DOCTOR-PATIENT COMMUNICATION AND INFORMATION GIVING IN AN ACUTE GENERAL HOSPITAL IN MALTA

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A project submitted in part fulfilment of the requirements for the Masters in Health Science (Health Services Management)

Institute of Health Care
University of Malta

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DEDICATION

I dedicate this project to the three women of my life

– My wife and two daughters
Declaration of Originality

I the undersigned hereby attest to the originality of the work within this research project entitled 'Doctor-Patient Communication and Information Giving in an Acute Hospital in Malta', which is being submitted in conformity with the requirements for the Masters in Health Services Management at the Institute of Health Care, University of Malta.

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June 2010

MR. MICHAEL BEZZINA
June 2010
Acknowledgments:

I would like to formally dedicate this page to a number of persons from whom I have found valuable help and support that was needed to complete my study. First of all, I thank the participating wards and their consultants, doctors, managers, and the patients at Mater Dei Hospital, all of whose commitment to the project made the study possible.

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ABSTRACT

Background: Communication is an important component of patient care. Providing patients with appropriate doctor-patient interactions while offering them complete information about their condition is important for patients' health, well-being and satisfaction. Improvements in doctor-patient communication can have beneficial effects on health outcomes.

Objectives: This study aimed at exploring the quality of interactions between doctors and patients at an acute general hospital in Malta namely Mater Dei Hospital. The main focus being the doctor-patient communication and information given by doctors and how the patients perceived these interactions.

Methods: Three cross-sectional sub-studies were performed using quantitative and qualitative research methods. Data for the first sub-study was collected through direct observations of 80 doctor-patient interactions for 36 consultants during ward round visits. This considered medical talk much like any other source for discourse analysis, with attention to the structure and functions of the medical interaction. Data for the second sub-study was collected through patient satisfaction questionnaire which included 251 participants representing 96.2% response rate. The patient satisfaction questionnaire considered important doctor characteristics elements towards patients’ health outcomes, satisfaction, adherence to medication, lifestyle regimens, and communication skills between patient and doctor. Data for the third sub-study was collected through structured interviews with 10 ward managers. The author once again focused on doctor-patient communication issues with regard to interpersonal skills and confidentiality, facilitation and listening skills, medical and healthy living information, treatment and medicinal information, technical and empathy skills, written information, and consultation time. Qualitative content analysis was applied within the structure of the thematic guide and for the data that was emerged from the materials.

Main findings: The collected data was analysed by means of SPSS Student Version 17.0. Results obtained from the direct observations on doctors indicated that some important aspects of positive interactions need to be improved during ward rounds. These included: inquiry on diet compliance, inquiry on risky habits, advice on healthy lifestyle, inquiry on
medicine compliance, inquiry on allergic reactions to medicines, and an explanation of medicine prescribed and its use by the patients.

In the qualitative data (Structured interviews) it was argued that although doctors have very good interpersonal, technical, and empathy skills, they still need to focus on consultation privacy, encouraging the patients to ask questions, emphasising on patients’ understanding of the provided information, inquiring about adverse events of medicines, and about risky habits like smoking and alcohol consumption. It was also revealed by ward managers that there exist low referrals to health educators or dietitians.

Findings from the patient satisfaction questionnaire indicated that most of the patients were satisfied with the type of communication being offered to them by the doctors. However when analysing deeper the author recognised that the same communication needs match closely with those found with the previous two methods. These included: advice on healthy lifestyle, inquiry about diet, written information on patient’s illness, importance on consent from patients, specifying possible side effects of prescribed treatment, information of what patient should do in case of adverse events, and inquiring from patient if help was needed at home following their discharge from hospital.

Overall findings from all three methods used indicated satisfaction with doctor-patient communication and information giving. This was indicated by mean scores of > 3.5. However there were also indications that quality of communication between doctors and patients needs refining in certain areas like patient consent and involvement in decision making, medical and treatment information, written information and consultation times.

**Conclusion:** Patient education needs to be improved and more tailored to patients’ individual information, support needs and abilities. By exploring the required amount and content of information, treatment goals and expectations, doctors would be automatically directing patients to high patient involvement in self-care activities. This movement towards a more patient centred approach should ameliorate and strengthen our health care system.

Recommendations are given to enhance recall of information in all patients; information giving needs to be more structured by summarising and repeating the most important, personally relevant information. Knowledge leaflets and written instructions can also be beneficial, as long as doctors use suitable language and the patient is competent to read them. To adapt to these specific information needs, communication training for doctors at all levels needs to be accentuated. Better doctor-patient communication may also be achieved through the involvement of multidisciplinary team approaches with emphasis on patient centred care.
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CHAPTER 1

Introduction
Chapter 1: INTRODUCTION

Despite the fact that everyone has ideas about what it means to be healthy or ill, the term health is a complicated concept to define, due to multiple interpretations based on individual experience and culture. The World Health Organisation (WHO) defines health as a “state of complete physical, mental and social well-being” (Costello, 1977). Moreover the WHO definition conceptualises health and disease as dynamic processes as opposed to stable entities. In other words, both health and disease are seen as being in a constant state of change. This definition also recognises that health goes beyond physical and psychological health to include aspects such as a person’s quality of life. A variety of communication problems can occur in healthcare settings due to different conceptions of health and disease.

Defining communication presents similar challenges. Most definitions of communication view it as a process that involves a sender, a receiver, a message and a channel. However, a variety of issues, such as the ability of multiple messages to be communicated simultaneously through verbal and nonverbal channels, the transaction nature of communication (when sender and receiver mutually influence one another), physical and psychological noise in the channel, channel limitations on multiple senders and receivers, and many other facets of the communication process, make it difficult to define.

The heart of medicine is the personal confrontation that is the coming together of doctor and patient with the purpose to alleviate suffering and ideally cure the whole patient. Most of what occurs during the doctor-patient encounter is talk. By talk one
could refer to what is said in the verbal message – the words that are used, the information exchanged, the recommendations given, and the social amenities that tie the conversation together. But one could also mean communication beyond words, the whole repertoire of nonverbal expressions and cues within which verbal transactions are embedded (Griffith et al., 2003). The smiles and head nods of accordance, the scowling facial expressions of pain, the high pitched voice of anxiety, and the various subtle cues indicative of interpersonal dominance; all of these nonverbal expressions give context and enhance meaning to the words spoken (Harrigan et al., 1985).

Despite its pivotal role, perception of the nature of this talk is often not very high. This occurs for several reasons. The exchanges are often highly scripted and do not leave many choices (such as the question-answer routine of a medical history taking). And, much of the nonverbal behaviour that people employ and react to remains below the brink of awareness (Ruusuvuori, 2001; Hall et al., 2009).

There are exceptions, of course. A doctor might give mindful thought to which questions to ask and how to express them, or a doctor might take an intentional note of a look of perplexity or discomfort on a patient’s face. A patient might formulate a question ahead of time, suffer oversights in descriptions of symptoms, or notice that the doctor is in a hurry. But generally the exchange is taken for granted, with the participants having little sense that they choose how it develops, that it can be different than it typically is, and that it has a profound impact not just on the doctor-patient relationship but also on the outcomes of care. Very often, consciousness of the communication process occurs only after there has been a failure in communication,
leading one or both of the parties to feel confused, let down, frustrated or angry (Heritage et al., 2007).

Meetings between doctors and patients can be loaded with expectations, hopes, and assumptions. Both patients and doctors bring their backgrounds to the doctor-patient relationship. Doctors might generate medical education, communication skills, and clinical judgement. Patients often bring their current symptoms and experiences of illness. When doctors meet patients, extra factors enter the relationship. These include knowledge about cultures, assumptions about health and socio-economic status. Patients bring both their personal and family histories and their experiences of preceding interactions with doctors (Roter & Hall, 1993). Doctors have a certain social dominion, located in specialised medical knowledge, which holds a guarantee of healing. This social power might be augmented for some patients who feel helpless as patients (Robinson & Whitfield, 1985).

1.1 Effective communication

Despite vast improvements in public health and healthcare in Malta, there is still a long way to go in terms of making the Maltese society a healthier place. Last year (2009) in Malta, the health care expenditure has been increased by thirty nine (39) million Euro to two hundred and eighty four (284) million Euro, making it the leading sector of the Maltese economy (Malta Budget - 2009). However, like elsewhere, a wide variety of problems still exist in terms of maximising efforts to prevent and control diseases and other health problems. It appears that the severity of many of these problems could potentially be lessened by improving communication between doctors and patients.
Good interpersonal communication skills can be considered as the basis of an effective patient care. Doctor communication skills determine the nature and quality of diagnostic information elicited from the patients and the effectiveness of the doctor's counselling. Communication also decides the patient's faith in the doctor, which is strongly connected to patient adherence and satisfaction (Roter & Hall, 2009). Comprehensive data has connected effective doctor-patient communication to biological, psychological, social, and legal outcomes of care. It has been tied to better adherence to treatment, shorter hospital stays, better efficiency and cost effectiveness, enhance quality of care, helping patients and doctors use time wisely, decrease the risk of malpractice claims, and not surprisingly, increase doctor and patient satisfaction (Rao et al., 2007). All these positive outcomes bring about a reduction in the patients' length of stay and also less re-admissions in hospital, therefore saving huge costs on the health care services.

The word "doctor" is originated from the Latin docere, "to teach." As part of the doctor-patient communication process, the doctor needs to educate his patients about their bodies, their illnesses, tests and treatments. This means consuming time with patients and using clear, straightforward language adjusted to each patient's educational and cultural background. The capability to communicate well is extremely significant for a doctor's effectiveness in clinical work (Roter & Hall, 2009). Unfortunately, many doctors tend to use "medspeak", professional jargon. Many centuries ago Hippocrates said, "The chief virtue that language can have is clearness, and nothing detracts from it so much as the use of unfamiliar words."
On the other hand, patients have the right to expect their doctors to provide them with full information about their health so they can make good health care decisions. From the patient's point of view, effective interpersonal communication is recognised as the hallmark of an excellent physician. Maybe, a doctor needs to encourage his patients to raise questions and should ask them to repeat basic instructions and precautions in order to see whether they have understood. This is an important objective; unfortunately, it needs a precious advantage that is being threatened with extinction by the calls of modern medicine: time.

Negligence to give information or providing undesired information can cause harm. This is because the information may be lacking because clinicians might under reckoning patients' needs, overrating the amount of information they give, have insufficient necessary skills, or use jargon. Moreover, patients may believe to be unable to ask questions, particularly patients with serious or life threatening diseases.

1.2 Poor communication

A related context in which poor communication has been found to have a particularly detrimental impact is on the quality of decisions patients are able to make in relation to their course of treatment (Kluge, 2008). Poor communication is known to increase the use of alternative and/or unnecessary treatment and it has also been linked with inadequate pain relief (Al-Atiyat, 2008). Furthermore, the fear and anxiety incurred in patients who have experienced poor communication is believed to lead to further demands upon the system in terms of the time and effort required to counteract the resultant emotional distress and misinformation it causes. In view of these negative impacts derived from poor communication, one finds it reasonable to extrapolate that
poor communication may well exert a significant burden upon the patient, the clinician, and also upon the service delivery system. There are three main categories within which significant costs may occur. These include costs to the patient associated with unnecessary psychological distress for the patient, costs to the system associated with unnecessary treatment, and costs to the clinicians and the care system as a whole associated with bad reputation which can be caused by the indirect effect of poor communication.

1.3 Aim:
The aim of this study is to explore doctor-patient communication and information giving in the medical and surgical wards of an acute general hospital in Malta.

1.4 Objectives:

- To observe the level of doctor communication and information given to their patients during their first encounter on the ward.
- To indicate (if any) aspects of doctor-patient communication which are not being met.
- To identify the views of experienced ward managers on the way doctors manage their medical consultations with patients in the medical and surgical wards.
- To explore patients' actual experience of how communication and information was being transferred to them by their doctor.
1.5 Brief explanation of the tools used to reach the objectives

In order to reach the above objectives the author used a triangulated method comprising three separate tools which consist of:

- Direct observations on doctors during their first consultation with the patient at the Medical and Surgical Admitting Units at Mater Dei Hospital.

- A cross-sectional quantitative study was performed in the acute medical and surgical wards within Mater Dei Hospital in the form of patient satisfaction with doctor-patient communication questionnaire.

- A qualitative study consisting of structured interviews with Ward Managers was carried out to identify how the impact of communication on behalf of doctors towards patients could affect the running of the medical and surgical wards.

1.6 Benefits

This study is likely to increase disease awareness, consciousness and conscientiousness on achieving better doctor-communication.
1.7 Conclusion

As this is a new study for Malta, this project attempts to act as a basis for future research work in the field of doctor-patient communication, and as a stimulator of knowledgeable policy-making and service provision changes directed at meeting the needs and demands of the patient. Lack of sufficient doctor-patient communication may lead to very stressful encounters for both patients and doctors (Fallowfield, 1997). Health services management research will contribute to uncovering ways of improving such a service and its outcomes.
CHAPTER 2

Literature Review
Chapter 2: Literature Review

2.1 Introduction

This chapter will look into past and recent literature that has explored the different aspects involved in the process of doctor-patient communication. In continuation with Chapter One, the purpose of this chapter is to show command of the subject area and understanding of the problem.

2.2 Search Strategy

A search was made for related studies carried out at the University of Malta. During the conception of the study and formulation phases of the data collection, further opinions and suggestions were sought from professionals involved in communication and information studies, such as experts from the Training Centre which is based at Mt. Carmel Hospital and from the Department of Health Information and Research, both with rich knowledge in the subject area being investigated. Huge amounts of journals related to the topic were found very useful and were easily accessible at the Faculty of Health Science library (University of Malta) in Mater Dei Hospital and the former Medical School library in Karen Grech Hospital. Books on clinical communication techniques and abilities distributed for recent general practitioner training were also recommended. These were all examined and utilised to further the body of knowledge acquired through the study.
Another rigorous search was made through the internet using several databases and search engines, and the following key phrases were used: ‘patient-centred care’, ‘provider-patient interaction’, ‘doctor-patient relationship’, ‘effective communication’, ‘patient rights’, ‘patient consent’, ‘clinical information’, ‘patient satisfaction’, ‘prognostic information’, ‘doctor information delivery’, ‘treatment compliance’, ‘doctor consultation time’, ‘doctor interruptions’, ‘clinical sociology’. Many relevant studies and abstracts were available online and used for this study. Authors of relevant abstracts were contacted and full reports of the actual studies were obtained. All the researched material was referenced in this literature review.

2.3 The sociological approaches to the doctor-patient relationships

The doctor-patient relationship is a mainstay of sociological writing (Mechanic 1978; Parsons 1951; Szasz and Hollender 1956). The importance of the social connection between the patient and the doctor during consultation with regards to clinical, psychosocial and behavioural outcomes has concluded in considerate attention being given to the various models and determinants of this relationship. Traditionally such relationships were hierarchical in nature, with doctors holding a dominant role and patients a submissive one. Over the years, the doctors have changed this approach according to the situation presented and the patients were more involved to participate as a joint venture and engaged in an exchange of ideas and sharing of belief systems.

In Parsons’ model, medical practice is society’s mechanism for controlling and mitigating a special kind of deviance – illness (Parsons 1951, 1975). Illness is a threat to society’s homeostasis because of its potential for interfering with role relations.
This threat is minimized via the doctor-patient relationship which is based on a set of internalized values, expectations, and obligations as well as the formal training and experience of the physician. The doctor’s behaviour is guided by universalistic principles in the application of biomedicine, affect neutrality in relating to patients, and a fiduciary responsibility for patients. The patient is guided by the sick role, which is defined by a set of expectations and obligations that place the patient in the role of supplicant. The asymmetry inherent in these institutionalized roles ultimately derives from the situational dependence of the patient and the professional prestige and authority of the physician.

Eliot Freidson (1970) took a different approach to explaining asymmetry. Rather than focusing on a set of internalized institutional roles that reflect an inevitable imbalance of power, he focused on a problem inherent in any professional-client relationship – the problem of professional authority. He viewed professional authority as a potential source of conflict that must be resolved if the professional-client relationship is to endure. Professional authority is inherently problematic because professional and client, although oriented to a common goal, have different perspectives on the problem at hand. The difference in perspective is a function of the specialized knowledge, formal training, and occupational experience of the professional, which the client lacks. Thus, solving the problem of authority in the doctor-patient relationship cannot ultimately be based on a debate between doctor and patient regarding the scientific merits of the case. For Freidson, the solution to the problem of professional authority is one of persuasion through appeal to the economic and professional prestige of the profession – in other words, social status: “in the case of the practicing profession of medicine, the application of knowledge is characteristically sustained by a form of
authority that is more like that of the bureaucrat than that of the scientific expert” (p. 124-125). This institutionalized “solution minimizes the role of persuasive evidence in his interaction with his clientele” (p. 110). For Freidson, the difference in status is the critical factor in explaining relational asymmetry in the doctor-patient relationship.

The medical community was aware of these major communication issues. Medical professionals felt a paradigm shift was inevitable and in the decades following Parsons’ analysis and Friedson’s approach, health communication started to evolve. Ever since, physicians and scholars agreed that a biomedical or traditional approach to the medical consultation was no longer efficient, and therefore a new doctor-patient approach was imminent as the direction of the medical consultation has been in flux.

The physician-patient relationship is not only maintained and established through communication, but also sustaining ongoing modification as the interactants negotiate new meanings (Walker, et al., 2002). Kreps and Thornton (1992) note that an effective patient interviewer may clarify four important factors: (1) the patient’s information, (2) assess the social and psychological factors involved in the illness, (3) watching for patients not listening or (4) patients not comprehending a statement. These factors are all important aspects in order for the medical interview and the physician-patient relationship to begin. However, McGee and Cegala (1998) argue that most of the literature focuses on providers’ communication skills and improving them through training. This will move the doctor-patient relationship towards patient-centred care.
Three important sociological approaches to the doctor-patient relationship are the Consensus Model, Conflict Model and the Strategic Interaction Model.

**Consensus Model**

Scambler (2003) described this model as a negotiation between the doctor and the patient. Such model involves patients in healthcare decisions and treatments and encourages patient autonomy (Mead and Bower, 2000). The Consensus model is thus premised on knowledgeable and empowered patient. Care is coordinated between patients and doctors rather than provided to patients by doctors. Disease awareness and self-help groups empowered patients need to become active participants in their own health care (Illich, 1977) and helped facilitate the shift away from traditional hierarchical doctor-patient relationships to more participatory ones (Zimmerman, 1987).

**Conflict Model**

Because communication is present in medical encounters between physicians and patients, there is potential for interpersonal conflict. Interpersonal conflict is generally defined as the interaction of interdependent people who have incompatible goals and who interfere with one another in achieving those goals. However, when the physician and patient are operating from different explanatory models, as with a biomedical physician and a patient who has different opinions on treatment options, there is potential for conflict and misunderstanding. Conflict model can be defined as the incompatibility (perceived or actual) of values, norms, expectations, processes, goals or outcomes between two or more parties and the existent culture in a communication
situation (Scambler, 2003). Examples of these might include ethical and morale evaluations, rationing of scarce resources, and confidentiality.

**Strategic Interaction Model**

Strategic interaction models are *a priori* plans that direct communication behaviour toward the successful realization of a communication goal (Scambler, 2003). The cumulative use of several communication strategies facilitates goal achievement. Strategies exemplify the notion of patient-centred communication as they allow individuals to adapt their communication to a variety of situations. A strategy can be accomplished in more than one way using different types of skills appropriate to the situation. For example, a communication strategy of “responding empathically to patient’s emotions” might include communication skills such as: legitimation, normalization, and offering hope, as well as process tasks such as: having tissues available and sitting at eye-level with the patient.

Scambler (2003) identified another model of doctor-patient relationship which is basically on the same wavelength as the previous ones. He established four scenarios: (1) the doctor acting in a paternalistic manner and decides what is best for the patient; (2) a mutual relationship where the doctor and patient are equal partners in decision-making; (3) a consumerist relationship where the patient takes the role while the doctor adopts a passive role; and (4) a relationship of default in which both the patient and the doctor take a passive role and therefore consultation lacks direction. Scambler (2003) explains how the mutual relationship is the best approach as this reaches the best outcomes for both doctor and patient, while the default relationship will get both parties nowhere due to their unreactiveness. On the other hand, the other two
approaches, paternalistic and consumerist, are also reversely related and in each approach only one actor could hold control of the consultation, namely the doctor and the patient respectively resulting that the relationship between both parties will never or can be difficult to reach agreement.

