

A Study of Patients' and Relatives' Experiences with Neurological Care at the University College Hospital Ibadan, Oyo State, Nigeria

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ABSTRACT

Aim of the Study: Neurological disorders when measured in Disability Adjusted Life Years; an estimate of individuals who are ill or die in each age-sex group and location is 8,079,967 people in Western Sub-Saharan Africa. Patients and their relatives are often faced with challenges when seeking neurological care. This study examined patients' and relatives' experiences with adult neurology care services in a Nigerian hospital.

Methods: The study's target subject was the university college hospital. Patients and their family members receiving care at the neurology department of the university college hospital were included in the target population. 26 In-depth Interviews (IDIs) were conducted with patients and their family members to collect information. Data were analyzed using Atlas.ti (Version 6.2). Eight domains were used to describe experiences with health care services, including hospital admission, the relationship between health workers and patients, the sharing of treatment information, referral services, support services like laboratory services, post-hospital rehabilitation programmes, family member involvement in treatment, and treatment costs.

Results: Generally, participants' experiences of care were both positive and negative. Experience with care was found to determine satisfaction which influenced treatment outcomes.

Conclusion: The study recommended the need for more training on effective management of health worker/patient relationship as a major determinant of positive experience and satisfaction with care.

Keywords: Ibadan, Neurological care, Patient Experience, Relatives, Service delivery

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Introduction

Focus has shifted in the healthcare sector from healthcare providers to users of these services. According to research, patients' experiences can be used as indicators to evaluate healthcare quality and create a successful action plan since they can tell us how well healthcare providers perform and how well care is supplied (Levine et al., 1997). It is a crucial tool for assessing healthcare interventions and improves patient outcomes (Kieft et al., 2014) and people's attitude towards healthcare services (Ogunfowokan & Mora, 2012). Patients' experience of care is built from their preconception of care; it includes the process of treatment, progression of treatment, outcome of services rendered and interaction with others (Chenail, 2011).

People living with neurological disorders often undergo series of traumatic experiences. Experiences such as surgeries, frequent hospitalization, lengthy rehabilitation and medical tests all form the basis of their perception of care. Also, the experience of relatives is borne out of the fact that they are the ones mostly communicated to on the state of health of their sick relative. They also bear the burden of long hours of waiting in queues to be attended to as well as standing, delayed diagnosis, sitting on the floor/corridor and are stressed up (Normand, 2009; Rodriguez and Young, 2006; Tastan et al., 2011; Bankole & Taiwo, 2013; Peters et al., 2013).

It is not widely known how patients, particularly those receiving care in a hospital context, perceive the care that builds on their experiences. This study described the experiences of patients and their families in relation to 8 domains, including admission into the hospital, the relationship between health workers and patients, communication of treatment information, referral service, support service, and post-hospital rehabilitation programme. Experiences with health care have frequently been described in the literature using various domains of care, such as technical quality of care, the hospital environment, and interpersonal relationship (Israr et al., 2016; Jawahar, 2007; Jha et al., 2008; Wain et al., 2008; Wilcock & Harding, 2011).

Focus has shifted in the healthcare sector from healthcare providers to users of these services. Research suggests that patient satisfaction is highly influenced by personal communication between patients and healthcare workers, and that patients' experiences are tied to interpersonal interactions (Lyu et al., 2013). This is based on the fact that it is a significant predictor of care quality (Aimola et al., 2019) and is helpful in assessing and developing an effective plan of action to improve the quality of health care through the data they provide about the performance of healthcare workers and the calibre of care provided (Levine et al., 1997). It is a crucial tool for assessing healthcare interventions and improves patient outcomes (Kieft et al., 2014; Garratt et al., 2005). Patients' experience of care is built from their preconception of care; it includes the process of treatment, progression of treatment, outcome of services rendered and interaction with others (Chenail, 2011).

People living with neurological disorders often undergo series of traumatic experiences. Experiences such as surgeries, frequent hospitalization, lengthy rehabilitation and medical tests all form the basis of their perception of care. Also, the experience of relatives is borne out of the fact that they are the ones mostly communicated to on the state of health of their sick relative. They also bear the burden of long hours of waiting in queues to be attended to as well as standing, sitting on the floor/corridor and are stressed up (Normand, 2009; Rodriguez and Young, 2006; Tastan et al., 2011).

