

**HUMAN RELATIONS AMONG NURSES AT PAKISTAN
INSTITUTE OF MEDICAL SCIENCES, ISLAMABAD**



**A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF
THE REQUIREMENTS FOR THE DEGREE OF
MASTER OF PRIMARY HEALTH CARE MANAGEMENT
FACULTY OF GRADUATE STUDIES
MAHIDOL UNIVERSITY**

2004

ISBN 974-9664-57-4

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Thesis
entitled

**HUMAN RELATIONS AMONG NURSES AT PAKISTAN INSTITUTE OF
MEDICAL SCIENCES, ISLAMABAD**



Imran Hameed

Mr. Imran Hameed
Candidate

B. Keiwekarnka

Assoc. Prof. Boonyong Keiwekarnka
Dr.P.H.
Major-advisor

Veena Sirisook

Asst. Prof. Veena Sirisook
Dr.P.H.
Co-advisor

S. Smitasiri

Lect. Suttalak Smitasiri
Ph.D.
Co-advisor

Rassmidara Hoonsawat

Assoc. Prof. Rassmidara Hoonsawat
Ph.D.
Dean
Faculty of Graduate Studies

B. Keiwekarnka


Assoc. Prof. Boonyong Keiwekarnka
Dr.P.H.
Chair
Master of Primary Health Care Management
ASEAN Institute for Health Development


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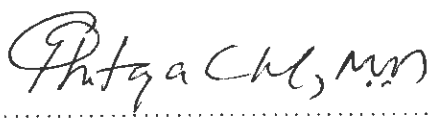
was submitted to the Faculty of Graduate Studies, Mahidol University
for the degree of Master of Primary Health Care Management


on
March 10, 2004

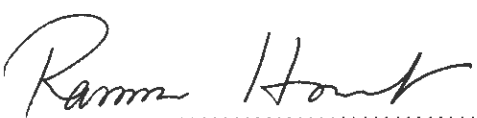

.....
Mr. Imran Hameed
Candidate



.....
Assoc. Prof. Boonyong Keiwkarnka
Dr.P.H.
Chair


.....
Asst. Prof. Veena Sirisook
Dr.P.H.
Member


.....
Assoc. Prof. Phitaya Charupoonphol
M.D., M.P.H.M., Dip. Thai Board of
Prev. Med.
Member


.....
Lect. Suttalak Smitasiri
Ph.D.
Member


.....
Assoc. Prof. Rassmidara Hoonsawat
Ph.D.
Dean
Faculty of Graduate Studies
Mahidol University


.....
Assoc. Prof. Boonyong Keiwkarnka
Dr.P.H.
Director
ASEAN Institute for Health Development
Mahidol University

ACKNOWLEDGEMENT

I wish to express my sincere gratitude to ASEAN Institute for Health Development, Mahidol University, Thailand, and Pakistan Institute of Medical Sciences, Islamabad, Pakistan, for providing me this opportunity to undertake the MPH M program.

This thesis would not have been possible without the help and support of many people. I would like to especially thank Prof Boonyong Keiwkarnka, my Major Advisor, for his profound help and guidance throughout the course. Prof Veena Sirisook, my Co-Advisor, for those long sessions of guidance and untiring advice as well as the support which made it possible for me to finish this thesis, and Prof Suttalak Smitasiri, my Co-Advisor for her help and kind advice. I would also like to express my heartfelt gratitude to all teachers and staff of AIHD, who taught us and shared their valuable experience with us during the MPH M course. I would like to particularly thank Mr Lerpong Wongsuthichoti for his humour and wit in the ASEAN House, Ms Sirilak Lyeskul for her support in the MPH M Office and Ms Chatchata Ruangkachorn for her help with travel and logistic arrangements.

I express my deep and sincere gratitude to all my friends and colleagues in the MPH M 18th Batch, especially my close friends, Mr Hussain Rasheed and Dr Eni Gustina for their support and companionship. Lastly I would like to thank my wife Dr Nazia, my daughter Maria and son Awais, for their support and sacrifice during the long period when I was away from home. I would like to dedicate this thesis to my father Mr Abdul Hameed Khan and my late mother Dr Edith Abdul Hameed for their profound love and faith in me.

Imran Hameed

HUMAN RELATIONS AMONG NURSES AT PAKISTAN INSTITUTE OF MEDICAL SCIENCES, ISLAMABAD

IMRAN HAMEED 4637984 ADPM/M

MPHM (PRIMARY HEALTH CARE MANAGEMENT)

THESIS ADVISORS: BOONYONG KEIWKARNKA, Dr.P.H., VEENA SIRISOOK, Dr.P.H., SUTTLAK SMITASIRI, Ph.D.

ABSTRACT

A cross-sectional study was conducted to assess the human relations among nurses working at the Pakistan Institute of Medical Sciences, Islamabad.

Two hundred and eighty one nurses were surveyed based on; listening skills, team work skills, decision making skills and the nurses' attitude towards human relations. Predisposing factors, such as socio demographic, family and work related factors, were also investigated. The data were gathered using a self administered questionnaire developed by the researcher using Hipple's Interpersonal Relationship Ranking Scale as a reference.

The results revealed that 58.7% of nurses had a high level of human relations. The team work skills were relatively high in 67.2%, communication skills in 61.2% and decision making skills in 55.9% of the respondents. A strong association was found between attitude and human relations (p -value < 0.001).

Chi square was used to determine the association between dependent and independent variables. The association between family income, and working hours and human relations were significant at p -value of < 0.001 , while the association between private practice and human relations was significant with a p -value of 0.006. The association between rank in the hospital and human relations was significant at p -value of 0.032. A strong association was also found between human relations, human relations before and after training, as well as lapse of relations after training, ($p < 0.001$).

KEY WORDS: HUMAN RELATIONS, NURSES, ATTITUDE

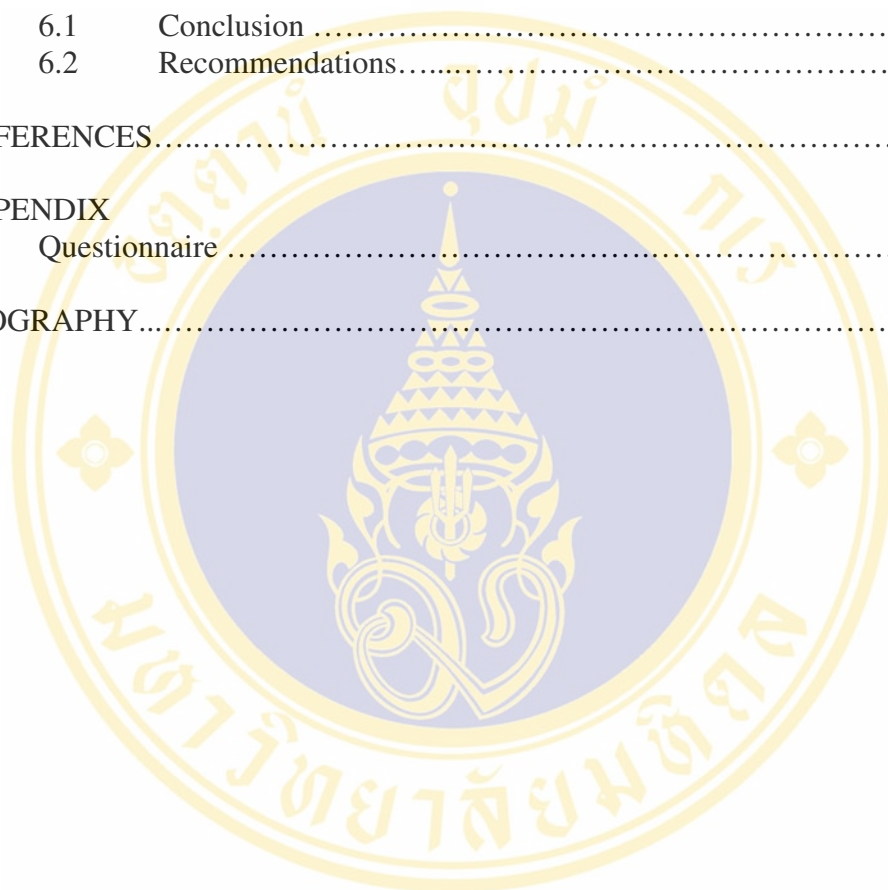
77 P. ISBN: 974-9664-57-4

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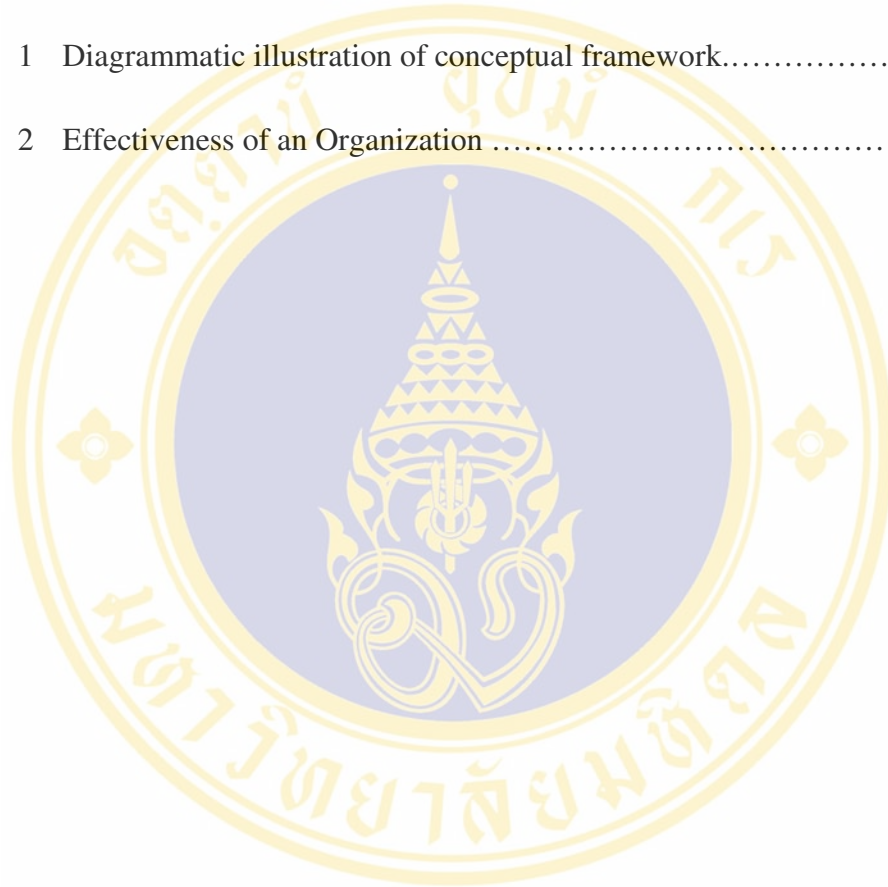


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LIST OF ABBREVIATIONS

DTCP	:	Development Training Communication and Planning
HRT	:	Human Relations Training
IRRS	:	Interpersonal Relationship Rating Scale
JICA	:	Japan International Cooperation Agency
MCH	:	Mother and Child Health Centre
NHS	:	National Health Service
PIMS	:	Pakistan Institute of Medical Sciences
Rs	:	Rupees
UNDP	:	United Nations Development Programme
WHO	:	World Health Organization

CHAPTER I

INTRODUCTION

1.1 Significance and justification

In the twenty first century, medical care has achieved high technological standards; nevertheless there is room for further improvement. One of the most important issues is human relations (1). In the race for state of the art technology, the consumer or patient has to pay a high price for health care, both monetarily as well as emotionally. “Patient” was previously considered as the tolerant, uncomplaining and long-suffering, person. Probably the term was coined by a physician to reflect the characteristics of an ill person. Instead these traits are the essential requirements of any good physician, himself. However the times are changing, as the population is increasing, and as frustrated patients have become angry consumers, the medical profession has started paying more attention to doctor-patient rapport. Hospitals now routinely survey patients on the quality of their care (2).

Pakistan Institute of Medical Sciences (PIMS) is a tertiary care institution located in Islamabad, the capital of Pakistan. It is a teaching institution and comprises of three teaching hospitals and four training institutions. There are approximately 1000 cumulative beds for indoor patients in the various clinical areas. A busy out patients department caters to over 3000 patients per day. To cater to these patients almost 2600 staff is employed on a regular basis by the institute in its various components (3).

Health care has seen many revolutions over the centuries. The 18th century has been dubbed as the symptom centered era, while disease was the focus of attention in the 19th century. The 20th century, was dedicated to clinical and community centered care. Whereas in Health for all in the 21st century, health care has reverted to the patient focused approach. WHO in the Health for All beyond the 21st century advocates the “patient centered approach” in health care. The World Conference

Supporting Health for All held in 1990, defined future developments in health to be human centered. A lot of emphasis was made on the investment in health, education and training as critical to human health resources. The shift in the patient load needs to be righted, but at the same time the patients' right to good health care with a humane attitude is to be ensured (4, 5).

