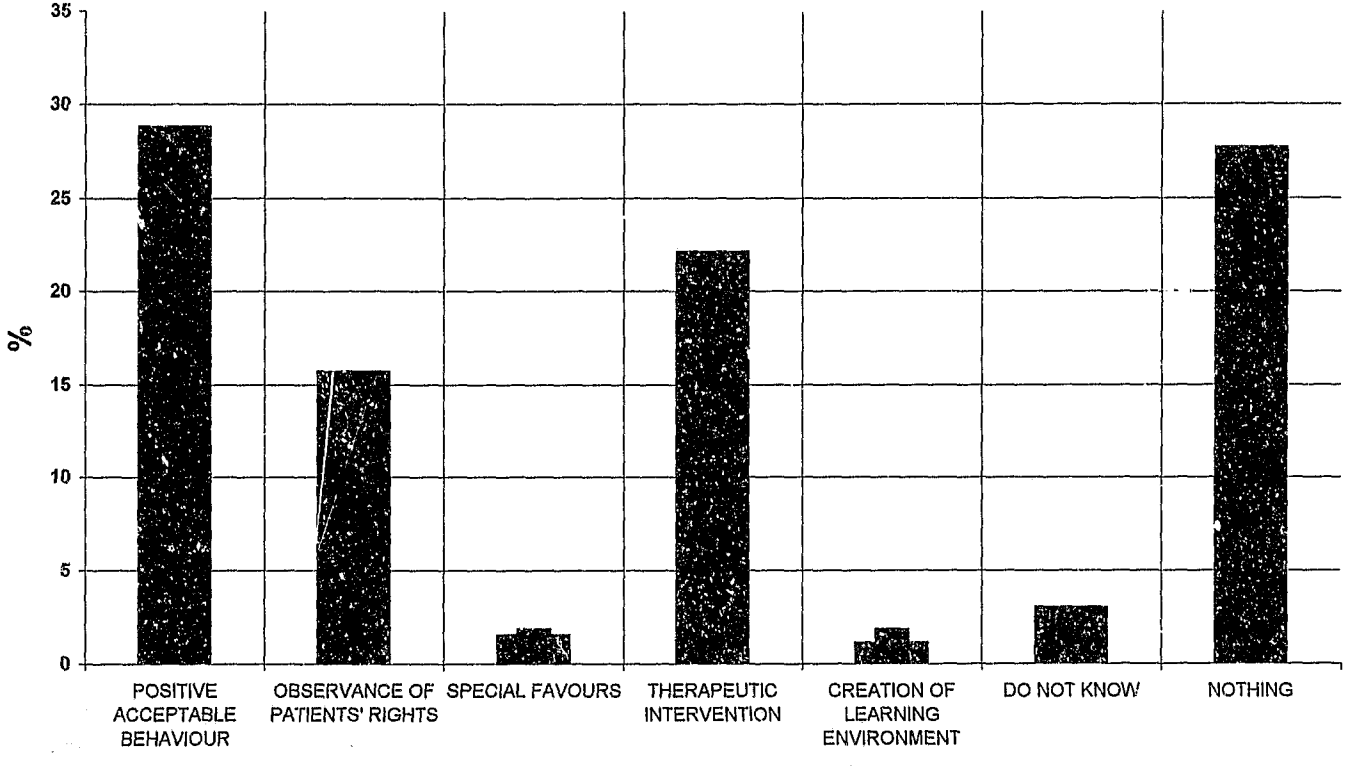


Figure 4.9 Patients' responses related to comfort during clinical teaching sessions

A total of 68,2% of patients (149) had positive experiences. Seventy-seven patients (35,8%) experienced positive, comforting and acceptable behaviours. These patients reported that the clinical teaching groups were compassionate, considerate and had an overall good manner of approach. They were helpful and sensitive to their needs and concerns. The following quotations are examples of some of the common responses

"... When I felt pain the clinical teaching group stopped examining me or became very gentle during physical examination.

" ...They took notice of every thing I told them ...and immediately wrote it ...this made me feel very important"

" ...They were so friendly ... they kept us company and they used my mother tongue during the session."

"...They showed confidence and commitment in what they were doing."

Simons et al. (1995) also discovered that almost half (46,5%) of their study participants enjoyed interacting with students especially for the attention they received. Forty-two patients (15,7%) were happy and comfortable because the clinical teaching group observed their rights during clinical teaching sessions. Most of these patients mentioned that their rights to privacy, respect, education and autonomy were observed. It seems that most patients are more sensitive to these rights because patients constantly make reference to them.

Fifty-nine patients (22,1%) felt comfortable when therapeutic interventions were done on them. They indicated that the clinical teaching group met their needs and offered care.

The most common responses were as follows:

"...They thoroughly examined me and asked many questions relating to my illness."

"... They relieved my pain... they gave me pain tablets."

" ...They took blood, put up a drip and discussed my illness with other doctors."

Patients were pleased to have been thoroughly examined by different health professionals. They indicated that this could contribute to a speedy recovery, as many health professionals with different skills and expertise were involved in their care. This seems to be confusing because generally patients think that those students who examined them were different health professionals with different expertise and skills, so they were pleased to have been physically examined in the same way by different students. This finding is supported by Holden and Pullon (1997) who found that patients felt that student involvement was advantageous because it brought improvements in the quality of both care and communication.

Four patients (1,5%) appreciated "special favours" from the students. Students bought them cool drinks and magazines after the sessions. Three patients (1.1%) were happy to create a learning situation for the students to learn especially when they discussed problems and learnt from each other. They felt they were helping future health

professionals and consequently other patients. In addition to the reasons mentioned, Smith et al. (1994) discovered that the patients enjoyed the experience and were willing to participate in other teaching sessions. They did not find the experience tiring and disruptive and did not feel that they were subjected to too many examinations.

4.3.2 Patients' negative experiences

To the question "What is it the facilitator or the participants did that you were not comfortable with during the clinical teaching sessions?", patients responded as presented in Figure 4.10. A total of 48,3% of patients (105) had negative experiences. Fifty percent of patients (109) felt that nothing in particular made them uncomfortable during clinical teaching sessions. Eighty-five patients (35,1%) felt that the behaviour of health professionals and students was negative, uncomfortable and unacceptable during clinical teaching sessions. The following are examples of common responses given by patients:

" ... I was so scared about their big number in front of me. I felt shocked and nervous."

" ... They all did the same thing. They all hit me with a hammer. Their examination was rough, stressful, tiring and painful. Their examination took too long. I could not even sleep well at night."

" ...They were laughing about my illness, changed my original position and left me like that."

"... I was hungry, they did not care to bring food, it became cold ...I was very hungry."

A study conducted by NPPHCN (1999) showed consistent findings and similar themes emerged. Patients also felt that health professionals do not respect patients' rights and do not always attend to their physical needs. In this study patients felt that the students came in excessive numbers. Table 4.9 (page 74) indicated that 108 patients (48,6%) had more than six people in their clinical teaching group. Patients found this frightening and shocking. They also indicated that their sessions were too long. On average 86 patients (40,3%) reported that the sessions were 36 to 45 minutes or longer (Table 4.7). The examinations themselves were exhausting and painful yet they were not given any time to rest. In their study, Holden and Pullon (1997) also indicated that patients felt that the disadvantage of clinical teaching sessions was a longer waiting time and a longer appointment time.

