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An Examination of Patients' Knowledge of Health Delivery Services in Tertiary-bound Health Institution

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Authors' contributions

Both authors designed, analysed, interpreted and prepared the manuscript.

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ABSTRACT

Supply of health services in teaching hospital usually provides confidence among users and this explains high patronage. Yet the bureaucratic characteristic of the hospital is a major concern. This study was designed to explore in-patients' knowledge of healthy services in a tertiary bound hospital and how this shaped patronage among users. Cross sectional design and multi stage sampling (purposive, random, systematic and accidental) was adopted. Some 420 sample, respondents were determined and used. Data were collected and analysed at quantitative and qualitative level, using statistics and text. Mean age of respondents was 42 years and 69.8% were married, while 44.0% were self employed. Respondents (98.8%) reported knowledge that patients had power to report health problems to medical officers which provide clear path for treatment. Similarly, 98.1% adequately know that medical doctors ultimately recommended treatment investigation or regimen. Although 96.1% abundantly distinguished the role of nurses and other paramedics in the teaching hospital, yet availability of equipment (97.1%), access to pharmacy (94.0%), clean hospital environment (95.0%), patients' knowledge of treatment (79.0%) and confidence in quality of service contributed to unbroken patronage. Knowledge was rated high (55.7%), moderate (27.6%) and low (16.7%) and this was strongly because the hospital operated patient oriented goal and flexible communication system which incorporated patients' inclusion. Desire to discontinue patronage and

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consultation was strongly reported by patients with low knowledge who perceived that vital information of their health investigation was concealed from them. Tertiary hospital must operate inclusive information system to improve health seeking behavior among users.

Keywords: Health-seeking; patients-knowledge; teaching hospital; satisfaction.

1. INTRODUCTION

The provision of health services in teaching hospitals represents the tertiary division of health care supply. This unit of health service is a form of complex organization that is woven round strict rules and regulation. It is expected that members are placed and ranked hierarchically in the provision of official roles. The availability of health in the teaching hospital is a complex task such that services are subdivided in departments which are interconnected and interdependent in the performance of roles [1]. This ensures that tasks are effectively coordinated to achieve expected results. Basically, the components of roles in the teaching hospital consist of medicine, nursing, laboratory, pharmacy and social work [2]. Yet these components are sub divided accordingly to capture specialization of tasks. Again, the teaching hospital is a bureaucratic organization that ensures that tasks are performed effectively and comprehensively. The structure of teaching hospital is a distinct classification of tasks spread in departments and units. The departments perform overlapping tasks such that they are centrally coordinated [3]. Similarly, the hospital is designed to capture organogram of structure to provide easy access for users. In some cases, maps of location of treatment centres are designed in bill boards and erected in strategic points at the hospital to provide guide to health seeker.

Apparently, teaching hospitals are regimented location which gives accurate prescription of treatment and highly specialized provision of health service. The users of this type of health organization are bound by rules to follow leading in the path of treatment and patronage [4]. Users of the teaching hospital facilities are acquainted with the procedure and protocol that must be followed prior accessing health services [5]. This ensures that the bureaucratic bottleneck of the hospital setting is whittled down and become user friendly. Critically, there is large volume of health seekers that patronized the hospital on the ground that reliable and qualitative health supply can be accessed. This belief strengthens heavy population of the patients recorded in teaching hospital across Nigeria [6]. Consequently, Doctors, Nurses, Laboratory Technologists and other Paramedics are busy all day long attending to needs of patients on admission or the out-patients who visited for medical prescription or check-ups. This suggests that teaching hospitals provide services that cover varieties of needs which meet health demand of the people.

However, the structure of teaching hospital is a bureaucratic type that creates process in supply of health and accessing the service provided. People that access health in this type of hospital conceived that improved health services are available. At the same time, there is perception that services available in teaching hospital are prescribed for middle class and wealthy members of the society [5]. Similarly, the anxiety often expressed by users of teaching hospitals reflects cost of service, the highly regulated hospital environment, complex nature of the hospital organization, the queue hours of accessing health and interpersonal relationship exhibited by health providers. In this study, how these anxieties interplay to influence users of teaching hospital is a major focus. Therefore, the specific objective of the study is to investigate knowledge of users of tertiary hospital, using University of Benin Teaching Hospital (UBTH) as a case study. The hospital, UBTH is one of the tertiary hospitals located in Edo State, the South-South geo political zone in Nigeria. The hospital provides services in varieties of categories that fit tertiary hospital organization.