Poor human relationship among medical personnel is a global phenomenon. According to a survey commissioned by the National Coalition on Health Care, a majority of Americans has lost confidence in the nation's health care system's ability to care for people. Nearly 8 out of every 10 Americans believe the quality of medical care is being compromised in the interest of profit. This highlights the role of health personnel's attitude towards the patients which can improve their image, win respect and appreciation (6).

Vanaja et al (1997), state that medical sociology, which deals with an interface between the providers of health and medical care services, is comparatively a new concept in Asia, while it has made head way in the West. Traditionally the eastern culture which was known for strong family ties and respect of elders, and inter cultural harmony seems to have been replaced by an impersonal and materialistic approach towards one another in the society. Illness behavior has been focused on symptoms, discomfort and other signs of organic malfunction. Patients are often attended impersonally and without respect for their emotions and feelings. This attitude, affects the patients adversely, as it does not conform to the old values they are used to (7).

Santhat Sermisri, a Thai medical sociologist, noted that Bangkok residents often bypass the first contact health centers and go directly to hospitals for primary medical care. This causes congestion and long queues in the outpatient departments and long waiting lists, particularly for low income people who need welfare or charity support (8). Sita Ram Devkota also observed that although Bangkok is well supplied by government hospitals, crowding, long waiting periods and brief, impersonal consultations commonly occur (9).

A similar phenomenon also afflicts the health system in Pakistan. Shahid Pervez Ansari (1998) found that only 47% of the study patients were satisfied with health care in Urban Islamabad while a majority appeared to be unhappy with the care provided. The dissatisfaction was mainly attributed to impolite manner of doctors and paramedical staff and lack of essential drugs. In a survey conducted at Pakistan Institute of Medical Sciences, over 58% of patients displayed dissatisfaction with the behaviour of the staff (10). Patient satisfaction and improved compliance can be achieved through better human relations. Patient-physician communication is essential for quality of health care. This is especially true where long term relationships are needed when chronic and long standing diseases are to be treated.

Previously the medical curriculum lacked human relationship as a core subject. Most health professionals were not taught about effective ways to communicate with patients. Health care professionals focused on scientific knowledge and clinical skills, and a good bedside manner was deemed admirable but not necessary. However, revised medical school curricula include training in effective two-way communication skills. Doctors trained under the earlier curricula, or those having poor bedside skills are often enrolled – usually at the insistence of attorneys or medical boards – in remedial classes in communication skills (11).

The curriculum for nurses has also undergone major modification over time and interpersonal skills are now taught to the nurses as a core subject. The importance of humanistic approach has been highlighted in various studies, and it is recognized as an integral part of all nurses' trainings. Since the origin of nursing care, humanistic values have been part and parcel of nursing profession, but since, the focus of hospitals has become patient centered the role of nurses in promoting enhanced humanistic care to the patient has gained importance. To augment the deficiencies in the nurses' skills, those who had been trained in the pre-interpersonal skills era, short term courses have been added to retrain them in humanistic skills. Most hospitals are incorporating these refresher training programs in their continuing medical education and continual professional development strategies (12).

Behaviour specialists have identified three areas of strengthening human relations: listening, team work and decision making. Listening attentively, to a patient takes away half of his pain and reassures him that he is in safe hands. This also dilutes anxiety and frustration in the patient and replaces it with consideration and understanding. Interaction with patients is necessary to involve them in their care, and to ensure that they cooperate and assist the physician in treating them (13).

Human Relations are important for the improved performance of the care providers in terms of patient satisfaction and compliance. The patients feel comfortable with a compassionate doctor with whom they can identify themselves and their needs are met. Therefore Human Relations Training in Pakistan Institute of Medical Sciences was introduced to make the hospital patient centered health facility in line with WHO strategy (14). The goal of the program focuses on three areas: teamwork, listening skills and decision making. These three components of communication cover most of the areas of health worker – patient dealing, there by ensuring improvement in quality of care of the patient.

Profs. Boone and Kurtz in 2001, identified determinants of interpersonal behavior as cultural, social, and family influences. These determinants of human behavior influence the individual's actions and attitudes towards behaviour and others as well as towards the society in general. Moreover subcultures can differ by race, nationality, age, religion, geographic distribution etc., social influences include values, attitudes, and behaviors that a group deems appropriate for its members, status, social class, opinion leaders or peers etc. Regarding family influences, they include the socio-economic background of the family, number of siblings and dependents, social and economic support, values, ethics and decision making styles within the family (15).

Human Relations have also demonstrated considerable benefits for some specific groups of patients. Exposure to different types of emotional states moulds the behaviour of individuals. Oncology patients with terminal illness, who are on long

term therapy, have a closer interpersonal bond with their physicians. They are emotionally as well as clinically dependent on the care providers. Their terminal state evokes emotional response in the care providers and they are closer to the patients. Elderly patients with chronic or long term debilities also need strong relationships with their care providers. This enables them to cope with their illness and medication more effectively. Similarly care of children with disabilities is a highly emotional work. Specially trained personnel provide these children and their parents, with emotional and physical support (16).

Bonnie W. Duldt (1985), in her *Humanistic Nursing Communication Theory*, deals with the phenomenon of interpersonal communication between nurses, clients, peers and colleagues. She maintains that it is psychologically, emotionally and professionally necessary for nurses to provide a humanistic care and attitude towards the patients. This is necessary for the continuation of their professional growth and patient satisfaction (17).

All health professionals need to have good human relation skills, however, it is more important for the nurses as they are in prolonged and intimate contact with the patients and their relatives. The patients are dependent on the nurses for nursing care and medical advice as the physician is not accessible most of the time. This is especially true for admitted cases as well as for acute emergencies when time is crucial, and the nurse is the most readily available health professional.

The human relationship needs also vary in different department and cases. All patients are in need of good interpersonal relations, certain cases need more careful handling. This is more important in specialized care areas, where understanding nurses are needed to handle critical care patients and their relatives in psychologically volatile state of minds like intensive care units, pediatric wards, terminally ill cases and trauma centers etc.

Although PIMS have implemented a Human Relations program for their staff, however, the level of the human relationship among the Nurses has yet to be

investigated. Therefore this study intends to study the level of the human relationship in the nurses working there, and to study its development, as well as its related factors.

Good interpersonal relationship skills in health care providers can benefit both the patient as well as the health service, by reducing resource utilization and affecting quick remedy of the suffering of patients. Based upon the findings of the study, the main outcome expected is a recommendation could be made to include human relations training as part of the curriculum of medical studies

1.2 Research Questions

As human relations are an important characteristic in health professionals, through this study some related questions would be investigated as the following:

What is the level of human relations among the nurses working at Pakistan Institute of Medical Sciences, Islamabad?

What is the relationship between human relations and attitude towards human relations?

How does human relations training and time affect the human relations of the nurses working at Pakistan Institute of Medical Sciences, Islamabad?

What are the relationships between human relations and socio demographic and family factors of the nurses working at Pakistan Institute of Medical Sciences, Islamabad?

What are the relationships between working conditions and human relations among the nurses working at Pakistan Institute of Medical Sciences, Islamabad?

1.2.1 General Objective

The general objective of this study is to determine the human relations of nurses in Pakistan Institute of Medical Sciences, Islamabad.

1.2.2 Specific objectives

In this study the specific objectives which are planned to be studied are:

- To determine the level of human relations among the nurses working at Pakistan Institute of Medical Sciences, Islamabad.
- To examine the relationship between attitude towards human relations and the human relations among the nurses working at the Pakistan Institute of Medical Sciences, Islamabad.
- To examine the effect of training and time on human relations among the nurses working at Pakistan Institute of Medical Sciences, Islamabad.
- To examine the relationship between socio demographic and family factors and the human relations among the nurses at Pakistan Institute of Medical Sciences, Islamabad.
- To investigate the relationship between working conditions and the human relations among the nurses working at Pakistan Institute of Medical Sciences, Islamabad.

1.3 Conceptual framework

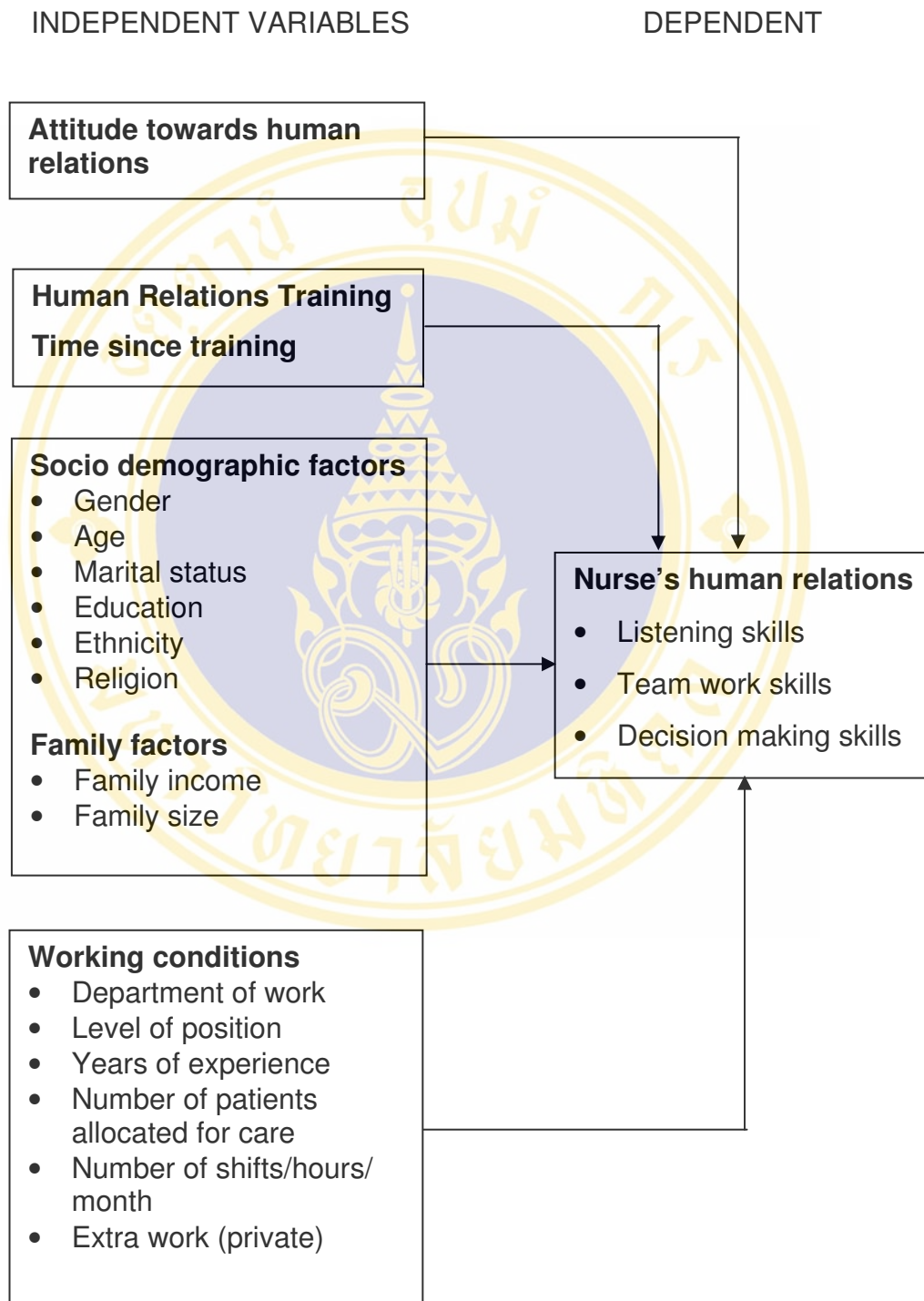


Figure 1: Diagrammatic illustration of the study conceptual framework

1.4 Operational definitions

Nurse's human relations are defined as interpersonal and inter-group adjustments. In this study, Nurse's human relations will include their, listening skill, teamwork skill and decision making skill.

Listening skill refers to the skills of the nurses to listen to their patients and other staff members with patience, without interruption and repetition of statements for clear comprehension. The listening skills will be classified as high or low level, depending on the mean of total score.

Teamwork skill refers to the ability of nurses to work in a team environment in the hospital. It includes leadership and the use of feedback in accomplishing common tasks. The skills will be judged as high or low level depending on the score being more or less than the mean.

Decision making skill refers to the nurses' involvement in making decisions in daily ward work. This includes participation in decision making process and voicing their opinion in decision making forums. The skill will also be classified as high or low level, depending on the mean of total score.

Attitude towards human relations refers to the general perception and affection towards human relations among nurses. It means how the nurses think and feel about working environment, relationship with others and how it can influence their work with patients and other staff.

Human Relations Training: refers to the specific Human Relations Training Program organized by the Pakistan Institute of Medical Sciences, Islamabad for their staff, including the nurses. It includes the three days training programme on team building, listening and decision making skills. This type of professional training has been conducted for the nurses since the past 2 years.

Time since training refers to the effect of time from the last Human Relations Training attended by the nurse, on her human relations. The time elapsed will be measured as training attended within last 6 months, between 6 and 12 months and earlier than 12 months.

Marital status: refers to the marital state of the nurse and is categorized into single (never married), married, divorced (separated), and widowed.

