The Social Basis for Patient-Female Nurse Misunderstandings: Reflections from Muleba and Chato Districts

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Abstract
Recent studies in Tanzania have revealed the nature and magnitude of patients' abuse and neglect under maternity care. However, the question of female nurses as main perpetrators of such misconducts has not been addressed. Quantitative data collected from systematically sampled health care users and qualitative data generated through in-depth interviews with healthcare providers in Chato and Muleba districts were used to explain the uneasy relations between patients and female nurses. The findings revealed that abusive nurses are mainly female nurses, perceived by patients as uncaring and less compassionate than their counterpart male nurses who are caring and empathetic. Viewed using the lenses of symbolic interactionism, such abusive behaviours displayed by female nurses are responses to patients' demeaning behaviours of regarding female nurses as a weak category of health providers in terms of their expertise and professional skills. Additionally, female nurses, who also occupy inferior social positions like other women, use medical power embodied in the control of medical information to elevate their gender position in medical settings and wider social settings, but in the process of achieving this goal they abuse patients. Any efforts to improve patient-female nurse relations need to consider women's position in general social settings and medical settings.

Introduction

The history of health care provision in Tanzania is characterized by a number of healthcare reforms implemented for improving the quality of healthcare. After the attainment of independence, in the period of 1961-1966, the independent state instituted healthcare reforms focused on eliminating a poor health system left behind by the colonial government. However, these reforms were urban biased (Mliga, 2003). The implementation of socialist development policies necessitated the second phase of health care reforms, 1967 – 1991, whereby the government banished all private health providers and took full responsibility in the provision of healthcare (URT, 1990; URT 2009; Tibaijuka 1998). The second phase of healthcare reforms was crippled by the 1980s economic crisis, and therefore, the third phase of healthcare reforms was implemented, starting from 1990s to date. Apart from encouraging the private sector in the provision of healthcare, among many things, the current reforms are aiming at improving the quality of healthcare by ensuring reliable availability of medication and medical supplies, improvement of healthcare physical infrastructure, and the availability of well trained and motivated healthcare personnel (URT, 2000; URT, 2009).

The current healthcare reforms are reported to have significantly improved healthcare services. There is a notable increase in the number of health facilities (URT, 2006; URT, 2008:24). The

reforms have also resulted into improvement of health services delivery regarding drugs availability and healthcare financing (URT, 2005:37). The collaboration between the government and the private sector in training of healthcare personnel has resulted in significant increase of healthcare staff in public and private healthcare facilities (Mamdani & Bangser, 2004; URT, 2005a:37; URT, 2008:24).

Despite all the success of the current healthcare reforms, there are reports about unease relationship between patients and some cadres of healthcare staff specifically nurses. The social media and mainstream media have continuously reported patients verbal abuse and mistreatments in some healthcare facilities with nursing healthcare staff being the main culprit (*Habari Leo*, 25th September 2007; *Mwananchi*, 4th June 2009, The African, 10th June 2009; Jamiiforumus, 17th September 2017; Jamiiforums, 19th August 2017; Global Publishers, 17th May 2016). Patients' abuses are reported even at high levels of healthcare provision where one would not expect such behaviour to persist given the expected healthcare standards. A study on patients' satisfaction at Muhimbili National Hospital reported poor behaviour of some nurses for being rude, uncaring and using humiliating language to patients (Mhondwa, 2008:70).

Some studies conducted in Tanzania indicated that cases of abuse and disrespect in maternity care are common. These studies revealed that women in maternity wards face discriminatory treatment, corruption, neglect, and verbal abuse leading to lack of patients' trust in their health providers. Furthermore, these studies showed that female patients respond passively to the abuses by bypassing abusive health providers or health facilities harbouring abusive health providers (McMahon et al, 2014; Tibandebage & Mackintosh, 2005, Sando et al 2014, Kujawski et al 2015). Whereas these studies have revealed the nature and magnitude of abuses in the maternity wards, the lingering question is why the nursing staff especially female nurses are mostly involved in clinical misunderstandings and patients' abuse. The current paper is an attempt at answering this question.