2. LITERATURE REVIEW

2.1 Patients' Expectations from Health Care Services in the Teaching Hospital

Individual expectations usually form the bedrock upon which satisfaction is evaluated. In a study carried out by Iliyasu, Abubakar and Lawani et al. [2] to examine what exactly satisfaction means to patients, findings showed that the respondents had a wide range of definitions of satisfaction. They identified four broad categories to include: Expectations about the facilities and the extent to which these meet the patients' expectation, providers' attitude towards patients,

cost of treatment and terms of treatment, as well as outcome of treatment. Alliyu and Oduwole [7] noted that these expectations become the basis for satisfaction or dissatisfaction with healthcare services. Further, frequently mentioned expectations include availability of the doctors for consultation. Other expectations were identified in a study by Alliyu and Oduwole [7]. Respondents in the study particularly wanted to consult the doctor and not any other cadre of health care provider; patients expect that health facilities would have all the required and prescribed drugs in stock as well as the equipment necessary to carry out laboratory test to arrive at correct diagnosis.

Similarly, other studies have shown that physician's failure in meeting patient's expectation is associated with low patient satisfaction [8,2]. This mindset shows the societal definition of the doctor's role along side with the prior experience of others or information from others in the society. Freidson [9] notes that expectations are socio-psychological in nature and the patient who encounters a doctor has the perception of doctor's role in mind and even how the doctor should perform his role. It is with this frame of reference that a patient attempts to evaluate the capabilities of the doctors and the other core health care professionals. The doctor/patient relationship is usually seen as roles which involve mutual relationship between two parties. The patient is on the one side of the divide, while the physician on the other side. Each participant in the social situation is expected to be familiar with the expectation of the other. The patient usually has his conception of who a physician is in terms of the social roles. Also the patient is expected to recognise the fact that being sick is undesirable and that he/she has the obligation to get well by seeking a physician's help. The physician in turn has an obligation to return the sick to his/her normal state of functioning. Thus it is a type of behaviour expectation.

Additionally, Freidson [9] remarked that physicians who are sensitive to the interpersonal dynamics that foster patient satisfaction are in a favourable position to understand their patients' perspective and help them develop positive attitude towards health promotion and satisfaction. For example, patients want to feel accepted and respected, they also want their physicians to take time to listen to them, give attention to their worries and questions as well. Alliyu et al. (2005) on patients with sexually transmitted infections (STIs) and other conditions in a teaching hospital revealed that patients have different expectations about the facilities and these expectations are important in their assessment. Patients also expect prompt attention which can compromise their satisfaction when lacking. Owumi [6] notes that the compatibility of patient's expectation and the doctor's performance, have important implications for treatment outcome. Donabedian [10] summarized that no longer will the quality of healing remain the sole purview of practitioners. He notes that it will be shared increasingly with other consumers (in-patients) and become a more homogenous blend of professional and customers' input with customers (in-patients) expectations as a primary component because large group of purchasers of health care have come to exercise such numerous leverage in the area of what is considered to be in patient satisfaction. Studies have shown that patients who are satisfied or dissatisfied behave differently; patients who are satisfied with health care services are more likely to comply with treatment and further utilise health services [11,12] and keep up appointment [11,13,3]. Such behavioural consequences that have relationship with satisfaction with health care services could affect outcome of health utilisation and help–seeking behavior of individuals.

2.2 Patient's Interaction with Health Professionals (Doctor/Nurse) and Patient Satisfaction with Health Care Services in Teaching Hospital

The importance of good doctor/patient relationship is well documented in the literature. Asuzu [1] noted that professional's interaction with their patients can substantially influence patient satisfaction. According to Erinosho [4] the doctor/patient relationship is intended to serve some therapeutic functions in most societies, and promote some significant changes in the health of the patient. Similarly poor patient/doctor communications is a major reason for dissatisfaction with health care service. In a study conducted in the United Kingdom by Nettleton and Harding [14] findings show that the commonest criticisms of general practitioners were: inadequate clinical treatment (27%), non response attitude of practitioners (27%), personal attribute of health professionals (25%), organisation of practice/staff (10%), financial issues (7%) and mistakes by practitioners (4%). Doctor's ability to dispense pills is not in question but his manner; abrupt and abrasive calls to question his ability as general practitioner. The

finding was consistent with a previous study by Williams and Calnan (2008) which reported patients' view of the relative importance of different attributes. Most important was that the doctor provided information; next the doctor was 'likeable', then that the consultation was long enough and the fourth in importance that the doctor had good medical skill.