In addition, the clinical teaching groups also came during awkward periods i.e. weekends, visiting hours and at night. On weekends, patients hoped to relax from most hospital procedures but they were usually disturbed. During visiting hours, patients were disturbed and could not enjoy the company of their friends and relatives. At night, patients were disturbed from sleeping and subsequently complained of lack of rest. Patients indicated that, when these students have finished a session with one patient, they go to the next and thus spend a long time in the ward

cubicle. One clinical teaching group come after another and each intended to do the same thing on the same patient.

As previously indicated in Figure 4.1 (page 59), approximately 133 patients (60,9%) did not know their right to refuse or withdraw from the clinical teaching sessions. One hundred and fifteen patients (52,8%) were involved in clinical teaching more than three times during that admission period (Table 4.6) and 214 patients (99,1%) were examined in the ward cubicle (Section 4.2.2.5). For example if clinical teaching groups identified four patients in the same ward cubicle and spent an hour with each patient, they tended to spend four hours in one cubicle. Because they are in big groups, they made a noise and therefore disturbed other patients from resting. Most often there were more than three groups in one ward which comprises four cubicles and three small side wards. The wards are in an open plan style and so there is no noise barrier from one cubicle to another. This situation becomes a matter of concern especially at night when patients have to sleep. Hence, most patients complained of sleep and rest deficiency. Some patients have also indicated that this behaviour became worse during university examination periods. During this period students practised on patients in the afternoon and at night and in the morning sometimes the same patients are used as models during the examination process.

Thirty patients (12,4%) reported that their rights were not observed. The following quotations denote the behaviour of clinical teaching groups as reported by the patients concerning the observation of rights.

" ... They isolated me in their presence they were talking alone. They did not involve me in their discussion. They said I should stop talking, I asked too many questions."

" They shouted me"

" They did not even greet me or say thank you after finishing."

" They did not ask for permission, they just came, undressed and exposed me"

"... They did not properly address me. I felt belittled

"...I was forced to participate, it was not my intention"

These patients (12,4%, 30) complained that their rights to communication, autonomy, respect and privacy were not observed. This finding correlates with the information displayed in Figure 4.2 which indicates that on average approximately 45 patients (20,9%) reported that their right to autonomy, privacy, and respect was violated. As previously mentioned most patients are more aware of and sensitive to these rights. This is also confirmed in Figure 4.9 where 42 patients (15,7%) stated that they were comfortable when the clinical teaching group observed their right to privacy, autonomy and respect.

This trend is also featured strongly in a survey conducted by NPPHCN (1999). African women also tended to focus more on their interactions with health workers and the right to be treated with dignity, sympathy and care. The common focus of these two studies is the right to dignity and respect, communication and quality care.

Two patients (0,8%) also felt that their needs were not taken into consideration during clinical teaching sessions. According to these patients relevant therapeutic interventions were not done during these sessions. As an example, patients indicated that medication was not given at prescribed times due to such sessions. This means that patient care was compromised during clinical teaching sessions. In total 105 patients (48,3%) experienced a negative situation that made them feel uncomfortable during clinical teaching.

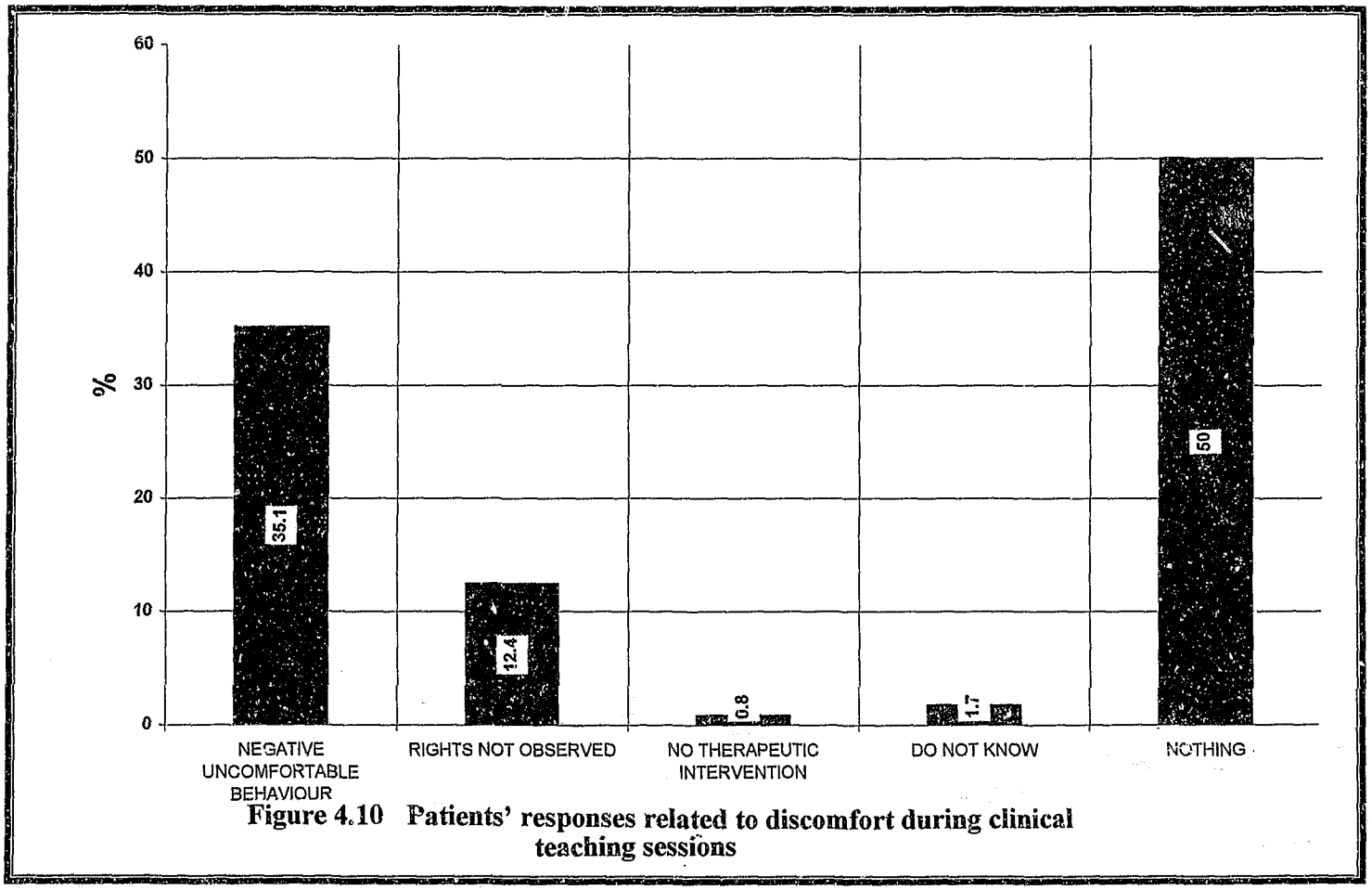


Figure 4.10 Patients' responses related to discomfort during clinical teaching sessions

4.3.3 Patients' perceptions

Patients' opinions concerning clinical teaching were requested. "What is your opinion about your involvement or patients' involvement in clinical teaching? Is it right or wrong? Please motivate your answer" was the question posed to patients. The main categories of patients' responses are presented in Figure 4.11. The majority of patients (76,9%, 163) felt it was right to be involved in clinical teaching whilst 37 patients (17,5%) felt it was wrong. Simon et al. (1997) had similar findings; approximately half (55,8%) of their participants did not prefer medical student participation, 43% were neutral and 10,3% disliked their encounters.

