Medical Ethics and Caring Practices in Pakistan: A Comparative Study of Government and Private Hospitals

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CHAPTER # 2

AREA PROFILE

CHAPTER # 3

CARE IN GOVERNMENT HOSPITAL

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CHAPTER # 1

1.1 INTRODUCTION

This research deals with the socio-cultural construction of the concept of care and ethics of care in government and private hospitals. That is how care is relatively perceived, defined, understood, explained and practiced and its ethical aspects in these two health care setups. The process and provision of care from ethical perspective has been studied.

"The term "Medical ethics" refers to the moral dimension of healing practices and health-care systems. In its broadest articulation, medical ethics is concerned with the cultural and philosophical construction of morality as it is expressed in beliefs and behavior about health and illness. The language of medical moral discourse, the negotiated meanings attached to illness experiences, the application of treatment modalities, and the development of new scientific technologies all fall within the purview of medical ethics."[1]

This research also focuses on the socio-economic and other factors that determine nature, extent and process of caring practices. It has been tried to find out that which socio-economic factors actually determine and affect the whole mechanism of caring in these two sectors. "Care as the "actions that 'carers'... carry out for the benefit of other individuals,"...."[2] The behavioral variation of patients, doctors, nurses, medical staff and patient's attendants has been focused on in care giving and receiving practices. The ethical dimensions of care giving process have been debated among the main actors

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[1] David Levinson and Melvin Ember, Medical Ethics, Encyclopedia of Cultural Anthropology, Volume 3, 1996, PP. 763-764, Richard Gottlieb

[2] Elisa J. Gordon, Extending the Boundaries of Care: Medical Ethics and Caring Practices, American Anthropologist, 2002, PP. 362, American Anthropological Association

involved in caring process. The variation of care and moral dimension of care has seen with reference to the nature, extent and treatment of illness. The differences between the theory of care and its practice have been studied as difficulties and ethical issues in care giving process. The main difficulties and ethical issues in caring process have been rationalized relatively. The mechanism of care varies greatly with the change of gender, age, the nature of disease and illness and personality development of people. There is also great variation in dialogue of moral dimension of care among main actors of caring practice. Ethical aspects of caring process have been debated among various actors of care on the basis of their religious beliefs and socialization. The study has also focused on the main factors that do not allow the ideal application of caring models when it is practiced. The caring mechanism greatly varies with division of gender. Females are considered to be more caring than males. This is why caring in medical profession is mainly related to nursing theory and practice. Nursing care has been studied comparatively in both hospitals. Patients' perceptions of nursing care and problems of nurses do raise some ethical issues in medical profession. The social and cultural values do affect the whole mechanism of care. The perception, understanding, and practice of care in medical profession also greatly vary with reference to class, status, role and socialization of an individual. Moral grounds for determining the ethical aspects of care vary from individual to individual. Understanding of care also varies according to individual's needs and psychology. The components and indicators of care in these both health care setups have been studied comparatively and rationalized relatively. The conception, perception, definition, understanding, explanation and practice are different among main actors of care. Ethical aspects of care have also been studied within the

institutional limits of these two different healthcare setups. Patients have been seen as active members rather than passive members while their treatment, so their needs of care vary accordingly. Doctors, nurses, medical staff and attendant's behavior has been according to their brought up and socialization, but their socio-economic status and personality development do affect mechanism and process of care to great extent.

1.2 THE STATEMENT OF THE PROBLEM

My focus, in this research is to find out what are the local perceptions, definition, understandings and practice of care in both government and private hospitals and its ethical aspects. It mainly focuses on the moral dimension of care debated and dialogued among main actors on the basis of their religious beliefs. The study also focuses on the socio-economic factors that determine the varying perceptions, procedures and provision of care in these both healthcare setups. The intra-interactional relationships among patients, doctors, nurses, medical staff and attendants have been comparatively studied and analyzed. It has also been tried to find out that how love, emotions and feelings-oriented relationship is between patients, doctors, nurses and other medical staff. The socio-cultural construction of the concept of care and its moral dimensions has been the main focus of this study. The relative conceptions, perceptions, interpretations and explanations of the concept of care and its moral dimensions in these two hospitals have been comparatively analyzed. And the whole phenomena of care and ethics of care have been analyzed comparatively from individual to individual.

1.3 PROPOSITION

The following is the proposition for this research.

Various socio-economic factors determine the nature, extent, and quality of caring practices in government and private hospitals.

1.4 OBJECTIVES OF THE STUDY

The following are the objectives of the study.

1. To find out how people conceive and perceive the phenomenon of care in both government and private hospitals.

2. To examine what are the main actors of care and how it is given and received.

3. To know what are the main socio-economic factors that affect people's conception, perception and provision of care in both government and private hospitals.

1.5 LITERATURE REVIEW

Review of the present literature is an integral part of the research. By reviewing the existing literature, we can get a lot of help in understanding our research problem. It gives justification to our research findings as well. Literature related to the medical ethics, care and ethics of care has been reviewed thoroughly. The reviewed literature is divided into the following sequence: medical ethics, care, the process and provision of care to patients by nurses, doctors, other medical staff and patient's attendants, ethics of care, the relationship between doctor, patient and nurse and the ethical dilemmas of care in hospital.

Health is perceived in different ways in different societies. World Health Organization defines health as

"Not merely the absence of disease and infirmity but complete physical, mental and social well-being."

(WHO, 1978)

Anthropologists have always been interested in different societies and their issues; health is also an important issue, so their interest in health gave birth to medical anthropology.

"...mat (a) elucidates the factors, mechanisms, and processes that play a role in or influence the way in which individuals or groups are offered by and respond to illness and disease, and (b) examines the problem with an emphasis on pattern of behavior"

(Faberga, 1971:167)

Forster and Anderson describe this discipline, it is the term used by anthropologist to describe,

"Their research whose goal is the comprehensive description and interpretation of the bio-cultural interpretation between human behaviors past and present, and health and disease levels without primary regard to practical utilization of this knowledge"

(Forster and Anderson, 1962:23)

Disease and death are universal human experiences. Every society has evolved its own recipe of substantial beliefs, knowledge and practices around the health area. Biological factors in abstraction determine the diseases and its treatment; it is more of a work of social factors. Disease emerges as threat to disrupt the functioning of social order. Efforts for restoration of health are in turn efforts to maintain the societal equilibrium; certain adapting strategies are adapted to overcome the ailment. Like consultation with doctor is one of these strategies. As Ruban has written

"By necessity man has undoubtedly always been concerned with question of health and survival, and has sought within the framework of his knowledge, solutions problems of illness."

(Foster and Anderson, 1978:34)

Every human being fulfills many social roles in a society. Every role is representative of certain responsibilities and rights. Disease causes disruption in physical state of being which alters its role in social organization. So the members of society will help recover the sick to health so that he may fulfill his normal role and obligations.

Both anthropologists and sociologists view the course of illness as marked by analytically distinguishable stage. The most widely used scheme is that of Suchman who says,

"The sequence of medical events.....representing major transition points involving decisions about the future course of medical care, and divided into five stages"

1. In first stage patient feels some physical discomfort, pain and change of appearance to his physiological state.

"These symptoms will be recognized and defined not in medically diagnostic categories, but in terms of their interference with normal social functioning."

(Suchman, 1965: 115)

2. Assumption of the sick role state

"The decision that one is sick and needs professional care" When the sufferer interprets these symptoms to himself and other people near him, he enters into second stage where care is initially limited to home remedies, and self care.

Suchman says

"How the individuals lay consultants react to his symptoms and their acceptance of any interference with his social functioning will do much to determine the individual's ability to enter the sick role."

(Clarke, 1959a:203-204)

3. The medical care contact stage.

Now the person has become a patient. He seeks two things one authoritative confirmation of the provisional validation of his sick role, previously granted to him by his lay consultants. Secondly, the patient tries to find a physician.

As Clarke says,

"In relation with medical personnel, then, a patient is not free to make immediate and conclusive decisions concerning his own health. He is acting not as an individual but as a family member."

4. The dependent – patient role stage

In this stage patient is under supervision of a doctor, he totally depends upon doctor and the hospital. He has to behave in a way obedient and institutionalized way from the patterns of dress to food. He loses control over his decision.

"It is also called patient role by Talcot parsons."

5. Recovery or rehabilitation stage.

In this role patient is again brought to his normal status, he can now fulfill his duties assigned to him, the patients says, "My doctor told me I can now do anything I want."

Hospitals have become the primary health care units. Patients often visit outpatients department and often they are admitted in hospital as patients. It is always recommended by doctors.

"While hospital services are oriented towards welfare, hospital rules and regulations are generally designed for the benefit of hospital personnel so that the work of treating large number of patients can be more efficient and easier to perform."

(William c-Cocker ham, 1982:194)

In "Encyclopedia of Cultural Anthropology" the David Levinson and Melvin Ember defines medical ethics as

"The term "Medical ethics" refers to the moral dimension of healing practices and health-care systems. In its broadest articulation, medical ethics is concerned with the cultural and philosophical construction of morality as it is expressed in beliefs and behavior about health and illness. The language of medical moral discourse, the negotiated meanings attached to illness experiences, the application of treatment modalities, and the development of new scientific technologies all fall within the purview of medical ethics."

(Levinson and Ember, 1996:763-764)

"Care" in medical profession in any society is relatively conceived, perceived, understood, explained and practiced. In "American Anthropologist" Elisa J. Gordon reviews the book "Extending the Boundaries of Care: Medical Ethics and caring Practices" as

"In Extending the Boundaries of Care, the editors are concerned with examining how care is socially constructed by challenging the "boundaries" of its current

conceptualization and use (p. 1). Specifically, the eight chapters of the book commonly seek to expand ideas about who performs care, its perceived value in society, and its contexts of performance and meanings. While the editors in the introduction present a definition of care as the "actions that 'carers'... carry out for the benefit of other individuals," they explicitly state that such a definition is conceptually limited and that they "do not aim to construct spurious consensus" on the term (p. 1)."

(Elisa J. Gordon, 2002:361-362)

He further reviews the book as

"Several chapters' examination of the socio-cultural construction of care were exceptional. One novel idea advanced by several chapters was that putatively healthy people are legitimate recipients of care as much as are sick people, as chapters 3 and 5 eloquently show. A noteworthy chapter, "Relative Strangers: Caring for patients as the Expression of Nurses' Moral/Political Voice" by Jan Savage, explores "new nursing's" ideology whereby nurses seek to reduce the emotional, spatial, and symbolic boundaries between nurses and patients. She contextualizes nurses' efforts in light of their aspiration for professional autonomy and by drawing on the cultural meanings of "closeness" in kinship studies in Britain."

(Elisa J. Gordon, 2002:362)

The ethics of care demand that how one should and wants to be treated in society. And these questions can only be answered if there is dialogue between different people involved in the process and provision of care. Elisa J. Gordon further reviews the book as

"The best treatment of ethics in relation to care was presented in "Ethics as Question," by Vangie Bergum, who proposes that ethics be construed as a question about "how do you and I want to be treated" (p. 175) in terms of who we are in our roles as a nurse, father, daughter, teacher, etc. Bergum posits, much like Okely does, that knowledge for answering such questions lies in the process of dialogue and its concomitant connection with others. This idea rings of the notion of "embodied knowledge" advanced by Patricia Benner in Interpretive Phenomenology: Embodiment, Caring, and Ethics in Health and Illness) 19940."

(Elisa J. Gordon, 2002:362-363)

Ethics of care are different from ethics of virtue. In ethics of care main focus is on the importance of the relationship between care giver and care receiver. It is a normative approach towards human relations in all aspects such as personal, political and global.

"The book presents the ethics of care as a promising alternative to more familiar moral theories. The ethics of care is only a few decades old, yet it has become a distinct moral theory or normative approach, relevant to global and political matters as well as to the personal relations that can most clearly exemplify care. The book examines the central ideas, characteristics, and potential importance of the ethics of care. It discusses the feminist roots of this moral approach and why the ethics of care can be a morality with universal appeal. The book explores what is meant by "care" and what a caring person is like. Where such other moral theories as Kantian morality and utilitarianism demand impartiality above all, the ethics of care understands the moral import of ties to families and groups. It evaluates such ties, differing from virtue ethics by focusing on

caring relations rather than the virtues of individuals. The book proposes how values such as justice, equality, and individual rights can "fit together" with values such as care, trust, mutual consideration, and solidarity. In considering the potential of the ethics of care for dealing with social issues, the book shows how the ethics of care is more promising than other moral theories for advice on how limited or expansive markets should be, showing how values other than market ones should have priority in such activities as childcare, health care, education, and in cultural activities. Finally, the book connects the ethics of care with the rising interest in civil society, and with limits on what law and rights are thought able to accomplish. It shows the promise of the ethics of care for dealing with global problems and with efforts to foster international civility."

(Virginia Held, 2006)

Most of the time the patients are not aware of the functions of the nurse in relation to their physical, psychological, social, spiritual, teaching and health team.

"From the responses, it seemed apparent that patients did not understand the functions of the nurse in reference to their nursing care. We then undertook a study to determine patient's perception of the role of the nurse. We attempted to answer three questions: What does the chronically ill, ambulatory patient expect of the nurse caring for him? Is he aware that he has needs which the nurse is prepared to meet? Does he have any idea what the role of the nurse is in meeting his needs?"

(Lippincott Williams & Wilkins, 1965:127)

Most of the patients perceive that nurse's primary role is to meet the physical needs of the patients. Patients often want nurses to note the important changes in their

conditions. They want nurse to explain them the treatment before it is given to them. They want sensitivity on the part of nurse to perform her duties.

"The majority of these 62 patients agreed that meeting physical needs was the primary role of the nurse. In the highest agreement, patients wanted the nurse to know the important changes in their conditions and how these affected them; specifically, patients expected the nurse to understand the action of medicines and treatments.

The next level of agreement showed that patients wanted treatments explained before they were given; they also expected treatments to be performed carefully and correctly. There was greater concern for medicines being given on time than for treatments being given on time."

(Lippincott Williams & Wilkins, 1965:127)

Often nurse does not meet the psychological needs of the patients. They mainly focus on meeting the physical needs of the patients.

"Although patients agreed that the nurse should meet their psychological care needs, they indicated that her role in this area also was less than her responsibility for meeting their physical needs."

(Lippincott Williams & Wilkins, 1965:128)

Some patients want nurses to teach them how to maintain best level of health. Some patients do want nurse to understand their feelings and emotions along with their physical needs. They also want nurse to listen to their problems and advise them in

"About four-fifths of the patients wanted nurses to teach them how to maintain an optimum state of health. They were less interested in having nurses know them as individuals, talk with them, and counsel them about their problems. Only two-thirds of

the patients wanted nurses to accept their feelings, regardless of what these were. Only two-thirds of the patients wanted nurses to talk with them about their conditions."

(Lippincott Williams & Wilkins, 1965:128)

Patients always want close coordination between doctor and nurse in the process and provision of their care. Meeting physical needs of patients by nurse was also considered one of the main important roles of the nurse. Meeting patients' other psychological, social, spiritual and teaching needs were considered less important than meeting physical needs

"We found that all the patients expected the nurse to follow the physician's orders in administering their care. Physical needs were the patients' next greatest concern. Teaching was considered less important, but there were a high percentage of affirmative responses. It was difficult to determine the relative significance of the remaining categories of nursing needs since there was such a wide variation of patient responses. The high levels of agreement in the physical categories were in keeping with our concept that the primary role of the nurse is to provide health care."

(Lippincott Williams & Wilkins, 1965:129)

Patients always have some needs to be met by nurses, doctors, other medical staff and patients' attendants. These needs may be physical, psychological, spiritual, socio-economic, educational and administrative.

"In order to determine the areas in which the nurse functions and her role in each, statements of the needs of chronically ill ambulatory patients were developed; these were then related to the behavior of nurses. The definition of a need was perceived as a condition within the individual that energizes and disposes him toward certain kinds of

behavior. Thus, because of some inner need, the individual might be led to seek food, rest, social recognition, self-esteem, and the like. These were categorized as: physical, psychological, socio-economic, spiritual, educational, and administrative."