Studies with robust evidence have shown some areas of care that influence patients' view. Professional's interaction with their patients substantially influences patient satisfaction; for example Dimatteo et al. (1980) cited in Black and Gruen [15] studied 71 doctors working in the New York community hospital where they were asked to perform two experimental tasks. First, they had to judge the emotions portrayed by actors in a film specifically made for the study. Second, they were asked to demonstrate a range of emotions that were then rated by other study participants. Subsequently patients actually attending the clinics of doctor being studied were asked to assess independently their doctor's interpersonal skills. Doctor's scores for interpreting emotions from non-verbal cues were found to be significantly related to Patient satisfaction. Stile, Putnan and Wolf, et al. [16] tape-recorded the consultations of 19 doctors presiding over general medical case in an American hospital and then subsequently asked their patients to complete a questionnaire about satisfaction with care. Rating scales were used to judge the dialogue between patients and doctors. Patient satisfaction with doctors' interpersonal skills was independently assessed from tape recording to facilitate patients in talking about their health problems in their own terms rather than following a rigid closed ended sequence of medical questions.

According to Smith, Sinclair and Raine, et al. [17] this approach to consultation is often referred to as patient centred style of communication in which questions are asked by the doctors during consultation using open-ended questions and the doctor facilitates the expression of patients' concerns and feelings about the problems they presented. The authors note that how well health professional can interact with their patients will enable them take active role in the consultation process. Good communication skills are particularly important in showing empathy, assessing the whole range of patients' concern. The dominant form of social interaction in the hospital and health industries has traditionally been between the physician and the patient. In this modern time however, medical treatment and health care services have come to involve other stake holders such as the nurses, pharmacists and laboratory scientists.

3. METHODOLOGY

This study adopts cross sectional design and the hospital was stratified into departments of medical units where data were collected within specific period. The population of the study consisted of patients on hospital admission and medical personnel such as Doctors and Nurses. The sample size was 420 and this was determined using Cochran's (2005) statistical formula. Sampling technique was multi stage and this consisted of purposive, random, systematic and stratified sampling. These sampling techniques were applied scientifically and technically to derive data for the study. Method of data collection was quantitative and qualitative and this generated data in numeric form and text of conversation. The instruments of data collection were structure questionnaire and in-depth interview guide. Similarly, method of data analysis combined quantitative and qualitative. Quantitative utilized tables, frequency and percentage. At this level, descriptive statistics was used. At qualitative data analysis, ethnographic method using content analysis, verbatim quotation and themes of discussion were utilized. The study was conducted under the approval of ethical unit, University of Benin Teaching Hospital. The ethical issues covered areas of anonymity, security of patients, confidentiality and non malfeasance. The inclusion criterion was that patients on hospital admission should be capable and conscious to respond to research questions.

4. RESULTS AND DISCUSSION

4.1 Socio-Demographic Characteristics

The analysis of data in this section covers variables that consist of age, education, religion, ethnic and occupation. Others are marital status and income. The importance of the variables in this analysis is to show how they tend to shape, affect and influence the opinions of respondents to main research questions.

The findings in Table 1 showed distribution of respondents by their socio-economic and demographic characteristics. Respondents were asked to give information about their age. There were 38.4% respondents in the age range 20-29 years, 30.7% in 30-39 years and 14.0% in 40-49 years. Others included 13.6% (50-59 years),

2.8% (60-69 years) and 0.5% (70 years and above). The implication of the finding is that most respondents under the age of 50 years (96.7%) tend to patronize tertiary health care services. Yet only 3.3% of the respondents aged 60 years and above patronized the services. This may have some socio-economic undertones such as income which tend to deprive aged individuals who may probably pensioners and could not afford the financial rigor of teaching hospital. Finding showed that there were 38.6% male and 61.4% female in-patients that utilized health care health care services in the study area. The educational qualification of the in-patients showed that 6.7% had no formal education, 22.4% had primary school education and 42.4% had secondary school education.

