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Nurses' and Doctor's Attitude to Patient Education Barriers in Najran Armed Forces Hospital, Saudi Arabia

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Abstract
Objective: We aimed to assess nurses' and doctor's attitude to patient education barriers in Najran Armed Forces Hospital (NAFH).
Materials and methods: This is a cross-sectional study targeting health care professionals in NAFH. The study was conducted during April 2015. The studied participants were all nurses and doctors who work in NAFH. Anonymous self-administered questionnaires were used to obtain information on socio-demographic background including age, gender, marital status and professional category. The questionnaire collected data on attitudes to barriers of participation in patient education. Descriptive statistics were used to analyze the main qualitative and quantitative variables. Chi-square was used to compare percentages. P-value < 0.05 was considered significant.
Results: A total of 128 nurses (n= 106) and doctors (n= 22) participated in the study. Most of the participants (71.9%) were female. The mean age was 33.8±8.1 years with statistical difference between males and females (36.2±8.8 years among males vs. 32.7 ±7.6 years among females; p=0.03). Participants believed that shortness of time (68.8%), lack of common language and culture for communication with patient (91.6%) and the lack of patient's motivation for learning (85.7%) were the most important causes of insufficiency of patient education.
Conclusion: the exploration of health professional attitudes concerning patient education issues is an essential precursor to a debate about how barriers may be overcome, and about the appropriate skill mix and employment arrangements required to manage health care services in the future.

Key words: Patient education, attitude, health care professionals

Introduction

Good educational skills and strategies are particularly important in the prevention, diagnosis, treatment and management of diseases (1-3). Patients' education is a fundamental aspect of patient care and yet poor education is the most common source of patient's complaints in the health-care sector (4). Miscommunication in education often occurs because of cultural differences between the communicator and recipient (5,6).

Problems of miscommunication and language may not only influence treatment but may also contribute to the reinforcement of stereotyped behavior (7). Patient education is an essential nursing practice standard that meaningfully impacts a patient's health and quality of life. Education process is a systematic, sequential, logical, planned course of action consisting of two major interdependent operations, teaching and learning (8).

To provide thorough and appropriate education, each patient requires an ongoing teaching plan. Education is used to empower the patient and is an important aspect of quality improvement given that it has been associated with improved health outcomes (9). The nurses' and doctor's role has undergone historical change, shifting from imparting disease-oriented health education toward empowering patients to use their own resources to attain health. Essentials for effective patient education include use of an open communication style, written instructions and addressing barriers (10). Demographic variables, such as education level, reading ability, and barriers to participation in education must be considered to maximize the effectiveness of self-management

education outcomes. Nurses' and doctor's attitude to patient education barriers can help to better understand and resolve the main issues related to health education practice. The purpose of our study was to assess nurses' and doctor's attitude to patient education barriers in Najran Armed Forces Hospital (NAFH).

Table 1. General characteristics of the studied population

Variable	Number	Percent
GENDER:		
Male	36	28.1
Female	92	71.9
AGE:		
<30	48	37.5
≥30	80	62.5
PROFESSION:		
Physician	22	17.2
Nurse/Technician	106	82.8
MARITAL STATUS:		
Married	91	71.1
Single	34	26.6
Divorced	03	2.3

Materials and Methods

Study design

It was a cross-sectional study targeting health care staff in NAFH. The study was conducted during April 2015. The studied participants were all nurses and doctors who work in NAFH. Census method was used for sampling and all nurses and all doctors of both sexes who filled the questionnaire entered into the study (Table 1). Subjects were surveyed in agreement with the research ethics.

Data collection procedure

Anonymous self-administered questionnaires were used to obtain information on socio-demographic background including age, gender, marital status and professional category. The questionnaire collected data on attitudes to barriers of participation in patient education. Three domains were studied: their working situation, hospital education facilities and patient's characteristics and motivation.

The participants were encouraged to give frank answers by explaining that the survey is anonymous and the privacy of participants will remain protected.

Data analysis

Data were coded, validated, and analyzed using Statistical Package for Social Science (SPSS) for Windows (version 17.0). Descriptive statistics were used to analyze the main qualitative and quantitative variables. Chi-square was used to compare percentages and P-value < 0.05 was considered significant

Results

In total 128 nurses (n= 106) and doctors (n= 22) were included in the study. Most of the participants (71.9%) were female (table I). The mean age was 33.8±8.10 years with statistical difference between males and females (36.2±8.8 years among males vs. 32.7±7.6 years among females; p=0.03).