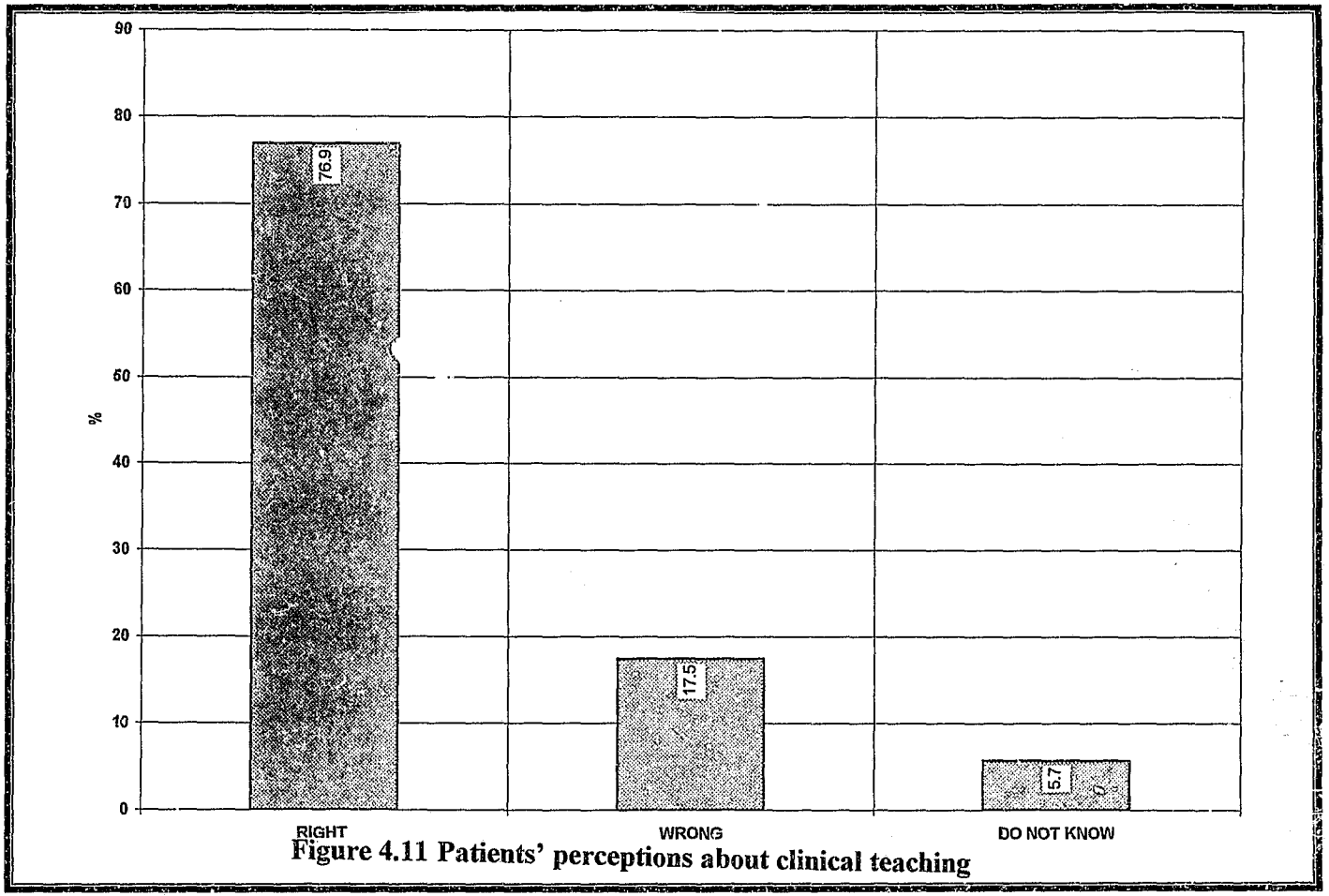


Figure 4.11 Patients' perceptions about clinical teaching

Patients who responded positively to the above question stated reasons displayed in Figure 4.12. Of the 76.9% who responded positively, 112 patients (70,4%) felt these sessions were the only way in which students could learn. Students get the opportunity to integrate theory and practical work so they can acquire clinical skills. This is the only way they can contribute towards the training of future health professionals for the present and the future nation

The other stated reasons were about the observance of patients' rights as cited by 11 patients (6,9%) and the caring aspect of the health profession as stated by 15 patients (9,4%). It is said that generally students are more caring, patient and observe patients' rights better than the qualified health professional. On the other hand, students learn to be more caring, patient and to observe patients' rights in the process of clinical teaching. Nineteen patients (12%) felt that both patients and students must benefit in the process. While the students acquire clinical skills, they should contribute towards correct diagnosis, treatment and speedy recovery of patients. Patients indicated that it is possible that during the clinical teaching sessions students could detect an abnormality that was never discovered by their supervisors and suggest other effective treatment options. This could also lead to a speedy recovery. One patient (0,6%) felt that based on students' status, these students are entitled to conduct clinical teaching sessions on patients. Clinical teaching sessions also encourage patients to help whilst being hospitalised. Hence, they feel they have contributed in some way towards health professional education.