There were 27.6% of the respondents that possessed post secondary education (e.g. colleges, polytechnic and university degrees). However 1.0% of the respondents possessed Post graduate degree. It can be inferred from these findings that majority of the respondents possessed academic qualifications which had influence on the patronage of tertiary health care services. When respondents were asked to identify their religious affiliations, 96.4% practiced Christianity, 1.9% of the respondents were identified with Islam and 1.0% traditional worshippers.

Although most respondents in the study were Christians, it is however not unconnected with the fact that Christianity dominated the Southern part of Nigeria (Omorogbe, 2017), where the study was conducted. Again, the affiliation of people with traditional belief further strengthens argument that African traditional religion still flourishes in modern society. Ethnic affiliation of the respondents showed that 56.9% were Edo origin, 7.6% Yoruba origin, and 12.1% Igbo. Also, 1.2% of the respondents were Hausa origin. Other ethnic (22.1%) consisted of Igala, Nupe, Igbira, Ijaw, itshekiri and Urhobo.

The implication of the above finding is that users of tertiary health care services in the study area came from different multi ethnic origins. This further suggests that in Benin, there are people of different ethnic affiliation resident in the location. The distribution of respondents by occupation showed that 20.5% were unemployed, 16.4% civil servants, 8.8% housewife, 44.0% self employed and 0.7% clergy men and women. Finding showed that 9.0% were school, college/university teachers or lecturers. Critically speaking, 20.5% of the respondents were unemployed. This suggests that they have no regular or source of income. This may as well affect the quality of health care services they received. Marital status of the respondents showed that 21.4% were single and never married, 1.9% cohabit, 69.8% married, 2.6% separated, and 1.2% divorced. Others were widow (1.9%) and widower (1.2%). In this finding, most respondents, 69.8% married were in-patients. This may draw line of conclusion that family pressure and tension mat have implications on people health.

The income distribution of respondents showed that 54.5% earned less than N20,000 monthly income, 17.6% earned N20,001- 40,000 and 10.2% received N 40,001-60,000. Other monthly income of respondents included N60,000-80000 (6.0%), N80,001-100,000 (3.8%) and above N100,000 (7.9%). The finding on personal income showed that 82.3% earned less than N60,000 monthly and 17.7% earned above N60,000. Income determines many things in human's life. It defines the quality of life and life chances. Access to desirable health care services and its utilization is one of the life chances people desire. However, few people especially in the context of the study area may not have such advantage because of the income earned. Similarly, when respondents were asked about their spouse's income, 57.1% rated it on less than N20,000 monthly. In this case, 80.6% earned less than N60,000 monthly and 19.2% earned above N60,000. Looking at income reported by respondents especially in the context of Nigeria standard of living and cost of living, it can be stated that most respondents were on low income, although they could still utilise medical services provided in a tertiary bound hospital.

Furthermore, respondents were asked about the duration of days which they had been on hospital admission. Some respondents, 11.9% were on less than 2days, 49.8% were between 2days and 7days and 14.8% between 8days and 14 days. Other in-patients (9.0%) have been on admission for 15-28 days and 14.5% on admission more than 28days. It may be stated not less than 88.1% of the in-patients were on admission 2days and above. This could contribute to their knowledge of care services and assessment thereof in terms of satisfaction. The respondents were asked to indicate whether they were on reference from other hospital or not. In this

regard, 38.1% of the in-patients were on reference and 61.9% were not on reference. Apparently, the availability of reference in-patients in the hospital helps to define the tertiary status of University of Benin Teaching Hospital (UBTH). At the same time, 81.4% of the in-patients lived in urban area of Benin and18.6% lived in rural areas.