Education refers to the level of highest education attained by the respondent nurse. The level is classified as under graduate, graduate and post graduate levels.

Ethnicity refers to the region of origin of the family of the nurse and is classified as Punjabi, Pathan, Sindhi and Baluchi.

Family income refers to the family total monthly income, including the nurses' salary and is categorized into four groups; corresponding to gross family income less than 20,000, 20,000 to 30,000 and over 30,000 Rs per month.

Family size: refers to the number of Nurse's family members living together. This is categorized into small and large family size corresponding to up to 4, and 5 or more members.

Number of patients allocated for care refers to the number of patients assigned to the care of a nurse in each day and are classified as; less than 20, 21 to 30, and more than 30.

Number of shifts/hours/month: refers to the three shifts of duty. These include morning and evening shifts of 6 hours duration from 8 am to 2 pm, 2 pm to 8 pm and night shift of 12 hours from 8 pm to 8 am the next day. These will be classified as: Regular; up to (6 hrs x 25 days) = 150 hours, and Over worked if more than 150 hours in a month.

Private practice refers to the extra jobs or temporary work outside the hospital, undertaken to supplement monthly salary by the nurse. This will be classified into two categories: currently working in the private sector and ever worked in private sector.

Currently working in private sector means that the nurse is presently working in any private clinic at the time of the interview, in addition to the regular hospital employment.

Ever worked in private sector means that the nurse had any time worked in the past, or is at present working in the private sector as a nurse.

Years of experience refers to the time spent in the nursing profession calculated in number of years of employment at the Pakistan Institute of Medical Sciences, Islamabad. In this study it is classified into less than 5 years, 5 to 10 years and more than 10 years.

Level of position refers to the designation of the nurse; that is staff nurse, head nurse or charge nurse, as classified by the hospital policy.

Department of work refers to the department in the Pakistan Institute of Medical Sciences, Islamabad, the nurse is assigned to, like administration, medical, surgical, intensive care areas, outpatients, pediatrics, operation theater, gynaecology, etc.

1.5 Limitation of the study

Multiple data sources are an identifying feature of behavioral study research (Grosser, 1990 and Eisenhardt, 1989) however the major reason for this is to provide triangulation of data when testing hypotheses. Since this research is descriptive study of behavior, the use of multiple data collection methods is not planned thus it may not

provide a more complete picture of the organisation being studied. The respondents may be influenced by the collection of the questionnaire by a senior staff member (18, 19).

Measurement of change in the personal growth of an individual or a group due to human relations training is a very difficult task. Many standardized personality instruments are too technical and unwieldy to use in research or training. The Interpersonal Relationship Rating Scale (IRRS) was developed by John L Hipple, specifically to meet the special needs of human relations training and is designed to test for outcomes in personal growth experiences (20). A specially tailored questionnaire has been designed to test the influence of specific skills imparted to the nurses using the Likert's rating scale (21). However more detailed studies need to be devised to fully understand the impact of this training on the individuals

In this study cross-sectional design was used to examine the changes or any development that we may have expected. This was due to the limitations of time constraints.

Scope of the study

Since this study was conducted at Pakistan Institute of Medical Sciences, the findings of this research may not be generalisable to all of health professionals as a whole, as the structure and culture of Pakistan Institute of Medical Sciences, is rather unique.

It is also possible that this investigation will not be generalisable to other hospitals in the country, since hospital being studied is the biggest and busiest. Other hospitals are much smaller and do not experience problems to the same extent as the larger hospital. It is also possible that these smaller hospitals experience problems that are unique to their type of setup which would not be reflected in the research in Islamabad.

CHAPTER II

LITERATURE REVIEW

2.1 What are human relations

Human relations are the study of how people get along with one another. Whenever people come in contact with one another on a personal or professional level, human relations are at work. The goal of human relations is to help people associate with one another in positive ways. When good human relations are practiced, people feel good about themselves. They can work together better, and they can accomplish more in their personal lives and in their jobs. Like so many other skills, human relations are something one learns. From the day one is born, one learns how to get along with others. One learns by experience that some things make people happy and other things make them sad or angry (22).

2.2 Human relations between nurses and patients

Human relations between nurses and patients are attracting an increasing amount of attention within health care studies. In the past two decades descriptive and experimental research has tried to shed light on the communication process during medical consultations. However, the insight gained from these efforts is limited. This is probably due to the fact that among inter-personal relationships, the nurse-patient relation is one of the most complex ones. It involves interaction between individuals in non-equal positions, is often non-voluntary, concerns issues of vital importance, is therefore emotionally laden, and requires close cooperation. While sophisticated technologies maybe used for medical diagnosis and treatment, inter-personal communication is the primary tool by which the health care provider and patient exchange information (23).

Certain aspects of nurse-patient communication seem to have an influence on patients' well being, for example satisfaction with care, adherence to treatment, recall and understanding of medical information, coping with the disease, quality of life and even state of health (24).

To understand more fully why communication between nurses and patients is such a powerful phenomenon, it is important to look at:

- (i) the different purposes of medical communication;
- (ii) the analysis of nurse-patient communication;
- (iii) the specific communicative behaviours displayed during consultations;
- (iv) the influence of communicative behaviours on certain patient outcomes.

2.3 Nurse-Patient communication

Three different purposes of communication between nurse and patients can be distinguished: creating a good inter-personal relationship, exchanging information and making treatment decisions.

Creating a good inter-personal relationship

Creating a good inter-personal relationship between health care provider and patients can be seen as an important purpose of communication (25). Roter and Hall (26) state that “ ... talk is the main ingredient in medical care and it is the fundamental instrument by which the nurse-patient relationship is crafted and by which therapeutic goals are achieved”. From this viewpoint, a good inter-personal relationship can be regarded as a prerequisite for optimal medical care.

Communication researchers differ in opinion on how to define good interrelationship. Some authors refer to this relationship as mainly social relationship where 'good manners' are most important. Necessary 'ingredients' are: laughing or making jokes, making personal remarks, giving the patient compliments, conveying

interest, friendliness, honesty, a desire to help, devotion, a non judgmental attitude and a social orientation (27, 28).

Other authors having a more clinical/psychotherapeutic background claim that the importance of a good nurse-patient relationship is determined by its therapeutic qualities. Irwin et.al. (29) see clinical medicine as communication between two people aiming to establish or sustain an effective working relationship in which mutual trust exists. Many of these concepts used by these psychotherapeutic researchers are based upon Carl Rogers' "client centered" theory. He distinguished basic 'core conditions' which are crucial to the efficacy of the therapy: empathy, respect, genuineness, unconditional acceptance, and warmth (30, 31). Empathic nurse-patient relations consist of: eliciting feelings, paraphrasing and reflecting, using silence, listening to what the patient is saying, but also to what he is unable to say, encouragements and non verbal behaviour (32).

Roter and Hall (26) call 'mutuality' a relationship that exists between health care provider and patient, in which the two share in the decision making process. The care provider plays the role of an interpreter and synthesizer, and accounts for 10% of the medical talk (33). Roter et al., point out that "little attention has been given to this type of statements in the literature, but they may be critical markers for a relatively more egalitarian exchange ...". The growing number of publications concerning 'shared decision-making' can be seen as a result of a growing interest in physicians and patients as equal 'partners' in the relationship.

Exchanging information

Another main purpose of medical communication is promoting the exchange of information between the physician and the patient. Information can be seen as a resource brought to the verbal interactions by both parties. The exchange of information consists of information-giving and information-seeking (33).

From a medical point of view, doctors need information to establish the right diagnosis and treatment plan. From the patient's point of view, two needs have to be met when visiting the doctor: 'the need to know and understand' (to know what is the matter, where the pain comes from) and to 'the need to feel known and understood' (to know the doctor accepts him and takes him seriously). In order to fulfill doctors' and patients' needs, both alternate between information-giving and information-seeking. Patients have to impart information about their symptoms, doctors need to actively seek out relevant information. Once the diagnosis and treatment plan has been established, doctors have to efficiently impart this information to their patients. Patients' 'need to know and understand' may lead to additional information-seeking about what has just been told (34).

Several studies report that the desire to seek information is great. Blanchard et al., (35) for example, found that 92% of the interviewed cancer patients desire all information about their disease, good or bad. When informing cancer patients about their disease, doctors may define medical information objectively (type of disease, its stage, type of treatment) while patients define it in terms of its personal relevance (will I fully recover? How much pain will I have?). As a result, the physician may feel he has given precise and relevant information, the patient on the other hand may feel he has learned nothing new (36).

A recent study showed that 47% of cancer patients reported that no information had been given about handling of their disease, although majority desired this information. Physicians should therefore first encourage their patients to discuss their main concerns without interruption (37).

Making treatment decisions.

Another purpose of medical communication is to enable physicians and patients to make decisions about treatment. Traditionally the ideal physician-patient relationship was paternalistic; the doctor directs care and makes decision about treatment. During the past two decades, this approach has been replaced by the ideal

of 'shared decision-making' (38). It appears logical that in order to make such decisions, patients need information. However, most studies report, that although patients are keen on having all possible information about their disease, they prefer the treatment decision to be taken by the doctors.

Blanchard et al., (35) found that the majority (92%) of hospitalized patients preferred all possible information to be given (either good or bad) but only 69% preferred to participate in treatment-related decisions. Of those wanting all the information, almost one fourth preferred a more authoritarian relationship with their oncologist. Results from a similar study showed a trend toward increased information seeking with increased preference for participation in treatment decisions. Many of the interviewed patients actively sought information, however, 63% felt the doctor should take primary responsibility in the decision-making process. Only 10% felt that they themselves should have major involvement. Another recent study indicated that women who are newly diagnosed with breast cancer prefer to entrust control over treatment to their physician (39).

Medical decision making seems especially difficult where clinical trials are concerned. In a study by Siminoff (40), it was found that 82% of breast cancer patients made final decisions about the treatment. Doctors were very clear about their own treatment preferences. Overall, patients followed these recommendations. However, only 45% of the trial-eligible patients chose to enter offered trials. It appears that physicians do not communicate recommendations for clinical trials as effectively as non-trial treatments.

2.4 Humanistic Nursing Communication Theory

Bonnie W. Duldt, Ph.D., R.N., in her Humanistic Nursing Communication Theory, describes the Phenomenon: Interpersonal Communication Between Nurse & Client, Peers and Colleagues, as follows:

Assumptions derived from philosophy (from humanistic and existential thought):

1. Human beings exist here and now--from which there is no escape.
2. Human beings are concerned with existential elements: being, becoming, choice, freedom, responsibility, solitude, loneliness, pain, struggle, tragedy, meaning, dread, uncertainty, despair, and death.
3. All elements of existential beings are the communication imperative and salient issues to be dealt with in critical life situations.
4. Growth and change arise from within the individual and to a considerable degree depend upon one's choice
5. The nurse shares with the client all the characteristics of being human.

Assumptions derived from communication:

1. Survival is based on one's ability to share feelings and facts about the environment and ways of coping.
2. The environment is a "booming, buzzing" world of strange sensations that must be sorted out to determine which are the most important; this sorting is achieved through communication with other people.
3. The need to communicate is an innate imperative for human beings.
4. Due to innate fallacies, human beings use and misuse all capabilities, especially the ability to communicate.
5. The way in which a person communicates determines what that person becomes.
6. Interpersonal communication is a humanizing factor that is an innate element of the nursing process (assessment, planning, intervention, and evaluation) and of the communication that occurs between nurses and clients, and nurses and professional colleagues.
7. Evaluation of a person's own communication skills is subjective; each individual must make his own decisions and choices about communication behavior and choose to change, depending upon his ability to utilize feedback.

Assumptions derived from nursing:

1. The purpose of nursing is to intervene to support, to maintain, and to augment the client's state of health.
2. A human being functions as a unique, whole being responding openly to the environment.

Specific assumptions to this theory:

1. Health, satisfaction and success in a person's life and work--in other words, that person's state of being--is derived from feeling human.
2. Due to the bureaucratic and complex nature of the present health-care delivery systems, there is a tendency for clients and professionals to be treated in a dehumanizing manner and to relate to one another in a dehumanizing manner.
3. Humanizing patterns of communication can be learned and can enhance the nurse's awareness of a sensitivity to the client's state of being and of becoming.
4. The goal of the humanistic nurse is to break the communication cycle of dehumanizing attitudes and interaction patterns, replacing these with attitudes and patterns that humanize.
5. Interpersonal communication is the means by which the nurse becomes; increasingly sensitive to and aware of the client's state of being, of the dynamic relationship between the client and his or her environment, and of the client's potential.

Concepts:

1. Human Beings. Man is a living being capable of symbolizing, perceiving the negative, transcending his environment by his inventions, ordering his environment, striving for perfection, making choices, and self-reflecting.

Characteristics of humans:

- a. Living: able to function biologically and physiologically as an animalistic, viable entity.