Reflection of Symbolic Interactionism on Patient-Female Nurse Interaction

Over many years nursing has been striving to assert its position within healthcare profession as a body of knowledge to reckon with (Hughes, 1984). The agenda for professional recognition is pushed in myriad ways by increasing their role in healthcare provision including possession of medical information and manipulating information distribution hence disempowering patients through control and minimization of clinical information flow to patients (Poter, 1992; Ousey & Johnson, 2007). Clinical areas are well known as one of the social arenas for asserting power and status for medical professionals with no exception to nursing specialty (Ousey & Johnson, 2007). The interaction between a nurse and a patient is intrinsically expert-layperson encounter weaved by administration of medical materials and knowledge both of which are tightly controlled by the expert, the nurse expert (Freund & McGuire, 1999: 219). Even in circumstances presumed to have a reduced social distance between nurses and patients such as female nurse – female patient interaction, the axis of power leans on the nurse's side due to medical knowledge monopoly (Fisher, 1995). Patient's acquisition of clinical information depends on patient's assertiveness because such information is concealed by medical

professionals due to the fact that clinical information constitutes the foundation of clinical power (Ibid: 221).

Medical knowledge monopolization is not specific to nursing care but it is a common practice across various specialities of healthcare. Much of the misunderstandings in clinical encounters are rooted in the lack of cordial exchange of clinical information between patients and healthcare providers (Kamugisha, 2014). The fundamental question is why such unease exchanges predominantly occur in female nurse-patient interactions than male nurse-patient interactions or any other interactions involving other cadres of health providers. To understand this situation, it is worth glancing at the situation of gender inequality and see how efforts for asserting female power and social position are manifested in clinical encounters.

The United Nations Human Development Report 2016 indicated that Tanzania is dragging in 129th position in the world on gender inequality index with only 10.1% of females aged 25 years and above attaining secondary education (UNDP, 2016). Furthermore, the report indicated that education is a vital tool for achieving gender equality (Ibid). By any standards, nursing is a prestigious education level and all female nurses who attain the nursing carrier have some feelings of liberation against gender oppression. However, it is important to understand that female nurses, like other women in the society, still occupy an inferior social position compared to their counterpart male nurses with the same level of professional skills. Additionally, the quest for holistic comprehension of the situation can also be supplemented by looking at a study by Gino & Brooks (2015). The study pointed out that people look at women in power positions as less competent than men, and such perception makes women in power or leadership positions face much challenges in executing their duties (Gino & Brooks, 2015). Employed women such as female nurses face similar challenges and they are cognizant of their expertise scepticism at their workplaces. It is a reality they live with. The copping mechanisms can take different forms including abuse of patients. As symbolic interactionists suggest, female nurses interact with patients by thoughtfully making sense of the general patients' perception of expertise of female professionals and the wide social position of women in the society.

It has been noted that the personality/nature of both patient and nurse influence the nature of patient-nurse communication (Fleischer et al, 2009). The patient-nurse communication, like many other social interactions, fundamentally involves verbal and non-verbal exchanges such as body posture, head nods, facial movements, gesture and looking/eye contact (Aguilera 1967; Davies 1994). Such communications are ideally characterized by nurse's empathy, but can also be seen as an arena for power showcasing especially in situations where nurses use medical register to cut off patients thus blocking medical information from reaching patients (Op cit).

In a society, as symbolic interactionists postulate, human beings are not just constrained by external structures but they are reflective in terms of their thoughts and actions (Ritzer, 1998:181). The mind, contrasted to the brain which every animal has, filters the stimulus and figures out response in different situations. In social interactions, people learn and respond to symbols thoughtfully ---- symbols could be words, artefacts or physical actions (Ibid: 183).

People use symbols to communicate something about themselves. We are reminded by symbolic interactionists that language is a vast system of symbols. In the process of clinical interaction, nurses and patients symbolically communicate meanings to each other. Both patients and nurses interpret those symbols, and mould their response according to their interpretation of the nature of interaction and thoughtful interpretation of the intent and perception of the other actor (Ibid:184).