Understanding the experience of patients and relatives is important because it determines their treatment outcome, satisfaction and whether they would refer people to seek help as it is an important component in the evaluation of healthcare delivery (LaVela & Gallan, 2014). Where there is a negative experience, or when experience does not meet expectations, there is most likely going to be a withdrawal, search for alternative care and discouragement of others who would want to seek help thereby increasing the burden of neurological disorders.

An evaluation will give an opportunity to uncover the gap in the services for future improvement and to reach the desired goal (Pramanik, 2016). It is not widely known how patients, particularly those receiving care in a hospital context, perceive the care that builds on their experiences. This study described the experiences of patients and their families in relation to 8 domains, including admission into the hospital, the relationship between health workers and patients, communication of treatment information, referral service, support service, and post-hospital rehabilitation programme. Experiences with health care have frequently been described in the literature using various domains of care, such as technical quality of care, the hospital environment, and interpersonal relationship (Israr et al., 2016; Jawahar, 2007; Jha et al., 2008; Wain et al., 2008; Wilcock & Harding, 2011).

Materials and Methods

Research Design and Study Area: Exploratory design was adopted using qualitative approach to understand the experiences of neurological services users. The study was conducted at the adult Neurology Department of the University College Hospital Ibadan. The hospital is a tertiary referral centre owned and funded by the Federal Government of Nigeria. The hospital was founded in 1948 and is strategically located in Ibadan, Oyo state Nigeria. The Neurology outpatient clinic holds every Friday but sometimes schedule alternate clinic on Tuesdays

Study Population: Participants for the interview were selected from the population of patients and relatives of patients. Twelve In-depth Interviews for patients and fourteen In-depth Interviews for relatives were employed to gather information from patients and their relatives receiving care at the neurology unit of the university college hospital. The participants were purposively selected based on their availability and ability to respond to the interviews.

Inclusion and Exclusion Criteria: The respondents included in this study were those diagnosed with neurological conditions such as stroke, epilepsy, migraine headache, insomnia, spinal muscular atrophy and Parkinson's disease. Also, they were to be admitted or receiving outpatient care in the unit and is 18 years and above. Participants, who were below 18 years, were unable to respond to the interview due to their state of health, as well as those who were not interested were excluded.

Instruments: The instruments used for data collection were interview guides designed for each group of participants. However, the interviewer was flexible in order to facilitate obtaining information on the objectives of the study.

Data Collection: Data were collected using in-depth interviews (IDI). Interviews were conducted with eleven out-patients (9 males and 2 females) and one in-patient (1 male) receiving neurological care at the University College Hospital Ibadan, and fourteen In-depth Interviews were conducted with relatives of the patients (7 males and 7 females).

Data Analysis: Qualitative data retrieved through In-Depth Interviews were recorded on tapes and were renamed using participants' codes. This ensured anonymity; easy identification and use. Data were then translated and transcribed depending on the medium in which the interview was conducted. Content analysis was done thematically in line with the study objectives and verbatim quotations were used in the course of the analysis where appropriate.

Ethical Approval: Ethical approval and permission letter were obtained from the University of Ibadan Social Sciences and Humanities Research Ethics Committee and the Chairman Medical Advisory Committee at the University College Hospital before the commencement of data collection. As much as possible, the principles of voluntariness, confidentiality of data, beneficence to participants and non-maleficence to participants were strictly adhered to.