- b. Communicating: able to label things and to talk about them when they are not present.
 - c. Negating: able to talk about the symbolic negative (-1, no, none, not), make rules (laws regarding the “thou shalt not’s”), worry about what may not happen, and consider one’s own non-existence.
 - d. Inventing: able to be aware of, know, and do things beyond his or her relationship to the environment.
 - e. Ordering: able to develop categories and hierarchies according to some value or theme; gives structure and system to one’s environment.
 - f. Dreaming: able to dream of how things could be if all were perfect; expectations, hopes for the future.
 - g. Choosing: able to consider numerous alternatives, implications for the future.
 - h. Self-reflecting: able to think about and talk about self, reflect on one’s own behavior and understand self, body, behaviors, etc. Conscious of the existential elements (see Assumption #2).
2. Roles: positions in society.
- a. Nurse: a human being who practices nursing, intervening through the application of the nursing process to develop a plan of nursing care for a specific client or group of clients. The nurse possesses special educational and licensure credentials as required by society.
 - b. Client: a human being who is experiencing a critical life situation, potential or actual. He or she has need of the services of the nurse and is the focus of the nursing process. The client can also be seen to include the support system of family, friends, and so on.
 - c. Peer: a nurse having equal standing or status to another nurse.
 - d. Colleague: a member of another profession with whom nurses coordinate and collaborate in the practice of nursing--that is, physicians, administrators, and members of health care professions and community service agencies.

3. Nursing: the art and science of positive, humanistic intervention in the changing health status of human beings interacting in the environment of critical life situations. Its elements are communicating, caring, and coaching.

4. Nursing Process: consists of

- a. assessing and diagnosing,
- b. planning
- c. implementing, and
- d. evaluating.

5. Health: one's state of being, of becoming: of self-awareness. It is indicative of one's adaptation to the environment.

6. Environment: One's time/space/environment context.

7. Critical Life Situation: a situation in which there is a perceived threat to one's health state, in which one's existential state of being is salient, as in cancer, childbirth, accidents, and so on.

8. Communication: a dynamic interpersonal process involving continual adaptation and adjustments between two or more human beings engaged in face-to-face interactions during which each person is continually aware of the other(s). Communication is a process characterized by being existential in nature, involving an exchange of meaning, concerning fact and feelings, and involving dialogical communing. Two dimensions of communication are the

- a. attitude with which one communicates and
- b. skills or patterns of interaction one uses to communicate.

9. Humanizing communication involves an awareness of the unique characteristics of being human. Dehumanizing communication ignores the unique characteristics of being human.

Table 1: Continuum of Attitudes

Humanizing	Dehumanizing
Dialogue	Monologue
Individual	Categories
Holistic	Parts
Choice	Directives
Equality	Degradation
Positive Regard	Disregard
Acceptance	Judgment
Empathy	Tolerance
Authenticity	Role-playing
Caring	Careless
Irreplaceable	Expendability
Intimacy	Isolation
Coping	Helpless
Power	Powerless

Source: Bonnie W. Duldt; Humanistic Nursing Communication Theory.

10. Patterns of interactions or skills:

- a. **Communing:** Dialogical, intimate communication between two or more people; the heart of humanistic communication.

Listening: is the core of communing and involves making a conscious effort to attend to what another person is saying, particularly to expressions of feelings, meanings, and perceived implications.

Relationship Statements

The central tripod of communing is trust, self-disclosure, and feedback. Trust is one person relying on another, risking potential loss in attempting to achieve a goal, when the outcome is uncertain; and the potential for loss is greater than for gain if the trust is violated. Self-disclosure is risking rejection in telling how one feels, thinks, and so on, regarding “here and now” or existential events.

- b. Assertiveness: expressing one's needs, thoughts, feelings or beliefs in a direct, honest, confident manner while being respectful of other's thoughts, feelings or beliefs; "asserting with authenticity".
- c. Confrontation: providing feedback about another plus requesting a change in his or her behavior; "confronting with caring".
- d. Conflict: requires a decision over an issue in which there is risk of loss as well as possible gain, in which two or more alternatives can be selected, and in which one's values are involved; "conflicting with dialogue."
- e. Separation: occurs at the end of a relationship due to change, choice, or outside commitments; "separation with sadness."

Relationship statements

1. The degree to which one receives humanizing communication from others, to that degree one will tend to feel recognized and accepted as a human being.
 - a. While applying the nursing process, the degree to which a nurse is able to use humanizing communication, to that degree will the client, peer, or colleague tend to feel recognized and accepted as a human being.
 - b. In a given environment, if a critical life situation develops for a client, to the degree the nurse uses humanizing communication attitudes and patterns while applying the nursing process, to a similar degree will the health of the client tend to move in a positive direction.
2. To the degree that trust, self disclosure, and feedback occur, to that degree humanizing communication or communing also occurs.
3. In the event one tends to experience dehumanizing communication--that is, monological rather than dialogical communication, categorical rather than

individualistic, and so on--then one tends to move outward (on the model) to the next pattern of interaction.

4. In an interpersonal relationship of trust, self-disclosure, and feedback, to the degree that dehumanizing communication attitudes are expressed by another, to that degree one tends to use assertiveness as a pattern of interaction.

5. To the degree that assertiveness tends not to re-establish trust, self-disclosure, and feedback, and to the degree that dehumanizing attitudes are expressed by another, to that degree one tends to use assertiveness as a pattern of interaction.

6. To the degree that confrontation tends not to re-establish trust, self-disclosure or feedback, and to the degree that dehumanizing communication attitudes continue to be expressed by another, to that degree one tends to use conflict resolution as a pattern of interaction.

7. To the degree that conflict tends not to reestablish trust, self-disclosure, and feedback, and to the degree that dehumanizing communication attitudes continue to be expressed by another, to that degree one tends to terminate the relationship by separation.

8. To the degree that humanizing communication attitudes occur in a relationship, in the event of separation, the relationship can be resumed to the same degree of closeness regardless of the separation.

9. To the degree to which a nurse uses humanizing communication, to that degree will be nurse receive humanizing communication from others--clients, peers, colleagues, and leaders.

10. To the degree that one is aware of one's own choice (and motives) about interaction patterns, to that degree one is able to develop communication skills

and habits which tend to have predictable results in establishing, maintaining and terminating interpersonal relationships.

Evaluation

1. Parsimony: Duldt's theory is organized into consecutive elements. The elements are devised into subsets so that the assumptions are grouped with the discipline from which they are derived. The concepts' definitions are clear cut and to the point. The assumptions, concepts and relationship statements are all interlocking and relevant. As new concepts are introduced, they have importance in supporting her theory. The structure of the relationship statements in conjunction with the models offers a vehicle for statistical analysis and research designs. The relationship statements that she uses are in the form of correlation, deterministic or probable statements.

2. Scope: Duldt's theory is a paradigm variation of the "I-Thou" theory by Buber, and of the Humanistic Nursing Theory by Pattern and Zderad (41). It differs in the following ways:

- a. It defines the human being as applicable to nursing practice.
- b. It provides easily testable relationship statements that are clearly stated.
- c. It provides a structured body of knowledge that can be implemented into the educational cognates of a nursing education program.

Duldt's theory is generalized in scope, not to say that it is simple. It is broad so that it can cover the area of communication. The specifics in her model speak to the nurse and some other person (specifically, nurse-client, nurse-peer, and nurse-colleagues) and their interactions. The concepts are Operationalized in such a way as to provide a simplified means of testing and measuring abstract ideas (41 - 57).

3. Limitations: This interpersonal communication theory is primarily applicable to relationships between two or three people, i.e., dyads or triads. Thus, it is believed applicable to the nurse-patient and perhaps a family member such as a parent or

spouse. It is not applicable to groups, organizations or systems; this limitation is typical of existential and symbolic interaction philosophical perspectives.

4. Applicability: Duldt's theory provides a perspective of communication which can be useful in all situations in nursing practice. The theory aids the nurse in coping with the negativity experienced in the practice of nursing. This nursing theory can be utilized in conjunction with other nursing theories to provide a unique perspective of the communication dimension of interpersonal interactions.

Duldt's theory is realistic in that it recognizes the dehumanizing aspects of communication with nurses, clients, and others. Her theory is an "is" rather than a "should be" theory. It provides the nurse with an option for escape from negative patterns of communication and the potential to change relationships into humanizing interaction patterns and attitudes. While Duldt's theory is easily understandable for clinical nurses, it is not widely used presently; it is relatively new and warrants further research for supportive for data.

Referring to the GRID, Duldt's adaptation of the definition of human beings in relation to the nursing process can be implemented into the curriculum of professional nursing.

The Manual for using the Nursing Communication Observation Tool (NCOT) has been published giving directions for collecting data for education, assessment and research purposes. The tool is validated by congruence of judgments of trained observers. The tool is based on the well known Interaction Process Analysis by Professor Robert F. Bales of Yale University.

5. Generalizability and agreement with known data: Duldt's theory, which fits in the symbolic-interaction model, pulls from disciplines other than nursing and utilizes these concepts to build this theory. Her theory implies "certain populations, experimental treatment variables, and methods of measuring these variables." Duldt & Giffin, 1985, pp. 228-230).

Duldt's theory has potential generally since it is a new theory and not widely tested, although efforts have recently been instituted. Her theory is congruent with other theorists, yet differs somewhat. For example, Pilette states that dialogue does not require special techniques. Duldt takes the opposite position and states that to maintain dialogue, it is imperative skills and attitudes in communing, for example, be learned, particularly in the health care professions.

Carkhuff and Truax theorized that training programs for health care professionals resulted in increased levels of empathy, respect, and genuineness; these concepts are included in Duldt's theory. LaMonica identified positive attitudes as determinants of behavior; this is congruent with humanistic nursing. King and Gerwig drew on humanistic education and psychology of humanistic nursing education. (Duldt & Giffin, 1985, pp. 235-6). Duldt drew from all these theorists' concepts and supporting data and implemented change in her theory as warranted and supported by data.

6. Relevant research: A number of research studies tend to support the theoretical statements (58).

7. Importance to the discipline and profession: The theory defines human beings specific for the scope of nursing, in a holistic and existentialist manner. It also defines the roles and function of nurses. The theory serves as a guide for research in the area of communication in nursing and potentially in other health care disciplines.

2.5 Attitude of nurses towards human relations

Attitude is described as learned predisposition to respond in a consistently favourable or unfavourable manner with the respect to given objects (Feisbein 1975). Edward (1957) and Thurston (1946) defined attitudes as the degree of positive or negative affection associated with some psychological objects (61).

There are many methods to make judgments of attitudes. One popular and acceptable method is the Likert method. He described that the personal attitude to objects, situations and other people have three components.

1. Cognitive or beliefs and ideas
2. Affective or evaluative
3. Cognitive, which includes behaviour tendencies or intentions

These three components are linked together (Grant 1981). Campbell (1970) describes the relationship between attitude and knowledge as a causal variable and the effectiveness of the organization in the following figure 4. (62)

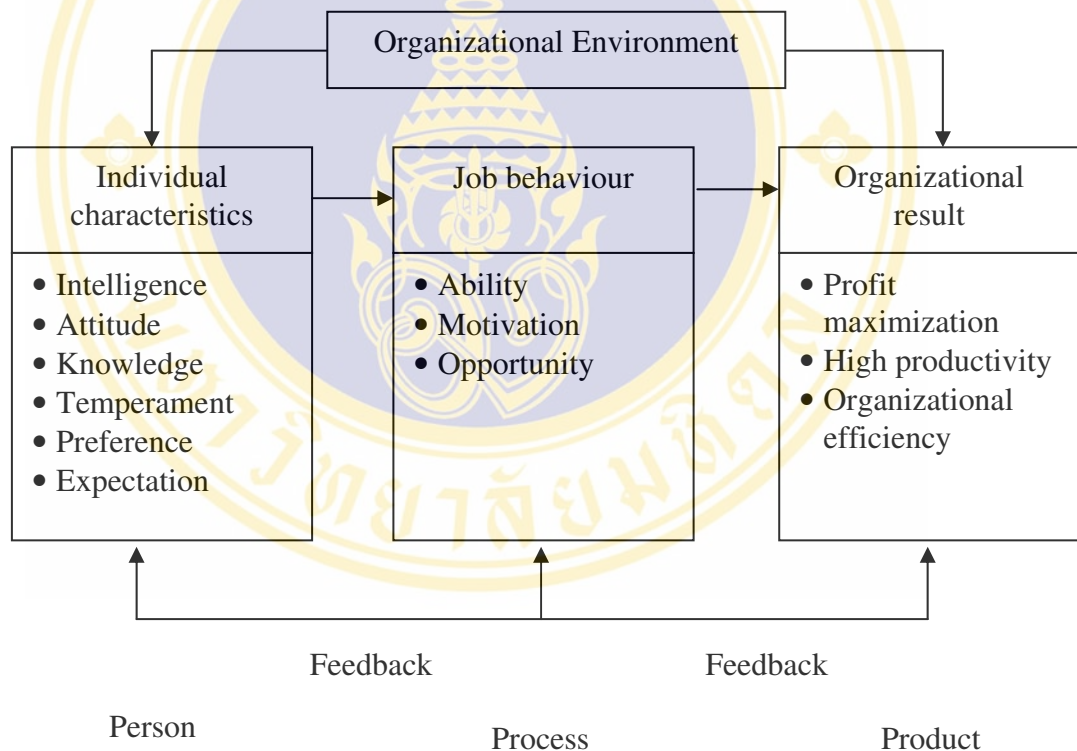


Figure 2: Effectiveness of an Organization

Source: Campbell JP, et al., Managerial behavior: performance and effectiveness. New York: Mc Graw Hill; 1970 (62)

From the diagram, job behavior interacts with other factors, e.g., organizational environment and individual characteristics. The job behavior depends on abilities that include intelligence, skill, attitude, knowledge, technical information, interest and implementing factors equipping one to meet organizational demand.

