Patient Attitudes to Major Surgery in Rural Kenya

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In this Kenyan study of patient perceptions of major surgery and involvement in decisions to operate, the attitudes of 89 female and 23 male patients who had undergone major surgery at a district hospital were studied. Semi-structured interviews were conducted in the wards by a social worker who had no employment or other relationship with the hospital. In 48 cases the decision about the operation was taken jointly by patient and doctor, while in 49 cases the decision was reportedly taken by the doctor alone. In 81 cases (64 female and 17 male) a relative or friend accompanied the patient to hospital. Only 21 patients reported being told details about the operation before the event. One quarter of the patients (housewives and school children) admitted feeling afraid or nervous prior to the operation while two-thirds reported having felt either confident or resigned about it. Ninety-eight patients characterized the care as good while seven felt it was poor. Copyright © 1996 Elsevier Science Ltd.

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INTRODUCTION

Hospital admission with major surgery is a dramatic, and to many patients frightening event, often combined with general anaesthesia, which is also associated with considerable anxiety [1,2]. Information tends to reduce patients' fear and pain, but some individuals are scared by detailed information about operations and anaesthesia and prefer not to have it [3,4].

Attitudes to surgery have been fairly well studied in the industrialized world. Visintainer [5] studied tonsillectomy in children and found reduced anxiety when there was strong parental support and some form of pre-operative rehearsal. Reactions after hysterectomy were investigated by Gath and Cooper [6], and psychological aspects of breast surgery were reviewed by Stevens [7]. A general review of the published literature on patient evaluations of hospital care was presented by Rubin [8], and the merits of different kinds of patient satisfaction surveys have been examined by Fitzpatrick [9]. Socio-cultural and ethnical aspects of surgery and the peri-operative period have been reviewed from an American perspective by Garner [10]. Williams and Calnan [11] studied general practitioner services, dental care and hospital in-patient care in south-east England and concluded that a generally high level of in-patient satisfaction may well coexist with displeasure with certain aspects such as excessive waiting time, poor doctor-patient relations and inadequate sharing of information.

We have found few published studies on perceptions of surgery and anaesthesia in developing countries. As regards anaesthetic preferences, for example of 200 Nigerian adults interviewed postoperatively in the late 1970s, 60% favoured general anaesthesia and expressed fear of waking up while the operation is still going on [12]. Similar results were obtained from adult Jamaican patients [13], of whom 83% stated that they were not afraid of general anaesthesia and surgery; the rest seemed more...
concerned about the surgery than the anaesthesia. Pre- and post-hysterectomy interviews with 18 Chinese women have been briefly reported by Tsoi et al.[14].

This study explored the perceptions and attitudes of patients who had undergone major surgery at a rural district hospital in Kenya. Its aim was to generate data helping to improve surgical patient satisfaction with surgery. It also aimed to test the methodology for investigating patient attitudes to major surgery and general anaesthesia in a rural African population.

MATERIAL AND METHODS

The study was conducted during 1990 at the 254-bed government district hospital in Meru District some 200 km north-east of Nairobi, Kenya. Postoperative interviews were conducted with all 112 in-patients, who had undergone major surgery and were awaiting discharge. The patients' characteristics are summarized in Table 1.

The interviews were semi-structured and conducted in the respective wards by a social worker who was employed and instructed for this particular task and did not belong to the staff of this or any other health facility in the district. The interviews were conducted in the local tribal language, Kimeru, and each interview took about 30 min. Interviewing took place at the bedside in the absence of hospital staff. Complete privacy was not usually possible, and some interviews were overheard by patients in adjacent beds. When patients were below 15 years of age one parent, usually the mother, was interviewed as proxy.

RESULTS

Of the 112 respondents 89 were females and 23 males. The mean age of the women was 28 years against 44 for the men. Fifty-six of the 112 patients had been hospitalized previously, and 24 (1 male and 23 females) had undergone surgery at least once before. Eighty-one patients (17 males and 64 females) were accompanied to the hospital by a relative or a friend.

The decision to operate was reportedly influenced in eight cases (all female) by the patient alone, in 49 cases by the doctor alone and in 48 cases jointly by patient and doctor. Only in four cases did relatives or others have a strong influence on the decision and these were all children below 15 years of age.

Twenty-one respondents (8 males and 13 females) stated that they were told details about the forthcoming operation. The information was provided by the doctor in 15 cases and by a nurse in 3. Some of the characteristics of more and less well-informed patients are shown in Table 2.