Results

Table 1: *Socio-Demographic Characteristics of Respondents*

Socio-Demographic Characteristics	Patients (%)	Relatives (%)
Age		
18-30	2(16.7%)	8 (57.1%)
31-50	6(50%)	4 (28.6%)
51 and above	4 (33.3%)	2 (14.3%)
Sex		
Males	9 (75%)	7 (50%)
Females	3 (25%)	7 (50%)
Marital status		
Married	7 (58.3%)	7 (50%)
Single	4 (33.3%)	6 (42.9%)
Widowed	1 (8.3%)	1 (7.1%)
Ethnicity		
Yoruba	8 (66.7%)	10 (71.4%)
Bini	2 (16.7%)	1 (7.1%)
Afemai	2 (16.7%)	1 (7.1%)
Igbo	1 (8.3%)	-
Arab	1 (8.3%)	-
Akoko	-	1 (7.1%)
Idoma	-	1 (7.1%)
Religion		
Christian	10 (83.3%)	12 (85.7%)
Moslem	2 (16.7%)	1 (7.1%)
African Traditional Religion	-	1 (7.1%)
Education		
No formal education	1 (8.3%)	-
FSLC	4 (33.3%)	1 (7.1%)
SSCE	2 (16.7%)	3 (21.4%)
Diploma	2 (16.7%)	4 (28.6%)
NCE	-	2 (14.3%)
B.Sc	2 (16.7%)	4 (28.6%)
Others	2 (16.7%)	-
Occupation		
Unemployed	2 (16.7%)	-
Students	-	2 (14.3%)
Self-employed	1 (8.3%)	3 (21.4%)
Trading	6 (50%)	3 (21.4%)
Civil Servants	3 (25%)	5 (35.7%)
Retired	-	1 (7.1%)
Income		
No source of income	3 (25%)	3 (21.4%)
Can't calculate monthly income	3 (25%)	4 (28.6%)
#10,000 - #30,000	2 (16.7%)	3 (21.4%)
#31,000 - #50,000	3 (25%)	2 (14.3%)
#51,000 and above	1 (8.3%)	2 (14.3%)
Relationship with patient		
Parent	-	1 (7.1%)
Son/Daughter	-	5 (35.7%)

Spouse	-	1 (7.1%)
Nephews/Nieces	-	2 (14.3%)
Brother/Sister	-	1 (7.1%)
Friend/Employee/Helper	-	4 (28.6%)
Medical condition		
Stroke	5 (41.7%)	6 (43%)
Epilepsy	2 (16.7%)	-
High blood pressure	2 (16.7%)	2 (16.7%)
Migraine headache	1 (8.3%)	1 (7.1%)
Insomnia	1 (8.3%)	-
Spinal muscular atrophy	1 (8.3%)	-
Parkinson's Disease	-	3 (21.4%)
Don't know the name	-	2 (14.3%)
Patient status		
In-Patients	1 (8.3%)	-
Out-Patients	11 (91.7%)	14 (100%)
Length of time of medical condition		
Less than 2 months	2 (16.7%)	3 (21.3%)
More than 2 months but less than 1 year	3 (25%)	2 (14.4%)
Between 1 – 3 years	3 (25%)	2 (14.3%)
Over 3 years	3 (25%)	2 (14.3%)
Can't say when it started	1 (8.3%)	5 (35.7%)
Who brought you to UCH?		
Referral	3 (25%)	-
On their own	3 (25%)	-
Child	1 (8.3%)	-
Brothers	2 (16.7%)	-
Spouse	2 (16.7%)	-
Parent	1 (8.3%)	-
How long you've been accessing care at UCH		
Can't say how long	3 (25%)	-
Less than 1 month	2 (16.7%)	-
1 – 2 months	3 (25%)	-
More than 2 months but less than 1 year	2 (16.7%)	-
Over 1 year	2 (16.7%)	-

Experiences of patients and relatives are central in understanding the performance of health providers and health institutions as well as the quality of services delivered. The study revealed that both patients and their relatives had positive and negative experiences which are reflective of their different personalities and perception towards things. The experiences are categorized into sub-themes which will be discussed individually.

Admission into the Hospital

Data gotten showed that most of the respondents had unpleasant experiences with the admission process due to the stress they went through. The data also revealed that UCH had been known and labeled as a place with so much stress as expressed by one the relatives.

One of the respondents had this to say:

You know UCH na for their stress, do this, go there, do that. When you think you have completed everything, another person might even come and say you have not done this one. That's the normal routine in UCH, the palaver (IDI/Female/43 years/Relative).

Although most of the respondents who were relatives expressed that the admission process was stressful, there were some, mostly patients who did not see it as stressful.

According to one of them:

When I got here I got card and I was at the emergency unit and they came to me to know what's wrong with me. The process was not stressful, not at all (CS/Male/27 years/Patient).

Health Workers-Patients Relationship

Data revealed that doctors had a good rapport as patients and their relatives spoke positively about them, whereas, they had issues with the way the nurses behaved.

One of the respondents reported that:

It's not that good, I won't lie. Because that night we were asked to take another drip, the nurse at the emergency refused to take the drip until morning when another person came. Because she was restless, even when the nurse removed the drip blood was gushing out nobody came. They said we should go and get admission pass, go and get this, we got everything ready. They didn't come until maybe in the night that was when another doctor now came to fix it. Even before she came me I've already fixed it because I know some little things about it (IDI/Female/30+ years/Relative).