The motivational forces within an individual will result in cooperative behavior focused on achieving organizational goals and favorable attitudes will promote productivity. (63)

According to Likert (63), in order to measure the effectiveness of organization, the variables that should be taken into account are as follows:

1. Kind of attitude; in effective organizations, general attitudes are strongly favorable
2. Amount of responsibility felt by each individual; in effective organizations, the involved personnel feel and react responsibly to organizational goals
3. Satisfaction derived;

2.6 Evaluation of human relations among nurses

Measurement of individual and group change in the personal growth area of human relations training is a very difficult task. Many standardized personality instruments are too technical and unwieldy to use in research or training. The Interpersonal Relationship Rating Scale (IRRS) was developed specifically to meet the special needs of human relations training and is designed to test for outcomes in personal growth experiences. In designing the items for the scale, the author John L. Hipple considered the following specifications (64):

The content of the items should attempt to measure attitudes and/or behaviors in the individual's relationships with others and how the individual sees himself or herself. The content of the items must be meaningful to the respondents so that they can respond as accurately as possible.

The statements have to be designed to assess observable behaviors and/or attitudes as much as possible. When dealing with interpersonal relationships, it is very difficult to be completely objective; consequently, many of the items are very subjective.

The scale had to examine behavior that would presumably be affected by participation in personal growth experiences of human relations training.

The scale is a self-administered, paper-and-pencil inventory that takes approximately ten minutes to complete. It consists of twenty-four seven-point numerical rating scales, written in such a way that high ratings are “positive” and low ratings are “negative.” At this stage in its development, the IRRS is best analyzed in terms of average group ratings on the individual scales, but future research and development is aimed at incorporating an analysis of the total numerical score for the instrument. The instrument is designed so that the participants and/or persons who know them well (significant others) may respond. Data from respondents in the participants’ lives can be very valuable in assessing behavioral changes.

Related studies on human relations

Hibbard et al., (abstract 1996) reported in a study how consumers view condition-specific performance measures and build on an earlier study to test an approach for communicating quality information. The study uses 3 separate designs: a small experiment, a cross-sectional analysis of survey data, and focus groups. The question of whether providing information on the health care context affects consumer understanding of indicators is tested. Focus groups were used to explore how consumers view performance measures. The cross-sectional survey analysis used survey data from the experiment and the focus groups to look at comprehension and the salience of condition-specific performance measures. Findings show that a general consumer population does view condition-specific performance measures as salient. Further, the findings provide evidence that information on the health care context makes a difference in how consumers understand performance measures. (65)

Scammon et al., (abstract 1983) studied the perceptions of 3 groups of participants in the health care system regarding health care providers were evaluated. Ratings on 26 aspects of health care services were obtained from 287 consumers, 39 health care administrators, and 71 physicians using measures of image and

satisfaction of both physicians in general, and of specific physicians. Data from questionnaires were analyzed using discriminant analysis. Administrators were dissatisfied with providers' bedside manner. However, providers' attempts to improve in this area might go unnoticed since consumers appeared to be generally satisfied with this dimension of their health care. In addition, providers may reject such directives from administrators, as providers tended to perceive a high degree of satisfaction among their patients. Consumers were largely dissatisfied with the pragmatic aspects of health care providers, such as doctors' speed in treating patients. Office decor and equipment were also unsatisfactory to the consumer. Considering the misperceptions held by physicians and administrators regarding consumer satisfaction, and given an increasingly competitive marketplace, the strategic benefits of implementing a consumer orientation should be substantial. (66)

Ludke et al., (abstract 1983) reported that marketing has emerged as a crucial element of health services management. The community survey has become a popular method for integrating consumer preferences into the planning and marketing processes and illustrating public accountability. This article offers health care managers an introduction to the community survey and guidelines for determining when it should be used. Data can be collected from individuals via questionnaire or interview; information may also be obtained from groups using either the focused group or nominal group method. The latter is a highly structured approach, while the former simply encourages group members to express their feelings about a particular subject. (67)

2.7 Summary

From the review of the literature, the need for good Human Relations Skills appear for health care providers. These skills can mitigate the dissatisfaction and distrust in the patients towards the health profession. It would also serve as a balm for the emotional pain and suffering of the patients. A sympathetic ear can take away the anger and hurt of a patient in misery.

Health professionals do not have the time nor training to use human relation skills with their patients. This has been established by the needs assessment of the health workers. The health workers need to be re trained in human relations skills, especially those of listening, team work and decision making. These skills are necessary for all health workers to work in harmony with the patients as well as their own brothers in arms. These skills would improve their efficacy and efficiency, and improve productivity in terms of satisfied patients.

Evaluation tools for these skills are deficient and unwieldy, because behaviour change is difficult to quantify necessary and measure. Different authors have attempted to evaluate such trainings, however, there is room for designing and developing a customized evaluating tool to assess the human relations of nurses having undergone this training.

CHAPTER III

RESEARCH METHODOLOGY

This chapter presents the research methodology used to study the Human Relations among nurses at the Pakistan Institute of Medical Sciences, Islamabad.

3.1 Research design

A cross sectional, descriptive study was conducted in Pakistan Institute of Medical Sciences, Islamabad, to determine the human relations in Nurses working there. The main purpose of the research was to determine the level of human relations among nurses working at PIMS, to study the attitude of nurses towards human relations, and to investigate any association between the attitude and other independent variables, like socio demographic characteristics, family factors, work related factors, which were human relations training, and the effect of time between training and the human relations in Nurses. This survey can be used to determine the future strategy of using human relations training in health professionals.

3.2 Study population

Pakistan Institute of Medical Sciences, Islamabad was purposively selected for the study. The hospital has a programme of human relations training in place since the last two years for its staff. Islamabad Hospital was therefore, purposively selected for the study. All regular registered nurses employed in Islamabad Hospital, PIMS, and working in all departments of the hospital, at the time of the administering of the questionnaire were included in the study.

Table 2: Nurses distribution in Islamabad Hospital

Designation	Strength
Staff Nurses	300
Charge Nurses	65
Head Nurses	46
Total	411

Source: PIMS 2004

3.3 Sampling technique

All nurses working in Islamabad Hospital, PIMS, were asked to participate in the survey through a self administered questionnaire. The questionnaire was provided to the nurses available in the hospital at the time of the survey. Those who were on leave or absent from duty, or working elsewhere or on special leave etc., were excluded from the survey.

The questionnaire was administered to all the nurses, and they were asked to fill out the form individually, without any discussion or help from one another – to avoid influence and bias. The completed questionnaire was collected and checked for errors and unfilled columns at the time of collection. Any empty columns were asked to be completed at the time of collection to ensure valid entries.

3.4 Research instrument

Data collection was done by using a self administered questionnaire developed by the author using the IRRS as a reference guide, and input from the advisors. The questionnaire comprised of three sections as follows:

Section I Socio demographic characteristics, family factors of the respondents and the general working factors.

Section II Attitude of nurses towards human relations.

Section III Human relations of the nurses including: Team work, Listening and Decision making skills

Section I

This section dealt with three areas comprising of socio demographic characteristics, family factors of the respondents and the general working factors. There were seven questions addressing socio economic characteristics, four for family factors , seven about working conditions and two questions about human relations training and the time elapsed since attending the training.

Section II

This section comprised of twenty questions addressing attitude towards nurses' human relations. The questions were rated using Likert's type scale ranging from strongly agree, agree, unsure, disagree and strongly disagree. The scores were added and the groups divided into two categories. Those scoring equal to or more than the mean were considered to have high level of attitude, while less than mean were considered as having low attitude.

Section III

The third section had been developed by using the guidelines from Hipple's Interpersonal Relationship Rating Scale (19). It comprised of Human Relations of Nurses Evaluation Checklist assessing: team work, listening and decision making skills.

There were 25 questions in this section. Ten addressing listening skills, another ten for team work skills and five for decision making skills. Both positive as well as negative questions were mixed to get a true representative response (20). The responses were classified as high which were equal to or more than the mean, and low if the score was less than the mean.

Pre-testing

Pre-testing of the questionnaire was done on a comparative group of thirty nurses working in Holy Family Hospital, Rawalpindi. The hospital is a teaching hospital similar in size and services offered as the Islamabad Hospital, PIMS. The scaling data was entered in database and analyzed using analytical software for reliability and correlation at an alpha value of 0.5529 for attitude scale and 0.5595 for human relations scale. The questionnaire was revised with the advisors to make the questions reliable and valid.

3.5 Data collection

The data was collected by the researcher personally from all the respondents, and collected questionnaires were also scrutinized for errors, invalid entries etc., at the time of data collection. Any errors were corrected by the respondent at the time of submission of completed forms. However a few forms with double entries were rejected at the time of data entry. The data were then entered into a database using Minitab ® software for running analytical tests.

3.6 Data analysis

Data collected was analyzed using various statistical tests;

Characteristics of nurses:

Univariate analysis (description and frequency distribution) were applied to examine socio-demographic characteristics of the nurses. For variable as nurse's income, age and years of working experience; mean, SD, median, minimum and maximum values were obtained in addition to frequency distribution. Then prior to the bivariate analysis, the distribution of each variable was examined for normality. If assumptions for normality were violated, then non-parametric statistics were used in

data analysis and mean of total score obtained was taken as cut off point in categorizing the continuous variables into two groups as high and low.

Nurses' Human Relations

The nurses human relations were classified into high and low using the mean of total score as cut off point in each of the three categories of team work, listening and decision making skills, independently as well as cumulatively. Where high was equal to or more than mean and low was less than mean of the score.

Statistical analysis used

Descriptive statistical analysis using number, percentage, mean SD, median, minimum, and maximum in order to describe the distribution of the variables; socio demographic characteristics, family factors, work related factors, and the dependent nurses' human relations factors were used.

Analytic statistics using chi square and correlation analysis to identify association between human relations among nurses comprising of team work, listening and decision making skills and the socio demographic factors composed of age, gender, marital status, educational background, as well as other demographic variables, family and work related factors.

The results were considered statistically significant when the p-value was less than 0.05

CHAPTER IV

RESULTS

In this chapter the results are presented in both descriptive and tabular form. It contains the following sections:

- 4.1 Socio-demographic and family factors.
- 4.2 Work related factors.
- 4.3 Nurses' human relations .
- 4.4 Attitude of nurses towards human relations.
- 4.5 Effect of training and time on nurses' human relations.
- 4.6 Association between independent and dependant variables.

The survey forms were distributed to 290 respondents who were on duty nurses, from January 5 to 24, 2004. The remainder of the nurses were either on leave, or had retired from service and their positions lying vacant. Correctly completed forms returned were 281 (96.89%).

The results of the study are presented by descriptive statistics using frequency, percentage distribution and Chi-square test to show association between some independent variables of interest and the dependent variable. The level of significance for all comparisons has been set at p-value of less than 0.05.

4.1 Socio-demographic and family factors.

The socio demographic and family factors in this study consisted of: gender, age, marital status, education, ethnicity, religion, family income and family size of the nurses working at the Pakistan Institute of Medical Sciences, Islamabad.

From table 3, it can be seen that the majority of the respondents were female (87.5%). However, a large number (n=35) of male nurses also responded. These were mostly deputed in operation theatre, surgical and medical wards to cater to male patients. More than half of the nurses (53%) were below 30 years of age, the youngest being 17 years and the oldest 52 years old, with mean age of 30.76. The median age was 29 years for the respondents.

Fifty three percent of the respondents were married, while 43% were single. Almost half of the respondents were undergraduate, while 18% had postgraduate qualifications. An overwhelming 79% of the nurses belonged to Punjab province; maybe as the hospital was located in Punjab, while a small number (6.4%) belonged to the distant Sind province. Nearly seventy percent of the respondents (68%) were Muslim, and 31% Christians, while there were only 3 Hindus.

Regarding the family factors, the combined income of the family, including that of the respondent nurses' ranged from a minimum of 6000 Rupees to 50,000 Rupees per month, with a mean of 19,406. Almost 64% of the respondents' family income was less than 20,000 Rupees per month. The family size ranged from a minimum of 2 to a maximum of 15 individuals in the household, with a mean of 6.33 persons per household. Almost 76% of the respondents lived in a house with 5 or more people.