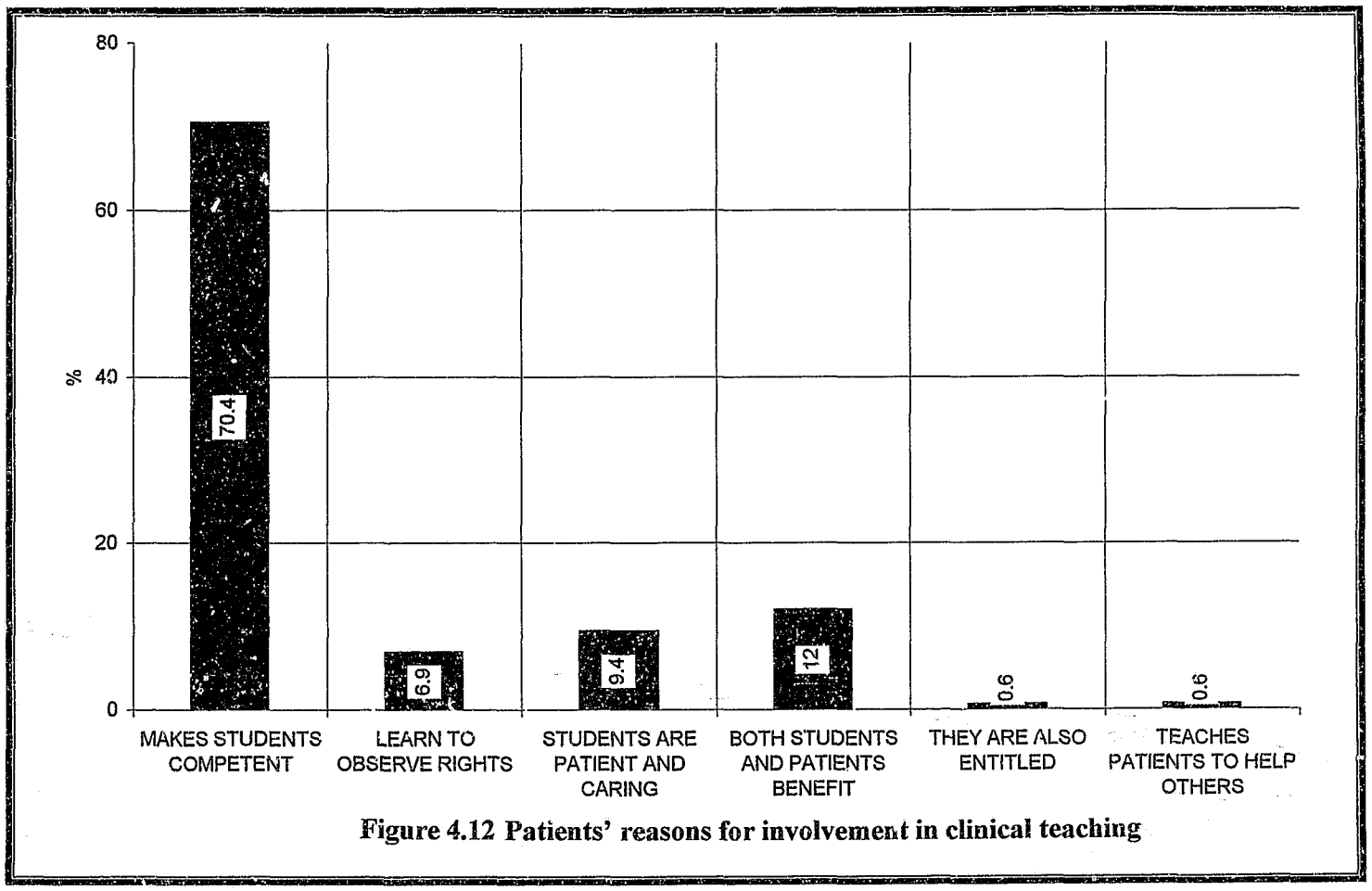


Figure 4.12 Patients' reasons for involvement in clinical teaching

A minority (17,5%, 37) felt that it was wrong to allow students to utilise patients in clinical teaching. The main reason for this opinion, as stipulated by 28 patients (75,7%), was that students are still clinically incompetent. Their incompetence could lead to mistakes that can cause adverse effects on their health. These patients stated that students should learn and become competent first using the literature and "dummies" before they could touch live patients. Due to the nature of these sessions (i.e. big groups and long sessions) and students' incompetence, seven patients (18,9%) reported that these sessions became uncomfortable, stressful and painful. One patient said " We are sick and these students play on us. We are not in hospital for that. We are not guinea pigs. These students waste our time instead of fighting the disease". In addition to this, three patients (5,4%) felt their rights were not observed.

The notion that patients know exactly how they would like to be treated also came up in this study. They indicated that they would like their rights to be respected, clinical teaching group members should behave acceptably and positively, make them comfortable and provide professional care during clinical teaching (Figure 4.13). This means that patients expect their care not to be compromised during clinical teaching sessions.

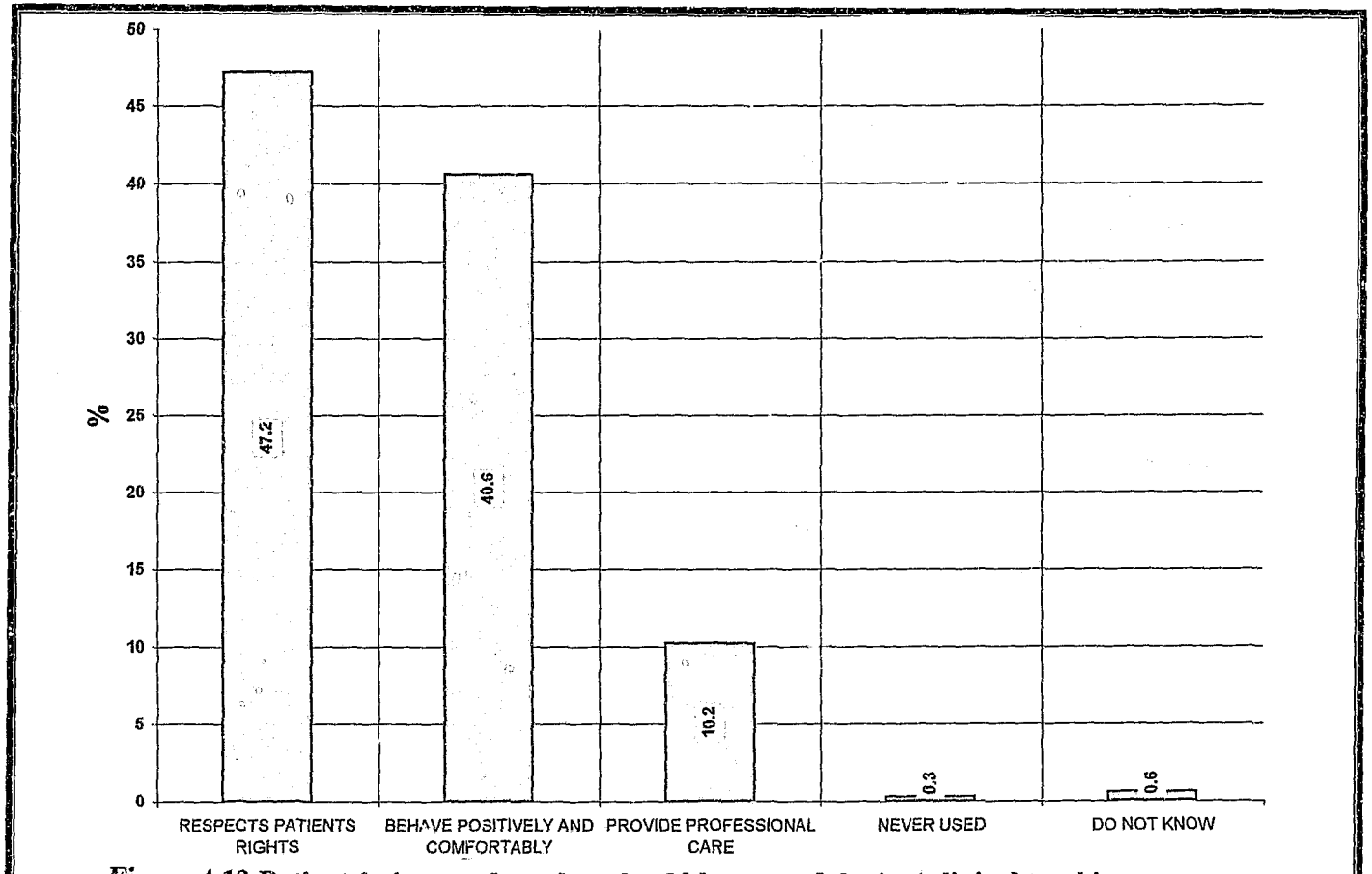


Figure 4.13 Patients' views on how they should be treated during clinical teaching

4.4 Summary

This chapter described the quantitative and qualitative data analysis method used, summarised and discussed the results. Data were analysed using the SAS Software Programme version 12.

More young and middle aged females were interviewed, mostly with low educational and socio-economic status. In general, a clinical teaching group consisted of 6-9 participants and most patients (71,6%) were comfortable regardless of the size of the clinical teaching group. Medical practitioners conducted most of the clinical teaching sessions, mostly in ward cubicles. On average, the majority of patients (61,3%) had knowledge of their rights (privacy, confidentiality, human dignity and respect, freedom and autonomy, communication, education and information) except for their rights to refuse to participate or withdraw from clinical teaching sessions. Patients' knowledge of their rights depended on the patients' educational status especially their rights to education and autonomy. In general feedback sessions were not conducted. The extent to which patients perceived whether or not their rights were observed also depended on the patients' knowledge of their rights.