Participants believed that shortness of time (68.8%), lack of common language and culture for communication with patient (91.6%) and the lack of patient's motivation for learning (85.7%) were the most important causes of insufficiency of patient education.

The most important barriers of patient education regarding nurses and doctors working situation were lack of knowledge about new patient education methods (64.7%), lack of patient education in medical and nursing programs (73.3%).

The most important barriers of patient education in terms of hospital education facilities were lack of teaching tools for patient education (92.9%) and especially the lack of coordination with health education division (92.2%).

Table 2: Main attitudes about barriers of patient education revealed by Nurses and Doctors

Variable	**Doctors n (%)**	**Nurses n(%)**	**P: degree of significance**
Working situation			
Lack of knowledge about new patient education methods	13(61.9)	62(65.3)	0.77
Lack of patient education in medical and nursing programs	18(81.8)	67(71.3)	0.31
Job dissatisfaction	5(23.8)	61(58.7)	0.004*
Salary insufficiency	5(23.8)	68(66)	<0.001*
Lack of time	17(81)	71(69.6)	0.29
Hospital education facilities			
Lack of teaching tools for patient education	20(95.2)	97(92.4)	0.64
Lack of good educational environment in NAFH	14(66.7)	63(67)	0.97
Lack of coordination with Health Education division	21(95.5)	97(91.5)	0.53
Patient characteristics			
Lack of common language and culture for communication with patient	16(76.2)	93(94.9)	0.005*
Lack of patient's motivation for learning	18(81.8)	90(86.5)	0.56
Existence of anxiety and pain in patient	14(66.7)	86(82.7)	0.09
** Significant statistical difference p <0.05*			

Regarding patient's situation and characteristics, the most important barriers in addition to those mentioned above, the existence of anxiety and pain in patient (80%) was an important factor of patient education insufficiency according to the participants.

The main patient education barriers revealed by the health care professionals at NAFH according to their profession were presented in Table 2. The analysis of information about education barriers showed also statistical differences between nurses and doctors attitudes regarding job dissatisfaction, salary insufficiency and Lack of common language and culture for communication with patient as barriers of patient's education (table II). Nurses considered more than doctors that these three factors were important barriers for patient education practices. Less than 10% of the participants (9.4%) believed that patient education is not their duty. Mostly of them were nurses (10 nurses vs 2 doctors). They were young females (age < 30 years) working mainly in outpatient clinics and intensive care unit.

Discussion

Any combination of educational barriers might interfere with the plan being relevant and timely for the targeted learner. Education, often delivered by nurses and doctors, is an important part of all management programs for patients, both in clinical practice and research (11). Patient education includes all educational activities provided to patients, including aspects of therapeutic education, health education and health promotion (12).

The interactions of patient, physician, nurse and systemic factors have implications for the implementation of patient education. The failure of adequately patient's education may be attributed to several factors. In our study, health staff believed that shortness of time, lack of common language and culture for communication with patient and the lack of patient's motivation for learning were the most important causes of insufficiency of patient education. These findings were similar to the results of other international studies (13-18).

Interventions at multiple levels that address obstacles to patient education are needed to ensure successful self-management training. In summary, essential principles for the education role include: use language the patient can understand, dialogue rather than monologue, not overload with verbal instructions, use memory aids such as written instructions and mailed reminders, and suggest specific helps to increase patient's motivation for learning (19).

Patients in hospital need education in order to adapt to their condition and perform self-care behavior. Despite the fact that many patients received education and perceived information about their treatment as important, they had low levels of knowledge and lacked a clear understanding of why they had developed diseases, how it was defined and what relevant self-care behavior should be performed. It is important to target barriers to learning such as functional and cognitive limitations, misconceptions, low motivation and self-esteem.

Health care professionals need to be skilled in assessing the requirements and the level of education given to the patient. Education can be further improved by combining clinical experience with new technologies and must explicitly support the patient teaching role of the nurses and doctors upon their employment, by providing the resources they need and rewarding their efforts (20).

Continuing education for nurses and doctors during new employee orientation programs and periodically thereafter can include information applicable to ambulatory care. This will allow hospital health staff to convey accurate information to patients regarding their care.

The exploration of health professional attitudes concerning patient education issues is an essential precursor to a debate about how barriers may be overcome, and about the appropriate skill mix and employment arrangements required to manage health care services in the future.

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