Table 3: Socio-demographic characteristics of the respondents

Characteristics	Frequency n = 281	Percentage (%)
Gender		
Female	246	87.5
Male	35	12.5
Age		
Less than 29	148	52.7
30 – 39	93	33.1
40 – 49	32	11.4
50 and above	8	2.8
$\bar{X} = 30.76$, $SD = 7.415$, $Min = 17$, $Max = 52$		
Marital status		
Single	120	42.7
Married	149	53.0
Widowed	9	3.2
Divorced	3	1.1
Education		
Undergraduate	142	50.5
Graduate	89	31.7
Postgraduate	50	17.8
Ethnicity		
Punjabi	222	79.0
Pathan	41	14.6
Sindhi	18	6.4
Religion		
Muslim	191	68.0
Christian	87	31.0
Hindu	3	1.0
Family income †		
Less than 20000	179	63.6
20000 – 30000	60	21.4
More than 40000	43	15.0
$\bar{X} = 19,406$ $SD = 9733$, $Min = 6000$, $Max = 50000$		
Family size		
1 – 4	68	24.2
5 or more	213	75.8
$\bar{X} = 6.33$, $SD = 2.469$, $Min = 2$, $Max = 15$		

† Note: exchange rate for Pak Rupee is 58 Rs = 1 US\$

4.2 Work related factors.

From 281 respondent nurses working at the Pakistan Institute of Medical Sciences, Islamabad Table 4 describes the work related factors. In all eight departments were represented in the study. A fairly uniform distribution (average 13.7%) was observed in all departments, except nursing administration, which had a low representation (3.6%). A majority of the respondents (67.6%) were Staff Nurses, with subsequent low experience. The majority 58.7% of the respondents had less than 5 years of working experience, while 18% had more than 10 years experience to their credit. The experience ranged from a minimum of only one year to a maximum of 35 years, with a mean of 6.48 years.

The number of patients' responsibility for each nurse varied from a minimum of 2 to a maximum of 100, with a mean of 27.85 patients. The critical areas of nursing having lesser number of patients allocated as compared to OPD and administration areas, where larger numbers were cared for. The working hours, ranged from a minimum of 126 hours to a maximum of 300 hours, with a mean of 165.05 hours per month. Approximately sixty percent of the respondents (57.7%) worked less than standard 150 hours per month, as compared to 42.3% who had to put in extra hours due to shift duties.

Regarding the working in the private sector, a large number of the respondents (70.5%) had never worked in the private sector in their entire careers. However, at the time of the interview, only 18.5% were working in a private setup to supplement their income from the hospital.

Table 4: Description of working conditions factors

Characteristic	Distribution (n = 281)	Percentage
Department		
Administration	10	3.6
Gynaecology	38	13.5
Intensive Care Units	41	14.6
Medical	39	13.9
Out Patients Department	33	11.7
Operation Theatre	36	12.8
Paediatrics	48	17.1
Surgical	36	12.8
Designation		
Staff Nurse	190	67.6
Charge Nurse	50	17.8
Head Nurse	41	14.6
Years of experience		
Less than 5 years	165	58.7
5 – 10 years	65	23.2
More than 10 years	51	18.1
$\bar{X} = 6.48, SD = 5.655, Min = 1, Max = 35$		
Number of patients allocated each day		
Less than 20	79	28.1
21 – 30	94	33.5
More than 30	108	38.4
$\bar{X} = 27.85, SD = 15.653, Min = 2, Max = 100$		
Working hours/shifts per month		
Upto 150 hours	162	57.7
More than 150 hours	119	42.3
$\bar{X} = 165.05, SD = 28.547, Min = 126, Max = 300$		
Work in private sector		
Ever worked in private sector	83	29.5
Never worked in private sector	198	70.5
Currently working in private sector		
Working	52	18.5
Not working	229	81.5

4.3 Nurses human relations

There were twenty five questions concerning the nurses' human relations among the respondents. Each answer of being engagement in each question was given a score. Those respondents who scored equal to or more than the mean were considered as having high human relations, while those who secured less than the mean score were considered as having low human relations. Table 5 shows the human relations among nurses at the Pakistan Institute of Medical Sciences. 58.4% of the respondents had a high human relations, while 41.6% had a low level of human relations, while the mean was 19.47 (SD = 2.393).

Table 5 also revealed that the listening skills were high in 61.2%, while 38.8% had low skills. While the team work skills were high in 67.2% and low in 32.7%, and the decision making skills were high in 55.9% and low in 44.1% of the respondents.

Table 5: Human Relations among Nurses at Pakistan Institute of Medical Sciences

Nurses' Human Relations	Distribution (n = 281)	Percentage
Listening skills		
High	172	61.2
Low	109	38.8
$\bar{X} = 7.89$, SD = 1.254, Min = 5, Max = 10		
Team Work Skills		
High	189	67.2
Low	92	32.7
$\bar{X} = 8.11$, SD = 1.355, Min = 4, Max = 10		
Decision Making Skills		
High	157	55.9
Low	124	44.1
$\bar{X} = 3.47$, SD = 0.746, Min = 0, Max = 5		
Overall Nurses' Human Relations		
High	164	58.4
Low	117	41.6
$\bar{X} = 19.47$, SD = 2.393, Min = 13, Max = 24		

Table 6 lists the questions testing the listening skill of the respondents with their answers. The respondents answered in the affirmative ranging from a minimum of 33.5% to a maximum of 88.6%. While the negative answers ranged from 11.4% to 66.5%.

Table 6 Responses to the statements concerning listening skill

Sr	Statement	Yes	No
1	Do you listen to the patient with patience?	249 (88.6)	32 (11.4)
2	Do you listen attentively to the instructions about patient care?	245 (87.2)	36 (12.8)
3	Do you listen to people without interrupting them?	243 (86.5)	38 (13.5)
4	Do you look at the patient while they are talking to you?	242 (86.1)	39 (13.9)
5	Do you generally understand the instructions about patient care given by the senior doctors?	233 (82.9)	48 (17.1)
6	Do you ask for clarification of instructions about patient care, given by senior doctors?	231 (82.2)	50 (17.8)
7	Do you clarify instructions given by your senior nurses?	225 (80.1)	56 (19.9)
8	Do you ask for clarification of a question before answering it?	194 (69.0)	87 (31.0)
9	Do you repeat what your patient says to you?	167 (59.4)	114 (40.6)
10	Do you answer a question before it is completely asked?	94 (33.5)	187 (66.5)

When asked about listening patiently, most of the respondents (88.6%) replied in the affirmative. However, when asked if they answered a question before it was asked completely, two third of the respondents (66.5%), replied in the negative. Most of the respondents (82%), accepted that they sought clarification about instructions from their senior nurses and doctors.

Table 7 displays the responses of the respondents concerning questions on the team work skill. The affirmative responses ranged from a minimum of 28.8% to a maximum of 89%. Most of the respondents (89%) acknowledged that they worked as a team in their wards. Almost three quarters of the respondents (71%) believed that the hospital could not function without team work.

Table 7 Responses to the statements concerning teamwork skill

Sr	Statement	Yes	No
1	Do you work as a team in your ward?	250 (89.0)	31 (11.0)
2	Do you distribute your work when working in a team?	249 (88.6)	32 (11.4)
3	Do you share information with your team members?	239 (85.1)	42 (14.9)
4	Do you get good results when working in a team?	237 (84.3)	44 (15.7)
5	Do you help your colleagues with their work?	235 (84.6)	46 (16.4)
6	Do your colleagues help you with your work?	226 (80.4)	55 (19.6)
7	Do you give feedback to your team members?	224 (79.7)	57 (20.3)
8	Do you resolve conflicts in your team?	214 (76.2)	67 (23.8)
9	Do you have a leader while working in a team?	206 (73.3)	75 (26.7)
10	Do you think a hospital can operate without teamwork?	81 (28.8)	200 (71.2)

Table 8 shows the responses to the questions concerning decision making skill. The positive responses ranged from 80.4% to 89.3%. Majority of the respondents (89.3%) acknowledged that their seniors made decisions for them. However, 86.8% said that they shared their opinions with their friends as well as their superiors. Almost eighty two percent said that they participated in decision making in the wards, and a large number (80.4%), were willing to compromise easily on issues.

Table 8 Responses to the statements concerning decision making skill

Sr	Statement	Yes	No
1	Do your seniors make decisions for you?	251 (89.3)	30 (10.7)
2	Do you give your opinion to your seniors?	244 (86.8)	37 (13.2)
3	Do you share your ideas with your friends?	244 (86.8)	37 (13.2)
4	Do you participate in decision making in your ward?	230 (81.9)	51 (18.1)
5	Do you compromise easily?	226 (80.4)	55 (19.6)

4.4 Attitude of nurses towards human relations.

To study the attitude of nurses towards human relations at Pakistan Institute of Medical Sciences, they were asked to answer twenty questions based on the Likert rating scale, and scored from 1 to 5. Those respondents who scored equal to or higher than the mean were considered as having high attitude while those scoring less than the mean were considered as having low attitude towards nurses' human relations as described in table 9. Approximately half of the respondents (49%) had high level while 51% had low attitude towards nurses' human relations.

Table 9: Attitude towards human relations among nurses at Pakistan Institute of Medical Sciences

Attitude towards Nurses' Human Relations	Distribution (n = 281)	Percentage
Attitude		
High	138	49.1
Low	143	50.9
$\bar{X} = 79.81$ (SD = 6.087)		

Table 10 shows the responses of the respondents to questions about attitude towards nurses' human relations. Almost ninety nine percent of the respondents agreed that human relations training can improve working environment. Over eighty six percent of the respondents disagreed that the human relations training was a waste of time and not needed. Almost 98% of the respondents agreed that feelings of others were important, while 90% felt that one can work better in a happy atmosphere.

Over ninety one percent of the respondents (91.1%) believed that nurses' human relations can improve the nursing care provided to the patients, while over ninety four percent of the respondents (94.3%), believed that nurses with humanistic approach were more popular with the patients.

Table 10 Responses to statements on attitude towards nurses' human relations

Sr	Statement	SA	A	U	D	SD
1	Human relations training can improve the working environment	116 (41.3)	161 (57.3)	2 (0.7)	2 (0.7)	-
2	Human relations can improve work efficiency	115 (40.9)	161 (57.3)	3 (1.1)	2 (0.7)	-
3	Nurses should have an awareness of the feelings of others	112 (39.9)	163 (58.0)	2 (0.7)	-	4 (1.4)
4	You can work more when you are happy	110 (39.1)	160 (56.9)	7 (2.5)	2 (0.7)	2 (0.7)
5	Nurses should have the ability to listen to others in an understanding way	110 (39.1)	160 (56.9)	7 (2.5)	2 (0.7)	2 (0.7)
6	Nurses should have the ability to influence others	105 (37.4)	164 (58.4)	8 (2.8)	3 (1.1)	1 (0.4)
7	Human relations can improve the nursing care provided to the patients	97 (34.5)	159 (56.6)	16 (5.7)	5 (1.8)	4 (1.4)
8	Nurses should show tolerance to differences in other people	88 (31.3)	187 (66.5)	6 (2.1)	-	-
9	Nurses with humanistic approach are more popular with patients	87 (31.0)	178 (63.3)	6 (2.1)	5 (1.8)	5 (1.8)
10	Nurses should seek close working relationships with other staff	85 (30.2)	188 (66.9)	2 (0.7)	6 (2.1)	-
11	Human relations are important for nurses in their work	76 (27.0)	199 (70.8)	2 (0.7)	2 (0.7)	2 (0.7)
12	Nurses must not react to conflict and antagonism from other people	54 (19.2)	161 (57.3)	16 (5.7)	49 (17.4)	1 (0.4)
13	Human relations in nurses can improve recovery of patients	52 (18.5)	141 (50.2)	65 (23.1)	10 (3.6)	13 (4.6)
14	Nurses should show reaction to others' comments about their behavior	31 (11.0)	86 (30.6)	55 (19.6)	48 (17.1)	61 (21.7)
15	Nurses should be able to suppress reaction to the opposing opinions of others	27 (9.6)	174 (61.9)	24 (8.5)	51 (18.1)	5 (1.8)
16	Nurses should not be independent	19 (6.8)	36 (12.8)	67 (23.8)	110 (39.1)	49 (17.4)
17	Nurses must express their anger openly	18 (6.4)	33 (11.7)	56 (19.9)	109 (38.8)	65 (23.1)
18	Human relations do not play any part in working with patients	17 (6.0)	36 (12.8)	11 (3.9)	161 (57.3)	56 (19.9)
19	One should have human relations only with one's family	13 (4.6)	49 (17.4)	19 (6.8)	161 (57.3)	39 (13.9)
20	Human relations training is useless and a waste of time	4 (1.4)	16 (5.7)	20 (7.1)	153 (54.4)	88 (31.3)

Only eighteen percent of the respondents (18.1%) believed that nurses should express their anger openly, while a large majority (61.9%), disagreed with this approach.

4.5 Effect of training and time on nurses' human relations.

In the 281 respondents in the study, 54.1% had not attended the human relations training, while 46% had undergone the training as described in table 11. Among the ones who had attended the training (n=129), almost one third (32.6%) had attended the training in the past six months, 43.4% in the last six to twelve months, while about a quarter (24%) had attended it more than one year earlier.