Research Methodology

This paper is based on data collected from Muleba and Chato districts. The districts are among rural districts in Tanzania with the lowest number of essential cadre of medical staff such as assistant medical officers and clinical officers (URT, 2008: 18; URT 2013: 25). At the time of the study, according to the information received from district authorities, Chato District had one (1) public hospital, two (2) public health centres, 15 public dispensaries, and three (3) privately owned dispensaries. Muleba District had three (3) private hospitals, four (4) public health centres, one (1) private health centre, 21 public dispensaries, and seven (7) private dispensaries.

Collection of quantitative data involved interviewing of 390 health care users who were selected by systematic random sampling. Sampling was done after developing a sampling frame of healthcare users from all hamlets within catchment areas of health centres and hospitals – a radius of 5 kilometres from a health facility. These health facilities involved one hospital in Chato District (Chato District Hospital); and one hospital and two health centres in Muleba District (Ndolage Hospital, Kaigara Health Centre, Rwantege Health Centre). Healthcare users who were interviewed were those who had reached 18 years, and patronized the aforementioned health facilities within a period of less than six months by the time the study was conducted.

The study used the formula developed by Krejcie & Morgan 1970 to determine the sample size (Bernard, 1995:77).

$$\text{Sample size} = \frac{\chi^2 NP(1-P)}{C^2(N-1) + \chi^2 P(1-P)}$$

Where χ^2 is the chi-square value for 1 degree of freedom at some desired probability level (3.841), N is the population size of the catchment area, P is the population parameter of a variable (0.5), and C^2 is the confidence interval (0.05) to ensure a 95% probability sample (Bernard, 1995: 77).

At the time of sampling, the representation of each catchment area in the overall study sample was proportional to the number of health care users in the specific catchment area. Due to the fact there was no comprehensive sampling frame (list of healthcare users), leaders of hamlets in each catchment area were requested to list the names of all people above the age of 18 years. The catchment area for Chato hospital (with a study population of 449 health seekers) contributed 112 respondents to the overall sample. The catchment area for Rwantege private health centre (with 113 health seekers eligible for this study) had 28 health seekers included in

the overall sample. A total of 128 health seekers from Kaigara public health centre (with a study population of 514) were supposed to be included in the overall sample, but only 123 were accessible and eligible for the interviews. The catchment area for Ndolage hospital (with a study population of 529) was supposed to contribute 132 respondents to the overall sample, but only 127 health seekers were available and eligible for interviews. The sampling interval for all catchment areas was 4.

The collection of qualitative data involved conducting in-depth interviews. A total of 28 in-depth interviews were conducted with medical staff who had long working experience. These include nurses, nurses' matrons, and health administrators. In-depth interviews were purposely conducted to gather detailed information about the misunderstandings between patients and nurses. Quantitative data were analysed using SPSS while the analysis of the qualitative data was done thematically.

Gender Differences in Clinical Misunderstandings

The data collected from Chato and Muleba Districts indicated that there are some misunderstandings between health providers and patients. The quantitative data indicated that 15.6% of healthcare users had misunderstandings with their health providers when they visited health facilities. Considering the group of healthcare users who experienced clinical misunderstandings, 81.7% reported that they had misunderstandings with nurses, 15.0% with doctors, and 1.7% with receptionists, and 1.6% reported misunderstanding with pharmacists. Unpleasant experiences which were perceived by healthcare users as misunderstandings included verbal and/or physical abuse, scolding, yelling, ridicule and demeaning gaze, harsh criticism and denial of illness and treatment information when requested by patients.