(Lippincott Williams & Wilkins, 1965:128)

Nurse mainly meets the physical needs of the patients. She is least concerned with the psychological, spiritual, socio-economic and educational needs of the patients. She also does not have sufficient knowledge to answer the patients' questions

"The majority of the 130 nurse respondents agreed with the hypothesis that the nurse stresses physical care and observation procedures of the chronically ill ambulatory patient more than she does total patient care, and that her primary role was recording and reporting the patient's condition; for example, the urinary output. In addition, there was agreement that the nurse needs a fundamental knowledge of normal physiology and its alterations to be able to answer patient's questions intelligently."

(Lippincott Williams & Wilkins, 1965:129)

Other than meeting the different needs of the patients nurse also performs some administrative functions in the hospital.

"Body hydration, skin protection, and the patient's participation in his care were considered significant in the care of the chronically ill ambulatory patient. Primary constituents of the nurse's role were seen to be orientating the patient to his environment, following hospital policies concerning visitors, patients, and personnel, and considering the patient's limitations when planning his care."

(Lippincott Williams & Wilkins, 1965:129)

Nurse's main role is to meet the physical needs of the patients as patients are unable to meet these needs on their own. These physical needs include things as cleaning the skin, dressing and undressing, changing position and posture, providing nourishment and suitable mode for excretion etc.

"By bodily care, we mean the process by which one human being meets the physical needs of another who, for any reason, is unable to do this for himself. It includes such things as cleaning the skin, dressing and undressing, changing position and posture, providing nourishment, and a suitable mode for excretion; and, in general, maintaining maximum bodily comfort of the dependent individual. The need to be cared for in this way is the earliest and most universal experience shared by every member of the human race. No matter when or where we are born, none of us could survive the utter dependency of infancy and early childhood without some more capable person giving us a minimum of protection and food."

(Marion Lesser & Vera Keane, 1955:804)

The nurse is often seen by the patients only as an assistant of the doctor. They do not see nurse meeting their specific needs.

"When the nurse is viewed as a person who cares for the sick, the women rarely see that she performs any necessary function for them during pregnancy. The things that women usually observe a nurse doing during antepartal visits, such as getting the patient ready for the doctor's examination, preparing equipment, charting, and acting as chaperon, confirm their belief that the nurse is there mainly to assist the doctor, rather than to meet specific needs of the pregnant women themselves. Most of the women accept what they see this nurse doing as sufficient: "There's really nothing you need her

for . . . she's there mainly to help the doctor." "After all, you're not sick or helpless, so you don't need much from her." Although pregnant women reveal a wide range of emotional and informational needs which are often unmet during pregnancy, they rarely associate these needs with nurses."

(Marion Lesser & Vera Keane, 1955:804-805)

The patients' attendants know the needs of the patients more than nurse knows. It is so because of the strong emotional attachment of the patients with their family members, relatives and friends. Patients also tell their problems to their attendants more than they tell nurse.

"The aides get to know the patients more than the nurses. They have the closer con- tact, making beds, giving water, rubbing backs. If you're just at the desk charting, you don't get that close contact. The patients don't talk to you. They tell the aides a lot more than they tell the nurses."

(Marion Lesser & Vera Keane, 1955:805)

Nurse often does not provide sufficient bodily care to her patients. She sees herself mainly as doctor's assistant. But she only provides sufficient body care to the patient in special circumstances.

"Sometimes, she gives less bodily care simply because she is not interested in doing so! Her goal in nursing may be something quite different; she may be scientifically inclined, and see herself primarily as the doctor's assistant, identifying with him more closely than with the patient. She may regard the giving of bodily care as a domestic service, which she, a professional person, would do only under special circumstances."

(Marion Lesser & Vera Keane, 1955:805)

Most of the patients consider nurse as a technician unless she expresses her personal interest in them.

"However, unless she manages to convey personal interest to the patient in some other way when she gives up bodily care, patients are likely to identify her as a "technician" or other worker, rather than as a nurse."

(Marion Lesser & Vera Keane, 1955:805)

Sometimes, patients' attendants take care of their patients. They provide bodily care to their patients in the absence of nurse.

"They had a lot more aides this time than before. They really took care of us-and that was good, because it left the nurse freer for more important things. You could always get her if you needed her. Last time, the nurses were-well, you might say -more like housewives, busy with baths and making beds. After all, they don't get all that education just to do things that you or I could do, with a little training. I think it's better this way, 'cause the aides were wonderful. They have time to talk to you-and the nurse can get her work done."

(Marion Lesser & Vera Keane, 1955:805)

Both patient's and nurse's satisfaction is subject to the positive attitude of the nurse. Positive attitude of nurse creates a strong relationship between patient and nurse.

"The whole attitude of "readiness to give" on the part of the nurse has tremendous influence on the satisfaction of both nurse and patient when both are seeking a human bond. Thus, one woman says that it wasn't what the nurse said or did that was important, but the fact that she demonstrated her interest in her."

(Marion Lesser & Vera Keane, 1955:806)

Nursing practice is also seen from ethical perspective. There are always ethics of care in nursing profession. Especially nursing ethics are seen from caring perspective of nursing practice.

"The development of nursing ethics as a field of inquiry has largely relied on theories of medical ethics that use autonomy, beneficence, and/or justice as foundational ethical principles. Such theories espouse a masculine approach to moral decision- making and ethical analysis. This paper challenges the presumption of medical ethics and its associated system of moral justification as an appropriate model for nursing ethics. It argues that the value foundations of nursing ethics are located within the existential phenomenon of human caring within the nurse/patient relationship instead of in models of patient good or rights-based notions of autonomy as articulated in prominent theories of medical ethics. Models of caring are analyzed and a moral-point-of-view (MPV) theory with caring as a fundamental value is proposed for the development of a theory of nursing ethics. This type of theory is supportive to feminist medical ethics because it focuses on the subscription to, and not merely the acceptance of, a particular view of morality."

(Sara T. Fry, 1989:88)

The construction of medical ethics is mainly constructed on the religious beliefs of the people. This cultural and societal construction of medical ethics is a relative phenomenon. It varies from society to society.

"All ethics has a religious dimension. This paper considers how specific Christian insights concerning death, suffering, human nature and human creatureliness can help to expose more fully the moral issues at stake in some of the dilemmas faced by

doctors. It ends by acknowledging the crushing burden of decision-making which rests on many in the medical profession, and indicates the importance of religious resources in dealing with this."

(J. S. Habgood, 1985:12)

Nursing practice is also seen from ethical perspective. There are always ethics of care in nursing profession. Especially nursing ethics are seen from caring perspective of nursing practice.

"This paper raises the questions: 'What do we expect from nursing ethics?' and 'Is the literature of nursing ethics any different from that of medical ethics?' It is suggested that rather than develop nursing ethics as a separate field writers in nursing ethics should take a lead in making the patient the central focus of health care ethics. The case is made for empirical work in health care ethics and it is suggested that a good way of setting about this is to ask practicing nurses about the real ethical problems they encounter."

(Kath M. Melia, 1994:7)

There is always relative cultural and societal construction of care in different societies. And so is the case with the moral construction of care. There is need of adequate study of the concept of the care and related terms to define care and ethics of in a given society.

"There is a growing body of writing, for instance from the nursing profession, espousing an approach to ethics based on care. I suggest that this approach is hopelessly vague and that the vagueness is due to an inadequate analysis of the concept of care. An analysis of 'care' and related terms suggests that care is morally neutral. Caring is not

good in itself, but only when it is for the right things and expressed in the right way. 'Caring' ethics assumes wrongly that caring is good, thus it can tell us neither what constitutes those right things, nor what constitutes the right way."

(Peter Allmark, 1995:19)

The care and the ethics of care have roots in religious beliefs. So, there can ethics of care if we see it from religious perspective.

"This paper is a response to Peter Allmark's thesis that 'there can be no "caring" ethics'. It argues that the current preoccupation in nursing to define an ethics of care is a direct result of breaking nursing tradition. Subsequent attempts to find a moral basis for care, whether from subjective experiential perspectives such as described by Noddings, or from rational and detached approaches derived from Kant, are inevitably flawed. Writers may still implicitly presuppose a concept of care drawn from the Judaeo-Christian tradition but without explicit recourse to its moral basis nursing is left rudderless and potentially without purpose. The very concept of 'care ' cut off from its roots becomes a meaningless term without either normative or descriptive content."

(Ann Bradshaw, 1996:8)

All ethical approaches suggest something about the 'what' and 'how' of care. That is there do exist ethics of care.

"My original paper suggested that an ethics of care which failed to specify how, and about what, to care would be devoid of normative and descriptive content. Bradshaw 's approach provides such a specification and is, therefore, not devoid of such content. However, as all ethical approaches suggest something about the 'what' and 'how' of care, they are all 'ethics of care' in this broader sense. This reinforces rather than undermines

my original conclusion. Furthermore, Bradshaw 's 'ethics of care' has philosophical and historical problems which I outline."

(Peter Allmark, 1996:13)

There are sometimes conflicts of interest, bias and obligation in managed care.

"Does managed care represent the death knell for the ethical provision of medical care? Much of the current literature suggests as much. In this essay I argue that the types of ethical conflicts brought on by managed care are, in fact, similar to those long faced by physicians and by other professionals. Managed care presents new, but not fundamentally different, factors to be considered in medical decision making. I also suggest ways of better understanding and resolving these conflicts, in part by distinguishing among conflicts of interest, of bias and of obligation."

(Christopher Meyers, 1999:382)

In the process and provision of care the patients' attendants face physical, emotional, social and financial problems. These problems are overcome with the help of health professionals to maximize the chances of contact between patients and their attendants.

"Caring by families and friends is the backbone of community care. Carers face physical, emotional, social, and financial problems. They need recognition, information, and support from the health professionals with whom they and the person they care for come in contact. Much information is available to assist carers and to enable their doctors to help them in their caring role."

(Anne F. Travers, 1996:482)

Care is a relative concept. There is different cultural and societal construction of care in different societies. And so is the case with the structure of care. Provision of care is also seen from gender division of labor.

"This article discusses concepts of care mainly as developed in Scandinavian social research, analyzes the institutional differentiation of caring, and introduces a typology of care giving work."Caring" is defined differently in different societies, and the structure of care provision also differs. The article concludes with a discussion of the division of labor between public and private and between formal and informal care giving. These processes, it is argued, interact with the gendered division of labor to produce a gendering of the social rights of citizenship."

(Arnlaug Leira, 1994:185)

There is debate whether to see care ethics as independent or part of virtue ethics. If care is considered as virtue, then, it will be part of virtue ethics.

"The paper argues that care ethics should be subsumed under virtue ethics by construing care as an important virtue. Doing so allows us to achieve two desirable goals. First, we preserve what is important about care ethics (for example, its insistence on particularity, partiality, emotional engagement, and the importance of care to our moral lives). Second, we avoid two important objections to care ethics, namely, that it neglects justice, and that it contains no mechanism by which care can be regulated so as not to be become morally corrupt."

(Raja Halwani, 2003:161)

Good quality caring is subject to the caring labor in the context of motivation, paid and unpaid labor.

"Caring has two different aspects: the motivation of caring for other people and the activity of caring for them. Furthermore, good-quality care depends on the developing relationship between a carer and the person cared for. In paid employment, however, relationships are usually assumed to be reduced to an exchange transaction and motivation to be simply monetary, provoking concern about whether paying for care diminishes its quality and authenticity. Similar issues have arisen in the context of emotional labor more generally. Much emotional labor, however, is of a transitory nature in which no long-term relationship is set up between worker and customer. This article argues that because of the relationship that tends to develop, paid caring may not be so different from unpaid caring. Rather, caring occupations should be seen as part of a whole class of occupations that are not fully commodified, in which workers have motivations that are not purely monetary and also care about the results of their work."

(Susan Himmelweit, 1999:27)

The concept of care in medical profession is mainly attached to nursing ethics. Here care is considered as a virtue rather than a mode of being. So that is why care is a central concept for nursing ethics.

"Sara T. Fry maintains that care is a central concept for nursing ethics. This requires, among other things, that care is a virtue rather than a mode of being. But if care is a central virtue of ethics and medical ethics then the claim that care is a central concept for nursing ethics is trivial. Otherwise, it is implausible."

(Howard J. Curzer, 1993:174)

Nursing practice is also seen from ethical perspective. There are always ethics of care in nursing profession. Especially nursing ethics are seen from caring perspective of nursing practice.

"The development of nursing ethics as a field of inquiry has largely relied on theories of medical ethics that use autonomy, beneficence, and/or justice as foundational ethical principles. Such theories espouse a masculine approach to moral decision- making and ethical analysis. This paper challenges the presumption of medical ethics and its associated system of moral justification as an appropriate model for nursing ethics. It argues that the value foundations of nursing ethics are located within the existential phenomenon of human caring within the nurse/patient relationship instead of in models of patient good or rights-based notions of autonomy as articulated in prominent theories of medical ethics. Models of caring are analyzed and a moral-point-of-view (MPV) theory with caring as a fundamental value is proposed for the development of a theory of nursing ethics. This type of theory is supportive to feminist medical ethics because it focuses on the subscription to, and not merely the acceptance of, a particular view of morality."

(Sara T. Fry, 1989:88)

1.6 RESEARCH METHODOLOGY

According to Pelto and Pelto,

"Methodology denotes "the logic-in-use" involved in selecting particular observational techniques, assessing their yield of data and relating these data to theoretical propositions."

(Pelto and Pelto, 1978:3)

The following are some of the methods that I have used in my fieldwork.

1.6.1 PARTICIPANT OBSERVATION

According to Malinowski,

"The anthropological fieldworker, Malinowski stressed, should totally immerse himself in the lives of people; and that can only be done through months of residence in the local community. Whenever possible the fieldworker should master the language of the people, though much of the behaviour available for observation is nonverbal."

(Pelto and Pelto, 1978:68)

I did my fieldwork in PIMS and Shifa International hospital. During my fieldwork I lived in the both hospitals for the period of four months. I did participant observation during my fieldwork. I met with different patients, doctors and nurses. I would visit different wards and observe the activities of patients, doctors, nurses and patients' attendants. Observing doctor-patient and nurse-patient relationship was main focus of my study.

1.6.2 CENSUS TAKING

According to Pelto and Pelto,

"Mapping and preliminary census taking often do not require language facility or a great deal of rapport with informants, so these activities can be carried out before the fieldworker is fully assimilated in the community."

(Pelto and Pelto, 1978:193)

Census taking and mapping is one of the research methods and it is used to study at micro level i.e. small units to do holistic study. It is of qualitative nature but basis for quantitative data. I have used the method of census taking and mapping to know the total number of patients, their age, caste, religion, occupation, education etc. in my locale. I have used this method in the beginning of my research to have complete details of people under study.

1.6.3 SAMPLING

According to H. Russell Bernard,

"...You are better off with the sample than with the whole population."

(Bernard, 1994:73)

A lot of patients and their attendants visited hospitals daily on OPD days and in wards also. So it was very difficult for me to collect data from all these people in both

private and government hospitals. Therefore, through sampling I selected some doctors, nurses, patients, attendants, and other staff working in hospitals.

In government hospital I selected patients from different wards and patients at OPD. In private hospital I selected the patients, doctors' administrative officers and nurses. Total numbers of my respondents were 49 in both government and private hospitals. These respondents were patients, attendants, doctors and nurses. While selecting my respondents I gave equal representation to both male and female respondents. Socio-economic status was also kept in view. I selected these respondents from both hospitals. With the help of random sampling I selected these respondents. Some of these patients were OPD patients; some were admitted for different intervals of time in the hospitals. All age groups were given representation.

1.6.4 UNSTRUCTURED INTERVIEWS

According to H. Russell Bernard,

"Unstructured interviews are based on a clear plan that you keep constantly in mind but are also characterized by a minimum of control over the informant's responses."