Approximately 69% of respondents felt comfortable and 46,3% felt uncomfortable during clinical teaching sessions and indicated specific reasons that made them feel so. This implies that more patients had positive experiences during clinical teaching. The majority of the patients (76,9%) thought it was right to involve them during

clinical teaching sessions whereas 17,5% of patients felt it was wrong. These patients indicated specific reasons that qualify their perception and ways in which patients should be treated during such sessions.

This chapter presented and summarised the research results.

Chapter 5

Summary, main findings, limitations, recommendations and conclusion

5. 0 Introduction

This chapter summarises the study and its main findings, outlines the limitations and makes recommendations according to the research findings.

5.1 Summary

The main aim of the study was to elicit information and to describe the experiences and perceptions of adult patients in relation to their rights and their involvement in clinical teaching sessions. The first objective was to identify patients' positive and negative experiences associated with their involvement in clinical teaching. The second objective was to determine the perceptions of patients pertaining to their involvement in clinical teaching. The third objective was to determine the extent to which patients' rights were observed in clinical teaching.

A descriptive survey design was used. The researcher and a research assistant used a structured questionnaire with both open and closed-ended questions to interview a systematic random sample of 218 hospitalised patients. The sample included adult patients who experienced a clinical teaching session lasting for more than 10 minutes at Ga-Rankuwa Academic Hospital. Validity and reliability was ensured by using a

pilot study, an experienced educator and researcher, determining a reliability coefficient and training a research assistant.

Statistical Analysis System (SAS) Software Programme was used to analyse data. Data were codified, statistically analysed in terms of percentages and chi-square and a narrative qualitative text was written.

5.2 Main findings

5.2.1 Background

More young and middle aged females, with low educational and employment status, participated in the study (vide page 55). The majority of clinical teaching sessions (90,8%, 198) were conducted by medical practitioners and 8,3% (18) by nurses in ward cubicles.

5.2.2 Patients' knowledge of their rights

On average 61,3 % of patients had knowledge of their basic rights to human dignity and respect; privacy and confidentiality; education and information (vide page 57). Only 59,6 % (130%) and 62,2 % (135) respectively did not have knowledge of their right to freedom and autonomy (i.e. their right to refuse to participate and/or to withdraw from the clinical teaching session). Chi square analysis demonstrated that knowledge of patients' rights except for the right to education and information, refusal to participate or withdrawal from a clinical teaching session did not depend on

the educational status of patients. Patients with tertiary education were more aware of their rights to education and information, their rights to refuse to participate or to withdraw from the clinical teaching sessions [(x^2= 9,705, on 3 d.f. p= 0,001), (vide page 58)]. In addition patients with higher education were more aware of their right to refuse to participate in clinical teaching sessions (x^2 = 14,702 on 3 d. f. p = 0,002).

5.2.3 The extent to which patients' rights were observed during clinical teaching

There is statistical evidence that if patients have knowledge of their rights, then they are more likely to assess that those rights are observed (vide page 58). This was particularly true for patients' rights to privacy, confidentiality, human dignity and respect, education and information. The majority of patients (71,1%, 155) indicated that their rights were observed during clinical teaching sessions with the exception of their rights to human dignity and respect, health care, education and communication (vide page 61). Patients' assessment of whether their rights were observed or not could be reliable because it is evident that they had fair and clear understanding of their rights. Initially 72,5% of patients (158) indicated that their right to freedom and autonomy was observed. This finding is however questionable because more than half of the patients without tertiary education thought they were not allowed to refuse to participate or to withdraw from a clinical teaching sessions.

5.2.4 Patients' experiences in relation to observance of their rights

Patients had both positive and negative experiences during clinical teaching sessions. The majority of patients (68,2 %, 149) had positive experiences (vide page 93) and 48,3 % (105) had negative experiences that affected their comfort during clinical teaching sessions (vide page 95). Patients were generally comfortable when the behaviour and conduct of clinical teaching groups was positive especially when their rights were observed and health care was not compromised.

Patients complained of the negative behaviour and conduct of the clinical teaching groups who came in big numbers and too frequently and at inconvenient times(vide page 73). Patients also indicated that the teaching sessions were long (i.e. one hour and more) and strenuous (vide page 69). In addition the majority of patients (53,7%, 117) indicated that clinical teaching groups did not introduce themselves to patients (vide page 64).

Although 49% of patients (108) were subjected to very big groups (six to twenty five members), 156 patients (71,6%) reported to be comfortable with the size of the clinical teaching groups (vide page 73). This implies that the observation of privacy did not depend on the size of the clinical teaching group (x^2 = 4,155 on 3 d.f. p= 0,385). Neither did it depend on whether patients were comfortable or not (x^2 = 2,2024 on 1 d.f. p= 0,155).

Fifty six percent of patients (122) were given an explanation of the procedure, 62% of patients (137) were asked permission to participate in the study and 56% (123) were given an option to participate (vide page 76,79 & 82). There is evidence that if clinical teaching groups asked permission or gave patients an option to participate in clinical teaching, then it is much more likely that freedom and autonomy was observed ($x^2 = 7,806$ on 1 d.f. p=0,001). This discussion is however undermined by the fact that a majority of patients lacked knowledge of the right to refuse or withdraw from the clinical teaching session. It implies that the validity and legitimacy of these patients' informed consent is questionable.

On average 70,5% of patients (153) reported that clinical teaching groups communicated with them before, during and after clinical teaching session (vide page 84). There is also evidence that if there was communication before clinical teaching sessions, then it is much more likely that the procedure was explained to patients ($x^2 = 58,874$ on 1 d.f. p= 0,001). In addition this implies that permission to conduct clinical teaching sessions was asked from the patients ($x^2 = 32,123$ on 1 d.f. p=0,001).

Although the majority of clinical teaching groups communicated with the patients before, during and after clinical teaching sessions, there is a significant lack of feedback sessions between the clinical teaching group and the patient (vide page 86). One hundred and sixty-nine patients (77,5%) were not given a chance to give feedback to the clinical teaching group and 161 students (73,9%) did not give

feedback to patients. Despite the above, there is evidence that if there was communication during and/or after the clinical teaching sessions, then it is more likely that feedback was done by the patients (x^2 = 16, 573 on 2 d.f. p= 0,001) and/or the students (x^2 = 11,500 0n 1 d.f. p= 0,001).

5.2.5 Patients' perceptions of clinical teaching sessions

Patients participated in clinical teaching for positive and negative reasons. The negative reasons were lack of knowledge about their rights, lack of assertiveness and patients did not want to offend the health professional in-charge. The positive reasons were willingness to participate in health professional education, helping future patients and wanting to know more about their own disease condition (vide page 79).

A total of 163 patients (76,9%) felt it was right to be involved in clinical teaching although 37 patients (17,5%) felt it was wrong (vide page 101). Patients indicated that clinical teaching improves the quality of health professional education and helps the quality of patient care. In addition, students were generally more caring and observed patients' rights (vide page 103). Patients who felt that it was wrong to be involved in clinical teaching reported that students were clinically incompetent and therefore the clinical teaching sessions were uncomfortable and stressful and can lead to disastrous effects on patients' health (vide page 105).