The qualitative data revealed that the use of harsh language to expectant mothers was common in the nursing and midwifery speciality. Most nurses and Health Administrators repeatedly explained that in the process of assisting delivery the nursing primacy rests upon saving the life of a baby rather than compassion to the delivering mother. In-depth interviews revealed that there is a general feeling among nurses that a misconduct of physical abuse or scolding a delivering mother can be easily explained and resolved than a loss of a baby during the labour process which could be interpreted by health facility authorities as nurse's professional negligence. The nurses reported that if a baby dies amid labour, the nurse who assisted the delivery could shoulder the blame of a medical misconduct, unless it is proved by the authorities that the neonatal death was due to a natural cause. This suggests that nurses would do whatever it takes, including yelling at and scolding a delivering mother, to achieve a successful delivery of a baby rather than appease a delivering mother and risk career insecurity due to neonatal deaths. Nurses assisting labour make a cost and benefit analysis and the option of being harsh to a woman in labour seems to be less expensive as such misconducts are tolerated by the authorities but not the death of the baby. Such work ethics, as similarly observed by Jewkes et al. (1998), can result in abuse of patient especially if the working infrastructure is not conducive to ensure delivery of live births.

In-depth interviews with health administrators and matrons of nurses revealed that while patient abuse in other wards is strictly monitored and sanctioned, scolding and shouting at

expectant mothers in labour wards does not attract the same magnitude of punitive measures. The health administrators shared the nurses' view that nurses in labour wards need to be strict and uncompromising so as to save lives of babies during delivery. This suggests that verbal abuse in labour wards is, in some ways, institutionalized as they are somehow encouraged in difficult situations for the sake of saving lives of babies.

It was also reported by health administrators that patient complaints are prevalent in all sections of a health facility, but predominantly reported in labour wards. There are different ways in which patients can file complaints. Among them is the use of suggestion boxes, but health administrators reported that the rate of reporting patients' abuse to the health authorities was low. Hesitation in reporting patients' abuse was said to be a result of wide spread fear among patients that filing a complaint against an abusive health provider could antagonize patient's relationship with the perpetrator of the abuse, and even spoil the relationship between the patient and other health providers on the next medical visit. Patients who complained against the abuses or aggressively demanded illness and treatment information were perceived by health providers as difficult patients.

There is an expectation that patients, and especially expecting mothers, should always build good relationship with health providers. This expectation is further cemented by a popular Swahili proverb which literally translates as "*You should not insult midwives while you are still fertile*". Filing a complaint against an abusive health provider was essentially perceived by most health providers as an insult. The priority for most patients, as reported by health administrators, was to build good relationship with their health providers so as to have a smooth treatment process even on the next medical visit. The proverb acts as a gentle reminder to all patients, and especially expectant mothers, that they should never annoy their health providers. This proverb puts health providers high on a pedestal, portraying them as powerful and infallible actors in the treatment process. Only a few courageous and risk-taking patients complain officially about abusive health providers. The proverb also indicates a social acceptance that patients should keep silent when abused by health providers.

Lack of compassion and acceptable language in healthcare interactions was found to be higher in public health facilities than private health facilities. Quantitative data indicated that 28.5% of healthcare users who resorted to public health facilities reported that health providers talked to them in harsh language, compared to 6.5% who reported to have faced similar abuses in private health facilities. It was further revealed that 45.2% of the healthcare users who made therapeutic recourse to private health facilities perceived the nature of their conversation with their health providers as friendly compared to 25.5% of healthcare users who had similar perceptions about their health providers in public health facilities. The percentage of health care users who reported to have conversed with their healthcare providers in a normal cordial conversation was 48.4% and 46.0% for the private and public health facilities respectively. This indicates a strong association between the type of health facility visited by a patient (private or public), and the nature of language (friendly, harsh or normal language) a patient faced during a health care encounter ($\chi^2 = 33.932$, P = .000, Cramer's V =. 295).

The rate of disrespectful behaviour to healthcare users was reported to be higher (37.0%) in public health facilities than in private health facilities (11.0%). The difference in the level of disrespectful behaviour between the two types of health providers was found to be statistically significant (χ^2 = 32.419, P = .000, Phi = .288). However, as it was revealed during in-depth interviews, male nurses were mostly considered by patients as friendly, caring, empathetic, and compassionate; whereas nurses who were mostly described as rude, harsh, and demeaning were mainly female nurses. Health administrators also reported that there is a difference between male nurses and female nurses when it comes to care and love for patients. They further reported that it was very rare to have a complaint filed against a male nurse in a maternity ward, whereas such complaints were common against female nurses.