(Bernard, 1994:209)

The method has been widely used in anthropology field works in a situation where there is an adequate time. I used to conduct such interviews during all the process of participant observation. After taking samples of census forms I interviewed from the patients, doctors, nurses, patients' attendants and other medical staff to know the

conception, perception and the practice of care from ethical perspective in these both hospitals. I made an interview guide for this purpose.

1.6.5 KEY INFORMANT INTERVIEWING

According to Pelto and Pelto,

"Most important we notice that human differ in their willingness as well as their capabilities for verbally expressing cultural informtion."

(Pelto and Pelto, 1978:72)

Key informants are small number of individuals on whom researcher depends heavily. Key informant is one of the main sources of information and it is an indispensible methodology for your research. Key informants were chosen very carefully for the job and I took a little time for choosing some of the key informants. Key informants were selected from both hospitals. I explained the objectives of my study to my key informants so that they can help me in providing valid and reliable data. I used the technique of key informant interviewing in order to know the doctor-patient and nurse-patient and general environment of the wards from ethical perspective.

1.6.6 CASE STUDY METHOD

Case study is detailed presentation of ethnographic data related to some sequence of events required by the researchers or anthropologists. It can be about individual, incident, institution, particular aspects of society or culture. I did the case study of these

hospitals as a process and provision of health care from ethical perspective. Besides that I also collected the individual case studies of different patients having different disease.

This helped me a lot to know the general conception, perception, explanation and practice of care in these both hospitals.

1.6.7 FOCUS GROUP DISCUSSION

This method has been considered as most widely used not only in the discipline of anthropology but also in other fields as well. Because it makes people open up about particular social problems. This technique is also a powerful source to produce rich ethnographic data, by discerning their general ideas that how they feel about the specific phenomena.

I often used this technique during my fieldwork. I conducted four focus group discussions with different patients, respondents and medical staff in order to know what are the general conception, perception, explanation and practice of care from ethical perspective in these both hospitals.

1.7 LOCALE OF STUDY

The locale of my study was PIMS and Shifa International hospital Islamabad. I selected these two hospitals as my locale because my research was comparative study of medical ethics and caring practices in both government and private hospitals.

1.8 SIGNIFICANCE OF STUDY

Every research and scientific study of any culture is an addition to the presently existing work. I tried to contribute in the existing literature and knowledge about the conceptions, perceptions, interpretations, explanations and practice of care. This study is an addition to the studies already done for understanding caring practices in both government and private hospitals. Significance of this research is primarily for the academic knowledge of medical ethics and caring practices. This study helps in understanding the general conceptions, perceptions, interpretations, explanations and practice of care in government and private health sectors from ethical perspective. It can also be helpful for government and private hospitals in implementing their policies for the provision of high quality healthcare from ethical perspective.

CHAPTER # 2

AREA PROFILE

2.1 PAKISTAN INSTITUTE OF MEDICAL SCIENCES[3]

Pakistan Institute of Medical Sciences is located in Islamabad, Pakistan. Objectives of Pakistan Institute of Medical Sciences (PIMS) are to provide a tertiary level patient care and serve as referral hospital and also to conduct teaching and training of doctors and other health workers at various level in the field of medicine and surgery.

Since its opening in 1985, PIMS has been expanding its services and equipment to meet the growing healthcare needs of the human community. The plan was conceived in the sixties (1960s). Initially named as the Islamabad Hospital Complex (IHC), the original site was located within the premises of the National Institute of Health but was shifted in favor of the present site due to its central position.

Apart from providing medical facilities to the residents of Rawalpindi-Islamabad and surrounding areas, the PIMS also function as a National Reference Centre for providing specialized diagnostic and curative services to the patients referred by other hospitals/institutions.

[3] www.pims.gov.pk

2.2 ISLAMABAD HOSPITAL

2.2.1 HISTORY

Islamabad Hospital (IH) is the major component of PIMS. It is a 592 bedded hospital and has 22 medical and surgical specialties. The spacious, centrally air conditioned OPD of Islamabad Hospital started on 18 December 1985, inpatients and Accident & Emergency centre started in October 1986.

It was formally inaugurated by the then Prime Minister Muhammed Khan Junejo in September 1987. Its covered area is approximately 356,976 sq ft (33,164.2 m^2). The Administration block is located on the ground floor.

2.2.2 OBJECTIVES

The main objective of the Islamabad Hospital is to provide medical facilities to the community of Rawalpindi/Islamabad as a National Referral Hospital for Northern areas of Azad Jammu and Kashmir NWFP and Northern area of Punjab. Another objective was to act as a focal point for research activities in health services.

2.2.3 STAFF

Total number of employees working in the Islamabad Hospital is nearly 1800 which include the senior and mid level management staff, Senior Consultants, Specialists, Medical and Non-medical staff, Nurses and Paramedics.

2.2.4 SERVICES

Clinical Services

It has outpatient and inpatient departments, which are fully equipped. It has its own excellent diagnostic facilities i.e. Radiology, Pathology, Blood Bank, Angiography, Scanning, stress electrocardiography, EMG and Nerve Contraction, Bronchoscopy, Endoscopy and other GI Procedures. Islamabad Hospital has a fully equipped Accident & Emergency Centre, Intensive Care Unit (ICU), Coronary Care Unit (CCU), Operation Theatre (OT) and Private wards with most modern and necessary facilities. The hospital has a dialysis unit for Nephrology patients and a Head Injury Unit in Neurosurgery.

Supporting Services

It has a social welfare department, mustahaqeen zakat counter, Accounts Department, Physiotherapy Department, Pharmacy Department, Statistic and Medical Record Section, Library, Audiovisual, Auditorium, Blood bank etc. as supporting services indirectly related to the patient care. Other services provided at the Institute comprise a sterilization system, a modern laundry, kitchen, central HVAC system and lift for patients.

2.3 SHIFA INTERNATIONAL HOSPITAL[4]

Shifa International Hospital is located in Islamabad, Pakistan. The Shifa International Hospital was conceived and incorporated in 1985-1987 by a small group of Pakistani doctors and other health care professionals working in the United States. Since

[4] www.shifa.com.pk

then Shifa has grown from over 450 contributing members to being a public limited company. It was established to become a center of health care excellence in Pakistan.

2.4 LOCATION

Shifa International Hospital is located on 11.2 acres in sector H-8/4 in Islamabad, Pakistan on PitrasBukhari Road. The Shifa Complex has also been expanded in recent years.

2.5 HISTORY

The Hospital was incorporated on September 20, 1987 as a Private Limited Company and converted into Public Limited Company on October 12, 1989. The first Shifa office was established at the residence of Dr. Zaheer Ahmad in sector F-8/3 of Islamabad. Later it was moved to a rental place in Blue Area (commercial buildings area in Islamabad), and finally the site office building was established in January 1988.

The construction activity to prepare the site for laying the foundation of the Hospital was started in the beginning of 1988. The foundation ceremony took place on October 6, 1989 by the parents and well-wishers of the sponsors and their dedicated team of colleagues and well- wishers. Within three years and six months, the hospital's Block-A structure of 65 ft. high with 70,000 square feet covered area.

The idea of developing a high class medical facility in Pakistan was conceived in New York, USA in the mid of 1985. The initiator Dr. Zaheer Ahmad, who had just finished his Internal Medicine Residency, called a meeting at his apartment in Brooklyn, New York on the weekend of July 20 & 21. Five professionals gathered there and

discussed the idea in detail and approved it. The participants included Dr. Manzoor H. Qazi from Leesville, Louisiana, Mr. Muhammad Zahid from Kew Gardens, New York, Mr. SamiullaSharief from Brooklyn, New York, Dr. Sabir Ali from Palm Bay, Florida besides the host. Dr. Zaheer Ahmad was asked to prepare the feasibility report and the action plan. Subsequently Dr. Zaheer Ahmad moved to Islamabad on December 17, 1985 to start the work on this project.

After extensive discussions and many meetings, the present site in the capital city of Islamabad was selected for this project. The name "SHIFA" was approved because of its comprehensiveness, originating from our Pakistani culture, belief and values in totality.

After acquiring over 11 acres of land in Islamabad in 1987, CRI, a hospital development company in Princeton, New Jersey was hired to develop the plan and design of the project. Mr. William Parker, Chief Architect of CRI headed the team, visited the site in Islamabad besides visiting the other hospitals across Pakistan. CRI finished its job in 1989.

The hospital's team (founders and sponsors) kept expanding from all across the globe. By the time of its opening on June 26, 1993, it had crossed 400 plus sponsors, with a Rupee 500 million equity. T

Within three and half years, the Hospital's Block-A with a five storey structure, plus deck slab area and a mosque with a total 100,000 square feet covered area was ready to take its first patient on June 26, 1993. Medical equipment were installed in the areas of

Radiology, Radiation Oncology, Laboratories, Operating Rooms, Dialysis and ICU/CCU. The building was fully equipped with all modern means i.e. central air conditioning, central gas supply systems, fire-alarm system, 750 KVA standby generator etc.

The humble start of June 26, 1993, with eight consultants in seven specialties, has progressed to more than 70 highly qualified consultants in almost all specialties under one roof. Shifa International Hospital offers 150 IPD beds with quality care and OPD facility in 35 different specializations. Nevertheless it is an unending journey. People at Shifa are continuously striving hard to bring improvement and novelty with every passing moment.

Now after more than one and a half decade Shifa International Hospital proudly stands as a symbol of quality healthcare with its own brand name "SHIFA". The short history of Shifa witnessed rare dedication and devotion of its consultants, management and staff who worked round the clock to make Shifa a reality of its own.

It was the vision of the founding Sponsors which took its shape into reality. The task was made possible only with the help of their dedicated team of experts and managers under the quality-oriented and inspiring leadership.

In 2009, the hospital's Block-A along with Block-B and partially constructed Block-C and Block-G sprawled on its site is efficiently functioning with already finished covered area of 315000 square feet.

2.6 EMERGENCY

Emergency Service is staffed round-the-clock with a team of highly skilled physicians, nurses and support staff specially trained in the emergency treatment of adults, children and infants.

2.7 TEACHING HOSPITAL

Shifa International Hospital is the teaching hospital of Shifa College of Medicine. The Pakistan Medical & Dental Council has approved the Shifa International Hospital for residency (medicine) of medical graduates in Medicine, Surgery, Obstetrics/Gynecology, and Pediatrics.

The College of Physicians and Surgeons of Pakistan has given approval for training in the specialties of Physiology, Medicine, Surgery, Obstetrics/Gynecology, Pediatrics, Anesthesia, Cardiology, Urology and Radiology, leading to FCPS qualification.

CHAPTER # 3

CARE IN GOVERNMENT HOSPITAL

3.1 INTRODUCTION

This chapter deals with the people's perception of health, illness conditions, reasons of illness and perception of care. Process and provision of care has been observed and noted from ethical perspective among patients, doctors, nurses, other medical staff and attendants. Ethics of care have been conceptualized, understood, explained and analyzed on the basis of religious beliefs of people involved in caring process in government hospital. Theoretical, practical and moral aspects of care in government hospital are the main focus of this chapter. And more importantly the socio-economic factors that actually determine the whole mechanism and morality of care have been discussed.

3.2 PEOPLE'S PERCEPTION OF HEALTH

People's perception about health is greatly influenced by number of socio-economic, religious and psychological factors in society. And when a person falls ill he perceives health accordingly. One's class, status, religious beliefs, socialization and brought up matters a lot in perceiving the phenomena of health

The perception of people about health varies from person to person. For the majority of the people the health is the ability to work. To some people adequate amount of flesh and blood is the parameter for health. Some people say that balance of body temperature is the reason behind good health. To some people health is due to fate. Some people say that if growth in weight and body with age is normal then we are

healthy. But if someone does not have any pain in body, then, it is called health. Some people are of the view that if we have no worries regarding health and our body, we are healthy. And if we are mentally and physically fit, it is health.

3.3 PEOPLE'S PERCEPTION OF ILLNESS

People's perception about illness is greatly influenced by number of socio-economic, religious and psychological factors in society. And when a person falls ill he perceives health accordingly. One's class, status, religious beliefs, socialization and brought up matters a lot in perceiving the phenomena of illness.

The perception of people about illness varies from person to person. For the majority of the people illness is the inability of individual to work well. To some people if different organs of human body are not working well, it is illness. Some people say that if there is lack of appetite and we are not eating enough, we are ill. Some people say that if we feel weakness, we are ill. And to some people one gets ill due to his/her fate.

3.4 CAUSES OF ILLNESS

There are numbers of causes of illness among people. These can be environmental, social and psychological. One may get ill because of unhygienic conditions. It can also be due to environmental severities. Extra load of work may also cause someone ill. Lack of blood in body also causes illness. Due to modern food habits we may also fall ill. Due to evil eye one may also get ill. Due to magic we may also fall ill.

3.5 PERCEPTION OF CARE

The perception of care in medical profession greatly varies among patients, doctors, nurses, other medical staff and attendants. There are number of socio-economic, religious and psychological factors which affect one's perception of care in medical profession. It also varies according to the nature, severity and treatment of disease and illness. It is extremely relative phenomenon. It varies from patient to patient on the basis of their age, sex, class, status, one's socialization and brought up, religious beliefs and personality development. For example, one patient who belongs to middle class, lower-middle class or poor class perceives care in his/her given physical and social environment.

3.5.1 PATIENTS' PERCEPTION OF CARE

The patient's perception about care in government health care hospital varies on the basis of age, sex, class, status, socialization and overall brought up and personality development. It also varies according to the nature of disease, its severity and the nature and mode of treatment. Children and young patients perceive it differently from old patients. To some patients it means the provision of different material needs properly. For example, food, medicine etc. To some patients care means the relationship between doctors, nurses and patients which is based on love. To some patients care means the fulfillment of both physical and psychological needs. Many patients emphasized on the importance of good communication, behavior and attitude on the part of doctors, patients and other medical staff and attendants more than just provision of material needs. To some patients care is more than provision of medicine. Good caring behavior matters a lot in the prevention and cure of disease. To some people care means understanding

patient's problems, emotions and feelings beyond just provision of material needs and good communication. That is the understanding of the circumstances in which the patients developed such health problems. To some people the sensitivity on the part of doctors, nurses, other medical staff and attendants matters a lot to the prevention and cure of their disease.

3.5.2 DOCTORS' PERCEPTION OF CARE

Doctors' perception of care in medical profession greatly varies from patients' perceptions of care. Doctors' perception of care is also based on several factors. They include age, sex, class, status, socialization, overall brought up and personality development. The most important factor which determines the doctors' perception of care is the institutional limits within which they have to work. That is why the perception of care is always seen within the limits of health institutions. To some doctors' the care is the right diagnosis of the disease, prescription disease, the treatment of disease. It may not necessarily involve the emotions, feeling, loving and empathy as all these concepts cannot be measured. Some doctors say that they have their own institutional and professional limitations within which they have to treat their patients. Their more emotional attachment may be harmful for both patients and doctors themselves. To some doctors perception of care means the right diagnosis, prescription and treatment of disease with love and empathy. The importance of good communication between regarding medical treatment has been emphasized as the part and parcel of caring concept according to some senior doctors.

3.5.3 NURSES' PERCEPTION OF CARE

Nurses' perception of care varies from patients' perception and doctors' perception of care. It also varies from nurse to nurse. Their perception is also subject to certain institutional limits in nursing profession. Other factors like age, class, status, socialization, brought up and training for nursing profession matters a lot. That is how they conceive, perceive and practice care within their institutional limits. To some nurses perception of care is the provision of some material needs. For example, giving medicine and injecting patients. To some nurses the perception of care is assisting patients to take medicine, food, in dressing and undressing, in changing position and posture and in providing nourishment etc. To some nurses the perception of care is other than just fulfillment of physical needs. It is the fulfillment of physical needs of patients with strong emotional attachment with patients. Their perception of care also varies with reference to male and female patients and the nature of disease patient has. Some nurses perceived care as understanding patients more than just fulfillment of their physical needs. Fulfillment of psychological needs of patients is also perceived by some nurses as care.