Although some of the patients' experiences were negative, patients were generally positive about their involvement in health professional education (clinical teaching sessions in particular). It was also deduced that patients know exactly how they would like to be treated during clinical teaching and suggested strategies to increase their comfort. Patients indicated that they expect the clinical teaching group to be respectful, to observe their rights and to provide professional care during clinical teaching (vide page 105).

5.3 Limitations

- Only adult patients who were admitted in general wards were involved in the study, yet clinical teaching sessions were also done at out-patients' department and other speciality wards.
- Mostly medical staff (students, practitioners and teachers) were involved in clinical teaching hence the results do not truly reflect the practices of other health professionals.
- Findings can only be generalised to situations similar to those at Ga-Rankuwa Hospital especially with regard to practices of medical staff during clinical teaching.
- This study did not include the final edition of the Patients' Rights Charter by the Department of Health as this was launched after the study was completed.

- As this field of Human and Patients' Rights is new in South Africa, very few published research reports could be identified, accessed and incorporated in the study

5.4 Recommendations

There is a concern that some patients felt uncomfortable during clinical teaching sessions. Therefore, there must be action to increase patients' comfort levels during clinical teaching. If patients are comfortable, clinical teaching can be beneficial to students. To make patients comfortable health professional educators have a vital role to play in maintaining quality patient care and competent clinical practice during clinical teaching session.

5.4.1 Health professional education

- A major challenge for health professional education is to sensibly balance the needs of students for hands-on training with the rights of patients to receive the highest quality of care. This can be achieved by entrenching the concept of human rights in the curriculum of health professional students and ensuring that they are tested on it. This should be done to ensure that the students as prospective health care consumers and future health professionals are sensitised about the recognition and observance of patients' rights.
- To motivate continued ethical practice, Professional ethics must be established and enforced by all professional organsations. As most professional organisations

or professions are proposing recertification of health workers after a specified period, a component of ethos and human/patients rights must always be included and accredited. This will compel health workers to attend specific courses on patients' rights or to continue with their education in this regard. With this type of education, health professionals would be patients' advocates who protect their rights and prevent unwarranted intrusion. Health care centers should therefore assist health professionals to gain confidence, knowledge and skill in inculcating and observing the culture of human rights.

- All health care settings should make an effort to educate patients about their rights especially their right to autonomy and freedom, their right to refuse to participate or to withdraw from clinical teaching. One way of achieving this could be informing all patients about human rights on admission, during their stay in hospital and on discharge. This information could be displayed in strategic areas in the hospital- wards, notice boards, and patient waiting areas. The use of audio-visual and various other means of communication (e.g. television, radio, posters, booklets, newspapers, magazines) could be used inside and outside the hospital premises. In addition, this information could be incorporated as part of health information given to patients by health professionals. Workshops on patient's rights could also be conducted for patients and the public.
- To assess the effectiveness of information dissemination, a continuous non-threatening form of evaluating patients' level of satisfaction should be conducted.

- Before clinical teaching sessions patients should be adequately prepared for health professional students' involvement. It is important that the size of the clinical teaching group should be small (approximately 4-8) to alleviate anxiety. The clinical teaching group should also introduce themselves (by name and position in the group) to the patient before going ahead with the session. In asking permission to participate in clinical teaching, the clinical teaching group must discuss and agree with the patient about the nature, duration and frequency of the clinical teaching session. This is done to make sure that the sessions remain comfortable to the patient. In addition the clinical teaching group must behave in a socially positive and acceptable manner to patients. The group must make sure that patients' rights are observed during clinical teaching and that the quality of patient care is always of a high standard. It seems that patients value communication and interaction with the clinical teaching groups. Open lines of communication must always be maintained between the patient and the clinical teaching group. This can also be enhanced by ensuring feedback sessions during and after clinical teaching sessions. During feedback sessions the patient is given a chance to verbalise his/her experiences. Similarly the other group members can inform the patient about their findings including the patients' general health status.

5.4.2 Research

- Due to the limited setting of this research the findings can not be generalised to other situations. It is therefore recommended that a wider research project be conducted that could depict the practices of other health professionals and in other settings.
- Another interesting topic would be to assess the readiness and preparedness of health professionals and students in observing patients' rights during clinical practice and clinical teaching.

5.5 Conclusion

More patients had positive than negative experiences during clinical teaching. Research results also indicated that it is also possible for patients to have both negative and positive experiences during the same clinical teaching sessions. The following factors determined whether the clinical teaching sessions were uncomfortable or comfortable for patients:

- The stage of illness of the patient
- The size of the clinical teaching group
- Behaviour and conduct of the clinical teaching group
- Duration and frequency of the clinical teaching session
- Time period during which the clinical teaching session is conducted
- Number of clinical teaching groups conducting clinical teaching sessions on the same client within a 24 hour period

- Nature of the procedure or examination conducted by the clinical teaching group
- Extent to which the patients' rights are observed
- Extent to which the health care and comfort needs of the patient were met
- Extent to which patients benefit from these sessions

On average patients experienced between one to five clinical teaching sessions. The frequency of clinical teaching sessions was mostly determined by the nature of the patients' disease, the number of patients in the ward, the tertiary institutions examination period and the number of students allocated to the ward.

Although many clinical teaching groups (71,6 %, 156) were big in number (6-25 in a group), patients felt comfortable about the size of such groups. This finding could be because patients see these groups almost every day; they become desensitised to their number. This is coupled with the idea that patients think all members of the clinical teaching group are different health professionals who could contribute to their speedy recovery. The validity of the informed consent given by patients was undermined by the educational level of respondents since more than half did not have knowledge of their right to refuse or withdraw from the clinical teaching session.

Patients were more sensitive and aware of their rights to human dignity and respect, privacy, communication and education, freedom and autonomy. In instances where

patients' rights were not observed this was attributed to the insensitivity, hurried approach, lack of knowledge of patients' rights (with regard to their recognition and observance) by the clinical teaching groups.

Although patients had both positive and negative experiences during clinical teaching, they were generally positive about their involvement in health professional education and suggested strategies to increase their comfort during clinical teaching sessions. Patients know exactly how they would like to be treated and they expect the clinical teaching groups to respect their rights.

This chapter summarised the study- its aims, objectives, the research methodology used, the main findings and limitations of the study. Recommendations, arising from the research findings were made in relation to education and research.

References

1. American Hospital Association. 1992. *A Patient's Bill of Rights.* Second Edition. Chicago

2. American Medical Association. 1997. Personal rights. *Archives of family medicine.* 6 (5): 422.

3. Berwirck, D., Hiatt, H., Janeway, P. and Smith, R. 1997. An ethical code for everybody in health care. *British Medical Journal,* 315:1633-1634.

4. Bewley, S. 1992. The law, medical student and assault. *British Medical Journal,* 304:1551-3.

5. BIOETHICSLINE [database online] Smith, J.A. 1994. Ethical considerations of giving patients choices. Hospital Topics. (http://www.healthgate.com/cgi-bin/q-format.cgi) (14 July 1999)

6. Bruce, J. 1992. *Effect of practice setting on clinical learning among first year student nurses.* Johannesburg: University of Witwatersrand.

7. Burns, N. and Groves, S. K. 1993.*The Practice of Nursing Research. Conduct, Critique and Utilisation.* Second edition. Philadelphia: W. B. Saunders Company.

8. Centre for Disease control. 1994. *An Epidemiology Approach to Reproductive Health.* Columbia.

9. Creswell, J.W. 1994. *Research Design. Qualitative and Quantitative Approaches.* London: Sage Publication

10. Department of Education Directorate: Adult Education and Training. 1997. *A National multi-year implementation plan for Adult Education and Training: Provision and Accreditation.* Pretoria: Government Printers.