Although a model which is directed to a patient-centred approach is considered as the ideal model, one needs also to analyse the other models as all of them are essential in the long run. One can understand that the human being is very complex and every person (being doctor or patient) has different attitudes and personal characteristics. Bringing this reasoning into the consultation room, health and sickness issues are much more complicated as diseases can manifest differently within different people. Therefore different expectations from the part of the doctor and patients, together with the structural context of the consultation should be considered. Consequently, one can conclude that each model mentioned may need to be practiced or adopted by doctors at any time during the consultation depending on the situation presented in front of them. For example, a doctor enabling active involvement of the patient is much more appropriate when the patient’s condition is stable during ward round visits than during emergency and life saving situations where it is necessary for the doctor to act promptly and requires him or her to be dominant (Scambler, 2003).

The same thing can rightly be said on the models of treatment decision-making by Charles et al. (1999) in which they originated similar models to the above mentioned namely, (1) paternalistic model (doctor as solely responsible for treatment decisions and patient expected to cooperate), (2) shared model (where the doctor and patient reach a mutual agreement on the type of treatment to undertake), and (3) the informed
model (where the doctor is expected to give the full information on treatment options and the patient is the only person to decide which type of treatment to pursue). Realistically these three models do not exist in pure form and doctors can find ways to adapt according to the situation at hand (Scambler, 2003) as rightly mentioned above.

2.4 Key aspects of a patient-centred approach

Major advancements in the medical field call on developments in the quality of holistic care (Cook and Herbert, 2004). Measuring behaviours is an important step in determining a doctor’s degree of patient centeredness and taking steps to ensure a patient’s satisfaction with their medical encounter. One shortcoming with this branch of research is the complete focus on the doctor’s side of the relationship. Though the recognition of behaviours is important to the medical interaction, these behaviours do not always lead to patient satisfaction. Different behaviours and communication skills originating from a sociological context may be needed to address issues important to minority patients and patients of different genders.

A universal finding among past studies and articles documenting research (Mead & Bower, 2000; Zanbelt, et al., 2006; Heritage & Maynard, 2006) has been a convergence of several key dimensions that need to be included in any patient-centred approach throughout medical specialties. Below is a list and description of each dimension:
Biopsychosocial perspective - The willingness to understand all the key factors and potential difficulties patients bring to their doctors outside of their biomedical issues (Engel, 1977; Stewart et al., 1995).

The patient-as-person - This dimension focuses on how the patient experiences illness and the various cultural differences that may change that experience (Henbest & Stewart, 1989; Law & Britten, 1995). It is important to comprehend that all patients are individuals and thus differ in their tolerance to pain, or how they recognize their own symptoms, and last, how they present their case to doctors.

Sharing power and responsibility - Involving the patient in medical decisions (Mead & Bower, 2000). Scambler (2003) has described this aspect as 'a meeting between experts' where the doctor and the patient are equal partners, both contributing to bring about a mutual medical decision: the doctor, his or her knowledge and clinical skills and the patient, his or her explanations and experiences of the disease.

Therapeutic alliance - Important aspects of the professional-patient relationship including personal bond between doctor and patient, agreement over goals of medical care, and the patients perception of the relevance of interventions offered by their physician (Roth & Fonagy, 1996; Mead & Bower, 2000). This dimension is similar to sharing power and responsibility and could be taught as a combined dimension in regards to patient-centeredness.

Each of these dimensions have been cited primarily in medical practice journals, but in order to create a more universal approach throughout medical specialties, aspects of
patient-centeredness needs to include more substance from other disciplines. Areas including medicine, sociology, psychology, and communication can all help shape the social co-construction of the physician-patient relationship and contribute elements to the concept of patient-centeredness.

2.5 Patient-centred care

One major change in the medical profession over the past few generations has been a move towards patient-centred medicine and away from doctor-centred, technology-centred, hospital-centred, and disease-centred medicine (Stewart, 2001). The term ‘patient-centred medicine was introduced by Balint (1964) and the symptoms and signs found by the doctor, not just in terms of the underlying disease, but also in terms of the patient’s experience of their illness, and the impact of the illness on their lives (Henbest & Stewart, 1990). Patient-centred care seeks an integrated understanding of the patient’s world, their emotional needs, and life issues, and aims to find common ground on the problem and its management (Stewart, 2001).

Patient-centeredness is a multifaceted concept reflecting both a style of communication interaction that addresses patients’ wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care (National Healthcare Quality Report, 2004) as well as a goal of healthcare delivery systems (Epstein et al., 2005). Patient-centred communication can be broadly defined as the degree of provider effort to address patient initiated concerns. Moreover, each participant in the communication interaction possesses unique goals, values, and knowledge that influence communication interactions (Epstein et al., 2005;
Thus patient-centred communication is flexible, allowing for the emergence of many types of patient issues and concerns that are addressed by patients and their doctors during the course of their illness.

Dimensions of patient-centred communication as proposed by Mead and Bower (2000) include: a) an exploration of disease and symptoms, including medical information and doctor attempts to understand the patient's illness experience, b) an exploration of the entire person, or understanding the patient within the context of family, work, and culture, and c) a mutual definition of the problem achieved by establishing goals of treatment and identifying decision-making roles of patient and doctor. Other proposed dimensions include communication interactions that focus on enhancing the patient-provider relationship and enhancing future health promotion and prevention activities (Powles, 1973). Mead and Bower (2000) also acknowledge the influence of environmental influences such as available resources on patient-centred interactions.

Although the evidence linking patient-centred care to improved patient outcomes is somewhat equivocal (Mead & Bower, 2002), considerable scientific, ethical, and professional momentum are in favour of the adoption of a patient-centred care model (Steward et al., 1995). The inherent characteristics used to test the priorities placed on patient-centred care in published studies have not accurately reflected the complexity of the patient-centred care, however. Only one (1) study has examined patients' preferences for a particular aspect of patient-centred care, namely, shared decision making (Longo et al., 2006). The study found that although patients with chronic
disease valued shared decision making, they were more inclined to the listening skills of the doctor.

Feldman-Stewart et al., (2005) expanded upon Mead and Bower’s (2000) framework, focusing upon the unique goals of each participant as well as the actual process of the interaction. These authors specifically incorporate how messages are conveyed, noting that silence, as well as verbal and nonverbal interactions, impart meaning. Similar to Mead and Bower’s framework, these authors address the importance of environmental influencing factors such as values and beliefs, recent media events, and the contextual social, legal, or physical environment upon patient-doctor communication. Epstein and colleagues (2005) also expanded upon Mead and Bower’s framework, suggesting that patient-centred communication is influenced by specific health system factors, such as the physical environment, waiting, and interactions with ward personnel.

Patient-centred communication is a style of communication designed to elicit and address patient concerns. These concerns involve not only illness issues but factors that represent the context within which a patient lives such as family and/or employment issues that influence his/her health and well-being (Heritage & Maynard, 2006). Specific goals of patient-centred communication might be to address patient concerns about symptoms that may create episodic uncertainty (Bar-Anan, Wilson, & Gilbert, 2009) and anxiety about certain disease recurrence, and provide information about the interpretation of surveillance testing such as the physical exam, blood tests, and radiological investigations. Other patient-centred communication goals might be to understand how financial constraints impact a patient’s health, or how his/her family situation is influencing the patient’s adaptation to overcome the illness.
Mentioning the financial aspects and productivity costs of the patient, one could not miss out mentioning the financial aspects of the healthcare services. Patient-centeredness can reduce under-utilization and over-utilization of health services (Berry, Seiders, & Wilder, 2003) and the demand on system resources by reducing the large number of unnecessary medical investigations and referrals (Anderson, 2002; Little et al., 2001). However although some studies have shown that being patient-centred reduces costs and use of health service resources (Little et al., 2001; Mead & Bower, 2000), others have shown that patient-centredness increases costs to providers, especially in the short term (Bechel, Meyers, & Smith, 2000) due to individualised care. Another financial aspect with the practice of patient-centred care is that it may also reduce the risk factors that often lead to malpractice suits (Forster, Schwartz, & DeRenzo, 2002; Fortin, 2002); however, others dispute this evidence (Wortzel, 2002).

Patient-centred communication has been shown to subjectively enhance patient quality of life (Stewart, 2001; Stewart, 1995). Yet patient subjective and researcher objective accounts of the patient-centeredness of the same patient-doctor encounter may differ, creating confusion about how to interpret, and more importantly how to ultimately intervene, to promote improved outcomes. Research investigating patient-centred communication among patients with life threatening diseases found that consultations were only 52% patient-centred using a verbal coding scheme for the objective measurement of communication interactions. However, patient self-report data demonstrated that patients thought their interactions were extremely patient-centred and that their concerns were completely addressed (Wolf et al., 2008).
The incongruence between objective and subjective accounts of the same doctor-patient communication encounter has been mentioned as a measurement challenge when evaluating patient-centred communication (Cegala et al., 2004; Epstein et al., 2005). Adding to interpretation difficulties, doctors and patients have been shown to assign differing importance to the dimensions of patient-centred communication (Ogden et al., 2002). For example, among cancer survivors, research has found that although conversations about symptoms demonstrated low patient-centred communication scores, conversations about symptoms were the strongest predictor of favourable survivor outcomes such as reduced uncertainty and a positive perception of patient-centred communication (Tomich and Helgeson, 2002). In summary, to improve understanding of complex events such as communication interactions, a mixture of qualitative and quantitative methods that evaluates multiple perspectives has been suggested (Epstein et al., 2005).

Clinical uncertainty, a provider factor noted to influence patient-centred communication as suggested by Mead and Bower (2000), is inherent in medical practice (Goodman, 1999; Savett, 1995). Medical literature often cite statistical probabilities which the provider must translate into understandable information for patients while considering the patient's unique patient personal, historical, and disease related factors. Conveying the uncertainty surrounding statistical information to patients may be truthful, but doctors may also worry that exposing this uncertainty can cause patients to lose trust in their knowledge and abilities (Ogden et al., 2002). Interestingly, one study among doctors found that clinical uncertainty with a corresponding loss of trust was not an issue, as patients' felt that their health care
provider would simply refer them to another provider in situations where clinical uncertainty was prevalent (Barnes, Crumble, Carlisle, & Pilling, 2004).

Research has examined many factors that contribute to both patient-centred communication and positive outcomes of a doctor-patient communication interaction. Patient factors (such as symptoms and other illness related concerns, uncertainty, contextual, and demographic characteristics), doctor factors (such as clinical uncertainty, patient-centred orientation, knowledge of the patient over time, and demographic characteristics) and health system factors (such as available time and the physical environment) may all influence patient-centred communication. One study suggests that positive provider affect and information sharing are associated with respect and familiarity with patients rather than provider or patient race, gender, patient education, provider length of practice, or race concordance (Beach et al., 2006). However, little is known about the specific content and temporal structure of regularly scheduled follow-up visits for long-term patients with life threatening diseases after leaving hospital, despite the fact that many of these patients consider these visits highly important (Janssen et al., 2009).

2.6 Patients’ rights to information and decision making

Patient education is fundamental to a patient-centred approach to health care, but the patient education process itself should also be a share, two-way relationship (Illich, 1977). In such a relationship, there is equivalence between the doctor and patient, with the doctor contributing his or her expert knowledge about the causes, symptoms and
treatment of a health condition and the patient contributing expertise about his or her health beliefs, prior learning, preferences for information and its delivery, and experience of the condition (Coulter, 1999).

The Universal Declaration of Human Rights (1948) has set the foundation for ‘patients' rights’ in the field of medical ethics which today constitutes a legal framework. Patients’ rights vary in different countries often depending upon the dominating cultural and social norms. Different models of the patient-doctor relationship exist. For instance in Europe and North America, there are at least four models to depict this relationship: the paternalistic model, the informative model, the interpretive model and the deliberative model (WHO, 2010).

The traditional paternalistic doctor-patient relationship, based on the principle of beneficence, namely ‘doing good’ for the patient, is such that the entire responsibility of decisions is placed on the doctor, as the expert. Nowadays, patients increasingly want to share the process of making medical decisions with their doctors (Blanchard et al., 1988). Patients increasingly expect their own understanding about their experience of their illness, their preferences, values, and social circumstances to be taken into account (Coulter, 1999). This change coincides with the ability of patients to source medical information independently of their doctor via the Internet. In some cases, patients can rightly be said to be experts in their conditions, and this has brought to the development of a new and more egalitarian relationship between doctors and at least some of their patients (Brown, 2008). This has led health systems to shift from the paternalistic model towards the autonomy based or deliberative model. This further developed in the communication model, where the focus turns on patient’s active
participation in managing his/her health (Deblanco, 1992). Despite the continuous debate as to the best doctor-patient relationship, ‘there is also growing international consensus that all patients have a right to privacy, to medical information and confidentiality of their medical condition, to safe clinical environment, to consent to or to refuse treatment and to be informed about the relevant risk to them of medical procedures’ (WHO, 2010)

A review of the research into shared decision making concluded that, although its benefits were not yet clearly demonstrated, generally patients want to be informed of treatment alternatives and to be involved in treatment decisions (Guadagnoli and Ward, 1998). For example, one Australian study of 233 cancer patients and their oncologists suggests that encouraging participation in decision making may be the best standard approach. Patients who reported involvement in decision making were most satisfied with the consultation, and those who reported that the decision was taken entirely by themselves or by the doctor were least satisfied (Gattellari et al., 2001).

Fallowfield and Jenkins (1999) found that patients and their families often want more information than is usually provided. After the consultation many patients are left unsure about diagnosis and prognosis, confused about meaning of and need for further diagnostic tests, unclear about management plan and uncertain about true therapeutic intent of treatment. Besides the demand for more information, Dolwsett et al. (2000) concluded that the patients and their families prefer a patient-centred approach to the consultation especially when a patient has a poor prognosis.
Predisposing factors play a significant role to the extent to which patients believe that patient participation is legitimate will influence their participation in the consultation. In addition, personality variables, such as extroversion and the extent to which individuals believe that they can control events that affect them, salience of health needs, and level of rapport with the health professional will also play an important role in any patient’s communication behaviour (Street, 2001). A patient who believes that active participation in medical consultations is legitimate, is very worried about his or her health, is in a lot of pain (so is motivated to discuss their concern), is extroverted, and feel he or she gets on well with the health professional, may be more likely to participate actively in the consultation communication. Street (2001) suggested that factors, such as knowledge about the topic and communicative skills, will also impact on the patient’s level of participation during the interaction. Street (1991) found that less educated people asked less questions, so elicited less information, and were given less information. It was also found that gender and age influenced patient participation, with female and younger patients less opinionated than male and older patients.

A participatory approach to health care may increase patients’ sense of control and confidence. Patients may be more motivated and empowered to change their health beliefs and behaviours when they are encouraged to set personally relevant goals, when they are provided with information that reflects their interests and concerns, and when they participate in a management programme designed for their specific needs and preferences (Fröjd et al., 2008). Other researchers (Hudak et al., 2008), concluded that patient preferences for participation in decision-making cannot be reliably judged on patient communication behaviour. The researchers insisted that the doctor needs to
engage and encourage the patients in a discussion of preferences for decision-making in order to obtain the role each patient wants to play in any given decision (Hudak et al., 2008).

However, although at face value this ideal seems sound, in practice there may be barriers to implement it. For example, one UK study of 62 doctor consultations found little evidence that doctor and patients participate in the way described by Charles et al. (1997). The first two of the four conditions which were considered to be necessary for shared decision making were not always present, so there was no foundation on which to create a consensus about the preferred method of treatment, and to reach an agreement on which treatment to implement. Even when information was shared, patients' beliefs were not taken seriously. The doctors identified a number of barriers to sharing decision making, including time pressures, and the doctors' perception that patients would not understand medical language and concepts (Stevenson et al., 2000). Another UK study interviewed 39 doctors and found that they felt they did not have sufficient information to explain the risks and benefits of treatment choices. They were concerned about sharing the uncertainties about the outcomes of medical treatments, and causing anxiety by exposing patients to the fact that data are often unavailable or unknown. The doctors admitted that they use 'friendly persuasion' as their usual practice (Elwyn et al., 1999).

Various studies in health care indicate that communication is highly valued (Gerard and Lattimer, 2005). A small pre-consultation survey found that "being able to express the feelings to the doctor" was more important than other attributes such as involvement in decision making and the type of explanation received (Vick and Scott,
1998), and this finding was repeated in a larger postal survey (Scott and Vick, 1999). Comparable results have been reported in studies of care outside of routine hours (Scott, Watson, and Ross, 2003).

The great importance that patients place on communication issues nonetheless requires critical examination. Substantial amount of studies do not include a measure of technical care, and patients may assume that technical care is of high quality if there is no suggestion to the contrary (Chapple et al., 2002). A study from the United States that asked patients to prioritise between doctor satisfaction characteristics differing on interpersonal and technical care found that more patients preferred the doctor with high technical care scores (Fung et al., 2005); however, the methods used in this study were unable to estimate the relative importance of different attributes. In a recent study conducted by Tung and Chang (2009), attributes of hospital quality were measured using four aspects of quality namely, doctor’s technical skill, doctor’s interpersonal skill, staff care and access. The authors found that the doctor’s technical skill was the most critical attribute of quality for both overall satisfaction and recommendation, with doctor’s interpersonal skill coming second. In this study (Tung and Chang, 2009), the patients valued the emphasis that the doctors have put on patient education which was based on disease prevention and control. Nevertheless such study could not be generalisable due to small sample size and using few clinics.
Examinations of medical malpractice claims imply as a possibility that the practice of informed consent to treatment is a major problem (e.g., Epstein, 2002; Gittler & Goldstein, 1996; Terry, 1994). Intended to respect patient autonomy and soundness of moral character, informed consent is defined as physician disclosure of information material to a patient (e.g., risks), physician recommendations of a plan and alternatives, and includes patient choice and consent (Beauchamp & Childress, 1994).

Informed consent is important to patients because it ameliorates outcomes such as treatment efficacy, coping, and satisfaction (Garrud, Wood, & Stainsby, 2001; Mills & Krantz, 1979; Levy & McGee, 1975; Shorten et al., 2005). Families value the practice because it gives them the opportunity to be involved, especially when patients are minors or medically incompetent. For providers, informed consent can facilitate patient involvement and choice, and protect them from litigation. Despite these important implications, informed consent has not received much attention in communication research nor has it been examined for reason and argument rather than intuition, or from theoretical perspectives.

Yet, studies have also showed problems in practice such as in setting the information standards, not giving enough information, and lack of informed consent. Standardization was reached as long as informed consent was temporally limited and represented with consent forms (Davis et al., 2003; Lidz, Appelbaum, & Meisel, 1988; Lidz, Meisel, Holden, Marx, & Munetz, 1982). However such practice can be
considered as a problem because for some patients the form itself does not signify a meaningful role in decision making (Everett et al., 2005; Harris & associates, 1982).

Past studies also found that doctors withheld information (Faden et al., 1981; Wu and Pearlman, 1988). A typical example is a study by Faden et al. (1981) who administered questionnaires to 387 doctors who treat epilepsy and 160 patients, or parents of patients. Results of the study showed that despite patients' desire for more knowledge, doctors made approximately six disclosures out of 16 possible risks of an epilepsy treatment. Further, twenty percent of doctors were found to favour withholding of anxiety-provoking information.

Adding to the withholding of information, some studies have confirmed the complete absence of informed consent (Brett & Rosenberg, 2001; Lidz et al., 1982). For example, Brett and Rosenberg (2001) performed a retrospective analysis of 154 hospitalized adult patients’ medical records for evidence of informed consent for gastrostomy tubes (used to feed and hydrate patients in the end stages of life). Evidence of benefits, risks, and alternatives to tube-feeding were found in only one of the 154 records. Also, Lidz et al. (1982) concluded that “informed consent is largely absent from the clinic”.

These problems have led to patient complaints and litigation. Gittler and Goldstein (1996) found informed consent to be the second on the list for the most frequently filed malpractice claim. Confirming this, Epstein (2002) found that in 64% of 36 malpractice cases in cervical spine surgery, there was a lack of informed consent. Nine of 36 cases were won by patients, averaging $3 million. Also, Terry (1994)
stated that out of the 96,000 malpractice claims that took place between 1985 and 1993, 30% were charged with a lack of informed consent resulting with a cash settlement of $155,619.

2.8 Information delivery by doctors

Doctor-patient communication is of supreme importance for an improved patient health status and compliance as well as for the patients' satisfaction and can be regarded as a mediator of health care quality and safety (Rao et al., 2007). A recent systematic review (Rao et al., 2007) emphasised that communication intervention in a group of doctors yielded suggestive improvements in communication behaviour. Intervention doctors are more probable to ask open-ended questions, to empathise, to reassure, and to provide information to patients. By contrast, the findings regarding interventions in the group of patients were intermingled, showing only some degree of amelioration in information providing behaviour and patient involvement.