One of the respondents who perceived the nurses negatively stated thus:

The nurses are mannerless, when it comes to communication, especially the auxiliary nurses, they behave nonchalantly each time. They prefer giving attention to the rich patients (IDI/Relative/Male/52 years/Relative).

Although, majority of the respondents expressed the fact that doctors have a better relationship with them unlike the nurses, a respondent had a different opinion about the doctors too.

A relative opined that:

Even some doctors, before they became doctors, maybe that was what they taught them in their school, that so far as you are a medical doctor you are above everybody. They see themselves as demi gods and we need to worship them and they talk to the patient anyhow, some of them are kind, gentle, caring. When you see some people you'll even feel bad, it will even worsen their situation (IDI/Female/43 years/Relative).

The way and manner doctors and nurses relate with the patients also affects not just the patient's perception of them, but also their psychology and could lead to negative health outcomes.

One of the respondents shared his experience thus:

The last time I came, I gave a nurse wearing white skirt and blouse my letter. But when we came here today, they said that they did not see our letter again. They made me to be confused and I took my phone to call the doctor who is a member of my church to tell her that this is what we met. Then she told me to meet a doctor that the doctor will connect me to the person that will attend to me (IDI/Male/40 years/Patient).

The data also revealed that some of the respondents had no reservations against the doctors and the nurses but saw them as good.

One of them reported that:

The doctors and nurses are good, loving and easily approachable. The nurses are good and the doctors are superb. They are very wonderful (IDI/Male/31+ years/Patient).

Generally, both patients and relatives' experiences of their relationship with the health professionals are similar. Both categories of respondents rated the doctors as having better relationship with them, whereas the nurses were spoken ill of due to their attitude.

Communication of Treatment Information

Results from the study showed that there was adequate dissemination of information that patients and relatives were supposed to know as regards their care. However, it was deduced from the responses that doctors were perceived as more efficient in communication and dissemination of treatment information.

One respondent stated that:

Even if I'm not in the ward, doctor would have dropped anything or lab test, even when he sees me outside, he'll tell me he has dropped some things and I should make enquiry about them. So, they do that very well (IDI/Female/21 years/Relative).

Nevertheless, incomplete treatment information is a challenge some people tend to face. One of the respondents had this to say:

They passed across some information to us but when they discharged her from the ward it was not that good. It was just sudden. We were not told what she'll be eating, what we were supposed to do. It was me and my husband that had to go on net to start googling and asking from our doctor friend, that was how we got how to treat her. After she was discharged from the ward, we were not told anything (IDI/Female/30+ years/Relative).

While it is expected that the doctors and nurses give the patients and their relatives all possible information they need, the doctors may not be able to remember all information. The onus then lies on the patient to ask questions about what should and should not be done.

One relative said:

When you are not clear about something you ask, some of the patients they don't even know their rights, they don't even ask questions. They are supposed to ask questions from the doctors and nurses even if they shout at you; you can still come back when you see that the person is calm. These people they are not even God, they also have their own challenges (IDI/Female/43 years/Relative).

Referral Service

Result from the data reveals that referral system is very strong and important in our society. We see lay referrals in action and this result from their experiences or what they've heard; we also see professional referrals taking place, from one hospital to another and within the same hospital, from one unit to another. The data also revealed that majority of the patients got there through lay referrals. One of the respondents stated that:

Someone actually told my dad's brothers that UCH was a good hospital and that he should be brought here (IDI/Relative/Male/19 years/Relative).

Data revealed that some of the respondents went through professional referral from another hospital to UCH because UCH had a better chance of restoring their health. One of the respondents reported thus:

My doctor referred me here when he couldn't continue with my state of health (CS/Male/73 years/Patient).

Additionally, within the university college hospital, referrals were being made from doctor to doctor and from one unit to another. While a respondent described the process as stressful, another saw it otherwise saying that it did not take long for the process to be completed. A male respondent stated thus:

Sometimes we move from one person (doctor) to another or from one place to another and it is stressful. Everything about UCH is stressful (IDI/Male/26 years/Relative).

On the other hand, another relative reported that:

We were in another department; I don't know the name of the department before we were referred to neuro. The process did not take long. We first of all went for some tests then we came to neuro (IDI/Female/26 years/Relative).