4.2 Health Care Services in Teaching Hospital and In-Patients' Knowledge

The availability of adequate and functional health care services in Tertiary Teaching Hospital (TTH) represents the rally point of the health sector. It is the reference point in which quality health services are expected to be offered to public

Table 1. Socio-economic and demographic characteristics

Sex	Frequency N=420	Percentage
Male	162	38.6
Female	258	61.4
Age range		
20-29	161	38.4
30-39	129	30.7
40-49	59	14.0
50-59	57	13.6
60 and above	14	3.3
Marital status		
Single (unmarried)	90	21.4
Cohabiting	8	1.9
Married	293	69.8
Separated	11	2.6
Divorced	5	1.2
Widowed	13	3.1
Education		
No formal education	28	6.7
Primary school	94	22.4
Post primary	178	42.4
Tertiary	120	28.6
Religious affiliation		
African traditional religion	7	1.7
Islam	8	1.9
Christianity	405	96.4
Personal monthly income (in naira)		
Less than N20,000	229	54.5
N20,001- 40,000	74	17.6
N40,001- 60,000	43	10.2
N60,001- 80,000	25	6.0
N80,001 and above	49	11.7
Ethnic origin		
Edo	239	56.9
Yoruba	32	7.6
Igbo	51	12.1
Hausa	5	1.2
Other ethnic group	93	22.1
Total	420	100.0
Occupation		
Unemployed	86	21.5
Civil servant	69	16.4
Housewife	37	8.8
Self employed	185	44.0
Traditional rulers	3	0.7
Teacher/Lecturer	2	0.5

Source: Researchers' Field Work, 2017

seeking health. Services in tertiary hospitals are diverse aiming at meeting the needs of users. The findings in this context sought to examine knowledge of in-patients in their utilization of health services in UBTH. The in-patients' knowledge covered the period before and after entrance into the hospital.

Table 2 contained information about in-patients knowledge of their utilization of health services in UBTH. Respondents in the hospital were asked to give their knowledge about Nurses' assessment on patients before Doctors' consultation. In this case 90.5% had knowledge of Nurses' medical examination of patients, while 9.5% of the respondents were not aware of the services. There were 90.8% of the respondents that had knowledge that Doctors listen to patients' complaints, while 1.2% had no knowledge of the services. Further findings showed that 98.1% know that Doctors recommend medical investigation for patients on admission. There were 97.6% respondents who ascertained Doctors' role to explain cause and treatment regimen of illness and prescribed treatment for illness. A male respondent was asked to give his views about medical services in UBTH. He stated:

This is not the first time I am visiting the hospital for treatment. I suffered from terminal disease. I'm looking unto God for divine healing. Really the medical service in UBTH is good. Doctors are friendly and kind. They attend to patient regularly. Doctors come at right time to ensure that patients respond to treatment. I have spent more than 3days on admission now. I don't have complaint about their services. Although sometimes when health workers do not do their work regularly, it may be difficult to complain. Every patient wants to get well on time (IDI/In-patient/Medical Unit/UBTH/ 2017).

In a similar view a respondent held:

I was advised to seek health in UBTH. I have patronised other medical centres. The services which have been rendered to me in this hospital are encouraging. This is not my first time that I will be visiting hospital for medical treatment. Some Nurses are not friendly. They shout on their patient at slightest provocation. The attitude of many nurses in government hospitals sometimes discourages health seekers. Some nurses are still good and caring. I have been on admission in this hospital for four days. Doctors come for regular check. Both Doctors and Nurses examine me. I'm responding to treatment as you can see. Nurses applied my drugs for me and Doctors conduct their regular checks (IDI/male orthopedic/UBTH/ 2017).

The findings in the above revealed that patients who patronised the Teaching Hospital were familiar with the services and operations of the health centre. The in-patients could identify the role of Nurses and Doctors in the hospital. Although patients complained about the attitudes of Nurses in the hospital, this did not however stop them from utilising the health services. Furthermore, when respondents were asked to give their knowledge about the role of nurses to administer prescribed treatment on patient, 96.9% were aware and 3.1% lacked the knowledge. There were 91.7% of the respondents that had the knowledge that different nutritional diets should be provided for different patients. Again, 97.1% of the respondents were aware that it is the responsibility of the hospital to provide medical equipment for the treatment of patients; 94.0% of the respondents know that pharmacy department of the hospital should supply drugs to patients' wards on Doctors' prescription; 97.9% know that hospital organisation is responsible to provide clean and hygienic environment and 91.9% of the respondents know that patients get specialist consultation services in UBTH.

In the similar vein, 92.4% of the respondents know that patients participate in their health decision making with health care professionals; 97.1% expressed the knowledge that patients are discharged by Doctors after recovering. The finding further showed that 91.4% of the respondents had knowledge of the illness they were diagnosed; 79.0% could identify the prescribed treatment for their illness and 82.9% know the disease they were treated.