In a study for comparing survival expectations with actual outcomes for patients with leukaemia, Lee (2001) argues that they do not know the reasons for discrepancies between patient expectations, physician expectations and reality, but it is easy to imagine that as prognosis worsens, both patients and doctors may avoid dwelling on discouraging statistics and focus instead on the possibility of cure. However the researcher clarified that she did not know how prognostic information was communicated or what process led to the formation of patient expectations because doctor-patient interactions were not observed. Lee (2001) concluded that
discrepancies between doctor and patient expectations are certainly not new. The study stressed the need for doctors to ask patients what they expect from treatment choices, especially when high risks are involved. Even if this discussion does not change their desire to undergo transplantation, it may help patients and their families better prepare themselves for the challenges ahead.

In another study Goodlin et al. (2008) concluded that despite the inherent uncertainty in individual outcomes with heart failure, doctors should discuss prognosis as desired by the patient or as needed to plan care, particularly when anticipated survival is shorter than one year. Adding to this, the authors confirmed that exploring and reflecting patient responses and attending to their emotions can decrease patient anxiety and promote shared decision-making (Goodlin et al., 2008).

Offering information to patients and successfully conveying it in a clear and comprehensive format is a central component of the medical encounter (Epstein and Peters, 2009). While it is crucial for doctors to be informative and to teach patients how to take responsibility for their health and actively manage their chronic conditions, ascertaining this process of information delivery can be complicated. Different patient means different information giving and doctors must gauge the appropriate amount of information for each patient. Excess information can devastate some patients, while too little may leave some distressed and confused (Beach et al., 2006). Adequate and suitable information giving for each patient is a critical part for the recognition of an impressive and effective therapeutic relationship and can have valuable effects on patients' health (Comstock, et al., 1982). Doctors should equip patients with information which matches the individual patients’ needs and preferences.
as patients' satisfaction with doctors' provision of information is related to patients' health related quality of life, anxiety and depression (Fröjd et al., 2008).

It is also known that patients and doctors have differing opinion over the relative importance of different types of medical information. In a study that combined personal experience with other evidence, Anderson and Marlett (2004) looked at the type of information (rather than the amount of information) that healthcare providers give to stroke patients and their families and how people use that communication to restructure life after stroke. They regarded with respect how communication influences stroke outcome – often for the worse because of its emphasis on what will no longer be possible.

Talking about the patient's chance of recovery is more than just a difficult undertaking. To many doctors, it seems like the wrong thing to do (Helft, 2005). The concern that prognostic information can cause distress (bioTheranostics, 2009) and loss of hope (Mack et al., 2009) leads some doctors to avoid the topic (Back et al., 2005), to disclose vague (Daugherty & Hlubocky, 2008) or overly optimistic information (Clayton et al., 2005) when pressed, and to focus on treatment rather than expected outcomes (Lee, 2001). Even though physician decisions to limit communication about prognosis often emanate from compassion (Doebbeling, 2009), inappropriate expectations for outcomes can unreasonably alter choices that patients make about treatment and how to live their lives (Lamont & Christakis, 2003).

In fact the most common plans that doctors use in discussing prognosis are realism, optimism, and avoidance (Lamont & Christakis, 2001). Although these plans are
deliberate and commonly used, they also create unintended consequences. The beneficial feature of realism is that prognostic information helps patients and doctors to make sound medical choices. Both bioethical reasoning and empirical evidence support the importance of accurate patient understanding of prognosis (Lehmann et al., 2007). Yet patients also report that realistic prognostic discussions can be blunt and sometimes brutal (Lagarde et al., 2008). A doctor who introduces prognosis realistically, but without building the conversation before the information or answering empathetically afterwards, can be perceived as uncaring. Beyond that, empirical data propose that roughly 20% of patients, especially those with complex metastatic disease, do not want thorough information about their prognosis (Fried, Bradley and O’Leary, 2003). Evidence suggests that patients value both expertise and openness when bad news is being broken (Burkitt et al., 2004: Hagerty et al., 2005). Patients want their doctor to be up to date on the facts, but also to take time to answer questions completely, and to be honest about the severity of the situation (Parker et al., 2001). Brusqueness, lack of sympathy, impatience, or inconsistencies can lead patients to view the doctor unfavourably (Barnett, 2002). However delivering the real information to these patients may produce psychological harm, although there are no evidenced studies that address this question.

On the other hand, optimism can perform a useful function in supporting a patient’s hopes and many patients report that they express a desire for a doctor who inspires hope (Hagerty et al., 2005). In discussions about prognosis, however, doctors who deliberately exaggerate or overemphasise optimistic information may risk losing the trust of patients who later discover that the information they received was not entirely true (Royal College of Doctors, 2005).
A variation in which doctors avoid providing realistic information by creating a tacit understanding that neither patient nor physician will bring up the topic is called collusion (Helft, 2005). Avoidance is established on reasonable concerns. Doctors realise that they are often inaccurate when predicting survival for an individual (Daugherty and Hlubocky, 2008). Doctors are concerned that discussing survival transmits a subtle psychological message that a patient will die at a given time (Back et al., 2005). Doctors find that some patients do not want prognostic information and that bad news often causes patient distress (bioTheranostics, 2009). Nevertheless doctors who avoid prediction may seem evasive and consequently untrustworthy, especially when studies demonstrate that many patients want to talk about life expectancy (Clayton, Butow and Ellis, 2005).

All in all, research identifies ample difficulties with doctors in the explanation and planning period of the consultation. In fact, many studies show that doctors give very little information to their patients. According to a study by Waitzkin (1984), American doctors allocated just a little more than one minute (on average) out of a 20 minute consultation to the task of information giving for the patient. Another study in the United Kingdom conducted by Makoul et al (1995), resulted that doctors overestimated the extent to which they accomplished key tasks in explanation and planning. Key objectives included discussing the risks of medication, discussing the patient’s capacity to follow the treatment plan and drawing out the patient’s opinion about medication prescribed.
2.9 Doctor-patient relationship

The doctor-patient relationship can be described as one of the most important communication a person can have with another human being and having access to a well-developed and effective association is important for the experienced and objective quality of health care. Studies have concluded that unfriendly behaviour of health-care providers during medical encounters could be due to stress, work overload (Roland, 2005), and social inequalities between doctors and patients (Bury, 2004). It was found in one interview study that encounters with professionals who were friendly and welcoming were considered as satisfying to patients, while they described the dissatisfying encounters as being characterised by ignorance, including being treated unkindly or being made to feel unwelcome (Hornsten et al., 2005). Moreover, attentive listening; eye contact with fewer gazes; uninterrupted consultation; and consultation lengths are important factors for a good patient-doctor communication and relationship (Beck et al., 2002; Rhoades et al., 2001). Furthermore, in a study by Ridsdale and Hudd (1994), resulted that patients were not ignored by writing during the patient interview as long as the doctors continued to use verbal skills, and maintained eye contact with them during consultations.

In a systematic review (van Dam et al., 2003), it was concluded that a combination of approaches for improving diabetic patients' behaviour and enhancing their participation in the consultations, and a provider behaviour change of the consulting style into a more patient-centred one, possibly has got a considerable potential to produce improvement in adherence and health outcomes. However, improving health outcomes may not be possible without improving patients' self management behaviour (Illich, 1977; van Dam et al., 2003), which in turn could considerably improve
adherence to treatment and motivate patients to make appropriate life style changes (Welchen et al., 2005) hence preventing re-admissions in hospital.

2.10 Effective doctor-patient communication

One of the principles of effective communication in the medical encounter is reducing unnecessary uncertainty. Unresolved uncertainties can lead to lack of concentration or anxiety, which in turn can block effective communication (Bar-Anan, Wilson, & Gilbert, 2009). For example, patients may be uncertain about what to expect during a given doctor encounter, about the significance of a line of questioning, about the role of a particular member of the healthcare team, or about the attitudes, intentions or trustworthiness of the healthcare professional. Therefore one important aspect of building the relationship in the consultation is for doctors to employ skills which limit the uncertainty that can so easily block communication (Lee et al., 2009).

While the potential benefits of communication are many, effective communication is a necessary condition for the benefits to patient outcomes to be reaped (Goldszer, 2004). As Jehn, Northcraft, and Neale (1999) argue, the success of healthcare organisations is not only dependent on doctors’ abilities to perform their tasks but also on doctors’ abilities to manage their interactions with patients. It is through communication that individual perspectives and expertise are shared, concerns are heard, work efforts are coordinated, and collaborative decision making ultimately may be achieved. Lyndon (2006) even suggests that communication is the key to patient safety.
Research also shows that patients do better when they are provided with extra psychological interventions to help them deal with the medical crisis they are going through. For example, in one review of 34 studies in surgical or coronary care contexts, patients were split into two groups – one group that received more information or emotional support and a ‘control’ group who only received standard care. The review found that those patients who received enhanced communication input spent on average two days less in hospital than those in the control groups. This beneficial effect was despite the fact that most of the psychological interventions used were quite modest and in most studies were not matched in any way to patients’ particular needs or coping styles (Mumford, Schlesinger & Glass, 1982).

Effective communication is paramount, and as Poole and Real (2003) put it so eloquently, “communication is the glue which holds people together”. Knaus et al. (1986) performed a landmark study in which they supported a link between the presence of “excellent” communication and patient mortality in hospital. They found that mortality rates were forty one percent lower than predicted when doctors collaborated effectively with their patients. Even more telling, they found that when they practiced with poor communication, mortality rates exceeded the predicted amount by fifty eight percent. Poor communication has also been shown to be a significant contributor to medical errors.

Wilson, Runciman, and Gibberd (1995) examined adverse events in twenty eight Australian hospitals, and found that communication errors were associated with twice as many deaths as clinical inadequacy. Similarly, Neily, Dunn, & Mills (2004) report that poor communication is listed as one of the root causes of patient error in
approximately seventy five percent of all adverse events that occur. In fact, the literature is replete with examples of how effective or ineffective communication in health care has an impact on patient outcomes conducted in a variety of healthcare settings, including risk adjusted length of stay in intensive care units (Shortell et al., 1994), excess home care costs following patients' discharge after giving caesarean birth (Brooten et al., 1994), unplanned visits to the emergency department and unplanned re-hospitalization after elderly patients' discharge (Naylor et al., 1994), disruptions in the care of elderly patients (Cortes, Wexler, & Fitzpatrick, 2004), and patients' therapeutic self-care ability on general medical, surgical and cardiac units (Doran et al., 2002).

Many factors make it difficult to coordinate the work between the doctor and patient, and can hamper the quantity and quality of interactions. Lingard et al. (2004) posit that even when communication protocols are adopted, communication failures continue to persist due to poor integration. Oriel (2006) states that the traditional prominence on technical expertise in the education of healthcare workers leaves little room for instruction and practice on interpersonal skills like the development of relationships. The relative lack of communication training may be exacerbated by the fact that most healthcare workers are trained to work independently, resulting in poorer communication with colleagues and patients (Williams, Kirkman-Liff, & Netting, 1999).
2.11 Determinants of Patient Satisfaction

Patients' perspectives and expectations are important factors in the patient-physician relationship regarding their health care (Wens et al., 2005). If expectations are met during consultations, there is a positive association with patient satisfaction (Williams et al., 1995). It is important for health-care providers to have good communication skills and relationships with patients to continue building their learning and to take control of their illness in an appropriate way (Holmstrom et al., 2003).

Patients are more satisfied with the doctor who appears warm, friendly and with a reassuring manner (Di Blazi, 2001), who is confident (Safran et al., 1998; Tarrant, 2003), and provides patient-centred care (Stewart et al., 2000; Little et al., 2001), who shows an interest in the patient's concerns and expectations (Little et al., 2001), who discusses the health problem, who provides a clear explanation of the diagnosis and prognosis and who involves the patient in the treatment decision (Little et al., 2001). Increased satisfaction occurs when the patient has the feeling of being listened to, of being treated with respect, humanely and as fairly as others (Little et al., 2001). An overall personal patient-doctor relationship increases the odds of the patient being satisfied with the consultation (Hjortdahl & Laerum, 1992). Doctors who held patient-centred beliefs regarding power and information-sharing were rated no more positively on measures of satisfaction (Krupat et al., 2001).

Perceived health improvement is based on confidence and belief in the doctor (Tarrant et al., 2003), holistic care, detailed physical examination, good communication and knowledge of the patient (Wilson & Childs, 2002). Patient adherence to treatment is
related to greater empathy with the doctor who has a more detailed knowledge of the patient (Roter & Hall, 2009) and to those patients who evidence a greater reliance on their doctor (Wilson & Childs, 2002). The health status of the patient improves when the doctor provides a clear diagnosis, positively transmits the prognosis and treatment, and pays attention to the cognitive and emotional aspects of the patient (Di Blazi et al., 2001). When the patient and doctor have the same opinions and understandings, there is an increase in the patient’s confidence in the professional health care provider, the patient is more likely to recommend the service to other potential patients, and the patients are more likely to adhere to doctor’s advice (Krupat et al., 2001). When the consultation is patient centred, there is a faster recovery from the disease and a greater health-status improvement (Little et al., 2001).

Baum (2006) explored the question of whether hospital patients differed in how they prioritized various service quality dimensions when assessing their satisfaction. He found that patient confidence (e.g. sense of well-being, confidence in the doctor’s technical skills, and the thoroughness of communication) was the major quality dimension influencing satisfaction, whereas interpersonal skills (i.e. tangibles) were significant factors underlying their satisfaction.

With few expectations, research studies indicate that patient satisfaction is positively related to accessibility, availability, and convenience of care (Parchman et al., 2005). Continuity of care for hospitalized patients is addressed by looking at length of stay and prior hospitalization within the same hospital. Specifically, they note that patients who are hospitalized for less than two weeks rate their care better than patients who are in the hospital for more than two weeks. Parchman et al. (2005) also report that a
positive relationship exists between previous admission at the same hospital and the patient’s total satisfaction score.

Besides the above mentioned factors, emotional status, past experiences during a hospital stay, length of stay, age, gender, occupation, and many other issues have been shown to have a little or a strong effect on the results of patient satisfaction surveys (Dube, Trudeau & Belanger, 1994).

The doctor-patient relationship directly determines the quality and completeness of information elicited and understood by the patient, and is critical for vulnerable patients as they experience a heightened dependency on the physician’s competence, skills and good will (Goold & Lipkin, 1999).

2.12 Treatment compliance

It is proposed that health providers’ use of emotional expression, interpersonal control, discourse management, empathy, partnership building and interpretability would influence patients’ perceptions. Past research has demonstrated that consultation communication was related to patient satisfaction (Ley, 1993; Watson, 2006; Watson & Gallois, 1998), understanding of health needs (Street, 1991), and desire to be treated by the same health professional again (Watson & Gallois, 2004). The quality of care measure theorised by Street (2001) assessed a combination of these aspects, but had not yet been tested in empirical research.
Researchers have noted that non-compliance with proposed treatments, such as not following health professionals’ advice, or not adhering to prescribed treatment regimens, can have important negative outcomes for patients (DiMatteo et al., 2002). The mentioned outcomes vary from causing frustration for the patient or health professional, to causing incorrect diagnoses, increased health problems, or even death (DiMatteo et al.; Ley, 1993). DiMatteo et al. (2002) reported that, on average, patients who adhered to their treatment plan experienced twenty six percent better factually measured health outcomes. Therefore, it is important to develop an understanding of what may improve patient compliance to health professional treatment recommendations. However, these researchers have not directly investigated the predictors of patient treatment compliance.

Richard and Lussier (2003) studied the discussion of medications in a Canadian clinical setting. They examined audiotapes of 40 experienced doctors engaging in 462 patient interactions. Much of their findings correspond to those from earlier research. In circumstances such as the prescription of new medications, instructions were discussed in 75.9% of cases, risks and side-effects were hardly discussed, and reasons to be seen again by doctor were discussed in only 35.4% of cases. However discussion regarding compliance issues with the new prescriptions was undertaken for only 5% of cases. Interestingly, research indicates that improved patient knowledge as a result of receiving more information that is understandable to the patient is associated with a subsequent greater awareness to take treatments or participate in trials (Edwards et al., 2001).
2.13 Consultation time

The accessibility of health information has improved. The media consistently includes health news, containing the latest information. Major newspapers, radio and television programmes have special health sections, and there are specific channels dedicated to health news. Direct marketing brings about consumers to be increasingly knowledgeable of new drugs, treatments, and medical technologies. Patients are frequently told to seek advice from their doctors about the products. The growth of the internet and its accessibility offers the public opportunities to acquire information. Patients have more questions and uncertainties about their care than before, requiring doctors to consume more time answering questions, comparing treatments, and dealing with misinformation.

Patients’ anticipations of doctors also continue to increase. Fröjd et al., (2008) state that doctors are not only expected to take measures in high quality medical care but also to deal with psychiatric disorders and substance misuse and to promote health with information related to various aspects depending on the patient’s condition (for example: smoking cessation, exercise, nutrition, safe sexual behaviour, and so on). All these tasks take time, and despite using up more time with patients, doctors increasingly experience equality between the time needed and the realities of practice.

Inadequate time with patients is often quoted by doctors as a major consequence for poor relationship development and communication (Mechanic, 2001). In countries with robust health care systems, deciding how much time is needed to provide quality care is a subject of ongoing research yielded contradicting results (Freeman et al.,
Other health system factors besides the duration of the overall encounter are available resources and environmental factors such as noise, space and temperature (Epstein et al., 2005). The sequential structure of an acute hospital ward visit is often taught in medical education as if it followed a script: The motive for the visit is discovered (the chief complaint) then one proceeds to documenting or updating the patient's health history. Examination of the patient follows, and then the visit concludes with planning discussions for treatment, follow-up, and possibly referrals to other providers. In reality, the temporal structure and lines of demarcation between sections often become blurred. For example, new symptoms and concerns are often initiated in the closing moments of the ward visit. Thus, Epstein (2005) suggests that provider receptiveness and flexibility are two key components of a good doctor-patient communication.

Visit length is affected by many other issues including the number and complexity of problems drawn out and addressed, the degree of psychosocial distress, and the gender and age of the patient and the doctors (Britt et al., 2002). Factual information from the clinical settings in the United States implies that visits shorter than 15 minutes are related with lower quality (Dugdale et al., 1999). In Great Britain where visit lengths are not as long as in the United States, researchers have debated that consultations should be lengthened to enhance quality of care (Howie et al., 1999).

Many studies suggest that better communication takes more time (Epstein et al., 2005; Focke et al., 2002; Goedhuys & Rethans, 2001). Nevertheless, more time does not ensure better communication, as was plainly visible by patient perception of time use.
(Cape, 2002) and poor communication was established to be present even in very long consultation period (Scheitel et al., 1996).

Research has demonstrated that doctor-patient communication interactions can be undertaken without lengthening medical consultations (Bauman, Fardy, & Harris, 2003). Further, a lack of adequate communication in life threatening diseases settings may result in increased healthcare costs as suggested in a comprehensive review by Thorne, Bultz, and Baile (2005). When patient concerns are not addressed or needs are not met, time spent in extra and/or subsequent ward visits may be longer (Thorne, 1999). Yet, despite patient discontents that providers do not spend enough time with them, it remains unknown how much time is actually needed to effectively meet patient concerns.

2.14 Doctors’ early interruptions

Most medical consultations begin with the patients describing their illness. Evidence points out that doctors often interrupt this description of the problem, as if they fear losing control of the length of the consultations if they let patients talk. Many doctors maintain that if they are generous in letting them speak, they could never manage. For example, one North American study examined 264 interviews between doctors and their patients and found that, while in 75% of cases doctors successfully solicited patient concerns, in 28% of the interviews, doctors interrupted the patient’s opening statement after a mean time of only 23 seconds. These interrupted opening statements were rarely completed. Nor were these interruptions particularly efficient, as those
patients who were allowed to complete their statement of concerns used only 6 seconds more time on average than those who were redirected. In those interviews where doctors did not solicit the patient concerns during the interview, patients were more likely to raise further concerns later in the interview (Marvel et al., 1999). Another U.S. study of 60 doctor consultations found that patients spoke without being interrupted for an average of only 12 seconds after the doctor entered the room. A quarter of the time, doctors interrupted patients before they had finished speaking, interfering them on average twice during a consultation (Rhoades et al., 2001).