Support Service

The data shows that majority of the respondents were okay with support services such as their experiences at the laboratory and the pharmacy.

One of the respondents said:

The experience at the laboratory was not stressful. They asked us to pay, we paid, then later they now gave us the date that we are going to come and collect the result. The pharmacy is not stressful (IDI/Female/26 years/Relative).

To a very large extent, an individual has to wait to get results for test conducted and most of the results cannot be gotten immediately. The period of waiting could range from a few minutes, to hours and even to days, depending on the type of test and work load of the laboratory. While the experience at the laboratory and pharmacy is described as good, we see respondents being particularly concerned about the time they get to spend waiting. One of them said:

In UCH, for everything you just have to wait, wait, wait, wait, wait. You just have to wait. Is there any choice? We don't have any choice.... About the laboratory, when you get specimen, they'll have to pile it up. They will tell you, come back in an hour time and you go back in three hours but they'll say it's not ready (IDI/Female/30+ years/Relative).

Another respondent who got immediate response had something else to say:

For the lab test, they answer us immediately but it is the procedures that is quite stressful (payment, running around and all) (IDI/Male/30 years/Relative).

Also, in addition to the fact that long waiting time is characteristic of the UCH, the study revealed that some of the respondents buy their drugs from outside as they are not available at the university college hospital pharmacy. A respondent reported thus:

Sometimes I buy the drugs outside because there is nothing like drug here. Once you know the drug to use, you can buy them outside (IDI/Male/41 years/Patient).

Post-Hospital Rehabilitation Program or Plan of Action

The survey shows that most of the respondents do not have a plan of action. Almost all of the respondents believed that they or their relative will be well before leaving UCH, thus they do not have a plan for post-hospital rehabilitation. This may perhaps, be due to the nature of the ailment presented at the hospital.

According to one of them:

I don't have any because I believe that anybody that has sickness and come to UCH will receive treatment and will be hale and hearty (CS/Male/73 years/Patient).

Their lack of plans for post-hospital rehabilitation is influenced by the improvement in the health of the patient. A relative said:

When we brought her here, she couldn't talk and walk but now she speaks well and she can also walk (IDI/Male/30 years/Relative).

Nonetheless, there are some of the respondents that have embarked on post-hospital rehabilitation and thus shared their experience.

One of them stated:

We have a physiotherapist and a speech therapist attending to him at home and they are doing well. They keep an appointment and they don't miss it (IDI/Female/21 years/Relative).

Family Member Involvement in Treatment

Result from the survey shows that the families of the patients are actively involved in the treatment of the patient through their financial, physical, emotional and psychological support. A respondent stated:

There are other people. His brothers are helping in every way they can. I wish I had income of my own I would have contributed; at least I'm the one that brings him to UCH (IDI/Male/19 years/Relative).

The data also revealed that for some of the patients, family member involvement in the treatment goes beyond the immediate family:

A respondent had this to say:

As you can see everybody is here, in fact we are not even enough, only him there are 6 persons here (IDI/Female/21 years/Relative).

Cost of Treatment

The data shows that perceived cost of treatment is relative depending on several factors such as the individual's financial standing, the importance they place on the health of the patient, their expectation of the amount they thought they would be asked to pay, whether they are on NHIS and discount because the parent works there; while for some, the cost is okay in comparison to other hospitals they've been to. Thus, some of the respondents regarded the cost of treatment as being okay.

A relative reported that:

Well, the only thing I know is the treatment is okay. The amount I'm paying is worth the treatment (IDI/Male/37 years/Relative).

On the other hand, some of the respondents saw the treatment at the UCH as very expensive.

One respondent said:

Everything here is so high o. Those that don't have anything cannot even come to UCH because if you want to do a test, test of #500 before is now #3,000 (IDI/Female/43 years/Relative).

Also, from the data gathered, relatives perceived the cost of treatment as expensive while for patients it was okay. Some of them opined that though the treatment is very expensive there is nothing they can do about it and they don't have a choice than to pay. Although for them it was not easy paying for something that is not profitable.

Discussion of Findings

The study found that patients and their families experienced both good and bad things, but that patients' opinions are different from those of their relatives. This is consistent with Normand's (2009) assertion that patients' experiences may vary from those of their relatives' because family caregivers often experience greater financial, emotional, physical, and psychological strains as a result of providing care for a sick relative, and these experiences have a significant impact on the treatment's outcome.