3.6 DOCTOR AND PATIENT'S CARE: AN ETHICAL PERSPECTIVE

The relationship between a doctor and a patient is a very important part of medicine. Only when there is a good relationship between the two is it possible to have high-quality healthcare. This relationship is also at the base of medical ethics. Many medical schools teach the doctors to be to keep a professional relationship with their patients, to respect the patients' dignity and privacy. This relationship has asymmetric

information though. The doctor knows more than the patient, but has to explain the patient's situation, and has to ask the patient what treatments should be done. There is a very similar relationship between the patient and nurses, psychologists. There are different legal norms that regulate this relationship. Examples of such norms are the Hippocratic oath, the Declaration of Geneva. Professional responsibility may also govern such a relationship. Ideally, patient and doctor trust each other. If they do, this can have a positive influence on the development of disease or condition. Healing can be hindered if the patient does not take the prescribed drugs, of if these drugs are not taken in the doses prescribed. If the relationship is too good this can preclude efficiency. In certain cases, it may be good to get the opinion of a second doctor, regarding a condition.

3.6.1 ILLNESS

In government hospital it has been observed and noted that most of the doctors conceive and perceive illness as a disease process. They are also of the view that this process can be measured and understood through different laboratory tests and clinical observations. That is the doctors in government hospital see the phenomenon of illness purely from scientific and professional perspectives. And their perspectives about illness cannot cross the institutional boundaries and limitations, whereas most of the patients in government hospital conceive and perceive their illness as disrupted life. They are least concerned with the scientific and professional explanations of their disease. This is where the ethical issue arises between patient and doctor. From patient's point of view it may not be the ideal or desired diagnosis of his/her illness. There are of course some socio-economic, religious and psychological factors that determine the doctor's conception and perception of illness and patient's conception and perception of illness.

3.6.2 TECHNOLOGY, PATIENT'S FEELINGS AND CONCERNS

Advancement in medical technology has also created some serious ethical issues on the part of patients, doctors, nurses, other medical staff and attendants. It has been observed and noted that most of the doctors focus more on keeping up with the rapid advances in medical science than on trying to understand the patient's feelings and concerns. That is most of the doctors always focus on the use of new technology for the treatment of patient's disease. This is how they are least concerned with the feelings and concerns of patients regarding their illness and its treatment. And if we see on the other side, patient satisfaction comes primarily from a sense of being heard and understood. Most of the patients want their doctors to listen to them their point of view of about their illness, their concerns regarding the diagnosis process and treatment of illness. Their psychological fears matter a lot in the treatment of their illness. This is where the ethical issue arises between patient and doctor. They always want the doctor to listen to their concerns regarding their illness and its treatment and want the doctors to understand their feelings. If patient's feelings are totally ignored in the process of diagnosis and treatment of his/her illness, it badly affects the process of provision of care and overall well-being of patient. So, advancement in medical science has created some serious ethical issues in medical profession.

3.6.3 CARE AS MECHANICAL PROCESS

It has been also observed and noted most of the doctors do not see their role as listener to their patients, but instead view their function as more as a human car mechanic. That is to find the cause of illness and fix it. So, it looks purely mechanical process which may not be up to the expectations of patients. In such mechanical

environment some patients feel devalued when their illness is reduced to mechanical process. So here arises the ethical issue in the process and provision of care. Most of the patients psychologically feel very uncomfortable during their treatment of their illness. Their psychological state of mind does not cope with their physical conditions.

3.6.4 CONCEALMENT OF INFORMATION

The concealment of information on the part of patient is one of the major ethical issues in government hospital. They conceal information regarding what they feel about their illness and the proper use of medicine. Some patients also use alternative medicine which is altogether prescribed the doctors, which ultimately affects their treatment of illness. So, in case of use of alternative medicine they hesitate to tell their doctors so that they become angry with them. When doctors come to know about the concealment of information regarding illness and use of medicine by patients, they really feel frustrated, even betrayed. Often it is the responsibility of patient's attendants to provide medicine to the patient on regular interval. Attendants play very important role of communication between doctor and patient.

3.6.5 DOCTOR-PATIENT COMMUNICATION

Doctor-patient communication plays an important role in the treatment of illness.[5] But it has been observed and noted in government hospital that there is lack good doctor-patient communication. Doctors often talk more than listen to patients regarding their feelings and concerns. They do not give sufficient time to their patients individually. While patient tells his/her concerns and feelings regarding illness and its treatment the doctor interrupts immediately. That is often patients are not given

[5] Barbara Seaman, Charting the doctor-patient relationship, The Spiral Note Book, Viewed 25 March, 2009,.

sufficient time to tell their feelings and concerns regarding their illness and its treatment. This attitude of doctor creates a communication gap between doctor and patient. So, effective communication between doctor and patient relationship matters a lot in the better treatment illness.

3.6.6 PATIENT'S EMOTIONS

The emotional aspects of patient matter a lot in the overall treatment and well-being of patient.[6] It has been observed and noted that doctors often take care of the patient's emotional health. Emotional health of patients helps a lot to get their physical health. The doctors do not acknowledge the feelings of patients whether they express them or not. Their emotions may be related to their perception of illness, the causes of illness or the desired treatment of their illness. So, the ignorance of the emotional aspects of patients while they are being treated further affects their psychological and physical health. For example, one old male patient who always kept telling his doctor about his perception of illness, the causes of illness and the desired treatment, the doctors did not often bother to listen to him. They rather kept focusing the technical talk about the illness, the causes of illness and the treatment of illness. They were seen least concerned about the emotional health of the patient. That is why the patient's treatment is prolonged for weeks and months. Emotional health of the patient is as necessary as the physical health of the patient.

3.6.7 AMOUNT OF INFORMATION

The patient's understandings of the his/her illness, the nature of illness, the possible causes of illness and the desired treatment of the illness matters a lot in the

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[6] Barbara Seaman, Charting the doctor-patient relationship, The Spiral Note Book, Viewed 25 March, 2009,.

overall treatment and well-being of the patient.[7] It has been observed and noted that the doctors often underestimate the amount of information patients want and overestimate how much they actually give. Doctors often spend less time to tell their patients the necessary information about their illness, the nature of illness, the mode of treatment and use of medicine. This is also due to the increase in number of patients in government hospital. In this way the patients are not much aware about their illness, the nature of illness, the causes of illness and the desired treatment of their illness. This lack of awareness among patients creates confusion in the minds of patients. This is also so because of the difference in education of doctors and patients. So, often their treatment is not up to their satisfaction.

3.6.8 KINDS OF PATIENTS

There are different kinds of patients in hospital. They vary in their conception, perception and explanation of their illness, causes of illness and the desired treatment. Often patients have different personalities. Some of them may be called easy patients and some of them may be called difficult patients from doctors' point of view. But it has been observed that one patient who is difficult for one doctor may be the same patient is easy for other doctor.

Difficult patients may be of the following characteristics. They often do not trust or agree with the doctor. They present too many problems for one visit. They often do not follow the instructions of doctors. Sometimes they are demanding and controlling. Difficult patients are more likely to be single and often have a history of unexplained physical symptoms, depression, panic states, obsessive-compulsive disorders, or physical

[7] Barbara Seaman, Charting the doctor-patient relationship, The Spiral Note Book, Viewed 25 March, 2009,.

abuse etc.[8]

Patients who use the doctor as a scapegoat for their anger at the illness are less likely to get good care. Doctors are profoundly influenced by the demeanor, comments, and attitudes of their patients. A patient who is consistently rude and irritable will almost certainly not receive the same medical care as a patient who conveys more positive attitudes.

3.7 NURSING CARE: AN ETHICAL PERSPECTIVE

Patient care is part of a nurse's role. Nurses use the nursing process to assess, plan, implement and evaluate patient care. Patient care is founded in critical thinking and caring in a holistic framework. Nursing care is increasingly framed in best practice, which is the application of evidence-based concepts to patient problems in a particular setting.

3.8 PERCEPTIONS OF NURSING CARE

3.8.1 PATIENTS' VIEWS

The present research was designed to learn what patients expected of nurses, what concepts patients had of their own needs and their comprehension of the role of nurses in caring for them. From the responses, it seemed apparent that patients did not understand the functions of the nurse in reference to their nursing care. I then undertook a study to determine patients' perception of the role of the nurse. I attempted to answer three questions: What does the patient expect of the nurse caring for him? Is he aware

[8] Barbara Seaman, Charting the doctor-patient relationship, The Spiral Note Book, Viewed 25 March, 2009,.

that he has needs which the nurse is prepared to meet? Does he have any idea what the role of the nurse is in meeting his needs? The results were organized according to two methods. First, the statements were considered in relation to six categories of nursing needs: physical, psychological, social, spiritual, teaching, and health team. Levels of agreement with behaviors then were noted. The majority of patients agreed that meeting physical needs was the primary role of the nurse. In the highest level of agreement, patients wanted the nurse to know the important changes in their conditions and how these affected them; specifically, patients expected the nurse to understand the action of medicines and treatments. The next level of agreement showed that patients wanted treatments explained before they were given; they also expected treatments to be performed carefully and correctly. There was greater concern for medicines being given on time than for treatments being given on time. Although the patients expressed great desire to have their physical needs met by nurses, they considered teaching functions less important. However, some patients did express a desire to have the nurses teach them and their families how to give medicines and treatments they might need at home. Several patients indicated a desire to learn the effects of their medicines and treatments. A high percentage of the patients wanted nurses to be aware that they were on special diets, but they seemed less concerned about the nurse's knowledge of the foods included in these diets. Although patients agreed that the nurse should meet their psychological care needs, they indicated that her role in this area also was less than her responsibility for meeting their physical needs. According to the responses to questions about their own activities, almost all of the respondents showed concern about the need to be independent. Even if nurses were willing to do things for them, the majority of the

respondents preferred to do things for themselves. However, they were somewhat less interested in having nurses show them how to do things. In general, these patients displayed an understanding of the nurse's role in helping the chronically ill ambulatory patient progress from dependency to intradependency. Some of the patients wanted nurses to teach them how to maintain an optimum state of health. They were less interested in having nurses know them as individuals, talk with them, and counsel them about their problems. Only few patients wanted nurses to accept their feelings, regardless of what these were. Only few patients wanted nurses to talk with them about their conditions. By their responses to the nursing behaviors, the respondents in this study saw the nurse as a person who could answer their families' questions about illness and discuss the care these patients needed. Patients indicated that they expected nurses to recognize their economic needs by teaching them how to prepare economically well-balanced meals and by showing them how to substitute household items for the expensive equipment they might need when they went home. Patients wanted nurses to help them maintain a realistic outlook about their physical conditions. I found that all the patients expected the nurse to follow the physician's orders in administering their care. Physical needs were the patients' next greatest concern. Teaching was considered less important, but there was a high percentage of affirmative responses. It was difficult to determine the relative significance of the remaining categories of nursing needs since there was such a wide variation of patient responses. The high levels of agreement in the physical categories were in keeping with our concept that the primary role of the nurse is to provide health care. The varied responses to statements in other categories may be due to the fact that these areas are dependent on specific patient circumstances. I concluded, therefore, that

nurses should be cognizant of all the aspects of the care of patients yet be able to adapt to individual needs.

3.8.2 NURSES' VIEWS

Patients believed that caring for their physical needs was the most important function of nurses. Results showed that nurses also placed physical care as the most important aspect of their role in caring for such patients. How does she see her role in the care of patient? The purposes of the study were threefold: to determine the nurse's perception of her role in the care of the patient, to more clearly define the nurse's role in caring for such patients, and to develop nursing care implications from these perceptions. The definition of a need was perceived as a condition within the individual that energizes and disposes him to- ward certain kinds of behavior. Thus, because of some inner need, the individual might be led to seek food, rest, social recognition, self-esteem, and the like. These were categorized as: physical, psychological, socioeconomic, spiritual, educational, and administrative. The majority of the nurse respondents agreed with the hypothesis that the nurse stresses physical care and observation procedures of the patient more than she does total patient care, and that her primary role was recording and reporting the patient's condition; for example, the urinary output. The respondents believed that the patient's religious needs should be met by a member of the clergy when needed, or requested, by the patient. However, they indicated that nurses are not always aware of the religious beliefs of patients. The respondents further indicated that the nurse should have a thorough knowledge of the purposes and procedures of diagnostic tests in order to perform them as prescribed and in order to explain them to patients. The respondents considered administrative activities secondary to providing physical care.

Body hydration, skin protection, and the patient's participation in his care were considered significant in the care of the patient. Primary constituents of the nurse's role were seen to be orientating the patient to his environment, following hospital policies concerning visitors, patients, and personnel, and considering the patient's limitations when planning his care. Although the respondents ranked the nutritional status of the patient high in the list of physical needs, the nurse's function as a teacher of personnel and patients in dietary matters was ranked low. The nutritional needs that nurses specifically noted were: providing supplemental diversified fluids and suggesting modifications in diet when patients' conditions or needs changed. The nurse respondents agreed that identifying the patient's physical abilities in order to promote an environment which radiates confidence and permits the patient to utilize his strengths and compensate for his weaknesses was important. Encouraging the patient to express his feelings through acceptable modes of behavior was noted. The respondents showed an awareness of psychological factors as an important part of total patient care. These data indicate that the respondents placed emphasis on administrative functions and patient teaching functions, particularly regarding medications and treatments. But, a definite lack of concern with continuity of care beyond the hospital setting was obvious from the limited reference to referrals to community resources. From this study we see need for investigation of the nurse's perception of the concept of continuity of care, and study of methods used for communicating plans for nursing care of individual patients to others within the general hospital setting.

3.9 NURSING AND BODILY CARE

The components of nursing, its limitations, scope, and unique contribution to human health, appear to shift and expand almost daily, as the number and quality of preventive and therapeutic measures increases. To herself and to her public, the nurse seems to be all things to all men. She directs this plea very pointedly to the nurse in particular, and gives strong indication that bodily care is one major channel the nurse can use to convey such interest. Why this should be so, and the effect on the patient-nurse relationship when someone else gives bodily care, or such care is not needed, is a problem the profession might well explore. All we can do, on the basis of our findings, is take the first step toward this. We can begin by defining our terms.

By bodily care, we mean the process by which one human being meets the physical needs of another who, for any reason, is unable to do this for himself. It includes such things as cleaning the skin, dressing and un- dressing, changing position and posture, providing nourishment, and a suitable mode for excretion; and, in general, maintaining maximum bodily comfort of the dependent individual. The need to be cared for in this way is the earliest and most universal experience shared by every member of the human race.

3.9.1 THE PATIENT PICTURES THE NURSE

Despite the fact that modern nursing has become extremely complex, and the scientific and technical skills needed by the nurse are so varied, this fundamentally humane image remains deeply rooted in our cultural consciousness. Many people still picture the nurse essentially as a warm, womanly figure, who sustains the weak and helpless, seeing to their bodily needs, until such time as they are once more capable of

caring for themselves. When patients were asked to describe a typical or average nurse, they usually pictured a nurse as "a person who takes care of you when you're sick," or "someone who knows what you need to make you comfortable in bed." This stereotype is, significantly, most frequently voiced by patients who say that they had never had any personal contact with a nurse before they were ill. When the nurse is viewed as a person who cares for the sick, the patients rarely see that she performs any necessary function for them during illness. The things that patients usually observe a nurse doing during daily visits, such as getting the patient ready for the doctor's examination, preparing equipment, charting, and acting as chaperon, confirm their belief that the nurse is there mainly to assist the doctor, rather than to meet specific needs of the patients themselves. Most of the patients accept what they see this nurse doing as sufficient: "There's really nothing you need her for . . . she's there mainly to help the doctor." "After all, you're not sick or helpless, so you don't need much from her." Although patients reveal a wide range of emotional and informational needs which are often unmet during illness, they rarely associate these needs with nurses. The link between emotional support and bodily care is very definite in the patient's mind.