In another study, Langewitz et al. (2002), asked doctors not to interrupt their patients while they answered a simple question, “What brings you here (hospital) today?” The exercise took place in an internal medicine hospital facility in Switzerland, with a representative segment of patients who were consulting for the first time; 335 interviews were recorded. The average time period of instinctive talk by patients was 92 seconds and the median was a mere 59 seconds. Actually, 77% of patients (258/335) accomplished their initial declaration within 2 minutes, and only 2% (7/335) expressed themselves for more than 5 interrupted minutes. In all cases, doctors weighed the information they were given to be pertinent. The researchers deducted that doctors would not risk being overpowered by their patients’ complaints if, at the beginning of interviews they were to listen to patients without interrupting. Thus, even in a setting of financial and time constraints, two minutes of listening should be sufficient to obtain a fairly complete list of the patient’s reasons for seeking consultation in almost 80% of cases. Consequently, effective plans to take hold of the conversation very early appear to be needless and might have harmful results for the type, clarity, and quality of the exchanges between doctor and patient.
2.15 Conclusion

Knowing how patients perceive the quality of service and being able to measure service quality can benefit health care professionals in qualitative and quantitative ways. The measurement of quality in doctor-patient communication and information giving can provide specific data that can be used in quality management; hence, the service organisation would be able to monitor and maintain better service. Assessing service quality and better understand how various dimensions affect overall service quality would enable health care professionals to ameliorate and upgrade the service delivery process. By identifying strengths and weaknesses pertaining to the dimensions of service quality, the organisation can better allocate resources to provide excellent service.

The literature review amalgamated various aspects of patient care that are highly relevant to the health care system today. It highlights the need of an efficient and effective measurement of the doctor-patient relationship and the positive effect that this can have on the quality of care.
CHAPTER 3

Methodology
Chapter 3: METHODOLOGY

3.1 Introduction

The previous chapter reviewed literature pertaining to doctor-patient communication and information giving. The current chapter focuses on the research methodology, which is discussed in terms of methods, population, sampling, research instrument, data collection and analysis procedures as they pertain to the present research. The chosen research design enabled the author to achieve the purpose and objectives of the study.

3.2 The Aim of the study

The aim of this study is to explore doctor-patient communication and information giving in the medical and surgical wards of the main acute general hospital in Malta namely Mater Dei Hospital. As one could see further on, when results of patient satisfaction feedback, direct observations on doctors and structured interviews with ward managers are compared and evaluated, they can be used by administrators to assess whether or not they are meeting, exceeding, or falling below the desired levels of service quality. Associating this information with the weighted importance of each individual service quality criterion used, administrators will have a prioritised
indication as to which aspects of the service more urgently require more detailed and emphasised attention.

This study will also examine patient satisfaction with doctor-patient communication and why such measurement matters in the clinical setting. A well designed, implemented, and utilized patient satisfaction measurement system can help the medical team improve the quality of their clinical and administrative activities. Specifically, patient satisfaction measurements can be used to protect or increase patient safety, conduct sound procedure techniques, and improve the quality of care.

Being the first study of its kind in Malta, results are expected to shed light on the real nature of doctor-patient relationship versus expected service quality in Malta as seen through the eyes of the patient, health care professionals and the author. Thus, this study intends to give a real picture of what standards of service provision are expected by the patient and the actual medical care practice. Hospitals are realising that meeting the patient’s wants and needs would lead to patient satisfaction (Jensen, 1988). Donabedian (1988) described patient satisfaction as a desired outcome of care provided and that the level of satisfaction reflects the quality of care.

Furthermore, this project also attempts to act as a basis for future research work in the field, and as a stimulator of knowledgeable service provision changes directed at meeting the needs and demands of the patient.
3.3 Specific Objectives

- To observe the level of doctor communication and information given to the patients during their first consultation in hospital.
- To indicate aspects (if any) of doctor-patient communication which are not being met.
- To identify the views of experienced ward managers on the way doctors manage their medical consultations with patients on the medical and surgical wards.
- To explore patients’ actual experience of how communication and information was being transferred to them by their doctor.

3.4 Research Design

In this qualitative and quantitative study, a cross-sectional explorative design was used. Qualitative approach is a methodological stance which holds that information about human events and experience, and if reduced to numerical form loses most of its meaning and hence value to research and understanding. As a qualitative approach, structured interviews with Ward Managers resulted in statements of their positive and negative opinions (through their experience) with past and present witnessing of doctor-patient encounters. This has marked an onset in this study.

On the other hand, quantitative studies seek to gain more information about characteristics within a particular field of study (Burns & Grove, 1997), which in this case is a population of patients within Mater Dei Hospital whose perspectives on the
type of communication which the doctors have used towards them (patients) has been explored and evaluated. To achieve this, a patient satisfaction with doctor-patient communication questionnaire and direct observations (by the author) on doctors were seen to be relevant. According to Waltz & Bausell (1981), this research design is considered to be appropriate since the study was intended to describe and explore the subjects and identifies problems with current practice. This research will serve also the purpose to analyse the results which lead to determine where improvement is needed and in what way (Patton, 1987).

Therefore triangulated methods (the use of three or more methods) have been used to enhance the validity of the findings (Webb et al., 1966). All three methods incorporated the same themes and variables to measure communication skills. At the end of the study, the results of all three methods used have been compared so that similarities of results for the same aspects of doctor-patient communication and information giving would emerge and an evaluation would be formed. The three methods that were applied in this study were as follows:

### 3.4.1 Direct observation study – population, sample and criteria

The observation method (participant or non-participant) involves a systematic, detailed observation of behaviours and talk, watching and recording what people do and say. Observations are particularly well suited for the study of the working of organisations and how the people within them perform their functions. In addition, observations may uncover behaviours and routines of which the participants themselves may be unaware (Mays & Pope, 1995).
A direct observation study on medical and surgical doctors during their first encounter with newly admitted patients was carried out by the author and an assessment on their individual communication performance was made. This was held at the Medical Admissions Unit and the Surgical Admissions Unit in Mater Dei Hospital. These two particular wards were selected as together they cater for all the thirty six (36) consultants working in the acute medical and surgical wards in Mater Dei Hospital (24 medical firms and 12 surgical firms). During this direct observation study, doctors were assessed and evaluated against a check list which contained nineteen (19) variables of good doctor communication qualities (a copy of this check list can be found in the appendix list).

This observation study was conducted during a three week period in September 2009, where according to the previous year’s annual trends based on Mater Dei Hospital Activity Reports, this month tends to have a very slight decrease in patient admissions compared to the other months of the year. According to literature findings, Mechanic (2001) stated that doctors consider poor quality relationships with their patients because of insufficient time.

During this observation study, convenience sampling of four (4) doctors per day from each of the two (2) units (Total of 8 observations daily from both Medical and Surgical Admission Units) were selected. The total number of direct observations on doctors was targeted to eighty (80) so as to increase the probability to include all or most of the thirty six (36) consultants. Every day during this three week period, the author had attended the Medical Admission Unit and the Surgical Admission Unit in which many of the patients were admitted everyday and under the care of any one of the above mentioned consultants (firms). Therefore the patients and the firms were conveniently
selected. The author spent four hours (from 8am till noon) in the Medical Admissions Unit and another four hours (from 1pm till 5pm) in the Surgical Admissions Unit. These time frames were alternated each day meaning that if the author started with the Medical Admissions Unit on Day 1, then he started off with the Surgical Admissions Unit on day 2 and so on. Again this feature was used in order to allow equality between both units in terms of high peak working time and most importantly because normally both medical and surgical consultants visit their patients during the mornings. The first four doctor-patient encounters for the newly admitted patients in each unit and within the above time frames were eligible for direct observations. This procedure was repeated everyday in the Medical and Surgical Admissions Units for three weeks.

Exclusions during this doctor observation study were those patients who for communication problems due to mental disabilities (eg. CVA, Huntington’s chorea, mentally disabled persons, unconscious patients etc.) could not be capable of taking part in a two way conversation as in this case it was a very important issue. This criterion was selected because the author’s intention was to observe an ongoing communication process and also to achieve the real responses of the patients. For this specific reason relatives of patients and subsequently paediatric wards were excluded to take part in this study.

3.4.1.1 Precluding any bias

At this point one might argue or comment that the doctors being under direct observation would act the part and perhaps control themselves perfectly with the
patient, knowing that the author was observing them (the doctors) for clinical communication skills and this could have caused a Hawthorne effect.

Actually this was not the case for a number of reasons. In spite of the fact that the consultants through the consent letter knew that there was going to be a direct observation study on their communication skills with patients, they were not told when this was going to take place. In fact the author handed out the consent forms four months earlier than they had actually been undertaken. This was done purposely so as to allow enough time for the consultants not to recall the whole thing. Besides this, the consent letters were not given to the consultants by the author but by an external person. This manoeuvre was undertaken in order to hide the identity of the author from the consultants and also helped them to forget the event more easily. However, the majority of the consultants knew personally the author as he happened to make part of the health care team as whose name was clearly written on the consent form. To tackle this problem the author took advantage of his position as a deputy nursing officer to attend ward rounds with these consultants at the above specified wards saying that he was making part of the ward’s staff for that day (indirectly making them believe that he was working overtime). This was only embarked after establishing an agreement with the ward managers concerned.

3.4.1.2 Advantages and disadvantages of using direct observations

Direct observations of a setting have several advantages. First: the observer is better able to understand and capture the context within which people interact. Second: firsthand experience with the people in the setting allows the inquirer to be discovery
oriented because by being on-site, the observer has less need to rely on prior written conceptualisations or verbal reports. A third strength of observations is that the inquirer has the opportunity to see things that may routinely escape awareness among the people in the setting (Patton, 1990).

On the other hand the disadvantages of direct observations are that they are expensive and time consuming; need well-qualified, highly trained observers; may affect behaviour of participants; selective perception of observer may distort data; investigator has little control over situation; and behaviour or set of behaviours observed may be atypical (Patton, 1990).

3.4.2 Structured interviews

A qualitative study consisting of structured interviews with Ward Managers was carried out to identify how the impact of communication on behalf of doctors towards patients could affect the running of the medical and surgical wards, and the health service in general. The opinions of ward managers were of great help for the author as these were used to justify or compare between what has been observed on the doctors during the direct observations and the ward manager’s perceptions (based on their experiences as ward administrators). These views also indicated how doctor-patient communication could ideally be performed and the implications that one might be faced with if such communication is missing. One needs also to remark that these ward managers could be of great help for defining new policies in the future which would perhaps be implemented as a result of this study.
A set of ten (10) interviews were performed and the subjects were selected according to the higher level of in-service seniority which would reflect the amount of personal experience on the topic. Equal number of subjects for the interview was selected from the surgical and medical wards (five from the medical and another five from the surgical) in Mater Dei Hospital and this took place during October 2009.

All interviews were conducted face-to-face by the author. The times of all interviews were at the convenience of the ward managers and most of them were held at their ward setting. The duration of each interview was planned at half an hour including around five minutes for greetings, warming up and an introductory chat to create a relaxing atmosphere for each person being interviewed. However the length of the interviews varied. One interview was as short as 12 minutes but three interviews went one hour and fifteen minutes and three interviews went for an hour. The average length of time for all interviews was fifty one point seven (51.7) minutes.

The same common set of questions concerning doctor-patient communication, which were created by the author, were asked to each participant and this mainly asked for their opinions, views, likes and dislikes regarding doctor-patient communication skills and information giving techniques. Subjects were also asked to give suggestions for future recommendations (A copy of this question guide for the face to face interview with ward managers can be found in the appendix list).

Each face to face interview was conducted in English and all interviews were audio-tape recorded with the participants consent. The latter were transcribed verbatim by the author and an external person. According to Lincoln and Guba (1985), member checking is a particular important technique for establishing the credibility of
qualitative data. The author also took notes of the interview and gathered information on the non-verbal communication.

Qualitative content analysis was applied within the structure of the thematic guide and for the data that was emerged from the materials as suggested by Pope et al. (2000). The transcripts were read through several times by the author to obtain a good sense of the entire interview. The text was then divided into meaning units and the meaning units were condensed. The condensed meaning units were then abstracted and labelled with codes by the author. The various codes were compared on the basis of differences and similarities and sorted into categories. The categories were further analysed by the author for identification and formulation of themes and sub-themes. Quotations were added to provide meaning to the text. All personal identifying information was removed and a pseudonym was assigned to each respondent to protect confidentiality.

3.4.2.1 Advantages and disadvantages of structured interviews

The advantages of using structured interviews are that all participants are asked the same set of questions, hence increasing comparability and completeness of responses; there is a degree of flexibility in adapting the questions to particular individuals and contexts; interviewer effects are reduced; and evaluation users may review and shape the interview protocol (Patton, 2002). Structured interviews also encourage capturing of respondents’ perceptions in their own words, a very desirable strategy in qualitative data collection.
The disadvantages of structured interviews like any other type of interview are that they are expensive and time-consuming; need well-qualified, highly trained interviewers; interviewee may distort information through recall error, selective perceptions, desire to please interviewer; volume of information may be too large and difficult to transcribe and reduce data; and the wording of questions might constrain the relevance of the questions and answers.

### 3.4.3 Patient satisfaction questionnaire

The third and last method of this triangulation included a questionnaire for patients who had experienced doctor interaction at Mater Dei Hospital during their hospitalisation. This questionnaire was initiated after a complete evaluation of differences between the above mentioned groups (Phase 1 and Phase 2) that is the direct observations on doctors and structured interviews with key personnel namely Ward Managers, all working at Mater Dei Hospital have been completed.

A cross-sectional quantitative study was performed in the form of patient satisfaction with doctor-patient communication questionnaire. This was initiated after approvals from Mater Dei Hospital authorities and Research Ethics Committee were granted (Copies of the letters for approval can be found in the appendix list).

A questionnaire measuring patient satisfaction was created by the author (a copy of the questionnaire in both Maltese and English versions is found in the appendix list) and it was quick to complete (approximately 10 minutes). Continuous response rather than dichotomous (divided) response options were used. The response options were based on a five point Likert scale. The questionnaire consisted of about forty questions to be
answered. Subjects were asked to indicate how strongly they would agree or otherwise (strongly disagree, disagree, do not know, agree, strongly agree) with the statements that represent various specific attributes and overall satisfaction with doctor-patient communication and information given to them. Responses were scored from 1 to 5, with 1 representing the least positive response and 5 representing the most positive response.

Potential dimensions of patient satisfaction with doctor-patient interaction such as technical competence, facilitation skills, presentation skills, interpersonal skills, empathy, friendliness, confidentiality, listening skills, eye contact, medical information, medicinal information, leaflets and other educational material were included in the questionnaire. Such dimensions were extracted from the review of the literature.

A qualitative study was also performed through two open-ended questions for comments and opinions. According to Polit and Hungler, (1999), many structured questionnaires include some open-ended questions so as to allow participants to respond in their own words.

A section on demographic information was included in the questionnaire. Subjects were asked to indicate their gender, age, marital status, level of education, previous hospital experience, the number of days spent in hospital and whether they had a family physician.
3.4.3.1 Sample Population, Criteria and Data Collection for the questionnaire

All adult patients who were hospitalised for more than four (4) days but less than ten (10) days in the medical and surgical wards at Mater Dei Hospital during a four-week study period (December 2009) were eligible for inclusion in the study. Polit and Hungler (1997) described the population as the totality of all subjects that conform to a set of specifications.

<table>
<thead>
<tr>
<th>Surgical wards</th>
<th>Total admissions Dec. 2008</th>
<th>LOS of 4 to 10 days (criteria)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ear Nose Throat - ENT</td>
<td>154</td>
<td>14</td>
</tr>
<tr>
<td>Cardio-Thoracic Surgery Unit</td>
<td>64</td>
<td>4</td>
</tr>
<tr>
<td>Surgical Ward 1</td>
<td>106</td>
<td>25</td>
</tr>
<tr>
<td>Surgical Ward 2</td>
<td>133</td>
<td>35</td>
</tr>
<tr>
<td>Surgical Ward 3</td>
<td>111</td>
<td>22</td>
</tr>
<tr>
<td>Surgical Ward 4</td>
<td>96</td>
<td>11</td>
</tr>
<tr>
<td>Surgical Ward 5</td>
<td>132</td>
<td>41</td>
</tr>
<tr>
<td>Urology 1</td>
<td>96</td>
<td>26</td>
</tr>
<tr>
<td>Urology 2</td>
<td>83</td>
<td>10</td>
</tr>
<tr>
<td><strong>Sub total of Surgical Wards</strong></td>
<td><strong>975</strong></td>
<td><strong>188</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Medical wards</th>
<th>Total admissions Dec. 2008</th>
<th>LOS of 4 to 10 days (criteria)*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac Medical Unit</td>
<td>119</td>
<td>31</td>
</tr>
<tr>
<td>Coronary Care Unit</td>
<td>43</td>
<td>15</td>
</tr>
<tr>
<td>Medical Ward 1</td>
<td>113</td>
<td>31</td>
</tr>
<tr>
<td>Medical Ward 2</td>
<td>61</td>
<td>19</td>
</tr>
<tr>
<td>Medical Ward 3</td>
<td>97</td>
<td>31</td>
</tr>
<tr>
<td>Medical Ward 4</td>
<td>47</td>
<td>16</td>
</tr>
<tr>
<td>Medical Ward 5</td>
<td>82</td>
<td>23</td>
</tr>
<tr>
<td>Medical Ward 6</td>
<td>52</td>
<td>17</td>
</tr>
<tr>
<td>Neuro Medical Ward</td>
<td>45</td>
<td>7</td>
</tr>
<tr>
<td><strong>Sub total of Medical Wards</strong></td>
<td><strong>659</strong></td>
<td><strong>190</strong></td>
</tr>
</tbody>
</table>

**OVERALL TOTAL**       | **1634**                  | **378**                         |

Table 1 represents the total amount of patients admitted in Mater Dei Hospital during December 2008 and the number of patients for the same period of time with a length of stay corresponding to the criteria used in the study. The type and specialities of wards included in this list also conform to the criteria used in the study.

*LOS representing Length of Stay of patient in hospital
Statistics produced by the Hospital Activity Report (2008) indicate that the expected number of patients who were eligible to take part in this questionnaire in the stipulated time frame was that of around 378 patients. A four week period was identified in order to achieve the substantial amount of subjects. Furthermore a hospital stay of more than 4 days would have given the patients enough time to experience and be able to form an opinion of the impact of doctor-patient communication and information giving. On the other hand hospitalisation of over 10 days would skew the results due to ‘mood bias’ as a result perhaps of their negativity towards hope of healing or of their incurable illnesses which may also lead to recall bias (for example ‘if the doctor had given me that treatment I would not have been in this situation’). Orthopaedic wards were excluded from this study as in reality some of the patients’ hospital stay in these wards exceed ten (10) days. On the other hand, those orthopaedic patients who require a hospital stay within the eligible criteria (4-10 days) like most of the high technology surgical interventions such as Total Hip or Total Knee Replacements would perhaps distort the results because of the frustration and anger that these patients might have had towards the orthopaedic surgeons in view of the delay for such operations to be carried out (due to the long waiting list that exists). Exclusions from this study were also those patients who, for communication problems due to mental disabilities could not be capable of taking part in the study (eg. CVA, Huntington’s chorea, mentally disabled persons, sedated patients, etc.). Again this was done because the author was interested to achieve the real views of the patients and not those of their relatives.

A list of adult patients (eighteen years and over), who were eligible to participate in the study according to the above mentioned criteria, was obtained on a daily basis for four weeks during December 2009. All subjects on this list were approached during
their hospital stay and were asked whether they would want to participate in the study. This was carried out on a later stage during the day of their discharge from hospital. An explanation regarding the research aims, anonymity, confidentiality and voluntary participation in this study was given to each patient with the questionnaire. In fact a letter of consent about this issue was handed to and signed by each patient before taking part in the study (A copy of this letter can be found in the appendices section).

The questionnaires together with enclosed envelopes were delivered by the author himself to this group of patients and this was done one day prior to their discharge from hospital. This gave the patients enough time to reflect and be able to form an opinion on the effectiveness or otherwise of the doctor-patient communication. Subjects were told that the author was from the University of Malta. However, they were not told that he also belonged to the hospital to reduce any response bias.

On the day of the patient's discharge from hospital, the questionnaires were completed and sealed in the provided envelopes by the patients themselves. These envelopes were collected later on the same day by the ward manager in a tamper-proof fashion. This feature ensured that the hospital staff would have no access to the completed questionnaires and the author would not associate person with answer.