Table 11: Nurses' Human Relations Training

Nurses' Human Relations Training	Distribution (n = 281)	Percentage
Training		
Not attended	152	54.1
Attended	129	45.9
Time since training	n = 129	
Less than 6 months	42	32.6
Between 6 to 12 months	56	43.4
Earlier than 12 months	31	24.0

4.6 Association between dependent and independent variables.

The association between nurses' human relations and independent variables can be studied as follows:

4.6.1 Nurses' human relations by socio demographic and family factors of nurses

In this section statistical significance between the independent variable, socio demographic and family factors and dependent variable, nurses’ human relations was determined, see table 12.

Table 12: Nurses’ human relations by socio demographic, and family characteristics of nurses at PIMS

Factor	Nurses’ Human Relations (n = 281)			
	Low		High	
	Number	%	Number	%
Gender				
Male	14	40	21	60
Female	102	41.5	144	58.5
χ^2 0.027	p value 0.869			
Age				
< 29	63	42.6	85	57.4
30 – 39	38	40.9	55	59.1
> 40	15	37.5	25	62.5
χ^2 0.344	p value 0.842			
Marital status				
Single	49	40.8	71	59.2
Married	67	41.6	94	58.4
χ^2 0.17	p value 0.895			
Educational level				
Undergraduate	61	43	81	57
Graduate	36	40.4	53	59.6
Postgraduate	19	38	31	62
χ^2 0.412	p value 0.814			
Ethnicity				
Punjabi	92	41.4	130	58.6
Pathan	16	39	25	61
Sindhi	8	44.4	10	55.6
χ^2 0.163	p value 0.922			
Religion				
Muslim	72	37.7	119	62.3
Christian	43	49.4	44	50.6
Hindu	1	33.3	2	66.6
χ^2 3.471	p value 0.176			
Family income				
< 20,000	108	60.3	71	39.7
20,001 – 40,000	8	8.2	89	91.8
> 40,000	0		5	100
χ^2 73.993	p value 0.000***			
Family size				
1 – 4	31	45.6	37	54.4
> 5	85	39.9	128	60.1
χ^2 0.687	p value 0.407			

The socio-demographic and family factors, were regrouped for statistical analysis purpose. In this case there was significant association between the family income and the nurses' human relations at the p-value of < 0.001 . Sixty-one percent of the respondents having a family income of less than 20,000 Rupees, had low human relations compared to those who had a family income of more than 20,000 Rupees. This means that the higher the family income, the higher was the human relations. However no statistically significant association was found between other characteristics like gender, age, education, ethnicity, religion, and family size with nurses' human relations.

4.6.2 Nurses' human relations by working conditions of nurses

A statistically significant association was found between nurses' human relations and the working hours/shifts at a p-value of <0.001 . It was determined that three fourths of respondents (75%) working for 150 hours or less per month, had high level of human relations as compared to those working over 150 hours a month. Which clearly means that less working hours improves nurses' human relations as is seen in table 13.

The association between nurses' human relations and the designation, was found to be statistically significant at p-value of <0.05 . A statistically significant association was also found between nurses' human relations and those who had ever done private practice at a p-value of <0.05 . However, a statistically weaker significance was found between nurses' human relations and those who were currently working in the private sector at a p-value of <0.1 . No statistical significance was found between nurses' human relations and department of work, years of experience and number of patients allocated each day.

Table 13: Nurses human relations by working conditions among nurses at PIMS

Department	Nurses' Human Relations (n = 281)			
	Low		High	
	Number	%	Number	%
Department				
Medical and allied	47	36.2	83	63.8
Surgical and allied	69	45.7	82	54.3
χ^2 2.624	p value 0.105			
Designation				
Staff Nurse	78	41.1	112	58.9
Charge Nurse	27	54	23	46
Head Nurse	11	26.8	30	73.2
χ^2 6.874	p value 0.032**			
Years of experience				
Less than 5 years	68	41.2	97	58.8
5 – 10 years	27	41.5	38	58.5
More than 10 years	21	41.2	30	58.8
χ^2 0.002	p value 0.999			
Number of patients allocated each day				
Less than 20	29	36.7	50	63.3
21 – 30	43	45.7	51	54.3
More than 30	44	40.7	64	59.3
χ^2 1.467	p value 0.480			
Working hours/shifts per month				
Upto 150 hours	41	25.3	121	74.7
More than 150 hours	75	63	44	37
χ^2 40.262	p value 0.000***			
Private practice				
Worked in private practice	24	28.9	59	71.1
Never done private practice	92	46.5	106	53.5
χ^2 7.430	p value 0.006**			
Currently working in private sector				
Working	16	30.8	36	69.2
Not working	100	43.7	129	56.3
χ^2 2.909	p value 0.088*			

4.6.3 Nurses' human relations by attitude towards human relations among nurses

Table 14 shows a strong, statistically significant association between nurses' human relations and attitude towards human relations at a p-value of < 0.001. Over

two thirds of the respondents (69.9%) having a low attitude towards nurses' human relations had low human relations as well, while a large number of nurses (88.4%) having high attitude towards human relations also displayed high human relations as well.

Table 14 Nurses' human relations by attitude towards human relations among Nurses at PIMS

Attitude towards human relations	Nurses' Human Relations (n = 281)			
	Low		High	
	Number	%	Number	%
Low	100	69.9	43	30.1
High	16	11.6	122	88.4
χ^2 98.594	p value 0.000***			

4.6.3 Nurses' human relations by training among nurses

In this section there are two components, those who attended human relations training and the time since attending the training. Table 15 shows a statistically significant association between nurses' human relations and human relations training at a p-value of < 0.001. Almost ninety percent of the respondents (87.6%) who attended the training had high human relations, while almost two-third of the respondents (65.8%) who did not attend the training had low human relations. There was also a statistically significant association, between nurses' human relations and time since human relations training was attended (p-value of < 0.001).

Table 15 Nurses' human relations by training, among Nurses at PIMS

Variable	Nurses' Human Relations (n = 281)			
	Low		High	
	Number	%	Number	%
Training				
Attended	16	12.4	113	87.6
Not attended	100	65.8	52	34.2
χ^2 82.046	p value 0.000***			
Time since training				
Never attended	100	65.8	52	34.2
Less than 6 months	1	2.4	41	97.6
Between 6 to 12 months	9	16.1	47	83.9
Earlier than 12 months	6	19.4	25	80.6
χ^2 85.148	p value 0.000***			

*** p < 0.001

CHAPTER V

DISCUSSION

This study on human relations among nurses at the Pakistan Institute of Medical Sciences, Islamabad was conducted during the period from 5th to 24th January 2004. Data was collected from two hundred and eighty one nurses who were on duty during the period in the said hospital using a self administered questionnaire. The main purpose of this study was to determine the level of human relations among the nurses and to find relationship between nurses' human relations and socio demographic, family, work related factors and attitude of nurses towards human relations. The results will be discussed under the following sections:

- 5.1 Socio-demographic and family factors.
- 5.2 Work related factors.
- 5.3 Nurses human relations.
- 5.4 Attitude of nurses towards human relations.
- 5.5 Effect of training and time on nurses' human relations.

5.1 Socio-demographic and family factors

The nurses' human relations were studied in terms of the socio demographic and family characteristics of the nurses. The factors taken into consideration were, gender, age, marital status, education, ethnicity, religion, family income and family size. In all the factors studied, only statistically significant association was found between nurses' human relations and family income. No other factor displayed any significant association with nurses' human relations. It is assumed that those nurses who were financially well off had better human relations. It is possible that financial stability lead to high degree of mental satisfaction among the nurses and resulted in better human relations.

Weiss (68) mentioned that the most difficult relationships to pin down have been those between client's socio-demographic characteristics and level of satisfaction. While socio-demographic variables have been studied on numerous occasions, a consistent picture of their effect on client satisfaction has not emerged. This may be due to the fact that studies have varied widely in the nature of particular sample studied and specific package of background characteristics examined. A particular scale used may also have affected perceived relationship. Research has identified patient satisfaction as one of several important determinants of utilization of medical services.

In this study the relationship between nurses' human relations and socio demographic and family factors, only showed a significant association between family income groups. The Chi square showed a significant association at a p-value of 0.000. The higher income groups were more inclined towards higher human relations compared to the lower income groups. This supports the findings of a similar study by Smutrapapoot (69) in which he found significant association between income and client satisfaction. In this study no other significant association was found between nurses' human relations and other socio demographic characteristics. This was different from the earlier study by Smutrapapoot, in which he found significant association between educational qualification and client satisfaction. Probably it can be attributed to the fact that over half (50.5%) respondents in the study were undergraduate nurses.

5.2 Work related factors

In the study, association between nurses' human relations and work related factors was investigated. Factors studied were; department, designation, years of experience, number of patients allocated, working hours/shifts, ever worked in private sector and currently working in private sector. A statistically significant association was found between nurses' human relations and nurses working hours at a p-value of 0.000. This supports the findings of Josten, Tham and Thierry (70) in which they

found that several authors have claimed that 12-hour shifts in nursing are better for both employees and patient care. However, although the research has found positive effects on satisfaction with working hours and free time, the effects on employee fatigue, health and performance have mostly been neutral or negative. Nurses who worked 9-hour shifts were on average more fatigued, had more health complaints, and were less satisfied with their working hours and free time than those who worked 8-hour shifts. Their performance was slightly poorer. It was also suggested that increases in workload since the 1980s make current extended shifts in nursing more fatiguing.

In the study statistically significant association was also found between nurses' human relations and private practice. The Chi square was significant at p value of 0.006 in case of those nurses who had sometimes in their careers worked in the private sector. However, the association between nurses human relations and currently working in the private sector was found to be significant at a p-value of 0.088. There was a fall in the number of nurses who had ever worked in the private sector and those currently working in the private sector in addition to their hospital work from 29.5% to 18.5%. This could be attributed to two factors; either due to overwork, because of extra hours put in after hospital hours in the private sector, leading to fatigue and dissatisfaction (70); or due to attitudinal factors which provoked the nurses to give up private practice. However, the data is insufficient to be more concrete in this regard. More exhaustive work is required to study this phenomenon in detail.

In the study statistically significant association was established between nurses' human relations and nurses designation with a Chi square value of 6.874 which was significant at p-value 0.032. Knowles et al., (71) in their study in 2002, found similar results in nurse's satisfaction. They found that Direct nurses revealed that a large proportion of nurses were happy with working in NHS Direct, and that it presented some nurses with the opportunity of a new and challenging role. However, a minority found the work monotonous and felt that NHS Direct is likely to face the challenge of staff retention.

No other statistically significant association was observed between nurses' human relations and other factors. However it is pertinent to mention here that in this study no significant association was found between nurses' human relations and department of work, this is not consistent with the findings of Kaissi et al., (72) in whose study they found significant association between nurse's communication and departments of work.

5.3 Nurses human relations .

The results showed that more than half (58.4%) of the respondents had a high level of human relations with a mean of 19.47 (SD = 2.393), with a minimum 13 and a maximum of 24. These findings are different from a similar study conducted in 1998 in Islamabad by Ansari (10). In his study on client satisfaction towards health centre services in urban Islamabad, found that majority of the patients were not happy with the manner of the nurses and paramedic staff. The difference can be attributed to the training imparted to the nurses in human relations included in the study. This is also supported by Fellowes, Wilkinson and Moore, in their study in 2003 (73).

The nurses' human relations were based upon the listening skills of communication, team work skills and decision making skills. The results showed 61.2% respondents having high listening skills, mean 7.89 minimum 5 and maximum 10. These findings are substantiated by Calderón and Beltrán, who in 2004, found that language skills are essential for the proper interpersonal and inter-group communication (74).

In the survey, the teamwork skills were found to be high in 67.2% of respondents having a mean of 8.11 minimum 4 and maximum 10, while the decision making skills were high in 55.9% nurses with a mean of 3.47 minimum 0 and maximum 5. Kaissi, Johnson and Kirschbaum in 2003, found that nurses in general, perceived the effects of teamwork very positively. Almost all the respondents (99.6%) believed that good communication and coordination among team members were as

important as technical proficiency for patient care. Also, the majority believed that the team approach to patient care reduces errors committed by the team members (90.7%) and helps team members make better decisions (96.4%). Moreover, around 87% of the respondents did not agree that the team approach to patient care reduces efficiency (72). Similarly Wong and Anderson in a case study in 2003, reported that they found that nurses show sensitivity and are knowledgeable about the cultural background of their patients while treating them (75).

5.4 Attitude of nurses towards human relations.

In the study, the two hundred and eighty one nurses surveyed, out of which, less than half (49.1%) had a high attitude towards nurses' human relations mean 79.81 (SD = 6.087) minimum 64 and maximum 100. This was studied using a Likert's rating scale of 1 to 5 and then calculated as a percentage. This finding corresponds to the earlier study of Ansari (10) in 1998 in an urban Islamabad setting, where the patient's satisfaction with the manner of nursing paramedic staff showed high level of dissatisfaction. Kaissi, Johnson and Kirschbaum in their study (72) state that in general, teamwork consists of attitudes, knowledge, and skills (Stout, Salas, & Fowkles, 1997). Therefore, developing sustainable efforts to improve teamwork requires thoughtful application. Interventions focused on changing the behavior of team members must first take into account their attitudes. Subsequently, skills and knowledge are assessed, and a training program can be designed to improve teamwork. The benefits of improved teamwork are well documented in the literature. In general, teamwork results in enhanced effectiveness (Risser et al., 1999), fewer and shorter delays, improved morale and job satisfaction, increased efficiency, lower stress and improved patient satisfaction (Firth-Cozens, 2001; Majzun, 1998; Sexton, Thomas, & Helmreich, 2000).