3.9.2 NURSE'S PERSONAL INTEREST AND CARE

They recognize that everything they do is in some way designed to "help the patient," provision of bodily care is something personal, done for the patient's own sake, and not so tied in with medical and therapeutic measures. In areas of nursing where there is little or no possibility of rendering such service, nurses too seem to feel that an important link with the patient has been broken, and they have not yet forged an adequate substitute. These nurses feel that the patient develops a close relationship only with the

person who is giving her personal care. If the nurse is not the one who does this, then she is not the person to whom the patient turns. The aides get to know the patients more than the nurses. They have the closer contact, making beds, giving water, rubbing backs. If you're just at the desk charting, you don't get that close contact. The patients don't talk to you. They tell the aides a lot more than they tell the nurses. To some nurses, tending to bodily needs and making the patient comfortable is a chief source of satisfaction on the job. Thus, one nurse, speaking of post- partum care, says: Most of postpartum care is routine-giving medications and taking temperatures.

3.9.3 BODILY CARE AND EHICAL DILEMMAS

There are many reasons, of course, why the professional nurse today gives less bodily care than she did formerly. The volume of patients and relative shortage of nurses in all areas of hospital necessitates critical re-evaluation of everyone's functions, and the assignment of simpler tasks to auxiliary personnel. Complex technical procedures, and intricate administrative and teaching responsibilities necessarily claim the attention of a more thoroughly prepared professional person, so that the nurse finds she must often delegate such things as bathing and back rubbing to nonprofessional workers, whether she wants to or not. Sometimes, she gives less bodily care simply because she is not interested in doing so! Her goal in nursing may be something quite different; she may be scientifically inclined, and see her- self primarily as the doctor's assistant, identifying with him more closely than with the patient. She may regard the giving of bodily care as a domestic service, which she, a professional person, would do only under special circumstances. Technical, teaching, or administrative functions may be more appealing to her personally, so that she gladly relinquishes her strictly motherly, "ministering angel"

role to someone else. This is perfectly legitimate, since the organization of modern nursing provides scope for all these talents. However, unless she manages to convey personal interest to the patient in some other way when she gives up bodily care, patients are likely to identify her as a "technician" or other worker, rather than as a nurse.

3.9.4 NURSE, PATIET'S ATTENDATNS AND BODILY CARE

Actually, the patients have more contact with the attendants. They make you comfortable, and if you want anything, they're always there. They felt very close to them. They feel the nurse is too preoccupied with other things to have any interest in them and they retaliate by being equally indifferent. It seemed to me the aides did everything any nurse could do, and did it just as well. All the nurses did was give us pills. They have pills for everything. They didn't even know who the nurses were; they just whisk in and out, and it seems like it's a different one every time. You don't have any real contact. I think the nurses are there mainly for decoration. Unless they were in dire straits, they always tried to wait for the attendants, if they wanted anything. They were friendly, and seemed more willing to do things for them. They hated to ask a nurse to roll up their bed or give them a bed pan-they had the feeling it was beneath their dignity. The attendants always changed them and helped them, so they felt they were the right ones to do little things. They seemed more interested in them.

3.9.5 CARE AND SATISFACTION

Some nurses try to find other means than giving bodily care for achieving satisfaction and communicating their interest to the patient. The nurse for whom personal contact with patients is absolutely essential manages to utilize every contact-whether it be giving out the inevitable pills, making rounds with the doctor, or setting up infusion equipment-for warm, friendly exchange with the patient. In making her rounds, as she passes by each patient, they always have a little conversation about different events-about things she has done. And it makes a patient feel closer to her. She can't just look on them as patient. They are individual. The whole attitude of "readiness to give" on the part of the nurse has tremendous influence on the satisfaction of both nurse and patient when both are seeking a human bond. Thus, one patient says that it wasn't what the nurse said or did that was important, but the fact that she demonstrated her interest in her. The nurses' attitudes were very helpful. It was not actually what they said or did, or how long they were there, but just that they were trying to be helpful. It was an interest in them, and interest in helping them. On the other hand, the nurse may accept her displacement from intimate care of the patient philosophically. She adjusts to the necessity for assuming her technical and administrative roles so well that, eventually, she may substitute pride in her competence and efficiency for the satisfaction they used to get from her relationship with the patient.

A final alternative which a few nurses demonstrate when they are no longer "taking care of" people in the way they would like, is to take no action, but passively accept their new roles, without achieving much satisfaction from them. The nurse may express resentment

or distrust of the auxiliary worker, who, in her opinion, is usurping her place. Possibly such feelings may contribute to her discouragement, apathy, and disinterest in her work.

3.10 PATIENTS' ATTENDANTS AS CARE-GIVERS

Patient's attendants include his/her family members, relatives, friends and neighbors. It has been observed and noted that in government hospital there are always some attendants with the patient. In government hospital settings the attendants are the most important care givers. Attendants can help the patient for fulfillment his/her physical needs, emotional needs, psychological needs, social needs, religious needs and financial needs. They play the role of mediator between the doctor, nurse and patient regarding the diagnosis and treatment of illness.

3.10.1 ATTENDANTS AS MEDIATOR BETWEEN DOCTOR, NURSE AND PATIENT

The family members of patient, his/her relatives, friends and neighbors play very important role of mediator between doctor, nurse and patient regarding the diagnosis and treatment of illness. As often doctors and nurses do not talk to patients directly, so they communicate with their attendants regarding the diagnosis and treatment of illness. There can be number of reasons lack of communication between the doctors, nurses and patients. Some patients may not be educated and literate enough to communicate with their doctors regarding their illness and its treatment. They may be unable to express their feelings that how they are feelings at the moment, their perception of illness and the desired treatment of illness. They can also be incompetency or negligence of on the part of nurses and doctors to properly communicate with their patients. So, patient's attendants play very important role in the process and provision of care.

3.10.2 ATTENDANTS AND BODILY CARE

In government hospital it has been observed that most of the time attendants give bodily care to patient. Thought it is the responsibility of nurse to provide maximum bodily care to the patient. Bodily care of patient include feeding, hand-washing, oral care, dressing and undressing, hair care, bed making, nail care, bed-bath, serving water, positioning, range of motion excretion, vital signs and medication. The attendants do the bodily care of the patient on their own. They doctors, nurses and other medical staff is least concerned with the caring activities of attendants. They attendants even do not consult the doctors, nurses and other medical staff regarding the routine of medication for patient.

3.10.3 ATTENDANTS AND EMOTIONAL HEALTH OF PATIENT

Emotional health of patients matters a lot for the overall well-being of the patients. The presence of the patient's attendants is a great emotional and psychological support for patient. Attendants' emotional and psychological really helps patient get well soon. In some cases, the kinship ties are so strong that patient feels insecure socially and psychologically in the absence of his/her attendants. Sometimes, the patient's emotional and psychological affiliations are so strong that they cannot help looking and meeting their family members and relatives. In some cases, it has been observed that patient's emotional attachments with his/her friends matters a lot for the recovery of the patient. If patient's emotional needs are fulfilled, then, he can very easily recover. Often patients expect more from their attendants than from doctors, nurses and other medical staff. They are least concerned about doctors, nurses and other medical staff because of their

strong emotional family attachments and expectations from their family members, relatives and friends.

3.10.4 ATTENDANTS AND FINANCIAL HELP OF PATIENT

One of the main favors of patient's attendants for patient is to help him financially for the expenditure of his/her treatment of illness. It was observed and noted that the family members, the relatives and friends of patient feel it their morally duty to help patient financially. By using financial aid the patient buy his/her medicine, gets his/her different tests and meets his/her daily expenditures. Unfortunately all required medicine is not provided by government hospital to its patients. All required tests are not available in the hospital. So, the patients are often in dire need of money to afford the expenses of his/her treatment.

3.11 SOCIO-ECONOMIC STATUS OF PATIENTS AND PROVISION OF CARE

Socio-economic status of the patients matters a lot to determine the nature, extent, process and provision of care. The behavior of the doctors, nurses and other medical staff vary to the great extent according to the socio-economic status of the patients. Patients may belong to rich, middle or poor class. They may also have different status in the society. The behavior of the doctors, nurses and other medical staff is often subject to the socio-economic status of the patients.

It was observed and noted that behavior of the doctors, nurses and other medical staff in the process and provision of care varied to the great extent according to the class and status of the patients. In government hospital the most of the patients belong to poor and middle class. They had different occupation. Some of them worked on daily wages.

Some were government employees. The doctors' behavior was not same with all patients. Doctors did not behave well with those patients who were from poor class. Their behavior was very rude with such patients. They even did not bother to listen to the concerns and problems of such patients regarding their illness and treatment. There were treated as someone untouchable. Doctors such rude behavior really affected emotional health of such patients. According to some patients they did not feel any emotional attachment with their doctors. Doctors such rude behavior with their patients also affected the process of diagnosis of illness and its treatment. This is why patients in government hospital always feel emotionally detached from doctors. It seemed that they always underestimated their patients in different contexts. Patients' self-respect and ego was often hurt by doctors, nurses and other medical staff's behavior. Those patients who had any sort of reference in hospital for their treatment they were treated differently by doctors, nurses and other medical staff. Such patients were given proper care during their stay in hospital. They did not have any difficult regarding different tests for the diagnosis of disease and treatment. Whether they have emotional attachment with doctors, nurses and other medical staff nor not at least their self-respect and ego is not hurt. They were regularly visited by doctors, nurses and other medical staff. So is the case with nurses' behavior with patients. Nurses also behave with patients according to their socio-economic status. It was observed and noted that nurses did not communicate well with patients who belonged to poor class. Patients' outlook also matters a lot for the provision of care. Those patients who apparently looked poor and uneducated they were often behaved differently by the nurses. The nurses' perception of patients and their behavior with them was mainly determined by the socio-economic status of the patients. They

nurses simply come in the patient's room and do their activities without often talking and listening to patients. They are least concerned with the concerns and feelings of the patients regarding their illness and treatment. Such perceptions of doctors, nurses and other medical staff about patients and their behavior with patients is actually the outcome of overall socialization and brought up doctors, nurses and other medical staff. It has been observed and noted that often nurses treat such patients as objects, and not as human beings. They always underestimate the different needs of patients. Most of the time nurses give less time to such patients. They do not try to understand the feelings, emotions and concerns of patients regarding illness and their treatment. Thus, the conception, perception, nature, extent, process and provision of care by doctors, nurses and other medical staff of the government hospital is subject to the socio-economic status of the patients.

3.12 CASE STUDIES

3.12.1 CASE STUDY # 1

My first case study was a man of 46 years. He was kidney patient. He had been in Nephrology department of PIMS for more than two months. When I observed and interviewed him I came to know about following facts. The overall physical and social environment of the ward was not up to the mark. The ward was not properly cleaned, and there was always a sort of noise of different patients, patients' attendants and other medical staff. The patient and his family did not know much about the exact nature of disease. This was due to two factors, one because of the lack of medical knowledge on the part of patient and his family and other because of the lack of communication between doctors, nurses and patients. There was also observed lack of trust between

doctor, patient and his family. The patient and his family were not provided full information about his disease and treatment on regular basis. The patient always had complaints about the doctors, nurses and other medical staff. The treatment of the patient was lacking proper care on the part of doctors, nurses and other medical staff. The doctors behaved and treated this patient as a sort of commodity rather than a human being. Doctors did not have regular visits to the ward and often did not give proper time to every patient. This attitude of doctors really affected the psycho-emotional health of the patient, and this was one of the main hurdles in recovering patient's good health. Same was the case with the attitude of the nurses. It was observed that nurses often behaved with and treated the patient without uttering any word from their mouth. They just treated the patient as sort of feeling less and emotionless human being. The role of the nurses was to only check the temperature, blood pressure, inject and drip the patient. They treated the patient without any feelings and emotions. In this way patient psycho-emotional health was badly affected. But the family members and attendants of the patient really helped him to recover physically, emotionally and psychologically. The played very important role to help the patient recover soon than doctors, nurses and other medical staff did.

3.12.2 CASE STUDY # 2

My second case study was a woman of 50 years. She was patient of TB. She had been in PIMS for more than one month. She was in critical condition. She had one son and one daughter as her attendants in hospital. It was observed that she was not given proper treatment and care by the concern doctors, nurses and other medical staff. The doctors did not visit this patient on regular basis. And if doctor visited the patient but did not give proper time to her. The doctors often did not bother to ask the patient how she was feeling then. The lack of communication and trust was noted between doctors, patient, nurses and other medical staff. The overall behavior of the doctors, nurses and other medical staff was not good with patient. There was observed lack of professionalism on the part of doctors, nurses and other medical staff. The attendants of the patients were the only people who were very much concerned about the time to time changing condition of patient and really took care of her in all respects. The nurses always behaved with patient as stranger rather than as their client. Their behavior was very rude with the patient and her attendants. Of they were reluctant to guide the patient's attendants regarding the nature of disease, the nature of treatment for such disease and the different timings giving medicine to the patient. The family and attendants of the patient often had difficulty regarding different tests of patient. No one was there to guide them properly that from where and how to get such tests. Nurses always kept distance from the patients. They would not ask the patient that how she felt then. The psycho-emotional aspects of the health of the patient were totally ignored by doctors, nurses and other medical staff.

3.12.3 CASE STUDY # 3

My third case study was a man of 65 years. He was patient of asthma. He had been in PIMS for last two weeks. He has one son as his attendant in hospital. He was very weak and suffering from pain. It was observed that and noted that despite of the serious and critical condition of the patient the doctors, nurses and other medical staff did not pay much attention towards this patient. Doctors did not visit on regular basis and did not give proper time to the patient. It looked as if all doctors, nurses and other medical staff are fulfilling their formality. None of them seriously asked the patient that how he was feeling then, whether he was feeling better or not and what did he need. Nurses and doctors were least concerned with the feelings and emotions of the patient. They were treating patient as a machine, not human being. There was lack of information and trust between doctors, nurses, other medical staff and the patient. The patient and his family were not told much about the nature, treatment and consequences of the disease. The doctors, nurses and other medical staff were reluctant to pay proper attention towards the patient and listen to his feelings and concerns regarding his treatment. The attendant of the patient was great source of financial, psychological and emotional support of the patient. His son really took care of him. The relatives of the patients visited him on regular basis. They were of great financial, psychological and emotional help to the patient. The patient looked least concerned about the behavior of doctors, nurses and other medical staff. He was not expecting much from hospital staff.

3.12.4 CASE STUDY # 4

My fourth case study was a man of 47 years. He was patient of yellow fever. He has his son and brother as his attendants. By profession he was taxi driver. He had been in PIMS for last few days. It was noted and observed that he was not given proper care by the doctors, nurses and other medical staff. The patient and his family knew very little about the nature of the disease and its treatment. The doctors, nurses and other medical staff did pay much attention towards this patient. They doctors did not give proper time to check the patient in detailed. They were least concerned about the feelings and emotions of the patients. They did not give much time to the patient to describe his feelings about the disease and its treatment. The administrative work of the hospital was not up to the mark. The nurses would not give proper time to the patient to check his temperature, blood pressure and to give medicine on time. Instead the patient's attendants were to take care of patient in all respects. They would give food and medicine to the patient on regular basis. The nurses and ward boys looked least concerned with the needs and desires of the patient. Instead of looking at patients the nurses often would get busy in their own gossips with each other. Sometimes, they did not even guide their patient regarding timings of the medicine. They often would not show any interest in their patient. Sometimes, their caring practices were exclusive of their feelings and emotions for their patient. They would just do formality. The administrative staff of the hospital was least concerned with the cleanliness of the rooms of the patients. The physical environment of the room was not clean enough for the treatment of such patients.

3.12.5 CASE STUDY # 5

My fifth case study was a man of 24 years. He was patient of hepatitis. By profession he was student. He was recently brought to the hospital. He had his brother and mother as his attendants. This patient was not financially strong enough to buy all the medicines and injections. That's why they kept requesting the hospital administration to either provide them with required medicine or help them buy these medicines from market. But they were not given any attention by the hospital administration. The doctors would not visit the patient regularly. They did not give proper time to the patient. The family and attendants of the patients were often confused about different tests and medicine of the patient. They were not properly guided in this regard. The behavior of doctors and nurses was very rude towards their patient. The doctors and nurses often would not talk to the patient to know about his feelings. The patient did not look satisfied with the behavior of doctors and nurses. He often did not find them polite and friendly with them. The doctors and nurses would often behaved with patient as if he was untouchable. It was the sole responsibility of the attendants of patients to provide patient with food, medicine and other necessasities.