11. Department of Health. 1999. *Patients' Rights.* Pretoria: Government Printers.

12. Department of Health. 1997. *The White Paper for the Transformation of the Health System in South Africa.* Pretoria: Government Printers.

13. Department of Health. *April/May* 1998. *Health Talk.* South Africa.

14. Diedericks, E. and Lategan, L.O.K. 1994. *Introduction to Clinical Ethics. Theory and Practice for Nursing.* Bloemfontein: Institute for Nursing of the Orange Free State.

15. Flynn, N., Spencer, J. and Jones, R. 1997. Consent and confidentiality in teaching in general practice: Survey of patients' view on presence of students. *British Medical Journal.* 315:1138-1141.

16. Fourie, A. and Van Rensburg, H.C. 1994. Inequalities in South African health care. Part 1. The problem—manifestations and origins. *South African Medical Journal.* 84(2): 95-9.

17. Fraenkel, J. R. and Wallen, N. E. 1994. *How to design and evaluate Research in Education.* Second Edition. London: Mosby Company.

18. Gantley, M., Ricket, M., Sheldon, M. and Carter, Y. 1998. Patients in East London seem happy to give GPs consent for training. *British Medical Journal.* 316:1391.

19. Gillon, R. 1992. *Philosophical Medical Ethics.* Great Eritian: Antony Rowe Ltd, Chippenham, Wiltshire.

20. Hall, J.K. 1996. *Nursing ethics and Law.* Philadelphia: W. B. Saunders Company.

21. Holden, J. and Pullon, S. 1997. Trainee interns in general practices. *New Zealand Medical Journal.* 110 (1053): 377-9.

22. Lehmann, L. S., Brancati, F. L. and Roter, D. 1997. The effect of bedside case presentations on patients' perceptions of their medical care. *New England Journal of Medicine.* 336:1150-5.

23. Lestrade – Jefferif, J. 1997. Living in Gauteng – Selected findings of the 1995 October house hold survey. Pretoria: Central Statistics.

24. Neuman, W.L. 1994. *Social Research Methods. Qualitative and Quantitative Approaches.* Second edition. Boston: Allyn and Bacon.

25. Newble, D. and Cannon, R. 1994. *A handbook for Medical Teachers.* Third Edition. London: Kluwer Academic Publishers.

26. ONLINE ETHICS [database line]. Glosary of Ethical terms. (http://www.cwru.edu/affil/wwwethics/glossary.html) (14 July 1999)

27. Pera, S.A. and Van Tonder, S. (1996). *Ethics in Nursing Practice.* Cape Town: Juta.

28. Porter, P.A. and Perry, A.G. 1999. *Basic Nursing: A critical thinking approach.* Fourth Edition. St Louis: Mosby.

29. Savulescu, J., Marsden, R. and Hope, T. 1998. Respect for privacy and the case of Mr. K. *British Medical Journal.* 316:921-924.

30. Schmidt, J. M. 1996. Consumers' Healthcare Rights in Brazil. *International Nursing Review.*43 (5): 139-141.

31. Silverman, D. R. 1996. Narrowing the Gap between the Rhetoric and the Reality of Medical Ethics. *Academic Medicine.*71 (3): 227-235.

32. Simons, R. J., Imboden E., and Martel, J.K. 1995. Patients' attitudes toward medical students participation in a general internal medicine clinic. *Journal of General Internal Medicine (United States).* 10 (5) p251-4.

33. South Africa. 1996. *The Constitution of the Republic of South Africa.* Pretoria: Government Printer. (Act no 108 of 1996).

34. South African Nursing Council. 1992. *Standard for Nursing Practice: South African Nursing Council Policy statements.* Pretoria: South African Nursing Council.

35. Stengelhofen, J. 1993. *Teaching students in clinical settings.* London: Chapman and Hall Company.

36. The National Progressive Primary Health Care Network Rights Campaign. 1999. *Rights and Realities (Summary Report): A Qualitative Evaluation of the Rights Education Component of the National Health Rights Campaign (Phase Two).* Johannesburg: The National Progressive Primary Health Care Network Media and Training Centre.

37. Tschudin, V. 1990. *Values: a primer for nurses.* London: Bailliere Tindal.

38. Webster's Revised Unabridged dictionary.1998. Hypertext Webster Gateway.

39. White, R. and Ewan, C. 1994. *Clinical Teaching in Nursing.* London: Chapman and Hall.

40. Williamson, C. and Wilkie, P. 1997. Teaching medical students in general practice: respecting patients' rights. *British Medical Journal.* 315: 1108-1109.

41. Wright, H.J. 1974. Patients' attitudes to medical students in general practice. *British Medical Journal* 1:372-6.

APPENDIX A

Questionnaire

Date

DD	MM	YY

Research code

Questionnaire number

Instructions

Kindly ask the respondent the following questions. When the respondent answers, categorise the answers and make a tick ( ) in the appropriate box for closed-ended questions. For open-ended questions write the respondent's responses in the space provided.

Section A: Personal information and background knowledge of participants

1. Sex

Male	Female
1	2

2. Age

16-25	26-40	41-55	56 and above	Don't know
1	2	3	4	5

3. Employment status

Employed not self-employed	Unemployed	Self employed	At school	Pensioner
1	2	3	4	5

4. Educational status

No schooling	Grade 10 and <	Grade 11 and 12	Tertiary Education	Other
1	2	3	4	5

5. What do you know about your rights as a person and as a patient?

I have the right to the following during clinical teaching:

	Yes	No
Privacy	1	2
Confidentiality	1	2
Human dignity and respect	1	2
Freedom and autonomy	1	2
Education and information	1	2
Refuse to participate in clinical teaching	1	2
Withdraw from clinical teaching	1	2

Section B: Clinical teaching sessions

1. Who was conducting the most recent clinical teaching session(s)?

Medical practitioner	Nurses	Physiotherapist	Occupational therapist	Radiographer
1	2	3	4	5

2. Did the facilitator introduce her/himself and other participants before the sessions?

Yes	No
1	2

3. How were you addressed during the session?

By name	By surname	Mr., Mrs., Ms	Uncle, Aunt, Grandpa	Patient	No addressed
1	2	3	4	5	6

Other, specify_____

_____

4. How long was the clinical teaching session?

0-5min	6-15min	16-35min	36-59min	60-180min	180<
1	2	3	4	5	6

5. Did the facilitator or participant ask for your permission to be involved in clinical teaching?

Yes	No
1	2

6. Do you think you were given an option to participate in clinical teaching?

Yes	No
1	2

If yes, what motivated you to participate?

_____

7. Was the procedure explained to you?

Yes	No
1	2

If yes, what was said?

_____

8. How often have you been involved in clinical teaching during this admission period?

1-3	4-6	7-10	>10
1	2	3	4

Other, specify_____

9. On average, how long was/were the session(s)?

0-5 min	6-15 min	16-35 min	36-60 min
1	2	3	4

Other, specify_____

_____

10. How many participants were in the most recent group?

1-2	3-5	9	10-15	16-25
1	2	3	4	5

Other, specify

_____

11. Were you comfortable about the number of participants in the group?

Yes	No
1	2

12. Where was the last session conducted?

Ward cubicle	Side ward	Ward corridor	Examination room
1	2	3	4

Other, specify

_____

13. Did the facilitator or participant interact and /or communicate with you?

	Yes	No
Before the session	1	2
During the session	1	2
After the session	1	2

If yes in the above, what was communicated?