Based on the sample technique chosen and inclusion/exclusion criteria, around 378 patients/clients were predicted to be eligible to take part in this study. This amount came out using Mater Dei Hospital's patient flow trend for December of the previous year (Hospital Activity Report, December 2008) as already shown in Figure 1. As a matter of fact, the clients' (patients') sample consisted of 260 participants of which 96.2% response rate was achieved meaning 251 participants. The sample was drawn from a list of 3940 patients being the overall total amount of patients admitted to the
above mentioned medical and surgical wards in Mater Dei Hospital during December 2009 (Hospital Activity Report for 2009 - issued February, 2010).

The total number of patients admitted last year (2009) in the acute Mater Dei Hospital reached 48,836 patients, of which 47,846 patients were treated and discharged, whereas 1,508 have passed away (6% mortality rate). Statistics also indicate that during 2009, the number of hospital days amounted to 30,919, giving rise to 87.5% Bed Occupancy rate and an average Length of Stay of 4.1 days. All these figures gave a turnover rate of 77.1 days (This information was extracted from the Hospital Activity Report for 2009 – Mater Dei Hospital)

3.4.3.2 Format of the questionnaire

Each questionnaire which was given to each patient was accompanied by a covering letter which provided a brief description of the purpose of the study (a copy can be found in the appendix list).

The questionnaire was divided into three sections and each section contained questions/statements that helped to gather data in relation to the objectives of the study.

Section A of the questionnaire comprised questions relating to statements that were considered to represent specific attributes of doctor-patient communication and information giving, including:-

- Questions/Statements 1–8, dealt with doctors’ interpersonal skills and confidentiality.
• Questions/Statements 9 – 15, dealt with facilitation and listening skills.
• Questions/Statements 16 – 21, dealt with medical and healthy living information.
• Questions/Statements 22 – 28, dealt with treatment / medicinal information.
• Questions/Statements 29 – 32, dealt with technical and empathy skills.
• Question/Statement 33 dealt with information leaflets for patients.
• Question 34 asked the patients how many minutes did the consultation take.

Section B – A qualitative study was also performed through two open-ended questions (questions 35 and 36) that were included in the questionnaire. These questions were related to patients’ perceptions, views and opinions. These included any undesired expectation/s that might have occurred during the doctor-patient encounter, overall satisfaction with doctor communication and information, and patients’ opinions of how things could be changed or introduced in the doctor-patient interaction in order to improve the quality of service in this aspect.

Section C – Demographic information was included in the questionnaire. Subjects were asked to indicate their age, gender, marital status, whether living alone, with family or in an institution, level of education, length of hospital stay, any previous hospitalisations and whether they had a family doctor.

The questionnaire was drafted in English, and then translated in Maltese. It was ensured that both the English and Maltese versions gave the same meaning. One particular technique which was used is back-translation. Back-translation is the translation of a survey instrument or questionnaire that has already been translated into a foreign language back to the original language. In this case, the back-
translation was done by a different independent translator than the one who did the
forward-translation. After the back-translation, the original and back-translated
instruments were compared and points of divergence were noted. The translation was
then corrected to more accurately reflect the intent of the wording in the original
language. When both versions were available, the subjects/patients who agreed to
participate were asked beforehand which one of the two languages they would opt to
answer.

3.4.3.3 Using a questionnaire

The advantages of using a questionnaire in this study included the following:

- Questionnaires were less expensive in terms of money and time.
- The questionnaire format was standardised for all respondents.
- The respondents experienced a sense of anonymity and were more likely to
  provide honest answers, knowing that the findings could not be linked to any
  specific person.

The disadvantages of using a questionnaire in this study were as follows:

- Respondents might fail to answer some of the questions because the author might
  not be around to clarify some misunderstood questions, or to explore responses to
  obtain more detailed answers. However to maintain equality with everyone, the
  author also included the illiterate patients in the study and this had entailed loads of
  hidden costs in view of patience and time consumption for the author in reading
  and explaining every detail in the questionnaire without exerting any influence on
  the participant. The author believed that this manoeuvre was worth doing as it
  allowed a much more transparent and robust results.
Negative feedback on doctors' attitudes could be low perhaps patients fear that if they complain about their doctor they might get less attention / care from their doctor. However it was made very clear to the patients about the confidentiality and anonymity (please refer to letter of consent in appendices section).

The use of closed-ended questions might lead to important information being missed because closed-ended questions could not provide for the full variety of possible response options which might exist. Therefore, to address some of these disadvantages, two open-ended questions were included in order to allow the respondents to portray their unique opinions, views, perceptions and/or experiences in their own words.

3.5 Assessing the research questionnaire

3.5.1 Validity of the questionnaire

According to Heffner (2004), validity refers to whether an instrument actually measures what it is supposed to measure, given the context in which it is applied. The questionnaire was given to five independent experts to evaluate it for content validity as well as for conceptual clarity and investigative bias. In some instances question alterations were suggested and implemented but no major changes were identified. After making the agreed question wording, the author evaluated the research questionnaire for validity by pretesting the questionnaire.
3.5.2 Pretesting the research questionnaire

According to Polit and Hungler (1999), a pretest is a trial run to determine whether the instruments are clearly worded and free from major biases and whether they solicit the type of information envisioned. Pretesting will ensure that the final tool will be easy for the subjects to understand and complete.

The only way to know whether the questions were understandable to the respondents was to pretest them in a similar population (LoBiondo-Wood & Haber, 2002). The questionnaires were administered to ten patients with the same inclusion and exclusion criteria in the medical and surgical wards in Mater Dei Hospital. These ten patients were not included in the final data collection. No major problems were experienced by these ten patients who participated in the pretest. In fact the only change in the questionnaire was the removal of question number thirty seven (37) in the demographic section where the subjects were asked to indicate the date when the form was filled. This was done to ensure that the questionnaire would not be associated to the subject/client as in such case the date was representing the client’s discharge from hospital.

3.5.3 Reliability of the questionnaire

Reliability refers to the degree to which the instrument can be depended upon to yield consistent results (Heffner, 2004). To test the questionnaire for reliability, the author handed the questionnaire to another different set of sixteen patients at the Renal Unit. This unit was targeted as it offers treatment to a particular group of long term ‘out-
patient's basis who could be easily tracked back as the questionnaire needed to be given on two separate occasions (test re-test) and compare their individual response to test for reliability. The questionnaire would be considered as reliable only if the responses on the first administration should be similar to the responses on the second. In fact a non parametric paired test was used. This was the Wilcoxin signed ranks test as the number of subjects used for reliability testing was less than twenty. The result of this test showed that all variables obtained a p-value of more than 0.05 suggesting that they are not statistically different and therefore indicating that the questionnaire possessed reliability and can yield consistent results. It is imperative to note that these patients' responses were not considered as part of the study results but specifically to test for the reliability of the tool.

3.6 Ethical considerations

The author paid consideration to the following ethical issues pertaining to the study so as to reassure the respondents / participants that the information would be treated anonymously and confidentially.

3.6.1 Written informed consent

A written consent from patients, doctors and ward managers were obtained for the participation in all of the three segments of the research design. Participants were informed about the aim of the study and their opportunity to participate. They were also assured that the service provided to them would not be altered or influenced by their participation or otherwise.
3.6.2 Confidentiality

According to Burns and Grove (1995), confidentiality refers to the author’s management of private information shared by the respondents. No respondent could be linked to any particular completed questionnaire or other information gathered. The respondents were assured that the information would be used for the purpose of this research and would be made available to them if they requested it. The information from the completed questionnaires and direct observations would be used to generate frequencies and percentages to be discussed in a research report only. No person will be identified in the research report.

3.6.3 Anonymity

Anonymity implies that the information collected cannot be linked, even by the author, to a particular respondent (Polit & Hungler, 1999). Neither the respondent’s name, nor ward’s name, was required on the questionnaire. In spite of the fact that no names were entered on any questionnaire, the completed questionnaires were kept under lock and key. Only the author and statistician had access to the completed questionnaires. Once the research report had been completed, the author would destroy all the completed questionnaires.

3.6.4 Permission to conduct the study

Permission to conduct the study was requested in writing from various authorities of Mater Dei Hospital where the study was conducted. Appendix 1 contains copies of letters granting permission to conduct the study.
Approvals were sought from:

- The Board of Ethics formed by the Institute of Health Care (University of Malta) to ensure confidentiality, privacy and anonymity of respondents as well as to respect data protection act.
- Chief Executive Officer (Mater Dei Hospital).
- The Director Nursing Services (Mater Dei Hospital).
- The Medical Superintendent (Mater Dei Hospital).
- The Chairman of Medicine.
- The Chairman of Surgery.
- All participating consultants
- The Departmental Nursing Managers allocated to the wards involved in the study.

3.7 Benefits

The respondents were informed that they will not receive any remuneration for participating in the study. However the result of this study (Doctor-Patient communication and information giving in the acute medical and surgical wards) could benefit each participating patient, other future patients, health care professionals and health care administrators by the increase in awareness, consciousness and conscientiousness on achieving better doctor-patient communication.
3.8 Conclusion

This chapter discussed the research methodology adopted to study the attitudes, perceptions and feelings of three different groups of people namely doctors, patients and nursing officers at Mater Dei Hospital. The study design, population and sampling procedures were described. The data collection instruments and collection of data were also described. Chapter 4 will present the analysis and evaluation of data obtained from direct observations, structured interviews and questionnaires in the identified institution.
CHAPTER 4

Results
Chapter 4: RESULTS

4.1 Patients’ and Doctors’ profiles

This chapter describes the quantitative results achieved from two sources of data collection: the first one being the Doctor-Patient communication questionnaire (a patient perception questionnaire) where the patients were asked to give a rating (Likert scale) for each of the statements given concerning doctor communication attitudes and behaviour during the consultation. The second one being the data collected by means of a check list during a direct observation study which the author had made on doctors during their first consultation (visit) with newly admitted patients.

Based on the sample technique chosen and inclusion/exclusion criteria, the clients’ (inpatients’) sample for the questionnaire consisted of 260 participants of which a 96.2% response rate was achieved (N = 251). The sample was drawn from a list of 1634 patients who were the total number of patients admitted in the medical and surgical wards in Mater Dei Hospital during this specific 4 week period (December 2009). This indicates that only 15.5% of the overall patients were eligible to take part in the study.

The majority of data collected from the close-ended questions/statements in Section A of the questionnaire were analysed quantitatively and presented in various statistical figures and tables. The comments derived from the open-ended questions in Section B of the questionnaire were also analysed.
On the other hand with regards to the direct observations study on doctors, the total number of these direct observations was predetermined and limited to eighty (80). This amount was established after the author calculated the number of consultants/firms (which at the time of the study amounted to 36) working in the medical and surgical specialities, thus giving rise to increasing the probability to include all or most of the thirty six (36) consultants during this 3-week study (September 2009). The data collected from these direct observations were also analysed and presented in various statistical figures and tables.

4.2 Ward managers’ perceptions

This chapter also includes qualitative data through structured interviews which the author carried out during October 2009 with ten (10) senior ward managers. These managers, five from each specialty (medical and surgical) were interviewed against a check list held by the author so that a sequence of questions and answers could be maintained.

The advantage of this method is because communication can be somewhat disordered at times – individuals can start off discussing a specific topic, go off on a tangent about something else and then glide right back into the original topic without skipping a beat. People will answer a second question, then recall something related to the previous question and insert that in their answer to the second question, often without signalling that it was related to their previous train of thought.
The interview responses were systematically brought together and categorized in themes using the same variables that were used for the quantitative tools mentioned above. These variables concerned looking for distinct opinion types that might convey the perceptions of the interviewees in how individual doctors behave with patients during the consultation.

4.3 Findings from the patient questionnaire

4.3.1 Demographics of respondents (inpatients)

Figure 1 represents the distribution of male inpatients (respondents) by age. The age of male respondents varied between 18 and 83 years. The majority of male respondents were between 56 and 65 years.
Figure 2 represents the distribution of female respondents by age groups. The age of the female respondents varied between 18 and 84 years. The majority of female respondents were between 46 and 55 years.
Inpatients' Age Distribution

Figure 3  Inpatients Age Distribution

Figure 3 represents all the respondents' (inpatient) age distribution. The majority of the overall inpatient respondents were between 56 and 65 years of age (Mean age 57 years).

Figure 4  Distribution by gender
<table>
<thead>
<tr>
<th>Variables</th>
<th>Categories</th>
<th>Total % (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Status</td>
<td>Single</td>
<td>22.5% (54)</td>
</tr>
<tr>
<td></td>
<td>Married</td>
<td>68.9% (173)</td>
</tr>
<tr>
<td></td>
<td>Widow/er</td>
<td>8.4% (21)</td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td>1.2% (30)</td>
</tr>
<tr>
<td>Education</td>
<td>Primary</td>
<td>20.3% (51)</td>
</tr>
<tr>
<td></td>
<td>Secondary</td>
<td>59.4% (149)</td>
</tr>
<tr>
<td></td>
<td>Tertiary</td>
<td>19.1% (48)</td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td>1.2% (3)</td>
</tr>
<tr>
<td>Residence outside hospital</td>
<td>Living alone</td>
<td>16.3% (41)</td>
</tr>
<tr>
<td></td>
<td>Living with family</td>
<td>78.5% (197)</td>
</tr>
<tr>
<td></td>
<td>Living in an institution</td>
<td>2.4% (6)</td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td>2.8% (7)</td>
</tr>
</tbody>
</table>

All these variables are based on a total of 100% (251) 'N' = number of respondents

Table 2 - Socio-demographic Data of the Respondents (Inpatients)

Figure 4 and Table 2 show that more females 53.4% (N = 133) participated than males 46.2% (N = 111). The largest proportion of respondents were married 68.9% (N = 173), had a secondary level of education 59.4% (N = 149) and 78.5% (197) lived at home with their relatives.
4.3.2 Other important demographic information

In the demographic data section, other information was needed. This included the average time the doctor spent with the patient during the consultation, the length of hospital stay of the patient, whether the patient had other hospitalisation in the past and whether the patient had a family doctor.

Table 3 demonstrates that the majority of doctors 34.7% (N = 87) spent 4 to 7 minutes near each patient during their consultations, while 29.9% (N = 75) of the doctors spent 8 to 11 minutes. It has also been noted that more than one fifth of the doctors 22.3% (N = 56) spent very little time near the patient (0 to 3 minutes). The table also shows that the majority of patients had a length of stay of 5 days 28.3% (N = 71) with the smallest group of patients 5.2% (N = 13) spending 9 days hospital stay (One of the inclusion criteria in this study was that patients must have been hospitalised for 4 to 10 days to be able to give an opinion). The largest segment of patients that is 78.1% (N = 196) had previously been hospitalised (past experience), and 86.9% (N = 218) stated that they had a family physician.
<table>
<thead>
<tr>
<th>Variables</th>
<th>Categories</th>
<th>Total % (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultation time</td>
<td>0 to 3 minutes</td>
<td>22.3% (56)</td>
</tr>
<tr>
<td></td>
<td>4 to 7 minutes</td>
<td>34.7% (87)</td>
</tr>
<tr>
<td></td>
<td>8 to 11 minutes</td>
<td>29.9% (75)</td>
</tr>
<tr>
<td></td>
<td>More than 12 mins.</td>
<td>12.4% (31)</td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td>0.8% (2)</td>
</tr>
<tr>
<td>Length of hospital stay</td>
<td>4 days</td>
<td>25.5% (64)</td>
</tr>
<tr>
<td></td>
<td>5 days</td>
<td>28.3% (71)</td>
</tr>
<tr>
<td></td>
<td>6 days</td>
<td>13.1% (33)</td>
</tr>
<tr>
<td></td>
<td>7 days</td>
<td>10.0% (25)</td>
</tr>
<tr>
<td></td>
<td>8 days</td>
<td>6.0% (15)</td>
</tr>
<tr>
<td></td>
<td>9 days</td>
<td>5.2% (13)</td>
</tr>
<tr>
<td></td>
<td>10 days</td>
<td>10.8% (27)</td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td>1.2% (3)</td>
</tr>
<tr>
<td>Past hospitalisation</td>
<td>Yes</td>
<td>78.1% (196)</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>17.1% (43)</td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td>4.8% (12)</td>
</tr>
<tr>
<td>Family physician</td>
<td>Yes</td>
<td>86.9% (218)</td>
</tr>
<tr>
<td></td>
<td>No</td>
<td>12.7% (32)</td>
</tr>
<tr>
<td></td>
<td>Unspecified</td>
<td>0.4% (1)</td>
</tr>
</tbody>
</table>

All these variables are based on a total of 100% (251) 'N' = number of respondents

Table 3 - Information on relevant variables that may affect patient satisfaction with 'Doctor communication and information giving'
4.4 Quantitative results for Patient Questionnaire

4.4.1 Doctors’ interpersonal skills

In the first part of the patient satisfaction questionnaire, there were eight statements directed to doctors’ interpersonal skills (Statements 1 to 8 of the questionnaire). Patients’ views regarding the quality of the interaction with the doctor during the consultation in the ward were measured.

<table>
<thead>
<tr>
<th>DOCTORS’ INTERPERSONAL SKILLS</th>
<th>Strongly disagree % (N)</th>
<th>Disagree % (N)</th>
<th>Do not know % (N)</th>
<th>Agree % (N)</th>
<th>Strongly agree % (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor was welcoming</td>
<td>2.8% (7)</td>
<td>3.6% (9)</td>
<td>6.8% (17)</td>
<td>38.2% (96)</td>
<td>48.6% (122)</td>
</tr>
<tr>
<td>Doctor respected privacy</td>
<td>2.8% (7)</td>
<td>5.2% (13)</td>
<td>12.4% (31)</td>
<td>32.3% (81)</td>
<td>47.4% (119)</td>
</tr>
<tr>
<td>Asked about symptoms</td>
<td>1.6% (4)</td>
<td>2.0% (5)</td>
<td>4.8% (12)</td>
<td>37.5% (94)</td>
<td>54.2% (136)</td>
</tr>
<tr>
<td>Listened carefully</td>
<td>1.6% (4)</td>
<td>0.8% (2)</td>
<td>4.4% (11)</td>
<td>35.1% (88)</td>
<td>58.2% (146)</td>
</tr>
<tr>
<td>Was attentive to needs</td>
<td>0.8% (2)</td>
<td>2.4% (6)</td>
<td>8.0% (20)</td>
<td>33.5% (84)</td>
<td>55.4% (139)</td>
</tr>
<tr>
<td>Used eye contact</td>
<td>1.2% (3)</td>
<td>5.6% (14)</td>
<td>16.7% (42)</td>
<td>29.1% (73)</td>
<td>47.4% (119)</td>
</tr>
<tr>
<td>Encouraged speaking</td>
<td>0.8% (2)</td>
<td>2.4% (6)</td>
<td>12.4% (31)</td>
<td>40.6% (102)</td>
<td>43.8% (110)</td>
</tr>
<tr>
<td>Patient felt understood</td>
<td>0.4% (1)</td>
<td>2.8% (7)</td>
<td>8.4% (21)</td>
<td>36.3% (91)</td>
<td>52.2% (131)</td>
</tr>
<tr>
<td>Mean percentages (N)</td>
<td>1.5% (4)</td>
<td>3.1% (8)</td>
<td>9.2% (23)</td>
<td>35.3% (88)</td>
<td>50.9% (128)</td>
</tr>
</tbody>
</table>

All these variables are based on a Total of 100% (251)  
'N' = number of respondents

Table 4 - Aspects of doctors’ interpersonal skills.

Responses to statements in Table 4 were very highly positive and this indicates that the majority of patients are fully satisfied with the doctors’ interpersonal skills. However there were considerable amount of patients who were not quite sure of their reply especially for statements like ‘Doctor respected my privacy’ 12.4% (N = 31), ‘Doctor used eye contact’ 16.7% (N = 42), and the ‘Doctor encouraged me to speak’ 12.4% (N = 31).
4.4.2 Doctors’ facilitation and listening skills

In this section, the patients were given the opportunity to rate the doctors according to their facilitation and listening skills.