CHAPTER # 4

CARE IN PRIVATE HOSPITAL

4.1 INTRODUCTION

This chapter deals with the people conception and perception of care in private hospital. Process and provision of care has been observed and noted from ethical perspective among patients, doctors, nurses, other medical staff and attendants. Ethics of care have been conceptualized, understood, explained and analyzed on the basis of religious beliefs of people involved in caring process in private hospital. Theoretical, practical and moral aspects of care in private hospital are the main focus of this chapter. And more importantly the socio-economic factors that actually determine the whole mechanism and morality of care have been discussed.

4.2 PERCEPTION OF CARE

The perception of care in medical profession greatly varies among patients, doctors, nurses, other medical staff and attendants. There are number of socio-economic, religious and psychological factors which affect one's perception of care in medical profession. It also varies according to the nature, severity and treatment of disease and illness. It is extremely relative phenomenon. It varies from patient to patient on the basis of their age, sex, class, status, one's socialization and brought up, religious beliefs and personality development. For example, one patient who belongs to middle class, lower-middle class or poor class perceives care differently in his/her given physical and social environment than patients from upper class.

4.2.1 PATIENTS' PERCEPTION OF CARE

The patient's perception of care in private hospital varies on the basis of his/her age, sex, class, status, socialization and overall brought up and personality development. It also varies according to the nature of disease, its severity and the nature and mode of treatment. Children and young patients perceive it differently from old patients. To some patients it means the provision of different material needs properly. For example, food, medicine etc. To some patients care means the relationship between doctors, nurses and patients which is based on love. To some patients care means the fulfillment of both physical and psychological needs. Many patients emphasized on the importance of good communication, behavior and attitude on the part of doctors, patients and other medical staff and attendants more than just provision of material needs. To some patients care is more than provision of medicine. Good caring behavior matters a lot in the prevention and cure of disease. To some people care means understanding patient's problems, emotions and feelings beyond just provision of material needs and good communication. That is the understanding of the circumstances in which the patients developed such health problems. To some people the sensitivity on the part of doctors, nurses, other medical staff and attendants matters a lot to the prevention and cure of their disease.

4.2.2 DOCTORS' PERCEPTION OF CARE

Doctors' perception of care in medical profession greatly varies from patients' perceptions of care. Doctors' perception of care is also based on several factors. They include age, sex, class, status, socialization, overall brought up and personality development. The most important factor which determines the doctors' perception of care is the institutional limits within which they have to work. That is why the perception

of care is always seen within the limits of health institutions. To some doctors' the care is the right diagnosis of the disease, prescription of disease, the treatment of disease. It must involve the emotions, feelings, love and empathy. Some doctors say that they have their own institutional and professional limitations within which they have to treat their patients. They all focused on high-quality of care. To some doctors perception of care means the right diagnosis, prescription and treatment of disease with love and empathy. Some doctors emphasized on the importance good doctor-patient relationship as the part and parcel of care in medical profession.

4.2.3 NURSES' PERCEPTION OF CARE

In private hospital nurses' perception of care does not vary to the great extent from patients' perception and doctors' perception of care. But it does vary from nurse to nurse. Their perception is also subject to certain institutional professional limits. Other factors like age, sex, class, status, socialization, brought up and nursing training matters a lot. That is how they conceive, perceive and practice care within their institutional and professional limits. To very few nurses perception of care is the only provision of some material needs. For example, giving medicine and injecting patients. To some nurses the perception of care is assisting patients to take medicine, food, in dressing and undressing, in changing position and posture and in providing nourishment etc. To most of the nurses the perception of care is beyond just fulfillment of physical needs. It is the fulfillment of material needs of patients with strong emotional attachment. Their perception of care also varies with reference to male and female patients and the nature of disease patient has. Some nurse perceived care as the development and importance of relationship of

friendship between nurses and patients. Fulfillment of psychological needs of patients is also perceived as care by some nurses.

4.3 DOCTOR AND PATIENT'S CARE: AN ETHICAL PERSPECTIVE

The relationship between a doctor and a patient is a very important part of medicine. Only when there is a good relationship between the two is it possible to have high-quality healthcare. This relationship is also at the base of medical ethics. Many medical schools teach the doctors to be to keep a professional relationship with their patients, to respect the patients' dignity and privacy. This relationship has asymmetric information though. The doctor knows more than the patient, but has to explain the patient's situation, and has to ask the patient what treatments should be done. There is a very similar relationship between the patient and nurses, psychologists. There are different legal norms that regulate this relationship. Examples of such norms are the Hippocratic oath, the Declaration of Geneva. Professional responsibility may also govern such a relationship. Ideally, patient and doctor trust each other. If they do, this can have a positive influence on the development of disease or condition. Healing can be hindered if the patient does not take the prescribed drugs, of if these drugs are not taken in the doses prescribed. If the relationship is too good this can preclude efficiency. In certain cases, it may be good to get the opinion of a second doctor, regarding a condition.

In private hospital patients have confidence in the competence of their doctor and confide in him. Most of the physicians have established good rapport with their patients. There is quality of doctor-patient relationship to both doctors and patients. They have better relationship in terms of mutual respect, knowledge, trust, shared values and

perspectives about disease and life, and time available. There is also better amount and quality of information about patient's disease transferred in both directions, and this enhances the accuracy of diagnosis and increases the patient's knowledge about the disease. As doctors have the ability to make a full assessment of the patients the patients do trust the diagnosis and proposed treatment which causes increased compliance to actually follow the medical advice. There is no divergence of medical opinions in private hospital.

4.3.1 PATIENT-CENTERED PARTNERSHIP

In private hospital the patients are treated as human beings rather than objects. That is doctors treat their patients keeping in consideration the emotions and feelings of the patients. The doctors encourage their patients to discuss about their psychological issues such as family and job. In this way they feel more satisfied with their patients. In this way both doctor and patient feels satisfied.

4.3.2 ILLNESS

In government hospital it has been observed and noted that most of the doctors conceive and perceive illness as a disease process. They are also of the view that this process can be measured and understood through different laboratory tests and clinical observations. That is the doctors in private hospital see the phenomenon of illness purely from scientific and professional perspectives. And their perspectives about illness cannot cross the institutional and professional limitations, whereas most of the patients in private hospital conceive and perceive their illness as disrupted life. They are least concerned with the scientific and professional explanations of their disease. This is where the ethical issue arises between patient and doctor. From patient's point of view it may not

be the ideal or desired diagnosis of his/her illness. There are of course some socio-economic, religious and psychological factors that determine the doctor's conception and perception of illness and patient's conception and perception of illness.

4.3.3 ADVANCEMENT IN TECHNOLOGY AND PATIENT'S FEELINGS AND CONCERNS

Advancement in medical technology has also created some serious ethical issues on the part of patients, doctors, nurses, other medical staff and attendants. It has been observed and noted that most of the doctors focus more on keeping up with the rapid advances in medical science than on trying to understand the patient's feelings and concerns. That is most of the doctors always focus on the use of new technology for the treatment of patient's disease. This is how they are least concerned with the feelings and concerns of patients regarding their illness and its treatment. And if we see on the other side, patient satisfaction comes primarily from a sense of being heard and understood. Most of the patients want their doctors to listen to them their point of view of about their illness, their concerns regarding the diagnosis process and treatment of illness. Their psychological fears matter a lot in the treatment of their illness. This is where the ethical issue arises between patient and doctor. They always want the doctor to listen to their concerns regarding their illness and its treatment and want the doctors to understand their feelings. If patient's feelings are totally ignored in the process of diagnosis and treatment of his/her illness, it badly affects the process of provision of care and overall well-being of patient. So, advancement in medical science has created some serious ethical issues in medical profession.

4.3.4 CARE AS MECHANICAL PROCESS

It has been observed and noted most of the doctors see their role as listener to their patients instead of viewing their function as a human car mechanic. That is doctors properly listen to their patients. So, it does not look purely mechanical process which may not be up to the expectations of patients. In such friendly environment patients do not feel devalued. Most of the patients feel psychologically very comfortable during treatment of their illness. Patients' psychological state of mind does cope with their physical conditions.

4.3.5 PROVISION OF INFORMATION

The provision of information on the part of patient is one of the major indicators of good doctor-patient relationship. They do not conceal information regarding what they feel about their illness and the proper use of medicine. Patients strictly follow the instructions of their doctors and use the prescribed medicine properly. So, there develops the relationship of trust between doctor and patient. The provision of information by patients regarding their illness and treatment does not make doctors feel frustrated and betrayed. Often it is the responsibility of nurses to give medicine to the patients with regular interval. Attendants play very important role of communication between doctor and patient.

4.3.6 DOCTOR-PATIENT COMMUNICATION

Doctor-patient communication plays an important role in the treatment of illness. It has been observed and noted that in private hospital there is good doctor-patient communication as compared to government hospital. Besides talking to the patients the doctors also listen to the patients regarding their feelings and concerns. They do give

sufficient time to their patients individually. While patient tells his/her concerns and feelings regarding illness and its treatment the doctors do not interrupt immediately. That is often patients are given sufficient time to tell their feelings and concerns regarding their illness and its treatment. This attitude of doctor does not create a communication gap between doctor and patient. So, effective communication between doctor and patient relationship matters a lot in the better treatment illness.

4.3.7 PATIENT'S EMOTIONS AND CARE

The emotional aspects of patient matter a lot in the overall treatment and well-being of patient. It has been observed and noted that doctors do not ignore the patient's emotional health in private hospital. Emotional health of patients helps a lot to get their physical health. The doctors acknowledge feelings of patients whether they express them or not. Their emotions may be related to their perception of illness, the causes of illness or the desired treatment of their illness. So, taking care of the emotional aspects of patients while they are being treated further helps to improve the psychological and physical health. For example, one old male patient who always kept telling his doctor about his perception of illness, the causes of illness and the desired treatment, the doctors did listen to him carefully. Instead of focusing the technical talk about the illness, the causes of illness and the treatment of illness they always took care of the emotions and feelings of their patients. They were seen most concerned about the emotional health of the patient. That is why the patient's treatment is not prolonged for weeks and months. Emotional health of the patient is as necessary as the physical health of the patient.

4.3.8 PATIENT'S UNDERSTANDING OF HIS/HER ILLNESS

The patient's understandings of the his/her illness, the nature of illness, the possible causes of illness and the desired treatment of the illness matters a lot in the overall treatment and well-being of the patient. It has been observed and noted that in private hospital the doctors do not underestimate the amount of information patients want and do not overestimate how much they actually give. Doctors often spend more time to tell their patients the necessary information about their illness, the nature of illness, the mode of treatment and use of medicine. This is also due to the adequate number of patients in private hospital. In this way the patients are much aware about their illness, the nature of illness, the causes of illness and the desired treatment of their illness. The sufficient amount of information does not create the state of confusion in the minds of patients. This is so because most of the patients in private hospital are educated enough to understand the matters regarding their illness and treatment. So, often their treatment is up to their satisfaction.

4.3.9 NATURE OF PATIENTS

There are different kinds of patients in hospital. They vary in their conception, perception and explanation of their illness, causes of illness and the desired treatment. Often patients have different personalities. Some of them may be called easy patients and some of them may be called difficult patients from doctors' point of view. But it has been observed that one patient who is difficult for one doctor may be the same patient is easy for other doctor.

Difficult patients may be of the following characteristics. They often do not trust or agree with the doctor. They present too many problems for one visit. They often do

not follow the instructions of doctors. Sometimes they are demanding and controlling. Difficult patients are more likely to be single and often have a history of unexplained physical symptoms, depression, panic states, obsessive-compulsive disorders, or physical abuse etc.

Patients who use the doctor as a scapegoat for their anger at the illness are less likely to get good care. Doctors are profoundly influenced by the demeanor, comments, and attitudes of their patients. A patient who is consistently rude and irritable will almost certainly not receive the same medical care as a patient who conveys more positive attitudes.

4.4 NURSE AND PROVISION OF CARE: AN ETHICAL PERSPECTIVE

Patient care is part of a nurse's role. Nurses use the nursing process to assess, plan, implement and evaluate patient care. Patient care is founded in critical thinking and caring in a holistic framework. Nursing care is increasingly framed in best practice, which is the application of evidence-based concepts to patient problems in a particular setting.

4.5 NURSING CARE

4.5.1 PATIENTS' POINT OF VIEW

The present research was designed to learn what patients expected of nurses, what concepts patients had of their own needs and their comprehension of the role of nurses in caring for them. From the responses, it seemed apparent that patients understood the functions of the nurse in reference to their nursing care. I then undertook a study to determine patients' perception of the role of the nurse. I attempted to answer three

questions: What does the patient expect of the nurse caring for him? Is he aware that he has needs which the nurse is prepared to meet? Does he have any idea what the role of the nurse is in meeting his needs? The results were organized according to two methods. First, the statements were considered in relation to six categories of nursing needs: physical, psychological, social, spiritual, teaching, and health team. Levels of agreement with behaviors then were noted. The majority of patients agreed that meeting physical needs was the primary role of the nurse. In the highest level of agreement, patients wanted the nurse to know the important changes in their conditions and how these affected them; specifically, patients expected the nurse to understand the action of medicines and treatments. The next level of agreement showed that patients wanted treatments explained before they were given; they also expected treatments to be performed carefully and correctly. There was greater concern for medicines being given on time than for treatments being given on time. Although the patients expressed great desire to have their physical needs met by nurses, they considered teaching functions less important. However, some patients did express a desire to have the nurses teach them and their families how to give medicines and treatments they might need at home. Several patients indicated a desire to learn the effects of their medicines and treatments. A high percentage of the patients wanted nurses to be aware that they were on special diets, but they seemed less concerned about the nurse's knowledge of the foods included in these diets. Although patients agreed that the nurse should meet their psychological care needs, they indicated that her role in this area also was less than her responsibility for meeting their physical needs. According to the responses to questions about their own activities, almost all of the respondents showed concern about the need to be

independent. Even if nurses were willing to do things for them, the majority of the respondents preferred to do things for themselves. However, they were somewhat less interested in having nurses show them how to do things. In general, these patients displayed an understanding of the nurse's role in helping the patient progress from dependency to intradependency. Some of the patients wanted nurses to teach them how to maintain an optimum state of health. They were less interested in having nurses know them as individuals, talk with them, and counsel them about their problems. Only few patients wanted nurses to accept their feelings, regardless of what these were. Only few patients wanted nurses to talk with them about their conditions. By their responses to the nursing behaviors, the respondents in this study saw the nurse as a person who could answer their families' questions about illness and discuss the care these patients needed. Patients indicated that they expected nurses to recognize their economic needs by teaching them how to prepare economically well-balanced meals and by showing them how to substitute household items for the expensive equipment they might need when they went home. Patients wanted nurses to help them maintain a realistic outlook about their physical conditions. I found that all the patients expected the nurse to follow the physician's orders in administering their care. Physical needs were the patients' next greatest concern. Teaching was considered less important, but there was a high percentage of affirmative responses. It was difficult to determine the relative significance of the remaining categories of nursing needs since there was such a wide variation of patient responses. The high levels of agreement in the physical categories were in keeping with our concept that the primary role of the nurse is to provide health care. The varied responses to statements in other categories may be due to the fact that these areas

are dependent on specific patient circumstances. I concluded, therefore, that nurses should be cognizant of all the aspects of the care of patients yet be able to adapt to individual needs.

4.5.2 NURSES' POINT OF VIEW

Patients believed that caring for their physical needs was the most important function of nurses. Results showed that nurses also placed physical care as the most important aspect of their role in caring for such patients.