According to the report, the majority of the respondents experienced an extremely trying entrance process. This supported the findings of other studies that discovered that patients often experienced long wait times and brief consultations (Aldana et al., 2001; Rahman et al., 2002; Adepoju, 2018). Result gotten revealed that doctors had a better relationship with their patients which is evident in the testimony of some of the patients as they described the doctors as caring, gentle, kind and having good rapport. These results corroborate Brock & Salinsky's (1993) claim that empathy and good communication abilities are necessary for developing a productive and trustworthy connection between doctors and patients. While doctors are reported to have better empathy and communication skills, it can be assumed ab initio that factors such as different work stress account for the differences of experience by patients and relatives from the different professional groups such as doctors and nurses. According to Brandon & Mullan (2011), it is crucial to communicate treatment information since it gives patients time to mentally prepare. Because respondents valued it when health professionals gave them all the information they required, their claim is supported by the study's findings.

Furthermore, referrals came from close friends, family members, and medical professionals. Medical personnel assisted medical referral to the UCH and the neurological section. This result supports the findings of Grumbach et al. (1999), who discovered that primary care physicians or medical groups either helped or hindered patients' ability to see a specialist, and where the patients felt that the referral had aided their diagnosis and treatment and resulted in a significant difference in their health; O'Keeffe, et al. (2021) recorded referral delays. Additionally, aside from the time spent waiting to be attended to and the lack of medication, patients and their families usually had positive experiences with support services including the laboratory and pharmacy. According to Israr et al. (2016), patients' top complaints were the length of time it took to complete testing and their difficulty to obtain medications from the hospital. On the other hand, O'Keeffe, et al. (2021) noted difficulties in accessing services.

The majority of patients also chose not to participate in post-hospital rehabilitation, largely because of their better health and their trust in UCH. However, some of the responders said that post-hospital rehabilitation had already started. It has been demonstrated to enhance physical performance, mobility, and quality of life, reduce disability, and is similar to the study by Shyu et al. (2013). Similar to Hudson & Payne (2008), these findings corroborated their assertion that family members interested in the care of their relatives can comprise a wide variety of ties, including blood relatives, spouses/partners, sons/daughters-in-law, acquaintances, neighbours, and others. This conclusion is supported by Haley's (2003) assessment, which said that they serve as a crucial adjunct to other official health care services while managing a wide range of tasks. Furthermore, the lack of rehabilitation may be due to ignorance, lack of facilities or lack of resources to access them. However, what relatives do or the social support patients receive is part of rehabilitation but cannot be as efficient.

Additionally, while some patients thought the price was reasonable, others thought it was too high. Previous research also showed that the financial strain and cost of care were considerably more upsetting and problematic for family members than how the sickness affected their everyday tasks (Martyns-Yellowe, 1992; Ige, 1993). Reasons for this disparity between patients and their relatives could be because the patients are eager to return to a state of health and wellbeing not minding the cost involved.

Hugel et al. (2006) found delays in diagnosis to be common, and O'Brien et al. (2011) also found that patients and caregivers of amyotrophic lateral sclerosis experienced inadequate information. Among other things, this study revealed delays, long waiting times, and incomplete information as some of the experiences of patients and their relatives. The fact that the UCH is a tertiary referral hospital could be a major factor responsible for longer waiting time as more persons tend to visit the hospital. Lambe et al. (2003) for instance showed in their study that teaching hospitals, public hospitals and trauma centres have significantly longer waiting time. Other factors could be limited resources, inadequate staffing as well as high demand due to increasing illnesses as identified by Xie & Or (2017).

Conclusion and Recommendation

Although it seems like health professionals are working hard to deliver high-quality care, there is still room for improvement in the human relations department, which affects how patients perceive the value of the services received and, ultimately, how well treatments work out. Healthcare professionals should concentrate on providing patient-centered treatment that takes into account patients' perceptions and expectations. Healthcare professionals should have access to improved resources and receive frequent training in the necessary skills in order to improve their interactions with patients, which are the foundation of the experiences of both patients and their families.

Suggestions for Further Research

The study found that doctors had greater relationships with patients and their families than nurses did, despite the fact that the nurses' mission calls for them to be closer to the patients. Therefore, more research is required to identify the variables that contributed to doctors' proximity to patients being greater than that of nurses.

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Conflict of Interest

Authors have no conflict of interest.

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