Respondents were engaged in verbal interaction to give their views about their knowledge of care services in UBTH. A female in-patient in the hospital echoed in her words:

I have known UBTH as one of the best teaching hospitals in Nigeria. The hospital is clean. Doctors are nice. I'm better now as you can see. I expected this from the hospital. I got it right in the hospital (IDI/medical unit/UBTH/2014).

Table 2. Knowledge of health care services

Knowledge of nurses' assessment of patients before doctor's consultation	Frequency N=420	Percentage
I'm aware of the nurses' role	380	90.5
I don't know about the role	40	9.5
Patients have the power to report health issue to Doctors		
I'm aware	415	98.8
I don't know	5	1.2
Doctors recommend medical investigations for patients on admission		
I'm aware of the service	412	98.1
I don't know	8	1.9
Doctors explain the cause and treatment regimen of illness		
I'm aware	410	97.6
I don't know	10	2.4
Doctors prescribe treatment for illness		
I'm aware	410	97.6
I don't know	10	2.4
Nurses administer treatment (drugs, injections etc.) prescribed		
I'm aware	407	96.9
I don't know	13	3.1
Different diets are provided for different patients		
I'm aware	385	91.7
I don't know	35	8.3
Hospitals make available equipment for patients treatment		
I'm aware	408	97.1
I don't know	12	2.9
Pharmacy unit supplies drugs to patients wards on Doctors' prescription		
I'm aware	395	94.0
I don't know	25	6.0
Hospital is responsible to provide clean hygienic environment		
I'm aware	411	94.0
I don't know	9	6.0
Patients get specialist consultation services in UBTH		
I'm aware	386	91.9
I don't know	34	8.1
Patients participate in their health decision making with health care professionals		
I'm aware	388	92.4
I don't know	32	7.6
Patients are discharged from the hospital on Doctors recommendation		
I'm aware	408	97.1
I don't know	12	2.9
Patients' knowledge of the illness diagnosed		
I'm aware	384	91.4
I don't know	36	8.6
Medical treatment in UBTH is not free		
I'm aware	402	95.7
I don't know	18	4.3
Patients' knowledge of the medical treatment received in UBTH		
The treatment was communicated to me	332	79.0
The treatment was not communicated	88	21.0
Patients' knowledge of the type of disease treated		
I was informed by the Doctor	348	82.9
I was not informed by the Doctor	72	17.1
In-patient's level of knowledge of health care services		
High	234	55.7
Moderate	116	27.6
Low	70	16.7

Source: Researchers' Field Work, 2017

Another respondent mentioned some of his experience in UBTH:

I was diagnosed in the laboratory of the teaching hospital. Doctor recommended the diagnosis. I have been treated now by more than two Doctors in the hospital. Doctors explained to me the ailment, the nature and the test results of the illness. Doctors come to check me and they have always given me hope of recovery. Although sometimes I used to feel uncomfortable when Doctors conduct their check especially when I am naked, but there is nothing I can do because it is part of care services. I complied with every instruction given by Doctors as pathway for me to get well. Doctors and Nurses in UBTH are punctual in their role. They give drugs, injection and treatment care at the right time. I love this (IDI/medical unit/UBTH/2017).

Another respondent said:

Knowledge is power. It is good to have knowledge of every service that you want to consume. It is in the knowledge that lies in your strength to reject or accept the product. I am a patient in this hospital. This is my 17th day running on admission in the hospital. I had fatal motor vehicle accident on my way to Lagos. I was rushed to this hospital to rescue my life. I thank God I'm getting better every day. Doctors and Nurses are friendly. The hospital has clean environment. The hospital is good example of health care centre. I used to know that hospitals should have adequate equipment and facilities for health services, qualified staff, clean environment, pharmacy shop and good ventilation bed space. All of these qualities are here in UBTH. The only thing I disliked sometimes is the attitudes of some Nurses. They can be aggressive (IDI/Accident unit/UBTH/ 2017).

Also a female respondent was happy when she expressed her feelings:

This is not my first time of patronizing health care centres. I have been into many hospitals as in-patient. I am a cancer diagnosed patient. This hospital has educated me about some of the rights and obligations I have as patient. In the past I thought patients have no decision about their health. Apart from the medical treatment I received in the hospital, health professionals educated us about the rights to complain against poor services and unprofessional conducts of health workers. Now I know that Nurses must not shout on patients seeking health. Nurses must follow up treatment path prescribed by Doctors. Doctors must follow up treatment path of patient. Both Doctors and Nurses must work in collaboration to effect treatment for patient (IDI/radiology unit/UBTH/2017).