How does she see her role in the care of patient? The purposes of the study were threefold: to determine the nurse's perception of her role in the care of the patient, to more clearly define the nurse's role in caring for such patients, and to develop nursing care implications from these perceptions. The definition of a need was perceived as a condition within the individual that energizes and disposes him to- ward certain kinds of behavior. Thus, because of some inner need, the individual might be led to seek food, rest, social recognition, self-esteem, and the like. These were categorized as: physical, psychological, socioeconomic, spiritual, educational, and administrative. The majority of the nurse respondents agreed with the hypothesis that the nurse stresses physical care and observation procedures of the patient more than she does total patient care, and that her primary role was recording and reporting the patient's condition; for example, the urinary output. The respondents believed that the patient's religious needs should be met by a member of the clergy when needed, or requested, by the patient. However, they indicated that nurses are not always aware of the religious beliefs of patients. The respondents further indicated that the nurse should have a thorough knowledge of the purposes and procedures of diagnostic tests in order to perform them as prescribed and in order to

explain them to patients. The respondents considered administrative activities secondary to providing physical care. Body hydration, skin protection, and the patient's participation in his care were considered significant in the care of the patient. Primary constituents of the nurse's role were seen to be orientating the patient to his environment, following hospital policies concerning visitors, patients, and personnel, and considering the patient's limitations when planning his care. Although the respondents ranked the nutritional status of the patient high in the list of physical needs, the nurse's function as a teacher of personnel and patients in dietary matters was ranked low. The nutritional needs that nurses specifically noted were: providing supplemental diversified fluids and suggesting modifications in diet when patients' conditions or needs changed. The nurse respondents agreed that identifying the patient's physical abilities in order to promote an environment which radiates confidence and permits the patient to utilize his strengths and compensate for his weaknesses was important. Encouraging the patient to express his feelings through acceptable modes of behavior was noted. The respondents showed an awareness of psychological factors as an important part of total patient care. These data indicate that the respondents placed emphasis on administrative functions and patient teaching functions, particularly regarding medications and treatments. But, a definite lack of concern with continuity of care beyond the hospital setting was obvious from the limited reference to referrals to community resources. From this study we see need for investigation of the nurse's perception of the concept of continuity of care, and study of methods used for communicating plans for nursing care of individual patients to others within the general hospital setting.

4.6 NURSE AND BODILY CARE

The components of nursing, its limitations, scope, and unique contribution to human health, appear to shift and expand almost daily, as the number and quality of preventive and therapeutic measures increases. To herself and to her public, the nurse seems to be all things to all men. She directs this plea very pointedly to the nurse in particular, and gives strong indication that bodily care is one major channel the nurse can use to convey such interest. Why this should be so, and the effect on the patient-nurse relationship when someone else gives bodily care, or such care is not needed, is a problem the profession might well explore. All we can do, on the basis of our findings, is take the first step toward this. We can begin by defining our terms.

By bodily care, we mean the process by which one human being meets the physical needs of another who, for any reason, is unable to do this for himself. It includes such things as cleaning the skin, dressing and undressing, changing position and posture, providing nourishment, and a suitable mode for excretion; and, in general, maintaining maximum bodily comfort of the dependent individual. The need to be cared for in this way is the earliest and most universal experience shared by every member of the human race.

4.6.1 THE PATIENT PICTURES THE NURSE

Despite the fact that modern nursing has become extremely complex, and the scientific and technical skills needed by the nurse are so varied, this fundamentally humane image remains deeply rooted in our cultural consciousness. Many people still picture the nurse essentially as a warm, womanly figure, who sustains the weak and helpless, seeing to their bodily needs, until such time as they are once more capable of

caring for themselves. When patients were asked to describe a typical or average nurse, they usually pictured a nurse as "a person who takes care of you when you're sick," or "someone who knows what you need to make you comfortable in bed." This stereotype is, significantly, most frequently voiced by patients who say that they had never had any personal contact with a nurse before they were ill. When the nurse is viewed as a person who cares for the sick, the patients rarely see that she performs any necessary function for them during illness. The things that patients usually observe a nurse doing during daily visits, such as getting the patient ready for the doctor's examination, preparing equipment, charting, and acting as chaperon, confirm their belief that the nurse is there mainly to assist the doctor, rather than to meet specific needs of the patients themselves. Most of the patients accept what they see this nurse doing as sufficient: "There's really nothing you need her for . . . she's there mainly to help the doctor." "After all, you're not sick or helpless, so you don't need much from her." Although patients reveal a wide range of emotional and informational needs which are often unmet during illness, they rarely associate these needs with nurses. The link between emotional support and bodily care is very definite in the patient's mind.

They recognize that everything they do is in some way designed to "help the patient," provision of bodily care is something personal, done for the patient's own sake, and not so tied in with medical and therapeutic measures. In areas of nursing where there is little or no possibility of rendering such service, nurses too seem to feel that an important link with the patient has been broken, and they have not yet forged an adequate substitute. These nurses feel that the patient develops a close relationship only with the person who is giving her personal care. If the nurse is not the one who does this, then she

is not the person to whom the patient turns. The aides get to know the patients more than the nurses. They have the closer contact, making beds, giving water, rubbing backs. If you're just at the desk charting, you don't get that close contact. The patients don't talk to you. They tell the aides a lot more than they tell the nurses. To some nurses, tending to bodily needs and making the patient comfortable is a chief source of satisfaction on the job. Thus, one nurse, speaking of post- partum care, says: Most of postpartum care is routine-giving medications and taking temperatures.

4.6.2 THE NURSE GIVES LESS BODILY CARE

There are many reasons, of course, why the professional nurse today gives less bodily care than she did formerly. The volume of patients and relative shortage of nurses in all areas of hospital necessitates critical re-evaluation of everyone's functions, and the assignment of simpler tasks to auxiliary personnel. Complex technical procedures, and intricate administrative and teaching responsibilities necessarily claim the attention of a more thoroughly prepared professional person, so that the nurse finds she must often delegate such things as bathing and back-rubbing to nonprofessional workers, whether she wants to or not. Sometimes, she gives less bodily care simply because she is not interested in doing so! Her goal in nursing may be something quite different; she may be scientifically inclined, and see herself primarily as the doctor's assistant, identifying with him more closely than with the patient. She may regard the giving of bodily care as a domestic service, which she, a professional person, would do only under special circumstances. Technical, teaching, or administrative functions may be more appealing to her personally, so that she gladly relinquishes her strictly motherly, "ministering angel" role to someone else. This is perfectly legitimate, since the organization of modern

nursing provides scope for all these talents. However, unless she manages to convey personal interest to the patient in some other way when she gives up bodily care, patients are likely to identify her as a "technician" or other worker, rather than as a nurse.

4.6.3 NURSE, PATIENT'S ATTENDANTS AND BODILY CARE

Actually, the patients have more contact with the attendants. They make you comfortable, and if you want anything, they're always there. They felt very close to them. They feel the nurse is too preoccupied with other things to have any interest in them and they retaliate by being equally indifferent. It seemed to me the aides did everything any nurse could do, and did it just as well. All the nurses did was give us pills. They have pills for everything. They didn't even know who the nurses were; they just whisk in and out, and it seems like it's a different one every time. You don't have any real contact. I think the nurses are there mainly for decoration. Unless they were in dire straits, they always tried to wait for the attendants, if they wanted anything. They were friendly, and seemed more willing to do things for them. They hated to ask a nurse to roll up their bed or give them a bed pan-they had the feeling it was beneath their dignity. The attendants always changed them and helped them, so they felt they were the right ones to do little things. They seemed more interested in them.

4.6.4 CARE AND SATISFACTION

Some nurses try to find other means than giving bodily care for achieving satisfaction and communicating their interest to the patient. The nurse for whom personal contact with patients is absolutely essential manages to utilize every contact-whether it be giving out the inevitable pills, making rounds with the doctor, or setting up infusion equipment-for warm, friendly exchange with the patient. In making her rounds, as she

passes by each patient, they always have a little conversation about different events-about things she has done. And it makes a patient feel closer to her. She cannot just look on them as patient. They are individual. The whole attitude of "readiness to give" on the part of the nurse has tremendous influence on the satisfaction of both nurse and patient when both are seeking a human bond. Thus, one patient says that it was not what the nurse said or did that was important, but the fact that she demonstrated her interest in her. The nurses' attitudes were very helpful. It was not actually what they said or did, or how long they were there, but just that they were trying to be helpful. It was an interest in them, and interest in helping them. On the other hand, the nurse may accept her displacement from intimate care of the patient philosophically. She adjusts to the necessity for assuming her technical and administrative roles so well that, eventually, she may substitute pride in her competence and efficiency for the satisfaction they used to get from her relationship with the patient.

A final alternative which a few nurses demonstrate when they are no longer "taking care of" people in the way they would like is to take no action, but passively accept their new roles, without achieving much satisfaction from them. The nurse may express resentment or distrust of the auxiliary worker, who, in her opinion, is usurping her place. Possibly such feelings may contribute to her discouragement, apathy, and disinterest in her work.

4.7 PATIENTS' ATTENDANTS AS CARE-GIVERS

Patient's attendants include his/her family members, relatives, friends and neighbors. It was observed and noted that in private hospital the attendants do not always remain with patients. In private hospital's settings the attendants are not as important in the caring process as in government hospital. Attendants can help the patient for fulfillment his/her physical needs, emotional needs, psychological needs, social needs, religious needs and financial needs. They also play the role of mediator between the doctor, nurse and patient regarding the diagnosis and treatment of illness.

The family members of patient, his/her relatives, friends and neighbors play very important role of mediator between doctor, nurse and patient regarding the diagnosis and treatment of illness. As often doctors and nurses do not talk to patients directly, so they communicate with their attendants regarding the diagnosis and treatment of illness. There can be number of reasons for lack of communication between the doctors, nurses and patients. Some patients may not be educated and literate enough to communicate with their doctors regarding their illness and its treatment. They may be unable to express their feelings that how they are feelings at the moment, their perception of illness and the desired treatment of illness. So, patient's attendants play very important role in the process and provision of care.

Emotional health of patients matters a lot for the overall well-being of the patients. The presence of the patient's attendants is a great emotional and psychological support for patient. Attendants' emotional and psychological really helps patient get well soon. In some cases, the kinship ties are so strong that patient feels insecure socially and psychologically in the absence of his/her attendants. Sometimes, the patient's emotional

and psychological affiliations are so strong that they cannot help looking and meeting their family members and relatives. In some cases, it has been observed that patient's emotional attachments with his/her friends matters a lot for the recovery of the patient. If patient's emotional needs are fulfilled, then, he can very easily recover. Often patients expect more from their attendants than from doctors, nurses and other medical staff. They are least concerned about doctors, nurses and other medical staff because of their strong emotional family attachments and expectations from their family members, relatives and friends.

One of the main favors of patient's attendants for patient is to help him financially for the expenditure of his/her treatment of illness. It was observed and noted that the family members, the relatives and friends of patient feel it their morally duty to help patient financially. By using financial aid the patient buy his/her medicine, gets his/her different tests and meets his/her daily expenditures. Unfortunately it is very expensive to get oneself treated in private hospital. So, the patients are often in dire need of money to afford the expenses of his/her treatment.

4.8 SOCIO-ECONOMIC STATUS OF PATIENTS AND PROVISION OF CARE

Socio-economic status of the patients matters a lot to determine the nature, extent, process and provision of care. The behavior of the doctors, nurses and other medical staff vary to the great extent according to the socio-economic status of the patients. Patients may belong to rich, middle or poor class. They may also have different status in the society. The behavior of the doctors, nurses and other medical staff is often subject to the socio-economic status of the patients.

It was observed and noted that behavior of the doctors, nurses and other medical staff in the process and provision of care varied to the great extent according to the class and status of the patients. In private hospital the most of the patients belong to upper class. They had different occupation. Some of them were businessmen. Some of them had good positions in different government departments. The doctors behaved well almost with all patients. Their behavior was very good with all patients. They did listen to the concerns and problems of all patients regarding their illness and treatment. There were treated as individuals. Doctors' good behavior really affected emotional health of patients. According to some patients they did feel some sort of emotional attachment with their doctors. Doctors' good behavior with their patients helped a lot in the process of diagnosis of illness and its treatment. This is why patients in private hospital always feel emotionally attached with their doctors. It was observed and noted that they did not underestimate their patients in any contexts. Doctors, nurses and other medical staff did not hurt the self-respect and ego of any patient. Almost all of the patients were equally treated by doctors, nurses and other medical staff irrespective of their class, status and any political influence. Such patients were given proper care during their stay in hospital. They did not have any difficult regarding different tests for the diagnosis of disease and treatment. Whether they have emotional attachment with doctors, nurses and other medical staff nor not at least their self-respect and ego is not hurt. They were regularly visited by doctors, nurses and other medical staff. So is the case with nurses' behavior with patients. Nurses also behave with patients equally. It was observed and noted that nurses did communicate well with patients irrespective of their class, status and any political influence. Patients' outlook does not matter a lot for the provision of care in

private hospital as compared to in government hospital. Those patients who apparently looked poor and uneducated they were also behaved well by the nurses. The nurses' perception of patients and their behavior with them was mainly determined by their professional training. They nurses did talk to patients and listen to them carefully. They were most concerned with the concerns and feelings of the patients regarding their illness and treatment. Such perceptions of doctors, nurses and other medical staff about patients and their behavior with patients is actually the outcome of overall socialization and brought up doctors, nurses and other medical staff. Nurses did treat their patients as individuals rather than as objects. They do not underestimate the different needs of patients. They spend sufficient time on each patient to listen to his/her concerns regarding their illness and treatment. They do try to understand the feelings, emotions and concerns of patients regarding illness and their treatment. Thus, the conception, perception, nature, extent, process and provision of care by doctors, nurses and other medical staff of the government hospital are not only subject to the socio-economic status of the patients.

4.9 CASE STUDIES

4.9.1 CASE STUDY # 1

My first case study was a man of 65 years. He was patient of cancer. He had been in hospital for last three months. It was observed that and noted that the doctors, nurses and other medical staff paid much attention towards this patient. The doctors did visit on regular basis and did give proper time to the patient. All the doctors, nurses and other medical staff performed their duty with dedication and determination. All of them would ask the patient that how he was feeling then. Nurses and doctors were most

concerned with the feelings and emotions of the patient. They were treating patient as a human being. There was exchange of information and trust between doctors, nurses, other medical staff and the patient. The patient and his family were told about the nature, treatment and consequences of the disease. The doctors, nurses and other medical staff were willing to pay proper attention towards the patient and listen to his feelings and concerns regarding his treatment. The relatives of the patients visited him on regular basis. They were of great financial, psychological and emotional help to the patient. The patient looked concerned about the behavior of doctors, nurses and other medical staff. He was expecting from hospital staff.

4.9.2 CASE STUDY # 2

My second case study was a man of 57 years. He was Typhoid. He had been in Shifa International hospital for more than one month. When I observed and interviewed him I came to know about following facts. The overall physical and social environment of the ward was up to the mark. The ward was properly cleaned, and there was not any noise of different patients, patients' attendants and other medical staff. The patient and his family knew a lot about the exact nature of disease. This was due to two factors, one because of sufficient medical knowledge on the part of patient and his family and other because of good communication between doctors, nurses and patients. There was also observed trust between doctor, patient and his family. The patient and his family were provided full information about his disease and treatment on regular basis. The patient did not have any complaints about the doctors, nurses and other medical staff. The treatment of the patient was having proper care on the part of doctors, nurses and other medical staff. The doctors behaved and treated this patient as a human being rather than

as a sort of commodity. The doctors did have regular visits to the ward and often gave proper time to every patient. This attitude of doctors really affected the psycho-emotional health of the patient, and this was one of the main factors in recovering patient's good health. Same was the case with the attitude of the nurses. It was observed that nurses behaved well with this patient. They just treated the patient as human being. The role of the nurses was not to only check the temperature, blood pressure, inject and drip the patient but to listen to the feelings, emotions and concerns of the patient. They treated the patient with feelings and emotions. In this way patient psycho-emotional health was really improved. There was not attendant with this patient on regular basis.