5.5 Effect of training and time on nurses human relations.

In the study the association between nurses' human relations and human relations training was studied. The factors included whether training attended or not, and if attended the time lapsed since the training. A statistically significant association was observed between nurses' human relations and training attended with a Chi square significant at p-value of 0.000. This strongly supports that human relations training improves the human relations among the nurses. This is supported by the study in 2003 by Fellowes, Wilkinson, and Moore, in which they found that communication skills training is effective in changing the behavior of health professionals. They found that the trained group were more in control in patient follow up care than the untrained group (73).

In the second part of the study, association between nurses' human relations and time elapsed since training attended was studied. It was found that there was a statistically significant association between nurses' human relations and time elapsed since training, with a p-value of 0.000. This is supported by research conducted by Fellowes, Wilkinson, and Moore, in which they claim that research suggests communication skills do not reliably improve with experience and considerable effort is dedicated to courses improving communication skills for health professionals. The evaluation of such courses is of importance to enable evidence-based teaching and practice. It was found that communication skills training is effective in changing of health professionals in patient care with regard to communication/interaction with patients. The data available is insufficient to further analyse the correlation between time and change. Subsequent time-series studies can be conducted to study the effect in detail.

CHAPTER VI

CONCLUSION AND RECOMMENDATIONS

6.1 Conclusion

This study was conducted among nurses to determine their human relations and associated factors affecting it. Human relations are essential characteristics for all human beings, especially for those who deal with public, and in particular those who manage people in pain and misery. Nurses, are in constant contact with such people, who need sympathy, empathy and consideration. The objective of this study was to observe their state of nurses' human relations, their attitude towards it, and find factors that maybe associated with nurses' human relations.

Most patients complain about the indifference of the medical staff towards them. This leads to dissatisfaction and frustration, leading to delay in recovery and sometimes development of stress related disorders. Through this study it was observed that more than half of the nurses working at the Pakistan Institute of Medical Sciences, had high human relations. This refutes the claim of patients about indifference of medical staff towards their conditions. The conditions leading to this positive state of affairs had many causative factors. Some of the observations made in the study were as follows.

Economic considerations played an important role in determining the manner of the nurses. The nurses who belong to economically affluent class appeared to have more concern towards the human relations with others. Whereas the economically lesser fortunate, seemed to have lower regards for other peoples feelings and emotions. It is probable that certain psychological elements affected the attitude and of these nurses. Further elaboration of the factors are beyond the scope of this study and can be investigated in greater detail in subsequent studies.

Work load, in terms of working hours appeared to adversely affect the human relations and dealing with the patients, among the nurses as observed in the study. The more time spent on duty, especially in long night shifts, appeared to make the nurses less amenable, and lead to consequent poorer human relations . This is a well established phenomenon and a lot of research has been done on ‘burn out’ phenomenon in nurses.

The study also observed that level of position in the nursing hierarchy seems to be associated with the nurses’ human relations. A statistically significant association at a p-value 0.032 was established between the level in the hierarchy and nurses’ human relations. Further studies are required to investigate the association in greater detail.

Working in the private sector by the nurses was found to be statistically significant. However, the association was found to differ among those who had ever worked in the private sector from those who were currently working in the private practice. The reason for this could be attributed to the mental approach of the individual towards private practice as well as towards nurses’ human relations. The association can be studied in greater detail in subsequent studies.

The study found that that the attitude of individuals was strongly associated with their human relations . Whereas, no statistical significance was observed in the association between nurses’ human relations and other socio demographic, and other related factors studied. However, it was noted that training played an important role in improving the human relations of nurses. A strong association was discovered to exist between nurses’ human relations and training in human relations. Furthermore, it was also observed that there was a statistically significant evidence that there was a strong association between time elapsed since training and the human relations of the respondents. There is room for further inquiry in this aspect and maybe a time series or a cohort study could determine the effect of time on the human relations of the respondents.

6.2 Recommendations

This study has highlighted the importance of human relations in the nursing profession. Based upon the results obtained from the study the following recommendations are made:

6.2.1 Recommendations for implementation

The overall human relations of the nurses in the hospital was found to be reasonably good, however, there was a room for improvement. It is recommended that:

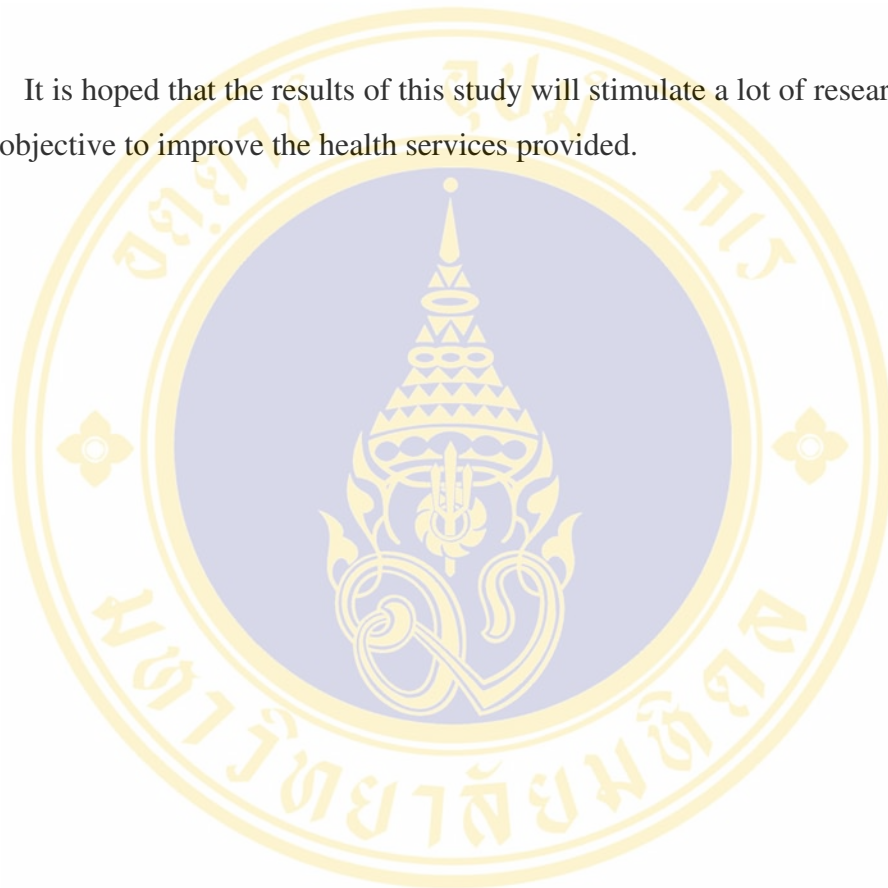
1. The respondents expressed their desire for on the job training in human relations in the questionnaire. It is therefore recommended that training should be provided to all the nurses regularly.
2. Low level of attitude towards nurses' human relations was observed in almost half of the nurses in this study. Efforts should be made to raise the attitude of the nurses towards human relations.
3. Financial stability appeared to improve nurses' human relations. The hospital may encourage the nurses to improve their human relations and reward them with financial incentives.
4. Overwork reduced the level of human relations among the nurses. The hospital may ensure that the nurses work an adequate number of hours and enough staff is available to provided relief in their working hours and shift duties.
5. Level in the hierarchy seems to influence the human relations among the nurses. Timely promotions and proper job structure will improve their performance in terms of human relations.

6.2.2 Recommendations for further study

This study can be useful for researchers who are interested in the social aspect of health care and want to improve the health care of patients. Time limitations did

not allow detailed inquiry for this study. It is recommended that further research is possible to determine the effect of time on nurses' human relations in those who have undergone training, using a time series, cohort or case control methodology. Also the study of other hospitals where such programs are not yet introduced could be studied to see the level of human relations in their staff.

It is hoped that the results of this study will stimulate a lot of research work with the objective to improve the health services provided.



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APPENDIX A QUESTIONNAIRE

HUMAN RELATIONS AMONG NURSES AT PAKISTAN INSTITUTE OF MEDICAL SCIENCES, ISLAMABAD

This questionnaire has been prepared for conducting a research survey of the Nurses. The findings will be used in the thesis writing for Masters in Primary Health Management course at the ASEAN Institute of Health Development, Mahidol University. The answers will be kept secret and will not be shared with anyone or used for any other purpose.

Sr Nr:

Department _____ **Date** _____

Section 1 Socio demographic characteristics

Please check whichever is most suitable in the box [✓], and fill the blanks with your response:

- 1.1 What is your gender?
 Male Female
- 1.2 How old are you? (completed years) _____ years
- 1.3 What was your date of birth? _____ / _____ / _____
 day / month / year
- 1.4 What is your marital status?
 Single Married
 Widowed Divorced
 Separated
- 1.5 What is your highest level of education?
 Under graduate
 Graduate (BSN, BSc)
 Post graduate, please specify _____
 Other, please specify _____
- 1.6 Where do you belong from?
 Punjab
 NWFP
 Sind
 Baluchistan
- 1.7 Are you a.....
 Muslim
 Christian
 Other, please specify _____

Section 2:

Instructions: Complete this form quickly without thinking too much about each item. For each of the following items, mark [✓] in the corresponding box that best describes the degree to which the statement matches your opinion.

5.1 One should have human relations only with one's family

Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree

5.2 Nurses with humanistic approach are more popular with patients

Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree

5.3 You can work more when you are happy

Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree

5.4 Nurses should have the ability to listen to others in an understanding way

Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree

5.5 Human relations can improve work efficiency

Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree

5.6 Nurses should have an awareness of the feelings of others

Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree

5.7 Human relations do not play any part in working with patients

Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree

5.8 Nurses should show tolerance to differences in other people

Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree

5.9 Human relations are important for nurses in their work

Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree

5.10 Nurses should seek close working relationships with other staff

Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree

5.11 Human relations training can improve the working environment

Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree

5.12 Nurses should have the ability to influence others

Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree

5.13 Human relations training is useless and a waste of time

Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree

5.14 Nurses should be able to suppress reaction to the opposing opinions of others

Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree

5.15 Nurses must not react to conflict and antagonism from other people

Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree

5.16 Human relations can improve the nursing care provided to the patients

Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree

5.17 Nurses should show reaction to others' comments about their behavior

Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree

5.18 Nurses must express their anger openly

Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree

5.19 Nurses should not be independent

Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree

5.20 Human relations in nurses can improve recovery of patients

Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree

Please read the following questions carefully and check [✓] whichever is your most suitable response, in the corresponding box

6.1 Do you listen to the patient with patience?

[] Yes [] No

6.2 Do you listen to people without interrupting them?

[] Yes [] No

6.3 Do you repeat what your patient says to you?

[] Yes [] No

6.4 Do you look at the patient while they are talking to you?

[] Yes [] No

6.5 Do you answer a question before it is completely asked?

[] Yes [] No

6.6 Do you ask for clarification of a question before answering it?

[] Yes [] No

6.7 Do you clarify instructions given by your senior nurses?

[] Yes [] No

6.8 Do you listen attentively to the instructions about patient care?

[] Yes [] No

6.9 Do you generally understand the instructions about patient care given by the senior doctors?

[] Yes [] No

- 6.10 Do you ask for clarification of instructions about patient care, from Sr Drs?
 Yes No
- 6.11 Do you work as a team in your ward?
 Yes No
- 6.12 Do your colleagues help you with your work?
 Yes No
- 6.13 Do you help your colleagues with their work?
 Yes No
- 6.14 Do you have a leader while working in a team?
 Yes No
- 6.15 Do you give feedback to your team members?
 Yes No
- 6.16 Do you resolve conflicts in your team?
 Yes No
- 6.17 Do you share information with your team members?
 Yes No
- 6.18 Do you think a hospital can operate without teamwork?
 Yes No
- 6.19 Do you get good results when working in a team?
 Yes No
- 6.20 Do you distribute your work when working in a team?
 Yes No
- 6.21 Do you participate in decision making in your ward?
 Yes No
- 6.22 Do your seniors make decisions for you?
 Yes No
- 6.23 Do you give your opinion to your seniors?
 Yes No
- 6.24 Do you share your ideas with your friends?
 Yes No
- 6.25 Do you compromise easily?
 Yes No

Thank you for your cooperation

BIOGRAPHY

NAME	Imran Hameed
DATE OF BIRTH	January 15, 1958
PLACE OF BIRTH	Rawalpindi, Pakistan
INSTITUTIONS ATTENDED	MBBS University of the Punjab, Lahore, Pakistan MCPS (Obstetrics and Gynaecology) College of Physicians and Surgeons, Pakistan International Fellowship in Human Relations Nanzan University, Nagoya, Japan
POSITION	Training Coordinator Pakistan Institute of Medical Sciences Islamabad, Pakistan