The issue of nurses' gender difference in attitudes and compassion to patients was reported by both male and female nurses who explained that most of nurses, who are less compassionate, especially to delivering mothers, were mainly female nurses. Nurses also reported that in some cases they are not accorded respect by their patients in similar ways patients respect doctors and other health providers in other specialties. Nurses reported that the least respected health providers are nurses of the lowest cadre such as nurse assistants who are mostly described by patients as "small small nurses[1]". According to the nurses, this disrespectful description of nurses indicates that some patients perceive nurses of such cadre as inferior in terms of professional skills.

The gender differences of health providers in showing care and compassion to patients was also revealed by quantitative data. 64.9% of healthcare users reported that, there were clear differences among male and female health providers in expressing care, love and compassion to patients as compared to 31.9% of healthcare users who reported that there were no such differences. Further analysis of the group of healthcare users who reported that there were such differences, 85.8% reported that female health providers are less caring and compassionate; compared to 14.2% who stated that male health providers showed similar unethical behaviour in healthcare encounters. This difference in the expression of care and love was highly statistically significant (χ^2 = 5.863, P = .015, Phi = .015). This shows that any efforts to improve patient-nurse relationship should start by understanding the cause of such differences as female nurses and midwives constitute the majority (88.7%) in nursing care compared to 11.13% of male nurses and midwives (URT, 2013: 16). The overall picture is that nurses comprise 88% of all healthcare providers in the healthcare system in Tanzania (URT, 2014:16). Given this fact, incidences of misunderstanding between nurses and patients are likely to stain the general image of patient-health provider relationship in the country.

Patients' reference to "small small nurses", which the nurses are well aware of, is symbolically the patients' attempt to question nurses' professional expertise. Being aware of the perception of weak expertise of female professionals, female nurses would likely interact with patients vigilantly trying to spot such negative perceptions and react defensively whenever such perceptions are displayed by patients. Male nurses are less likely to face such negative

[1] The way patients describe youthful nurses of the lowest cadre with less nursing skills such as nurse assistants. Nurses perceive this description as disrespectful.

expertise perceptions as they are socially regarded as powerful. Incidentally, these perceptions are reflected in the clinical encounters with male nurses because they are respected by patients and therefore no need for being defensive or abusive. Clinical interaction is therefore a social interaction for mutual influence whereby reactions are thoughtfully calculated.

Like other women, female nurses are always in constant struggle to elevate their gender position and power in the society through various social interactions, including clinical encounters. Hence, it is in the process of asserting their social status, through the use of biomedical knowledge and resources, female nurses abuse patients, and especially female patients who also occupy similar inferior position in the society. Women occupy a weak position in healthcare encounters, and ultimately respond passively to abuse and disrespect unlike men who react assertively (McMahon et al, 2014). This explains why female patients in labour wards were reported to experience more verbal abuse than male patients. In the process of elevating their power, nurses tend to supress female patients who are weak actors in the clinical interactions. On the other hand, patients strive to gain some power in health care interactions by demanding access to medical resources such as medical knowledge related to clinical information on their diagnostics and therapeutics. Through interaction with nurses, patients devise ways of gaining power such as asking questions during medical encounters so as to negotiate access to vital medical information. As pointed out earlier, patients' access to medical information, by asking questions or demanding explanations on medical matters, is unpleasant for medical experts, and more so for female nurses who need medical information to elevate their social status while in hospital corridors and wider social settings. Female nurses, like other women in the society, are in constant struggle to improve their power status and this endeavour does not stop when they put on uniforms and enter clinical settings (Andersen, 2004).

Conclusion

Female nurses' overreaction while at the patients' bedside and hospital wards is in fact an extension of the wider gender emancipation struggles as they don't accept to be perceived as healthcare experts of a lesser category simply because of their female gender. Female nurses should not wholly be portrayed as patients' abusers but also be seen as victims of gender inequality in hospital wards and general social settings. What is seen as patients' abuse is possibly a harbinger of nurses' counteraction to gender stereotypes that female nurses face at their workplaces, and at the same time, it is a strategy for female nurses to elevate their social power by using medical knowledge.

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