4.9.3 CASE STUDY # 3

My third case study was a man of 47 years. He was patient of kidney. By profession he was businessman. He had been in hospital for last two months. It was noted and observed that he was given proper care by the doctors, nurses and other medical staff. The patient and his family knew about the nature of the disease and its treatment. The doctors, nurses and other medical staff paid proper attention towards this patient. They doctors gave proper time to check the patient in detailed. They were most concerned about the feelings and emotions of the patients. They gave sufficient time to the patient to describe his feelings about the disease and its treatment. The administrative work of the hospital was up to the mark. The nurses would give proper time to the patient to check his temperature, blood pressure and to give medicine on time. The nurses and ward boys looked concerned with the needs and desires of the patient. They would guide their patient regarding timings of the medicine. They would show interest in their patient. Their caring practices were inclusive of their feelings and emotions for

their patient. They would do their duty properly. The administrative staff of the hospital was concerned with the cleanliness of the rooms of the patients. The physical environment of the room was clean enough for the treatment of such patients.

4.9.4 CASE STUDY # 4

My fourth case study was a man of 55 years. He was patient of Hepatitis. By profession he was Banker. He had been in hospital for more than three months. The doctors would visit the patient regularly. They did give proper time to the patient. The family and attendants of the patients were not confused about different tests and medicine of the patient. They were properly guided in this regard. The behavior of doctors and nurses was very good towards their patient. The doctors and nurses often would talk to the patient to know about his feelings. The patient did look satisfied with the behavior of doctors and nurses. He always found them polite and friendly with them. The doctors and nurses would behave with the patient in good manners. It was the sole responsibility of the hospital administration to provide patient with food, medicine and other necessities of life.

4.9.5 CASE STUDY # 5

My fifth case study was a woman of 50 years. She was patient of TB. She had been in PIMS for more than one month. She was in critical condition. She had one son and one daughter as her attendants in hospital. It was observed that she was not given proper treatment and care by the concern doctors, nurses and other medical staff. The doctors did not visit this patient on regular basis. And if doctor visited the patient but did not give proper time to her. The doctors often did not bother to ask the patient how she was feeling then. The lack of communication and trust was noted between doctors,

patient, nurses and other medical staff. The overall behavior of the doctors, nurses and other medical staff was not good with patient. There was observed lack of professionalism on the part of doctors, nurses and other medical staff. The attendants of the patients were the only people who were very much concerned about the time to time changing condition of patient and really took care of her in all respects. The nurses always behaved with patient as stranger rather than as their client. Their behavior was very rude with the patient and her attendants. Of they were reluctant to guide the patient's attendants regarding the nature of disease, the nature of treatment for such disease and the different timings giving medicine to the patient. The family and attendants of the patient often had difficulty regarding different tests of patient. No one was there to guide them properly that from where and how to get such tests. Nurses always kept distance from the patients. They would not ask the patient that how she felt then. The psycho-emotional aspects of the health of the patient were totally ignored by doctors, nurses and other medical staff.

CHAPTER # 5

CONCLUSION

5.1 CONCLUSION

The care in medical profession is conceived, perceived, explained and practiced differently across different cultures of the world. It is extremely a relative phenomenon. And so is the case with the ethics of care. That is there is always different construction of ethics of care in different societies. Morality of care varies according to the belief system of the people of any culture. It was a comparative study of government and private hospital to research the phenomenon of care. Various socio-economic factors determine the nature, extent, and quality of caring practices in government and private hospitals was the proposition of this study. The research was attempted to explore the conception, perception, explanation, practice and ethical aspects of care in government and private hospital.

The patients, doctors, nurses, and other medical staff had different conception, perception and explanation of care in both government and private hospital. Conception and perception of care varied from patient to patient, from doctor to doctor and from nurse to nurse. The conception and perception of care was subject to the nature of disease, the sex, education, class and status and the religious beliefs of the patients, doctors and nurses. And so is the cultural construction of morality of care among different patients, doctors and nurses. In its broadest sense "care" means the actions which care givers take for the benefit of others. The emotional aspect of care has been emphasized in both hospitals. The construction of care was mainly based on the religious

belief system of the people. The ethical aspects of care were debated among patients, doctors and nurses on different moral ground. Actions of care which were ethical for doctors and nurses might be unethical from patients' point of view. The process and provision of care was quite different in government and private hospitals. In government hospital the patients were often not treated as human beings by nurses, doctors and other medical staff. They treated them as objects. The emotional aspects of patients were often ignored by doctors, nurses and other medical staff. Doctors and nurses were least concerned with the feelings and concerns of the patients regarding their illness and treatment. Doctors and nurses did not try to understand the patients other than just their illness. There was often lack of love, empathy, concern and friendship with the patient on the part of doctors and nurses in government hospital. The patients' attendants' role had been significant in the provision of care. They were great source of emotional, psychological, physical and financial help for their patients. They often acted as mediator between doctor and patient regarding the nature of illness, the causes of illness and the treatment of illness. The patients often felt physically, emotionally and psychologically insecure in the absence of their attendants. The attendants usually used to do the work of dressing, feeding, hair care, bed making, nail care, bed bath, serving water, positioning, and range of motion exercise, vital signs and medication. In government hospital the patients were least familiar with the doctors and nurses. There was evident lack of communication between doctors, nurses and patients. The rude behavior of nurses and doctors with patients affected the emotional health of the patients to the great extent. There was also lack of resources on the part of hospital administration to give high quality of care to their patients.

The conceptions, perceptions, explanation and practice of care were quite different in private hospital. The patients are provided quality of care in private hospital. They patients are treated as human beings rather than as objects. They doctors and nurses often took care of the emotional health of the patients. They doctors and nurses were also concerned with the feelings and concerns of the patients regarding their illness and treatment. Doctors and nurses always tried to understand the problems of patients beyond their illness. There was a relationship of love, empathy, concern and friendship between doctors, nurses and patients. The nurses usually do the work of dressing, feeding, hair care, bed making, nail care, bed bath, serving water, positioning, and range of motion exercise, vital signs and medication. There was good communication between doctors, nurses and patients. They good behavior of the doctors and nurses improved the emotional health of the patients. The hospital administration had sufficient resources to provide high quality of care their patients. The patients' rooms have centrally heating and cooling facility, attached washroom, automatic beds, supply of suction and oxygen unit, television, telephone, nurse call bell system, refrigerator, sofa-cum-bed, weighing scale and flower with vase. There were least chances of negligence on the part of doctors and nurses. The private hospital had state of the art technology and highly qualified, competent and trained doctors and nurses. This is where the private hospital created difference in the provision of high quality care to their patients.

The provision of care in government and private hospital was subject to certain socio-economic factors. The high quality of care is subject to the patient's class and status both in government and private hospital. Those patients who were financially, socially and politically sound were given proper care. Affordability for medical

treatment matter a lot get high quality of care. The patients in government hospital mainly belong to middle and poor class. But the patients in private hospital mainly belong to upper class. The doctors' and nurses' socialization and overall brought up also matters a lot in providing care to their patients. And doctors, nurses and other medical staff have to work in their institutional and professional limits. They cannot afford relations which are purely based on love, emotions and friendship. This might hinder their professional rights and responsibilities.

BIBLIOGRAPHY

Ann Bradshaw. "Yes! There Is an Ethics of Care: An Answer for Peter Allmark"

Source: Journal of Medical Ethics, Vol. 22, No. 1 (Feb., 1996), pp. 8-12

Published by: BMJ Publishing Group

Anne F. Travers. "Carers"

Source: BMJ: British Medical Journal, Vol. 313, No. 7055 (Aug. 24, 1996), pp. 482-486

Published by: BMJ Publishing Group

Arnlaug Leira. "Concepts of Caring: Loving, Thinking, and Doing"

Source: The Social Service Review, Vol. 68, No. 2 (Jun., 1994), pp. 185-201

Published by: The University of Chicago Press

Barbara Seaman, Charting the doctor-patient relationship, The Spiral Note Book, Viewed 25 March, 2009,.

Christopher Meyers. "Managed Care and Ethical Conflicts: Anything New?"

Source: Journal of Medical Ethics, Vol. 25, No. 5 (Oct., 1999), pp. 382-387

Published by: BMJ Publishing Group

Cockerhan William C. "Medical Sociology", 1965, Prentice Halle, Eglewood Clipps.

David Levinson and Melvin Ember, Medical Ethics, Encyclopedia of Cultural Anthropology, Volume 3, 1996, PP. 763-764, Richard Gottlieb

David B. Resnik, Paul L. Ranelli, Susan P. Resnik. "The Conflict between Ethics and Business in Community Pharmacy: What about Patient Counseling?"

Source: Journal of Business Ethics, Vol. 28, No. 2 (Nov., 2000), pp. 179-186

Published by: Springer

Elisa J. Gordon, Extending the Boundaries of Care: Medical Ethics and Caring Practices, American Anthropologist, 2002, PP. 362, American Anthropological Association

Fabrega H. "Medical Anthropology", Annual Review of Anthropology, 1971, (2:167-215).

Foster G.M and Anderson. "Medical Anthropology", 1978, New York, John Willy and son.

Gene Outka. "Social Justice and Equal Access to Health Care"

Source: The Journal of Religious Ethics, Vol. 2, No. 1 (Spring, 1974), pp. 11-32

Published by: Blackwell Publishing

Howard J. Curzer. "Fry's Concept of Care in Nursing Ethics"

Source: Hypatia, Vol. 8, No. 3 (Summer, 1993), pp. 174-183

Published by: Indiana University Press

H Russel Bernard. "Research Methods in Anthropology. Qualitative and Quantitative Approaches"

2nd edition Sage Publication: 1994.

Jean P. Rumsey. "Justice, Care, and Questionable Dichotomies"

Source: Hypatia, Vol. 12, No. 1 (Winter, 1997), pp. 99-113

Published by: Indiana University Press

J S. Habgood. "Medical Ethics: A Christian View"

Source: Journal of Medical Ethics, Vol. 11, No. 1 (Mar., 1985), pp. 12-13

Published by: BMJ Publishing Group

Kath M. Melia. "The Task of Nursing Ethics"

Source: Journal of Medical Ethics, Vol. 20, No. 1 (Mar., 1994), pp. 7-11

Published by: BMJ Publishing Group

Marion Lesser and Vera Keane. "Nursing and Bodily Care"

Source: The American Journal of Nursing, Vol. 55, No. 7 (Jul., 1955), pp. 804-806

Published by: Lippincott Williams & Wilkins

Michael H. Kottow. "In Defence of Medical Ethics"

Source: Journal of Medical Ethics, Vol. 25, No. 4 (Aug., 1999), pp. 340-343

Published by: BMJ Publishing Group

Mignon Duffy. "Reproducing Labor Inequalities: Challenges for Feminists Conceptualizing Care at the Intersections of Gender, Race, and Class"

Source: Gender and Society, Vol. 19, No. 1 (Feb., 2005), pp. 66-82

Published by: Sage Publications, Inc.

Patient Care And The General Practitioner

Source: BMJ: British Medical Journal, Vol. 309, No. 6962 (Oct. 29, 1994), pp. 1144-1147 Published by: BMJ Publishing Group

Perceptions of Nursing Care

Source: The American Journal of Nursing, Vol. 65, No. 5 (May, 1965), pp. 127-129 Published by: Lippincott Williams & Wilkins

Peter Allmark. "Can There Be an Ethics of Care?"

Source: Journal of Medical Ethics, Vol. 21, No. 1 (Feb., 1995), pp. 19-24

Published by: BMJ Publishing Group

Peter Allmark. "Reply to Ann Bradshaw"

Source: Journal of Medical Ethics, Vol. 22, No. 1 (Feb., 1996), pp. 13-15

Published by: BMJ Publishing Group

P J.Pelto and G H.Pelto. "Anthropological Research; The structure of Inquiry"

2nd edition Cambridge University Press: 1978.

Raja Halwani. "Care Ethics and Virtue Ethics"

Source: Hypatia, Vol. 18, No. 3 (Autumn, 2003), pp. 161-192

Published by: Indiana University Press

Robert Zussman. "Sociological Perspectives on Medical Ethics and Decision-Making"

Source: Annual Review of Sociology, Vol. 23 (1997), pp. 171-189

Published by: Annual Reviews

Sara T. Fry. "The Role of Caring in a Theory of Nursing Ethics"

Source: Hypatia, Vol. 4, No. 2, Feminist Ethics & Medicine (Summer, 1989), pp. 88-103

Published by: Blackwell Publishing on behalf of Hypatia, Inc.

Sara T. Fry. "The Role of Caring in a Theory of Nursing Ethics"

Source: Hypatia, Vol. 4, No. 2, Feminist Ethics & Medicine (Summer, 1989), pp. 88-103

Published by: Indiana University Press

Susan Himmelweit. "Caring Labor"

Source: Annals of the American Academy of Political and Social Science, Vol. 561, Emotional Labor in the Service Economy (Jan., 1999), pp. 27-38

Published by: Sage Publications, Inc. in association with the American Academy of Political and Social Science

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www.shifa.com.pk

INTERVIEW GUIDE

Name:

Age:

Sex:

Occupation:

Education:

Nature of disease:

PATIENTS:

1. What sort of illness do you have?
2. What is your socio-economic status?
3. What is your real issue?
4. What is your perception of care?
5. What are your issues or concerns regarding their treatment?
6. What is your level of satisfaction regarding their overall treatment?
7. What are your need and expectation from hospital staff?
8. How do you see doctor-patient relationship?
9. How do you see patient-nurse relationship?
10. How do you conceive and perceive hospital, doctors and nurses?
11. What is role of your family and relatives in this whole procedure of your treatment?

12. How much are you aware about your illness, the nature of illness, the treatment of illness and diagnosis of your disease?
13. How should you be behaved and treated?
14. How do you find your family and relatives while you are in hospital?
15. How do you want doctors, nurses and other medical staff to behave with you?

DOCTORS:

1. What are your institutional limitations regarding your job in hospital?
2. What is the extent of your relationship with the patients?
3. How do you see doctor-patient relationship?
4. What is the whole treatment procedure, from diagnosis to treatment of the patients?
5. What can be the problems, limitations and back draws in treating patients?
6. How feelings and emotions-oriented is your relationship with your patients?
7. Do you care for your patients?
8. How do you define care?
9. What is the ideal doctor-patient relationship?
10. How do you see ethics of care?
11. What are ethical dilemmas in treatment of patients?
12. Do you behave equally with all patients?
13. Which patients are difficult for you to take care of?
14. Which patients are easy for you to take care of?

15. Should there be ethics of care to be followed in hospitals?

NURSES:

1. What are your duties and responsibilities?
2. What is your scope of work and limitations?
3. How do you perceive patients?
4. How do you conceive, perceive and explain care?
5. What are ethical dilemmas in caring for patients?
6. What are your problems and issues regarding performing your job?
7. Do you have emotions and feelings for your patients?
8. How are you trained to take care of your patients?
9. Do you prefer to have friendly relationship with your patients?
10. To what extent do your try to understand the feelings, emotions and concerns of the patients?
11. What do you expect from patients?
12. What are your concerns, reservations and issues regarding patients?
13. Which patients are easy to handle?
14. Which patients are difficult to handle?
15. Which practical problems do you face while treating patients?
16. How nursing profession is conceived and perceived in our society?
17. How spontaneous and partial is your behavior with patients?
18. Do you treat all patients equally?

19. Do you listen to the patients beyond their illness?
20. To what extent do you involve yourself with patients?
21. How do you maintain balance between your professional work and personal attachments with patients?

FAMILY AND RELATIVES OF THE PATIENTS:

1. How do you feel for your patient?
2. How do you care for your patient?
3. Are you satisfied with the work of doctors, nurses and other medical staff?
4. What is your perception about doctors and nurses?
5. Which difficulties do you have while you get your patient treated?
6. What should be the role of doctors and nurses?
7. How should your patient be behaved in hospital?
8. How ethically good or bad do you find the behavior of doctors and nurses?
9. Are you satisfied with the treatment of your patient?
10. How doctors and nurses behavior should be with your patient?