<table>
<thead>
<tr>
<th>DOCTORS’ FACILITATION &amp; LISTENING SKILLS</th>
<th>Strongly disagree % (N)</th>
<th>Disagree % (N)</th>
<th>Do not know % (N)</th>
<th>Agree % (N)</th>
<th>Strongly agree % (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor explained plan</td>
<td>2.0% (5)</td>
<td>5.2% (13)</td>
<td>19.5% (49)</td>
<td>28.3% (71)</td>
<td>45.0% (113)</td>
</tr>
<tr>
<td>Encouraged questioning</td>
<td>4.8% (12)</td>
<td>7.6% (19)</td>
<td>14.7% (37)</td>
<td>31.5% (79)</td>
<td>41.4% (104)</td>
</tr>
<tr>
<td>Useful &amp; good information</td>
<td>1.6% (4)</td>
<td>9.2% (23)</td>
<td>21.1% (53)</td>
<td>29.5% (74)</td>
<td>38.6% (97)</td>
</tr>
<tr>
<td>Effective information</td>
<td>2.4% (6)</td>
<td>10.8% (27)</td>
<td>14.3% (36)</td>
<td>33.5% (84)</td>
<td>39.0% (98)</td>
</tr>
<tr>
<td>Care improved condition</td>
<td>4.4% (11)</td>
<td>2.4% (6)</td>
<td>19.5% (49)</td>
<td>31.5% (79)</td>
<td>42.2% (106)</td>
</tr>
<tr>
<td>Doctor explained carefully</td>
<td>-</td>
<td>3.6% (9)</td>
<td>9.2% (23)</td>
<td>42.2% (106)</td>
<td>45.0% (113)</td>
</tr>
<tr>
<td>Patient recovered faster</td>
<td>4.0% (10)</td>
<td>4.0% (10)</td>
<td>10.4% (26)</td>
<td>39.0% (98)</td>
<td>42.6% (107)</td>
</tr>
<tr>
<td>Mean percentages (N)</td>
<td>2.7% (7)</td>
<td>6.1% (16)</td>
<td>15.5% (39)</td>
<td>33.6% (84)</td>
<td>42.0% (105)</td>
</tr>
</tbody>
</table>

All these variables are based on a Total of 100% (251) ‘N’ = number of respondents

Table 5 - Analysing the aspects of doctors’ facilitation and listening skills

As shown in Table 5, the majority of patients strongly agreed or agreed with the doctors’ physical and management aspects of communication towards their patients. The ‘Doctors’ explanation of the treatment plan’ and ‘the careful and simple terms used in the explanation process’ were the highest and equally ranked with 45% (N = 113) of the patients. Second in line came ‘the care given by the doctor has helped the patient to recover faster’ with 42.6% (N = 107), and ‘the care received by the patients has improved their general health’ came third with 42.2% (N = 106) of patients.
4.4.3 Doctors’ medical and healthy living information

In this section, patients were asked to give their ranking in relation to the doctors’ medical and healthy living information.

<table>
<thead>
<tr>
<th>MEDICAL AND HEALTHY LIVING INFORMATION</th>
<th>Strongly disagree % (N)</th>
<th>Disagree % (N)</th>
<th>Do not know % (N)</th>
<th>Agree % (N)</th>
<th>Strongly agree % (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor was well presented</td>
<td>1.6% (4)</td>
<td>1.6% (4)</td>
<td>6.8% (17)</td>
<td>36.7% (92)</td>
<td>53.4% (134)</td>
</tr>
<tr>
<td>Inquired about my diet</td>
<td>15.9% (40)</td>
<td>19.5% (49)</td>
<td>13.9% (35)</td>
<td>19.1% (48)</td>
<td>31.5% (79)</td>
</tr>
<tr>
<td>Inquired about risky habits</td>
<td>5.2% (13)</td>
<td>4.8% (12)</td>
<td>8.8% (22)</td>
<td>37.1% (93)</td>
<td>44.2% (111)</td>
</tr>
<tr>
<td>Advised on healthy lifestyle</td>
<td>10.4% (26)</td>
<td>13.9% (35)</td>
<td>12.4% (31)</td>
<td>30.3% (76)</td>
<td>33.1% (83)</td>
</tr>
<tr>
<td>Performed physical exam.</td>
<td>1.2% (3)</td>
<td>4.8% (12)</td>
<td>5.6% (14)</td>
<td>34.7% (87)</td>
<td>53.8% (135)</td>
</tr>
<tr>
<td>Pt. was given written info.</td>
<td>22.3% (56)</td>
<td>18.7% (47)</td>
<td>15.5% (39)</td>
<td>14.7% (37)</td>
<td>28.7% (72)</td>
</tr>
<tr>
<td>Inquired about medicines</td>
<td>1.2% (3)</td>
<td>1.6% (4)</td>
<td>2.8% (7)</td>
<td>40.2% (101)</td>
<td>54.2% (136)</td>
</tr>
<tr>
<td>Mean percentages (N)</td>
<td>8.3% (25)</td>
<td>9.3% (23)</td>
<td>9.4% (24)</td>
<td>30.4% (76)</td>
<td>42.7% (107)</td>
</tr>
</tbody>
</table>

All these variables are based on a Total of 100% (251), 

*N* = number of respondents

Table 6 - Aspects of doctors’ medical and healthy living information

In Table 6, most of the patients strongly agreed with the type of information provided to them by the doctors, mostly with ‘the doctors’ inquiry on the medicine being taken by the patient’ 54.2% (N = 136), ‘the doctor performed physical examination’ 53.8% (N = 135), and ‘the doctor was well presented’ 53.4% (N = 134), respectively. However it has also been well noted that there was a strong negative shift towards statements like ‘the patient was given written information’ 41.0% (N = 103), ‘the doctor inquired about my diet’ 35.4% (N = 89), and ‘the doctor advised on healthy lifestyle’ 24.3% (N = 61).
4.4.4 Doctors’ information giving on medicines and treatment options

This type of analysis was carried out so that the author could identify the patients’ perception on treatment and medicinal information transferred to them by the doctors.

<table>
<thead>
<tr>
<th>TREATMENT AND MEDICINAL INFORMATION</th>
<th>Strongly disagree % (N)</th>
<th>Disagree % (N)</th>
<th>Do not know % (N)</th>
<th>Agree % (N)</th>
<th>Strongly agree % (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asked if meds taken regularly</td>
<td>5.6% (14)</td>
<td>6.0% (15)</td>
<td>7.6% (19)</td>
<td>36.7% (92)</td>
<td>42.6% (107)</td>
</tr>
<tr>
<td>Discussed prescription plan</td>
<td>9.6% (24)</td>
<td>12.4% (31)</td>
<td>19.5% (49)</td>
<td>23.1% (58)</td>
<td>35.5% (89)</td>
</tr>
<tr>
<td>Asked if allergic to any meds</td>
<td>0.8% (2)</td>
<td>4.0% (10)</td>
<td>5.2% (13)</td>
<td>39.8% (100)</td>
<td>50.2% (126)</td>
</tr>
<tr>
<td>Asked consent from patient</td>
<td>14.7% (37)</td>
<td>16.7% (42)</td>
<td>24.7% (62)</td>
<td>19.9% (50)</td>
<td>23.9% (60)</td>
</tr>
<tr>
<td>Explained medicinal usage</td>
<td>5.2% (13)</td>
<td>11.6% (29)</td>
<td>19.9% (50)</td>
<td>24.3% (61)</td>
<td>39.0% (98)</td>
</tr>
<tr>
<td>Specified possible side effects</td>
<td>19.1% (48)</td>
<td>21.9% (55)</td>
<td>26.7% (67)</td>
<td>16.3% (41)</td>
<td>15.9% (40)</td>
</tr>
<tr>
<td>What to do in adverse events</td>
<td>24.3% (61)</td>
<td>23.9% (60)</td>
<td>23.9% (60)</td>
<td>13.9% (35)</td>
<td>13.9% (35)</td>
</tr>
<tr>
<td>Mean percentages (N)</td>
<td>11.3% (28)</td>
<td>13.8% (35)</td>
<td>18.2% (46)</td>
<td>24.9% (62)</td>
<td>31.6% (79)</td>
</tr>
</tbody>
</table>

Table 7 - Perception of patients on various aspects of doctor information giving about medicines and treatment options.

In the above Table, the two main variables that the patients ranked as ‘strongly agree’ were ‘the doctor asked if the patient was allergic to any kind of medicines’ 50% (N = 126) and ‘the doctor asked if the patient was taking his/her medicines regularly before being admitted in hospital’ 42.6% (N = 107). All other variables included in this table demonstrate that the patients were rather sceptical and often showed their disagreement with the statements given. The most negatively accepted statements being ‘the doctor explained to me carefully what I should do in case of an adverse reaction to the medicine prescribed’ 48.1% (N = 121), ‘the doctor described the possible side effects of the medicine s/he prescribed’ 41.0% (N = 103) and ‘the doctor asked consent from the patient
before prescribing his/her treatment’ 31.4% (N = 79). Uncertainty ranked high with ‘doctor specifying possible side effects’ 26.7% (N = 67), ‘doctor asked consent from patients’ and ‘doctors stating what to do in case of adverse reactions to medicines’ respectively.

4.4.5 Doctors’ technical and empathy skills

Analysis of patients’ perceptions regarding the ‘Doctors’ technical and empathy skills’ was carried out. The four variables used which are related to this issue were: ‘politeness and courteousness of the doctor’, ‘competency of the doctor’, ‘doctor emphasis on patients’ understanding’ and ‘doctor asking patient whether help was needed at home after discharge from hospital’.

<table>
<thead>
<tr>
<th>TECHNICAL AND EMPATHY SKILLS</th>
<th>Strongly disagree % (N)</th>
<th>Disagree % (N)</th>
<th>Do not know % (N)</th>
<th>Agree % (N)</th>
<th>Strongly agree % (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. was polite &amp; courteous</td>
<td>1.6% (4)</td>
<td>4.4% (11)</td>
<td>12.4% (31)</td>
<td>31.9% (80)</td>
<td>49.8% (125)</td>
</tr>
<tr>
<td>Very competent</td>
<td>0.8% (2)</td>
<td>8.8% (22)</td>
<td>13.9% (35)</td>
<td>34.7% (87)</td>
<td>41.8% (105)</td>
</tr>
<tr>
<td>Focussed on understanding</td>
<td>1.2% (3)</td>
<td>8.4% (21)</td>
<td>8.0% (20)</td>
<td>35.9% (90)</td>
<td>46.6% (117)</td>
</tr>
<tr>
<td>Asked if help needed at home</td>
<td>17.1% (43)</td>
<td>22.3% (56)</td>
<td>10.8% (27)</td>
<td>22.7% (57)</td>
<td>27.1% (68)</td>
</tr>
<tr>
<td>Mean percentages (N)</td>
<td>5.2% (13)</td>
<td>11.0% (28)</td>
<td>11.3% (28)</td>
<td>31.3% (79)</td>
<td>41.3% (104)</td>
</tr>
</tbody>
</table>

All these variables are based on a Total of 100% (251) 

Table 8 - Perception of patients on the aspects of technical and empathy skills delivered by the doctors

In Table 8, out of four variables corresponding to doctors’ technical and empathy skills, three of them showed a strong agreement amongst patients especially with the issue of politeness and courteousness projected by the doctors 49.8% (N = 125). However there
was a deep disagreement with the statement indicating that the doctor asked if help was needed when the patient is due to be discharged home 17.1% (N = 43) Strongly Disagree and 22.3% (N = 56) Disagree.

4.5 Dimensions of doctor communication

The mean score for statements 1 to 33 of the questionnaire was established by grouping each one of them in categories corresponding to doctor communication characteristics namely ‘Interpersonal Skills’, ‘Facilitation Skills’, ‘Medical Information’, ‘Medicinal Information’, ‘Technical and Empathy Skills’ and ‘Written Information’. This was done so as to get an overall view of the general perceptions of the patients with regards to the quality of care with regards to ‘Doctor communication and information giving in Mater Dei Hospital’. Higher scores like ‘Strongly Agree’ were assigned a higher code (5), whereas lower scores like ‘Strongly Disagree’ was assigned a lower code (1). Scores 4 and 2 were assigned for agree and disagree respectively whereas code (3) was assigned as neutral point.

4.5.1 Doctor communication characteristics vs. Patient gender

In this section, the author analysed the doctors’ communication characteristics against the patients’ gender to get an overview of whether doctors’ attitude is perceived differently between male and female patients.
Figure 5 represents the Mean scores for Doctor Communication variables when compared to Patients' Gender.

Figure 6 represents the distribution of patients' gender.
<table>
<thead>
<tr>
<th>DOCTORS' COMMUNICATION CHARACTERISTICS</th>
<th>Mean by Gender</th>
<th>Average Mean</th>
<th>Sig. (p-Value)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interpersonal Skills</td>
<td>4.25 (N = 116)</td>
<td>4.31</td>
<td>0.240</td>
</tr>
<tr>
<td>Facilitation Skills</td>
<td>3.98 (N = 134)</td>
<td>4.06</td>
<td>0.014</td>
</tr>
<tr>
<td>Medical Information</td>
<td>3.86 (N = 116)</td>
<td>3.96</td>
<td>0.015</td>
</tr>
<tr>
<td>Medicinal Information</td>
<td>3.47 (N = 116)</td>
<td>3.51</td>
<td>0.086</td>
</tr>
<tr>
<td>Technical &amp; Empathy Skills</td>
<td>3.84 (N = 134)</td>
<td>3.93</td>
<td>0.032</td>
</tr>
<tr>
<td>Written Information</td>
<td>2.97 (N = 116)</td>
<td>3.09</td>
<td>0.430</td>
</tr>
</tbody>
</table>

All these variables are based on a Total of 100% (251)

'N' = number of respondents

Table 9 - Doctor communication characteristics vs. Patient gender

In Table 9, results show that the majority of patients rated ‘Doctor’s interpersonal skills’ as the most accepted with an average mean of 4.31. The most outstanding characteristic that patients seem to disagree with is the ‘Written information’ with an average mean score of 3.09 (Males giving a mean of 2.97). In this table it is clearly evident that the females are more lenient and tend to respond more positively than males especially with issues including ‘facilitation skills’, ‘medical information’, and ‘technical and empathy skills’ with p-values of 0.014, 0.015, and 0.032 respectively.

4.5.2 Doctor communication characteristics vs. Patients’ Status

The demographic information served to analyse if patients of different status categories have different perceptions and views about the expectations and satisfaction in terms of Doctor Communication traits.
Figure 7 represents the Mean scores for Doctor Communication variables when compared to the Patients' Status.

Status Distribution

Figure 8 represents the distribution of patients' Status.
Table 10 - Doctor communication characteristics vs. Patients' status

As indicated in Table 10, the overall mean score for statements 1 to 33 of the patient questionnaire did not vary significantly within each variable when tested using analysis of variance (ANOVA). When analysing the Means by patient status for each individual statement, two issues seemed to vary negatively with status namely 'Medicine information given by doctors' (Average mean = 3.51) and 'Written information given by doctors' (Average mean = 3.07). However these variations did not achieve statistical significance. Again the most respected statement was that concerning the 'Doctors' interpersonal skills' and achieved a p-Value of 0.058 which means that it was very near to statistical significance between groups. The most rejected variable was that for 'Patient being provided with written information'. In the latter variable, there was a marked downward shift by 'Married' patients compared to 'Single' or 'Widowed' patients.

4.5.3 Doctor communication characteristics vs. Patients' way of living at their Residence

Once again demographic data was used to analyse doctor communication traits compared to how the patients live at their residence. Since the number of subjects living in an institution was very small (less than 20), a Kruskal-Wallis test was engaged to achieve a real significant value for such group (p-value = 0.138).
Figure 9 represents the Mean scores for Doctor Communication variables when compared to the Patients' Residential Status.

Figure 10 represents the distribution of patients' Residential Status.
Table 11 illustrates the overall mean scores by estimating the rating response of patients when comparing ‘Doctor communication qualities’ vs. ‘Patients’ residence’ that is whether patient lives alone, with family or in an institution for statements 1 to 33 of the patient satisfaction questionnaire. It has been detected that those patients living in an institution ranked doctor communication attributes much higher than those living alone or with their families. However, once again one could also note that the ranking is always weaker with regards to medicine information and more so with written information. When tested with Kruskal-Wallis Test (Less than 20 respondents at any variable used), the overall mean score did not vary significantly.

<table>
<thead>
<tr>
<th>DOCTORS' COMMUNICATION CHARACTERISTICS</th>
<th>Mean by Patients' residence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Alone (N = 41)</td>
</tr>
<tr>
<td>Interpersonal Skills</td>
<td>4.41</td>
</tr>
<tr>
<td>Facilitation Skills</td>
<td>4.03</td>
</tr>
<tr>
<td>Medical Information</td>
<td>4.02</td>
</tr>
<tr>
<td>Medicinal information</td>
<td>3.56</td>
</tr>
<tr>
<td>Technical &amp; Empathy Skills</td>
<td>3.92</td>
</tr>
<tr>
<td>Written Information</td>
<td>3.39</td>
</tr>
</tbody>
</table>

All these variables are based on a Total of 100% (251) 'N' = number of respondents

Table 11 - Mean scores for Doctor Communication characteristics vs. Patients' residence
### 4.5.4 Patients' perceptions of Doctor communication characteristics vs. Patients' Education level

<table>
<thead>
<tr>
<th>Communication Variables</th>
<th>Tertiary</th>
<th>Secondary</th>
<th>Primary</th>
</tr>
</thead>
<tbody>
<tr>
<td>Written Information</td>
<td>3.1</td>
<td>2.83</td>
<td>3.14</td>
</tr>
<tr>
<td>Technical &amp; Empathy Skills</td>
<td>3.27</td>
<td>3.71</td>
<td>4.02</td>
</tr>
<tr>
<td>Medicinal Information</td>
<td>3.55</td>
<td>3.57</td>
<td>3.95</td>
</tr>
<tr>
<td>Medical Information</td>
<td>3.96</td>
<td>3.99</td>
<td>4.02</td>
</tr>
<tr>
<td>Facilitation Skills</td>
<td>3.94</td>
<td>4.18</td>
<td>4.04</td>
</tr>
<tr>
<td>Interpersonal Skills</td>
<td>4.31</td>
<td>4.43</td>
<td>4.15</td>
</tr>
</tbody>
</table>

**Figure 11:** Represents the Mean scores for Doctor Communication variables when compared to the Patients' Educational Level.

**Educational Level Distribution**

- Tertiary, 19.4% (N = 48)
- Secondary, 60% (N = 149)
- Primary, 20.6% (N = 51)

**Figure 12:** Represents the distribution of patients' Level of Education.
Table 12 - Mean scores for questionnaire statements 1 to 33 compared with Patients' Level of Education

| DOCTORS' COMMUNICATION CHARACTERISTICS | Mean by Patients' Education Level |  |
|----------------------------------------|----------------------------------|--|---|
|                                        | Primary (N = 51)                 | Secondary (N = 149) | Tertiary (N = 48) | Total Mean (N = 248) | p-Value  |
| Interpersonal Skills                   | 4.43                             | 4.31                 | 4.15              | 4.30 | 0.027          |
| Facilitation Skills                    | 4.18                             | 4.04                 | 3.94              | 4.05 | 0.212          |
| Medical Information                    | 3.98                             | 3.96                 | 3.89              | 3.95 | 0.812          |
| Medicinal information                  | 3.57                             | 3.55                 | 3.27              | 3.50 | 0.116          |
| Technical & Empathy Skills            | 4.02                             | 3.95                 | 3.71              | 3.92 | 0.108          |
| Written Information                    | 3.10                             | 3.14                 | 2.83              | 3.07 | 0.483          |

All these variables are based on a Total of 100% (251) | ‘N’ = number of respondents

Table 12 demonstrates the overall mean scores for statements 1 to 33, by respondents, according to their level of education. Those patients with a tertiary level of education were less satisfied with all aspects of Doctor communication traits while patients with primary level of education were the most satisfied. In fact this showed a statistical significance between the three levels giving a p-Value of 0.027 indicating that patients with tertiary education are different from the rest of the group. Over again aspects of ‘medicine information’ and ‘written information’ are evidently the weakest points throughout all three educational levels.
4.6 Consultation time

Figure 13 Doctor-patient consultation time distribution (patient perspective)

Figure 13 shows the distribution of patients' feedback on the time doctors spent with them during their consultations. In the questionnaire, patients were given four different time frames to choose one which fits with the doctor's consultation dedicated time for each individual patient. The majority of patients 36% (N = 90) claimed that the doctor interaction took around 4 to 7 minutes, while only thirty patients (12% of respondents) stated that their contact with the doctor during the ward round took more than 12 minutes.
4.7 Open-ended questions for Patient Questionnaire

Section B of the patient questionnaire was reserved for two open-ended questions. The first question dealt with patients’ complaints while the second question focused on how to improve the doctor-patient encounter.