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Well-informed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Males</td>
</tr>
<tr>
<td>Farmer</td>
<td>1</td>
</tr>
<tr>
<td>Civil servant</td>
<td>0</td>
</tr>
<tr>
<td>Housewife</td>
<td>0</td>
</tr>
<tr>
<td>Merchant</td>
<td>0</td>
</tr>
<tr>
<td>School-child</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>3</td>
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</tbody>
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Thirty-three (29.5%) of the respondents reported having been referred, and the proportion was higher for the males (39.1%) than for the females (27.0%). Twenty-two (66.7%) of the referrals were made in writing and 11 with a verbal recommendation.

The feelings respondents reported about the operation before it took place were mostly confidence or resignation (36 and 38% respectively) while 23.2% (13% of males, 26% of females) admitted feeling afraid or nervous (Table 3). Male respondents felt less afraid or nervous — or were less willing to admit such fear when interviewed.

When the stated pre-operative feelings were matched against the level of education we found no association between level of education and fear in the face of the forthcoming operation (Table 4).

A more detailed analysis of those 30 who felt afraid or nervous shows that most were housewives [13] and schoolchildren [7]. Those 36 who claimed to have felt confident were mainly housewives [13] and farmers [15].

As regards anaesthesia during the operation; 40 (35.4%) of those interviewed knew little and 64 (56.6%) nothing about it before the operation. Postoperatively, 69 (61%) respondents felt aware of what had been done, and this proportion was slightly higher for males (73.9%) than for females (62.8%). A large majority of the 98 patients (90%) characterized the care they had received as good while 7 (4 males, 3 females) described it as poor.

**DISCUSSION**

As many as 90 out of 112 respondents considered themselves to be poorly informed about their forthcoming operation and the associated anaesthesia. This stated ignorance was most pronounced among the young and the poorly educated and more common among men than among women. However, no objective test of pre-operative patient knowledge was applied. Proclaimed ignorance does not necessarily mean that patients have not been informed. For example, studies regarding ‘informed consent’ to surgery have shown that half of the information given may be lost within minutes [16] and that patients’ recall is very selective [16]. We conclude that patient education and information regarding the operation and its implications need to be considerably improved and that

<p>| TABLE 3. Stated pre-operative feelings by age and sex |
|--------------------------------------|-----------------|</p>
<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0–4  5–14 15–64 65+</td>
</tr>
<tr>
<td>Afraid</td>
<td>0   0   2   1</td>
</tr>
<tr>
<td>Nervous</td>
<td>0   0   0   0</td>
</tr>
<tr>
<td>Confident</td>
<td>0   1   6   5</td>
</tr>
<tr>
<td>Resigned</td>
<td>0   2   5   1</td>
</tr>
<tr>
<td>Other</td>
<td>0   0   0   0</td>
</tr>
</tbody>
</table>
such efforts should be concentrated on the young and the least educated.

Surprisingly few respondents (20%) admitted feeling afraid or nervous prior to the operation. This may be compared to the findings of an American study by Ramsay [1] which stated that 70–76% felt pre-operative fear, and that the fear was most prominent in people of middle age. Twenty-four respondents had undergone surgery before, which may have influenced their attitudes and reduced their fear.

The respondents were all patients who had undergone major surgery at the district hospital and were awaiting discharge. They represented all age groups and both sexes, and their situations, including their prognosis, varied considerably. Poor comparability is, therefore, a problem, and we see good reasons to restrict future studies of this kind to cases belonging to a few more homogenous categories, even if this means extending the study over a longer period of time to secure sufficient numbers of respondents.

The external, independent interviewer was reasonably well accepted by the ward staff and could conduct the interviews with little interference. Patients volunteered sensitive information, including some critiques against the hospital staff, but were on such occasions visibly anxious to keep the interview confidential.

We are convinced that interviews of this kind should be conducted by people who are not on the hospital payroll or closely related to hospital staff. It is probably crucial for the interviewer early in the interview to declare independent status in relation to the hospital and to assure confidentiality. Privacy during interviews may be a condition for obtaining statements that are important but unflattering to hospital staff.

The study was descriptive and did not include enough interviewees for meaningful significance testing, but it illustrates the usefulness of in-hospital interviews as a basis for improving patient education and information. Larger studies of this kind need to be conducted, again with external interviewers and under strict privacy. It is probably wise to exclude from the study those or to analyse them separately. The fact that the majority of respondents were self-referrals indicates poor access to small local health facilities or a low level of confidence in them, possibly caused by low perceived quality of care. Performance assessments of such facilities are needed.

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