_____

_____

14. Was there an opportunity for you (patient) or the facilitator/participant to give feedback?

	Yes	No
For the patient	1	2
For the facilitator/participant	1	2

If no, what would you say if given a chance_____

_____

15. Do you think the following rights were taken into consideration during the session(s)?

	Yes	No
Privacy	1	2
Confidentiality	1	2
Human dignity and respect	1	2
Freedom and autonomy	1	2
Education and information	1	2

16. Did you have any special acute physical needs that could have caused remarkable discomfort (e.g. need to urinate or pass diarrhoeal stool)?

	Yes	No
Before the session	1	2
During the session	1	2
After the session	1	2

17. Was your spiritual belief taken into consideration during the clinical teaching session?

Yes	No	N/A
1	2	3

18. Was your cultural belief taken into consideration during the clinical teaching session?

Yes	No	N/A
1	2	3

19. Did the facilitator/participant(s) do the following before they departed?

	Yes	No
Thank you	1	2
Greet you	1	2
Make you comfortable	1	2

Section C: Patients' experiences and perceptions during clinical teaching

1. What is it the facilitator or participant(s) did that you were comfortable with?

_____

_____

2. What is it the facilitator or participant(s) did that you were not comfortable with?

_____

_____

3. What is your opinion about your involvement or patients' involvement in clinical teaching? Is it right or wrong? Please motivate your answer.

_____

_____

4. How do you think patients should be treated during clinical teaching sessions?

_____

_____

Is there any other thing you would you like to say?

_____

_____

THANK YOU FOR YOUR PARTICIPATION

CODES: N/A- Not applicable

APPENDIX B

Letter of Permission from the Committee on Human Subjects

(University of the Witwatersrand)

UNIVERSITY OF THE WITWATERSRAND, JOHANNESBURG

Division of the Deputy Registrar (Research)

COMMITTEE FOR RESEARCH ON HUMAN SUBJECTS (MEDICAL)
Ref: R14/49 Nxumalo

CLEARANCE CERTIFICATE PROTOCOL NUMBER M980323

PROJECT Parents' Experiences of Clinical Teaching Sessios in an Academic Hospital

INVESTIGATORS Mrs MZ Nxumalo

DEPARTMENT Nursing Education, Medunsa

DATE CONSIDERED 980327

DECISION OF THE COMMITTEE *

Approved unconditionally

DATE 980515 CHAIRMAN .....(Professor P E Cleaton-Jones)

* Guidelines for written "informed consent" attached where applicable.

c c Supervisor: Mrs J Bruce
Dept of Nursing Education, Wits University

Works2\lain0015\HumEth97.wdb\M 980323

APPENDIX C

Letter of permission from the Post graduate Committee (University of the Witwatersrand)

22 June 1998

Mrs M Z Nxumalo
P O Box 9469
PRETORIA
0001

Dear Mrs Nxumalo,

APPROVAL OF PROTOCOL ENTITLED "PATIENTS' EXPERIENCE OF CLINICAL TEACHING SESSIONS IN AN ACADEMIC HOSPITAL".

I should like to advise you that the protocol that you have submitted for the degree of MSc(Nursing) has been approved by the Postgraduate Committee for continuation of candidature, **subject to ethics clearance being obtained.** Please submit a copy of your ethics clearance certificate to the Faculty Office as soon as it has been obtained.

Mrs J Bruce and Mrs G Langley, of the Department of Nursing Education, have been appointed as your supervisors. You are asked to maintain regular contact with your supervisors who must be kept advised of your progress.

Please note that all candidates for higher degrees must make reference in their research reports to the clearance number of the relevant ethics committee, where applicable. The final title, when submitting the research, should comply with the above approved title, and a signed declaration, noting that the work has been your own and not submitted to any other University, must also be included.

Please also note that Postgraduate students are **required to register with the Faculty Office every year until they graduate from the University.**

Yours sincerely

MRS G GABRIEL
FACULTY OFFICER (POSTGRADUATE)
FACULTY OF HEALTH SCIENCES

cc: Ms P McInerney
Mrs J Bruce
Mrs G Langley

The University of the Witwatersrand rejects racism and racial segregation. It is committed to non-discrimination particularly in the constitution of its student body, in the selection and promotion of its staff, and in its administration.

APPENDIX D

Letter of permission from Ga-Rankuwa Hospital Superintendent

Tel: (012) 529-3201
Fax: (012) 560-0099
Cell: 082-450-7464
e-mail: supergar@iafrica.com

Office of the Chief Superintendent
Ga-Rankuwa Hospital
Private Bag X422
PRETORIA
0001
18 June, 1998

Sr. N. Z. Nxumalo
C/o University of the Witwatersrand
Department of Nursing
Johannesburg

Dear Sr. Nxumalo

RE: RESEARCH INTO CLINICAL TEACHING AT GA-RANKUWA HOSPITAL

It gives me great pleasure to approve your research project to be conducted at this hospital. Please will you make the necessary arrangements with the nursing staff in charge of the areas in which the research is to be conducted.

We wish you well with your project.

Dr. R. J. Broekmann
Chief Medical Superintendent
/protocol: clinical teaching

APPENDIX E

Patient's information letter

University of Witwatersrand

Department of Nursing Education

Medical School

7 York Road

PARKTOWN

2193

Dear Ms/Mrs/Mr.....

In my experience as a health professional I have observed patients involved in clinical teaching sessions and have wondered how you as a patient feel about your involvement in such sessions. This concern prompted me to conduct a research study to explore and describe your experiences and to investigate if your rights are observed in such sessions.

You are requested to volunteer and participate in this study. The research will under no circumstances interferes with your treatment or exposes you to any harm or danger. You may refuse or leave the study at any time with no effect on present or future treatment.

After the teaching session I will ask you questions about your feelings and experiences. Your responses will be recorded on a questionnaire. The whole exercise will take approximately 30 minutes. The interview will be conducted in a private place. I also want to assure you that the information received will remain confidential. Your name and other personal details will in no way be disclosed.

Although you are not compelled to participate nor will you directly benefit from the study, the information obtained will in future empower health professionals with knowledge and skill to comfortably handle patients during clinical teaching sessions.

For further information, please feel free to contact me at the following numbers:
(012) 521 3757 (W) or (012) 661 8816 (H)

If you agree to participate in this research, please complete the attached letter of consent and return it to me.

Enjoy the rest of your day

Yours sincerely

Zanele Nxumalo

Author Nxumalo M Z
Name of thesis The Experiences Of Adult Patients Involved In Clinical Teaching Sessions Conducted By Health Professionals In An Academic Hospital Nxumalo M Z 2000

PUBLISHER:
University of the Witwatersrand, Johannesburg
©2013

LEGAL NOTICES:

Copyright Notice: All materials on the University of the Witwatersrand, Johannesburg Library website are protected by South African copyright law and may not be distributed, transmitted, displayed, or otherwise published in any format, without the prior written permission of the copyright owner.

Disclaimer and Terms of Use: Provided that you maintain all copyright and other notices contained therein, you may download material (one machine readable copy and one print copy per page) for your personal and/or educational non-commercial use only.

The University of the Witwatersrand, Johannesburg, is not responsible for any errors or omissions and excludes any and all liability for any errors in or omissions from the information on the Library website.