4.7.1 Complaints being expressed by patients

In the first question (No. 35), participants were asked whether they were satisfied with the type of communication offered to them by the doctor and to comment on any aspect or event which went against their expectations (with regards to the subject) during their hospitalisation. For this question, 76.1% of the participants (n = 191) responded and the majority [52.9% (n = 101)] came up with various complaints following their experience with doctor interactions during consultations. The remaining 47.1% (n = 90) of the participants, stated that the quality of their communication with the doctors during the ward round was ‘good’, ‘very good’ and for some patients it was even ‘excellent’.

The remaining 23.9% (n = 60) of the overall participants did not respond to this question.
### Open Ended Section

<table>
<thead>
<tr>
<th>Symptoms Experienced by Patients</th>
<th>Total % (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients who were satisfied with the interaction</td>
<td>47.1% (90)</td>
</tr>
<tr>
<td>Patients who complained about doctor interaction</td>
<td>52.9% (101)</td>
</tr>
<tr>
<td>▪ Waiting time at casualty</td>
<td>24.9% (25)</td>
</tr>
<tr>
<td>▪ Lack of information</td>
<td>17.9% (18)</td>
</tr>
<tr>
<td>▪ Discharged home very early</td>
<td>13.9% (14)</td>
</tr>
<tr>
<td>▪ Lack of privacy</td>
<td>11.9% (12)</td>
</tr>
<tr>
<td>▪ Use of foreign language</td>
<td>11.9% (12)</td>
</tr>
<tr>
<td>▪ Hurried consultation</td>
<td>5.9% (6)</td>
</tr>
<tr>
<td>▪ Clinical errors</td>
<td>4.9% (5)</td>
</tr>
<tr>
<td>▪ Lack of understanding to my needs</td>
<td>3.9% (4)</td>
</tr>
<tr>
<td>▪ Cancellation of operations</td>
<td>2.9% (3)</td>
</tr>
<tr>
<td>▪ Consultants need to be more courteous</td>
<td>1.9% (2)</td>
</tr>
</tbody>
</table>

Two main variables are based on a Total of 100% (n = 191); Sub-variables 100% (n = 101).

**Table 13 - Feedback of the complaints that were received from inpatients**

Table 13 shows that 47.1% (n = 90) of respondents stated that they had no complaints with regards to doctor communication behaviour. On the other hand, the majority of patients [52.9% (n = 101)] had some sort of complaint. Of these, the top complaint was that the patients waited for too long at the E&A Dept. 24.9% (n = 25). Lack of information provided by doctors was the second complaint that patients had to encounter 17.9% (n = 18), with lack of privacy being the third leading complaint 11.9% (n = 12).
4.7.2 Patients' suggestions to improve the doctor-patient interaction

The second question (No. 36) of the open ended part of the questionnaire requested the patients to forward any suggestions for changing or introducing something that in their opinion could improve or optimise the service being offered to them by the doctors. There were 66.9% (n = 168) responses to this question where 61.9% (n = 104) of them stated that they were satisfied with the way they were treated by the doctors and that there was nothing to be added.

However the other 38.1% (n = 64) had various suggestions how to improve or optimise the service. Some of these suggestions included; prognosis and complications of the disease need to be told earlier, the doctor needs to ask permission before examining the patient in front of medical students, more consultation time so that the patient could be able to speak and ask questions, doctors need to be more compassionate with concerned patients, a culture where the doctor is a friend, junior doctors need to be supervised, avoiding medical jargon, and understanding the needs and wants of the patient. Please refer to Patients’ Statements in Appendix Section.
4.8  Findings from the Author’s Observation Study on Doctors

- Important demographic and variable information

4.8.1  Distribution of patients’ gender during Doctor Observation study

Figure 14  The distribution of gender among patients involved in the observation study

Figure 14 represents the distribution of patient gender with whom the consultants made their first contact on admission in the ward. The distribution between males and females was more or less at the same level.
4.8.2 Distribution of Doctors’ gender under study

The above graph (Figure 15) shows the massive discrepancy between the amount of male and female consultants working in the medical and surgical specialities who were observed examining their newly admitted patients in the medical and surgical admissions wards.
4.8.3 Distribution of patients classified as chronic and non chronic during doctor observation study

Figure 16 - Classification of patients as chronic or non chronic

Due to a considerable amount of Maltese people suffering from diabetes and heart disease, the author has decided to classify patients according to being chronic and non chronic so that this variable could be used for comparison purposes with doctor communication and information giving.

Figure 16 indicates that there are nearly one fourth (19 out of 80) of the admitted patients who were identified as suffering from chronic illnesses.
4.8.4 Doctors examining patients in single rooms

In the above graph (Figure 17) the patients were categorised with being hospitalised in a single room or not as a confidentiality variable. In fact the graph shows that around one fifth of the patients (15 out of 80) were nursed in a single room. One should note that every ward in Mater Dei Hospital has four single rooms out of a bed compliment of twenty four beds.
4.8.5 Consultation time

Figure 18 – Distribution of length of doctor consultation in minutes

Figure 18 indicates that the majority of consultants 58.8% (N = 47) take around 8 to 11 minutes to examine and communicate with their patients during their first contact with them on the admission wards. However doctor consultation time took longer for quite a good number of patients 38.8% (N = 31). The fact that the consultation times were longer during the observation study as compared to the other two sub-studies, is mainly due to doctors seeing their patients for the first time on their admission so they would have dedicated more time to diagnose and get a full history of the patient’s condition especially and more so when there is quite a good number of patients suffering from chronic illnesses as was clearly witnessed by the author (Also refer to Figure 16 – Classification of patients as being chronic or non chronic).
4.9 Quantitative results for Doctor Observation Study

4.9.1 Results for frequency of positive actions

Positive frequencies for each of the variables belonging to the five domains corresponding to the doctor behaviour during the clinical observations were documented so that an analysis of strengths and weaknesses with doctor performance during consultation could be carried out.

4.9.1.1 Domain 1: Doctor interpersonal skills

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>VARIABLES</th>
<th>Positive doctor performances % (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Performed eye contact</td>
<td>87.5% (70)</td>
</tr>
<tr>
<td></td>
<td>Asked about symptoms</td>
<td>82.5% (66)</td>
</tr>
<tr>
<td></td>
<td>Friendly welcoming</td>
<td>76.2% (61)</td>
</tr>
<tr>
<td></td>
<td>Ensured privacy</td>
<td>72.5% (58)</td>
</tr>
<tr>
<td></td>
<td>Mean percentages (N)</td>
<td>79.7% (64)</td>
</tr>
</tbody>
</table>

All these variables are based on a Total of 100% (80 Observations)  
‘N’ = number of positive actions performed by doctors

Table 14 – Positive behaviour with respect to Doctor Interpersonal skills as observed during the study

Table 14 demonstrates that the consultants are very skilled in interpersonal relationship with patients as all variables in this table ranked positively high. This is indicative with ‘doctor performing eye contact’ as being the most positive with 87.5% (N = 70). ‘Doctor ensuring privacy’ ranked the least positive in this group however it is still considered as
being highly positive. The mean percentage for positive actions in this domain being 79.7% (N = 64).

4.9.1.2 Domain 2: Doctor facilitation skills

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>VARIABLES</th>
<th>Positive doctor performances % (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Did gestures to encourage patient to speak</td>
<td>81.2% (65)</td>
</tr>
<tr>
<td>DOCTOR</td>
<td>Encouraged the patient to ask questions</td>
<td>76.2% (61)</td>
</tr>
<tr>
<td>FACILITATION SKILLS</td>
<td>Introductory chat</td>
<td>65.8% (52)</td>
</tr>
<tr>
<td></td>
<td>Mean percentages (N)</td>
<td>74.4% (59)</td>
</tr>
</tbody>
</table>

All these variables are based on a Total of 100% (80 Observations) ‘N’ = number of positive actions performed by doctors

Table 15 – Positive behaviour with respect to Doctor Facilitation skills as observed during the study

Table 15 shows that as with Doctor Interpersonal skills, Doctor Facilitation skills is once again proving that consultants are very good in this behaviour as well. ‘Doctors doing gestures to encourage their patients to speak out their queries’ ranked top of these three variables corresponding to Doctor facilitation skill with 81.2% (N = 65). ‘Doctors’ introductory chat although being least positively observed, it is still relatively good with 65.8% (N = 52). Overall ranking for this domain was 74.4% (N = 59).
4.9.1.3 Domain 3: Doctor medical information skills

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>VARIABLES</th>
<th>Positive doctor performances % (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical communication</td>
<td>82.5% (66)</td>
<td></td>
</tr>
<tr>
<td>Inquired risky habits</td>
<td>20.0% (16)</td>
<td></td>
</tr>
<tr>
<td>Advised healthy lifestyle</td>
<td>17.5% (14)</td>
<td></td>
</tr>
<tr>
<td>Inquired diet compliance</td>
<td>12.5% (10)</td>
<td></td>
</tr>
<tr>
<td>Mean percentages (N)</td>
<td>33.1% (27)</td>
<td></td>
</tr>
</tbody>
</table>

All these variables are based on a Total of 100% (80 Observations) ‘N’ = number of positive actions performed by doctors

Table 16 - Positive behaviour with respect to Doctor medical information skills as observed during the study

The above table (Table 16) indicates that consultants seem to be very consistent in performing medical communication with their patients 82.5% (N = 66). On the other hand doctors were observed to be rather inadequate with the other three variables corresponding to Doctor Medical Information Skills such as ‘inquiring about diet compliance’ 12.5% (N = 10), ‘advising healthy lifestyle’ – 17.5% (N = 14), and ‘inquiring risky habits’ 20% (N = 16). These three poorly ranked variables have skewed the mean percentage for this domain being 33.1% (N = 27). Variables like advice on healthy lifestyle and doctor’s inquiry on diet compliance were included because the majority of patients admitted in Mater Dei Hospital suffer from diabetes, heart disease and other chronic illnesses like arthritis and joint disease where obesity and consequently excessive body weight leads to delayed and ultimately regressive prognosis. These factors are detrimental to the patients’ quality of life and incur endless costs on health services due to more and frequent readmissions which also contribute to expensive treatment.
### 4.9.1.4 Domain 4: Doctor treatment information skills

<table>
<thead>
<tr>
<th>DOMAINS</th>
<th>VARIABLES</th>
<th>Positive doctor performances % (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor treatment information skills</td>
<td>Described medicine use to patient</td>
<td>12.5% (10)</td>
</tr>
<tr>
<td></td>
<td>Inquired allergic reactions to meds</td>
<td>11.2% (9)</td>
</tr>
<tr>
<td></td>
<td>Inquired medicine compliance</td>
<td>11.2% (9)</td>
</tr>
<tr>
<td></td>
<td>Mean percentages (N)</td>
<td>11.6% (9)</td>
</tr>
</tbody>
</table>

All these variables are based on a Total of 100% (80 Observations).

Table 17 showing above is indicative that this domain is a total weakness for consultants under observation to deal with treatment information giving with their patients. All variables were equally unsatisfactorily ranked resulting in a mean domain percentage of 11.6% (N = 9).
4.9.1.5 Domain 5: Doctor technical and empathy skills

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>VARIABLES</th>
<th>Positive doctor performances % (N)</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOCTOR TECHNICAL &amp;</td>
<td>Doctor paid attention to patient</td>
<td>92.5% (74)</td>
</tr>
<tr>
<td>EMPATHY SKILLS</td>
<td>Friendly closing of consultation</td>
<td>76.2% (61)</td>
</tr>
<tr>
<td></td>
<td>Emphasised on patient understanding</td>
<td>66.2% (53)</td>
</tr>
<tr>
<td></td>
<td>Mean percentages (N)</td>
<td>78.3% (63)</td>
</tr>
</tbody>
</table>

All these variables are based on a Total of 100% (80 Observations)  "N" = number of positive actions performed by doctors

Table 18 - Positive behaviour with respect to Doctor technical and empathy skills as observed during the study

Once again in Table 18 consultants were observed to be consistently stable with technical and empathy skills especially with ‘paying attention to the patient’ 92.5% (N = 74). The mean percentage score being second highest of all domains discussed above with 78.3% (N = 63).

4.10 Association tests used in Doctor Observation study

This part of the analysis includes the association tests between each of the five domains that were described previously in this chapter against three categories namely ‘Patient gender’, ‘Patient nursed in single room or not’, and ‘Patient having chronic illness or not’. The author decided to take such comparisons to detect any differences that may arise in doctors’ behaviour in view of the specified variables.
Since all the variables from both sides of the equation were categorical, and each of the variables contained more than five (5) subjects, Chi-Square Tests were used. On the other hand when there were less than 5 characters in any cell, Fisher’s Exact Test was employed always using SPSS Student Version 17.0

### 4.10.1 Doctor interpersonal skills

#### 4.10.1.1 Doctor interpersonal skills vs. Patient gender

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>VARIABLES</th>
<th>Males % (N)</th>
<th>Females % (N)</th>
<th>TOTAL % (N)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor interpersonal</td>
<td>Friendly welcoming</td>
<td>69.8% (30)</td>
<td>83.8% (31)</td>
<td>76.2% (61)</td>
<td>0.142</td>
</tr>
<tr>
<td></td>
<td>Ensured privacy</td>
<td>62.8% (27)</td>
<td>83.8% (31)</td>
<td>72.5% (58)</td>
<td><strong>0.036</strong></td>
</tr>
<tr>
<td></td>
<td>Asked about symptoms</td>
<td>79.1% (34)</td>
<td>86.5% (32)</td>
<td>82.5% (66)</td>
<td>0.384</td>
</tr>
<tr>
<td></td>
<td>Performed eye contact</td>
<td>86.0% (37)</td>
<td>89.2% (33)</td>
<td>87.5% (70)</td>
<td>0.672</td>
</tr>
</tbody>
</table>

All these variables are based on a Total of 100% (80 Observations) 'N' = number of positive actions performed by doctors

Table 19 – Doctor interpersonal skills versus male and female patients

In Table 19 it is being noted that of all four variables relating to ‘Doctor interpersonal skills’, ‘doctor ensuring privacy during consultation’ is seen as the only variable that is significantly different between male and female patients as it possessed a p-value of less than 0.05 (p = 0.036). The rest of the variables resulted to be not significantly different between male and female patients due to each having a p-value of more than 0.05.
4.10.1.2 Doctor interpersonal skills vs. Patient in single room or not

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>VARIABLES</th>
<th>Patient not in Single room % (N)</th>
<th>Patient in Single room % (N)</th>
<th>TOTAL % (N)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOCTOR INTERPERSONAL SKILLS</td>
<td>Friendly welcoming</td>
<td>72.3% (47)</td>
<td>93.3% (14)</td>
<td>76.2% (61)</td>
<td>0.085</td>
</tr>
<tr>
<td></td>
<td>Ensured privacy</td>
<td>66.2% (43)</td>
<td>100.0% (15)</td>
<td>72.5% (58)</td>
<td>0.008</td>
</tr>
<tr>
<td></td>
<td>Asked about symptoms</td>
<td>80.0% (52)</td>
<td>93.3% (14)</td>
<td>82.5% (66)</td>
<td>0.221</td>
</tr>
<tr>
<td></td>
<td>Performed eye contact</td>
<td>84.6% (55)</td>
<td>100.0% (15)</td>
<td>87.5% (70)</td>
<td>0.104</td>
</tr>
</tbody>
</table>

All these variables are based on a Total of 100% (80 Observations)

Table 20 - Doctor interpersonal skills versus Patient in single room or not

Table 20 states that as one would expect of such association, ensuring privacy as a variable for Doctor interpersonal skill, was highly ranked with a p-value of 0.008 indicating an obvious outcome that doctors ensured more privacy with ‘patients nursed in single rooms’ than with ‘patient nursed in open plan area’. The other variables were seen as having no association between the compared variables. However ‘friendly welcoming by doctors’ although being considered as not significantly different, it is much closer to significance than the other two variables.

4.10.1.3 Doctor interpersonal skills vs. Chronic and non chronic patients

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>VARIABLES</th>
<th>Patient not Chronic % (N)</th>
<th>Patient is Chronic % (N)</th>
<th>TOTAL % (N)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOCTOR INTERPERSONAL SKILLS</td>
<td>Friendly welcoming</td>
<td>73.8% (45)</td>
<td>84.2% (16)</td>
<td>76.2% (61)</td>
<td>0.538</td>
</tr>
<tr>
<td></td>
<td>Ensured privacy</td>
<td>68.9% (42)</td>
<td>84.2% (16)</td>
<td>72.5% (58)</td>
<td>0.190</td>
</tr>
<tr>
<td></td>
<td>Asked about symptoms</td>
<td>83.6% (51)</td>
<td>78.9% (15)</td>
<td>82.5% (66)</td>
<td>0.641</td>
</tr>
<tr>
<td></td>
<td>Performed eye contact</td>
<td>88.5% (54)</td>
<td>84.2% (16)</td>
<td>87.5% (70)</td>
<td>0.620</td>
</tr>
</tbody>
</table>

All these variables are based on a Total of 100% (80 Observations)

Table 21 - Doctor interpersonal skills versus Chronic and non chronic patients

114
Table 21 (above) demonstrates that all four variables dealing with Doctor interpersonal skills did not vary with patients being chronic or not as they all scored a p-value of more than 0.05

4.10.2 Doctor Facilitation Skills

### 4.10.2.1 Doctor facilitation skills vs. Patient gender

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>VARIABLES</th>
<th>Males % (N)</th>
<th>Females % (N)</th>
<th>TOTAL % (N)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOCTOR FACILITATION</td>
<td>Introductory chat</td>
<td>62.8% (27)</td>
<td>69.4% (25)</td>
<td>65.8% (52)</td>
<td>0.535</td>
</tr>
<tr>
<td></td>
<td>Encouraged the patient to ask</td>
<td>76.7% (33)</td>
<td>75.7% (28)</td>
<td>76.2% (61)</td>
<td>0.911</td>
</tr>
<tr>
<td></td>
<td>questions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Did gestures to encourage patient</td>
<td>79.1% (34)</td>
<td>83.8% (31)</td>
<td>81.2% (65)</td>
<td>0.590</td>
</tr>
<tr>
<td></td>
<td>to speak</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

All these variables are based on a Total of 100% (80 Observations) \( N \) = number of positive actions performed by doctors

Table 22 – Doctor facilitation skills versus Male and female patients

Table 22 reveals that all three variables dealing with Doctor facilitation skills made no significant difference with being a male or a female patient. All variables had a p-value of more than 0.05

### 4.10.2.2 Doctor facilitation skills vs. Patient in single room or not

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>VARIABLES</th>
<th>Patient not in Single room % (N)</th>
<th>Patient in Single room % (N)</th>
<th>TOTAL % (N)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOCTOR FACILITATION</td>
<td>Introductory chat</td>
<td>68.8% (44)</td>
<td>53.3% (8)</td>
<td>65.8% (52)</td>
<td>0.257</td>
</tr>
<tr>
<td></td>
<td>Encouraged the patient to ask</td>
<td>75.4% (49)</td>
<td>80.0% (12)</td>
<td>76.2% (61)</td>
<td>0.499</td>
</tr>
<tr>
<td></td>
<td>questions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Did gestures to encourage patient</td>
<td>81.5% (53)</td>
<td>80.0% (12)</td>
<td>81.2% (65)</td>
<td>0.891</td>
</tr>
<tr>
<td></td>
<td>to speak</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

All these variables are based on a Total of 100% (80 Observations) \( N \) = number of positive actions performed by doctors

Table 23 - Doctor facilitation skills versus Patient nursed in single room or not
Table 23 indicates that ‘Doctors’ facilitation skills’ did not differ with patients nursed in single room or not as all variables reached a p-value of more than 0.05.

### 4.10.2.3 Doctor facilitation skills vs. Chronic and non chronic patients

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>VARIABLES</th>
<th>Patient not Chronic % (N)</th>
<th>Patient is Chronic % (N)</th>
<th>TOTAL % (N)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOCTOR FACILITATION SKILLS</td>
<td>Introductory chat</td>
<td>63.3% (38)</td>
<td>73.7% (14)</td>
<td>65.8% (52)</td>
<td>0.407</td>
</tr>
<tr>
<td></td>
<td>Encouraged the patient to ask questions</td>
<td>78.7% (48)</td>
<td>68.4% (13)</td>
<td>76.2% (61)</td>
<td>0.265</td>
</tr>
<tr>
<td></td>
<td>Did gestures to encourage patient to speak</td>
<td>85.2% (52)</td>
<td>68.4% (13)</td>
<td>81.2% (65)</td>
<td>0.174</td>
</tr>
</tbody>
</table>

All these variables are based on a Total of 100% (80 Observations) \(^{1N} = \) number of positive actions performed by doctors

Table 24 - Doctor facilitation skills versus Chronic and non chronic patients

In Table 24 once again doctors proved that their facilitation skills were consistently equal with both chronic and non chronic patients. All variables reached a p-value of more than 0.05.