A respondent further said:

This is my first time of patronizing UBTH. The service here is good and qualitative. The environment is clean and conducive. Yes I know that it is the responsibility of the hospital to provide medical equipment; it is the duty of Doctor to prescribe treatment path that must be carried out by Nurses; it is the duty of Nurses to follow Doctors' instruction; it is the duty of Doctors to prescribe laboratory test. I was told the type of illness diagnosed for me. The Doctors told me the illness I was treated. Everything that happened to me in this hospital was to my knowledge. This really helped me to keep my mind set I was going to get well (IDI/medical unit/UBTH/2017).

Looking from the point of findings in the foregoing, it can be pointed that patients seeking health in UBTH could strongly identify many health care services available in the teaching hospital. Most of the patients were able to identify the roles of care givers or otherwise health professionals, how they operate and in-patient role on the other hand. Knowledge of health care services is attributed to one of the major causes of high death in Africa and Nigeria in particular [6] Omorogbe, 2017. The base of this argument is that people do not seek modern health care services because of their superstitious belief and unwillingness to know how modern hospital operates. Again these previous studies above revealed that many health seekers often showed apathy to the utilization of health services in teaching hospitals because of inaccessibility.

It is however revealed in the current study that health seekers of different social background now patronized teaching hospital to get well. They now know services available in teaching hospital, their role, rights and obligations and how health workers should relate to them. Findings in this study also showed that patients or health seekers now can recognize or know that it is duty of Nurses to assess patients before Doctor's consultation; Doctor has the role to listen to patient's complaints; Doctor should

recommend medical investigations for patients; and Doctor should explain cause and treatment regimen of illness. This knowledge plays vital role to determine the quality of health people get from hospitals. As a result, the level of knowledge of health care services among in-patients was high (55.7%), moderate (27.6%) and low (16.7%).

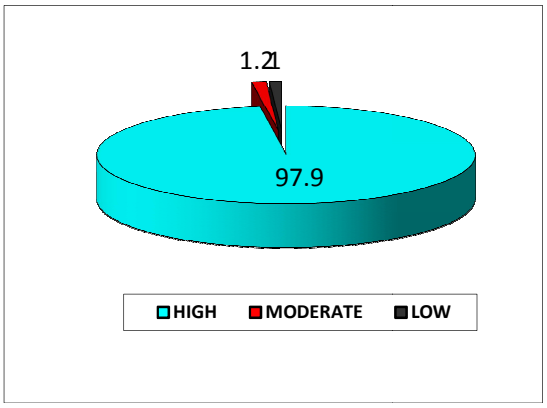

Fig. 1. Level of knowledge Respondents about available health care service

5. CONCLUSION

There is abundant evidence that patients who seek health in teaching hospital were motivated to get qualitative service. Although the UBTH is a bureaucratic medical setting that is highly regimented, there are evidences which reveal that the rigid structure of the hospital has little or no significant impact to distort patients' relationship and interaction with doctors, nurses and other medical personnel to get satisfied services. This is apparent in the volume of respondents that displayed explicit knowledge of the hospital activities pertaining to role of doctors or nurses to patients and vice versa. Fig. 1 above provides pictorial evidence. The knowledge of the in-patients in UBTH interplay vehemently to contribute to satisfaction with health services as shown in the text of conversation with respondents. This study hereby suggests that health organization must strongly recognize the importance of social relationship and patient centered policy as component of health dispensary. The UBTH evidence provides that there was unbroken interaction and social relationship between patient and medical officer from the point of entry as patient and exit when patients are discharged. Patients were not intimidated to ask questions and doctors/nurses were comprehensively involved in unbroken chain of communication with patients.

ETHICAL APPROVAL

The study was conducted under the approval of ethical unit, University of Benin Teaching Hospital. The ethical issues covered areas of anonymity, security of patients, confidentiality and non malfeasance. The inclusion criterion was that patients on hospital admission should be capable and conscious to respond to research questions.

COMPETING INTERESTS

Authors have declared that no competing interests exist.

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