### 4.10.3 Doctor medical information skills

#### 4.10.3.1 Doctor medical information skills vs. Patient gender

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>VARIABLES</th>
<th>Males % (N)</th>
<th>Females % (N)</th>
<th>TOTAL % (N)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOCTOR MEDICAL INFORMATION SKILLS</td>
<td>Inquired diet compliance</td>
<td>11.6% (5)</td>
<td>13.5% (5)</td>
<td>12.5% (10)</td>
<td>0.531</td>
</tr>
<tr>
<td></td>
<td>Inquired risky habits</td>
<td>30.2% (13)</td>
<td>8.1% (3)</td>
<td>20.0% (16)</td>
<td>0.013</td>
</tr>
<tr>
<td></td>
<td>Medical communication</td>
<td>79.1% (34)</td>
<td>86.5% (32)</td>
<td>82.5% (66)</td>
<td>0.384</td>
</tr>
<tr>
<td></td>
<td>Advised healthy lifestyle</td>
<td>25.6% (11)</td>
<td>8.1% (3)</td>
<td>17.5% (14)</td>
<td>0.040</td>
</tr>
</tbody>
</table>

All these variables are based on a Total of 100% (80 Observations) \(^{1N} = \) number of positive actions performed by doctors

Table 25 – Doctor medical information skills versus Patient gender
The above table (Table 25) reveals that of all four variables dealing with 'Doctor medical information skills', doctors acted differently with male and female patients when it came to 'inquiring about risky habits' and 'advising on healthy lifestyle' with p-values of 0.013 and 0.04 respectively. In fact doctors appear to ask male patients more than female patients regarding these two aspects. For these two associations, Fisher's Exact Test was used as some cells contained less than 5 subjects.

### 4.10.3.2 Doctor medical information skills vs. Patient in single room or not

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>VARIABLES</th>
<th>Patient not in Single room % (N)</th>
<th>Patient in Single room % (N)</th>
<th>TOTAL % (N)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOCTOR MEDICAL INFORMATION SKILLS</td>
<td>Inquired diet compliance</td>
<td>6.2% (4)</td>
<td>40.0% (6)</td>
<td>12.5% (10)</td>
<td>0.002</td>
</tr>
<tr>
<td></td>
<td>Inquired risky habits</td>
<td>23.1% (15)</td>
<td>6.7% (1)</td>
<td>20.0% (16)</td>
<td>0.139</td>
</tr>
<tr>
<td></td>
<td>Medical communication</td>
<td>84.6% (55)</td>
<td>73.3% (11)</td>
<td>82.5% (66)</td>
<td>0.286</td>
</tr>
<tr>
<td></td>
<td>Advised healthy lifestyle</td>
<td>16.9% (11)</td>
<td>20.0% (3)</td>
<td>17.5% (14)</td>
<td>0.720</td>
</tr>
</tbody>
</table>

All these variables are based on a Total of 100% (80 Observations) 'N' = number of positive actions performed by doctors

Table 26 - Doctor medical information skills versus Patient nursed in single room or not

Table 26 shows that doctors seem to 'inquire about diet compliance' with patients nursed in single rooms more than patients nursed in open plan areas within the ward. In fact this was strongly associated with a p-value of 0.002 and using Fisher’s Exact Test due to having any cell below five (5) positive actions. Other doctor communication variables shown in the same table had no statistical differences with patients nursed in single room or not.
### 4.10.3.3 Doctor medical information skills vs. Chronic and non chronic patients

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>VARIABLES</th>
<th>Patient not Chronic % (N)</th>
<th>Patient is Chronic % (N)</th>
<th>TOTAL % (N)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOCTOR MEDICAL INFORMATION SKILLS</td>
<td>Inquired diet compliance</td>
<td>9.8% (6)</td>
<td>21.1% (4)</td>
<td>12.5% (10)</td>
<td>0.183</td>
</tr>
<tr>
<td></td>
<td>Inquired risky habits</td>
<td>16.4% (10)</td>
<td>31.6% (6)</td>
<td>20.0% (16)</td>
<td>0.133</td>
</tr>
<tr>
<td></td>
<td>Medical communication</td>
<td>77.0% (47)</td>
<td>100.0% (19)</td>
<td>82.5% (66)</td>
<td>0.033</td>
</tr>
<tr>
<td></td>
<td>Advised healthy lifestyle</td>
<td>13.1% (8)</td>
<td>31.6% (6)</td>
<td>17.5% (14)</td>
<td>0.086</td>
</tr>
</tbody>
</table>

All these variables are based on a Total of 100% (80 Observations) \( N \) = number of positive actions performed by doctors

Table 27 - Doctor medical information skills versus Chronic and non chronic patients

Table 27 demonstrates that doctors communicated medical issues more with patients who are chronic compared to those who do not suffer from chronic illnesses. This variable displayed a p-value of 0.033. The remaining three variables in this domain indicated no differences in doctor communication between chronic and non chronic patients (p-value > 0.05).

### 4.10.4 Doctor treatment information skills

#### 4.10.4.1 Doctor treatment information skills vs. Patient gender

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>VARIABLES</th>
<th>Males % (N)</th>
<th>Females % (N)</th>
<th>TOTAL % (N)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOCTOR TREATMENT IN FORMATION SKILLS</td>
<td>Inquired medicine compliance</td>
<td>7.0% (3)</td>
<td>16.2% (6)</td>
<td>11.2% (9)</td>
<td>0.192</td>
</tr>
<tr>
<td></td>
<td>Inquired allergic reactions to meds</td>
<td>7.0% (3)</td>
<td>16.2% (6)</td>
<td>11.2% (9)</td>
<td>0.192</td>
</tr>
<tr>
<td></td>
<td>Described medicine use to patient</td>
<td>11.6% (5)</td>
<td>13.5% (5)</td>
<td>12.5% (10)</td>
<td>0.799</td>
</tr>
</tbody>
</table>

All these variables are based on a Total of 100% (80 Observations) \( N \) = number of positive actions performed by doctors

Table 28 – Doctor treatment information skills versus Patient gender

In Table 28 there seems to be no significant differences with all variables in connection to ‘Doctor treatment information skills’ with regards to patients being males or females. This is indicative of a p-value of more than 0.05
4.10.4.2 Doctor treatment information skills vs. Patient in single room or not

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>VARIABLES</th>
<th>Patient not in Single room % (N)</th>
<th>Patient in Single room % (N)</th>
<th>TOTAL % (N)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOCTOR TREATMENT INFORM</td>
<td>Inquired medicine compliance</td>
<td>12.3% (8)</td>
<td>6.7% (1)</td>
<td>11.2% (9)</td>
<td>0.533</td>
</tr>
<tr>
<td>INFORMATION SKILLS</td>
<td>Inquired allergic reactions to meds</td>
<td>12.3% (8)</td>
<td>6.7% (1)</td>
<td>11.2% (9)</td>
<td>0.533</td>
</tr>
<tr>
<td></td>
<td>Described medicine use to patient</td>
<td>15.4% (10)</td>
<td>0.0% (0)</td>
<td>12.5% (10)</td>
<td>0.104</td>
</tr>
</tbody>
</table>

All these variables are based on a Total of 100% (80 Observations)

Table 29 - Doctor treatment information skills versus Patient nursed in single room or not

Table 29 affirms that the three doctor variables included in this domain do not differ with patients either being nursed in single room or not. This is particularly denoted with all p-values being higher than 0.05. Fisher’s Exact Test was carried out in all three variables as they had less than 5 positive actions at any one cell.

4.10.4.3 Doctor treatment information skills vs. Chronic and non chronic patients

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>VARIABLES</th>
<th>Patient not Chronic % (N)</th>
<th>Patient is Chronic % (N)</th>
<th>TOTAL % (N)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOCTOR TREATMENT INFORM</td>
<td>Inquired medicine compliance</td>
<td>8.2% (5)</td>
<td>21.1% (4)</td>
<td>11.2% (9)</td>
<td>0.121</td>
</tr>
<tr>
<td>INFORMATION SKILLS</td>
<td>Inquired allergic reactions to meds</td>
<td>6.6% (4)</td>
<td>28.3% (5)</td>
<td>11.2% (9)</td>
<td>0.017</td>
</tr>
<tr>
<td></td>
<td>Described medicine use to patient</td>
<td>6.6% (4)</td>
<td>31.6% (6)</td>
<td>12.5% (10)</td>
<td>0.004</td>
</tr>
</tbody>
</table>

All these variables are based on a Total of 100% (80 Observations) "N" = number of positive actions performed by doctors

Table 30 - Doctor treatment information skills versus Chronic and non chronic patients

Table 30 reveals that there are high significant differences with two variables within this domain against patients being chronic or not. These variables being ‘doctors inquiring on whether patients had previous allergic reactions to any medications’ and ‘doctors explaining to patients how to use their medicines’ with respective p-values of 0.017 and 0.004. In fact doctors were inclined to transfer their information on treatment onto
Chronic patients rather than to the rest of the patients. Again Fisher’s Exact Test was used for these two variables.

4.10.5 Doctor technical and empathy skills

4.10.5.1 Doctor technical and empathy skills vs. Patient gender

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>VARIABLES</th>
<th>Males % (N)</th>
<th>Females % (N)</th>
<th>TOTAL % (N)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOCTOR TECHNICAL &amp; EMPATHY SKILLS</td>
<td>Doctor paid attention to patient</td>
<td>88.4% (38)</td>
<td>97.3% (36)</td>
<td>92.5% (74)</td>
<td>0.131</td>
</tr>
<tr>
<td></td>
<td>Emphasised on pat. understanding</td>
<td>65.1% (28)</td>
<td>67.6% (25)</td>
<td>66.2% (53)</td>
<td>0.817</td>
</tr>
<tr>
<td></td>
<td>Friendly closing of consultation</td>
<td>74.4% (32)</td>
<td>78.4% (29)</td>
<td>76.2% (61)</td>
<td>0.678</td>
</tr>
</tbody>
</table>

All these variables are based on a Total of 100% (80 Observations) 
*N* = number of positive actions performed by doctors

Table 31 – Doctor technical and empathy skills versus Patient gender

Table 31 shows that there were high positive performances in all doctor communication variables. It can also be noted that there are no significant differences with Doctor technical and empathy skills against patient being a male or a female. This resulted after achieving p-values higher than 0.05

4.10.5.2 Doctor technical and empathy skills vs. Patient in single room or not

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>VARIABLES</th>
<th>Patient not in Single room % (N)</th>
<th>Patient in Single room % (N)</th>
<th>TOTAL % (N)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOCTOR TECHNICAL &amp; EMPATHY SKILLS</td>
<td>Doctor paid attention to patient</td>
<td>90.8% (59)</td>
<td>100% (15)</td>
<td>92.5% (74)</td>
<td>0.221</td>
</tr>
<tr>
<td></td>
<td>Emphasised on pat. understanding</td>
<td>64.6% (42)</td>
<td>73.3% (11)</td>
<td>66.2% (53)</td>
<td>0.520</td>
</tr>
<tr>
<td></td>
<td>Friendly closing of consultation</td>
<td>75.4% (49)</td>
<td>80.0% (12)</td>
<td>76.2% (61)</td>
<td>0.705</td>
</tr>
</tbody>
</table>

All these variables are based on a Total of 100% (80 Observations) 
*N* = number of positive actions performed by doctors

Table 32 - Doctor technical and empathy skills versus Patient nursed in single room or not
Table 32 (Above) indicates that all three variables within this domain had no significant differences with dealing with patients being nursed in single rooms or otherwise. The p-values for each of the three variables were 0.221, 0.520, and 0.705 respectively.

4.10.5.3 Doctor technical and empathy skills vs. Chronic and non chronic patients

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>VARIABLES</th>
<th>Patient not Diabetic % (N)</th>
<th>Patient is Diabetic % (N)</th>
<th>TOTAL % (N)</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>DOCTOR TECHNICAL &amp; EMPATHY SKILLS</td>
<td>Doctor paid attention to patient</td>
<td>93.4% (57)</td>
<td>89.5% (17)</td>
<td>92.5% (74)</td>
<td>0.566</td>
</tr>
<tr>
<td></td>
<td>Emphasised on pat. understanding</td>
<td>65.6% (40)</td>
<td>68.4% (13)</td>
<td>66.2% (53)</td>
<td>0.819</td>
</tr>
<tr>
<td></td>
<td>Friendly closing of consultation</td>
<td>77.0% (47)</td>
<td>73.7% (14)</td>
<td>76.2% (61)</td>
<td>0.763</td>
</tr>
</tbody>
</table>

All these variables are based on a Total of 100% (80 Observations) "N" = number of positive actions performed by doctors

Table 33 – Doctor technical and empathy skills versus Chronic and non chronic patients

Table 33 concludes that doctors possess robust ‘technical and empathy skills’. This can be seen through the high rates of positive actions performed as indicated in the table. Once again the above table also demonstrates that there is no association between this domain and the patients’ particular illness.

4.11 Data analysis for Qualitative data obtained from interviews translated into themes for analysis

Ten senior ward managers were interviewed so that the author would get a clear picture of how these key people view the doctor-patient interactions (performance) during ward rounds in their respective wards. The qualitative data was translated into themes referred to as domains and each consisted of a series of variables which were analysed as follows:
<table>
<thead>
<tr>
<th>DOMAINS</th>
<th>VARIABLES</th>
<th>Positive feedback from Interviewees</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>% (N)</td>
</tr>
<tr>
<td>Interpersonal skills</td>
<td>Doctor performs eye contact</td>
<td>100% (10)</td>
</tr>
<tr>
<td></td>
<td>Asks patients about their symptoms</td>
<td>90% (9)</td>
</tr>
<tr>
<td></td>
<td>Doctor listens carefully to patients</td>
<td>70% (7)</td>
</tr>
<tr>
<td></td>
<td>Doctor encourages patients to speak</td>
<td>40% (4)</td>
</tr>
<tr>
<td></td>
<td>Doctor respects privacy</td>
<td>40% (4)</td>
</tr>
<tr>
<td></td>
<td>Welcoming</td>
<td>30% (3)</td>
</tr>
<tr>
<td>Facilitation skills</td>
<td>Explains things in a way patient could understand</td>
<td>80% (8)</td>
</tr>
<tr>
<td></td>
<td>Doctor explains his treatment plan to patient</td>
<td>50% (5)</td>
</tr>
<tr>
<td></td>
<td>Doctor encourages patient to ask questions</td>
<td>40% (4)</td>
</tr>
<tr>
<td></td>
<td>Asks patient’s consent for examination in front of students</td>
<td>20% (2)</td>
</tr>
<tr>
<td>Medical &amp; Healthy living information</td>
<td>Doctor inquires about medication</td>
<td>100% (10)</td>
</tr>
<tr>
<td></td>
<td>Doctor performs physical examination</td>
<td>90% (9)</td>
</tr>
<tr>
<td></td>
<td>Doctor inquires about patients’ diet</td>
<td>50% (5)</td>
</tr>
<tr>
<td></td>
<td>Doctor inquires about patients’ risky habits</td>
<td>50% (5)</td>
</tr>
<tr>
<td></td>
<td>Doctor gives information about patient’s disease</td>
<td>30% (3)</td>
</tr>
<tr>
<td>Treatment &amp; Medicine information</td>
<td>Doctor inquires if medicine was taken regularly</td>
<td>100% (10)</td>
</tr>
<tr>
<td></td>
<td>Doctor asks if patient was allergic to any medicine</td>
<td>100% (10)</td>
</tr>
<tr>
<td></td>
<td>Discusses the newly prescribed medicine with patient</td>
<td>50% (5)</td>
</tr>
<tr>
<td></td>
<td>Doctor described the possible side effects</td>
<td>40% (4)</td>
</tr>
<tr>
<td></td>
<td>Doctor explains carefully how to use the medicine</td>
<td>30% (3)</td>
</tr>
<tr>
<td></td>
<td>Doctor asks patient’s approval of prescribed medicine</td>
<td>10% (1)</td>
</tr>
<tr>
<td></td>
<td>Doctor explains what to do in case of adverse events</td>
<td>10% (1)</td>
</tr>
<tr>
<td>Technical &amp; Empathy skills</td>
<td>Doctors are polite and courteous</td>
<td>90% (9)</td>
</tr>
<tr>
<td></td>
<td>Doctors are very competent in their work</td>
<td>90% (9)</td>
</tr>
<tr>
<td></td>
<td>Doctor asks patient whether help is needed at home</td>
<td>50% (5)</td>
</tr>
<tr>
<td>Written information</td>
<td>About medication and treatment</td>
<td>50% (5)</td>
</tr>
<tr>
<td></td>
<td>Things to do and what to avoid (Eg. Exercise, diet, altitudes,..)</td>
<td>20% (2)</td>
</tr>
<tr>
<td></td>
<td>How to deal with the illness (if symptoms persist or get worse)</td>
<td>10% (1)</td>
</tr>
<tr>
<td>Consultation time</td>
<td>How much did the doctor spend near the patient?</td>
<td>Average 3.9 minutes</td>
</tr>
</tbody>
</table>

All these variables are based on a Total of 100% (10)  
"N" = number of respondents

Table 34 – Ward managers’ positive ranking of variables belonging to Doctor-patient communication and information giving during ward rounds.

In Table 34 it is evident that ward managers look at Doctors’ Interpersonal Skills as satisfactory especially with ‘keeping eye contact with the patient’ 100% (N = 10), but it seems that doctors need to focus more on ‘introducing themselves to the patient’ 30% (N = 3), ‘respecting the privacy during consultations’ 40% (N = 4), and ‘allowing the patient to speak’ 40% (N = 4).
With regards to Facilitation Skills, doctors are seen to be ‘explaining to the patient very well and in an understandable manner’ 80% (N = 8). However they seem to lack with ‘asking permission from the patients to examine them in front of the good number of medical students’ 20% (N = 2).

Medical Information Giving is quite positively ranked especially with ‘home medication’ 100% (N = 10), and ‘physical examination’ 90% (N = 9). However ward managers are doubtful if doctors ‘ask patients about their diet’ 50% (N = 5) and ‘risky habits’ 50% (N = 5).

Treatment and Medicine Information is very strong with ‘doctors asking if medication was being taken regularly at home’ 100% (N = 10), and with ‘asking patient whether they were allergic to any type of medicine’ 100% (N = 10), but the doctors’ Treatment and Information Giving was weak with ‘describing the possible side effects’ 40% (N = 4), ‘explaining how to use the medicine’ 30% (N = 3) and very weak with both ‘asking approval from patient on prescribing new treatment’ and ‘explaining to patients what to do in case of adverse events with medicines prescribed’ 10% (N = 1) each.

With regards to Technical and Empathy Skills, doctors are very well noted for their reputation since both ‘politeness’ and ‘competency’ were ranked at 90% (N = 9). However whether ‘doctors ask their patients if they needed help at home after being discharged’ puts them on borderline with 50% (N = 5).

Written Information given by doctors is the worst ranked variable especially with ‘how to deal with the illness’ and ‘things to do and what to avoid’ with 10% (N = 1) and 20% (N =
2) respectively. Written information about 'treatment and medication' was ranked at 50% (N = 5).

The overall score for 'doctor consultation time' given by ward managers was that of an average of 3.9 minutes per patient.

4.12 Conclusion

The findings helped the author to assess the quality of care with regards to doctor-patient communication skills due to the similarity of the doctor characteristic domains used within each undertaken sub-study and the good amount of participants and resulting response rate obtained. The findings also identified if the level of quality varies in relation to various aspects of doctor-patient communication and information giving.

The next chapter includes discussion on the findings and their implications for health services management.
CHAPTER 5

Discussion
Chapter 5: DISCUSSION

5.1 Introduction

In this section the data was interpreted in relation to the objectives of the study, based on information researched in the literature. The integration of both qualitative and quantitative methods is appropriate when addressing complex communication interactions to aid interpretation and understanding of results (Epstein et al., 2005). Therefore, one can consider this study as an innovative one for Malta in such field. The relevance of the study to health services management is also discussed.

Patient satisfaction may not be a major concern for doctors because they are not directly paid by the patient (Taylor, 1986). However, patient satisfaction is of great concern to health care stakeholders as an unsatisfied patient is less likely to adhere to the prescribed medical regime, thus resulting in unnecessary repeated tests and re-admissions, which may be costly to the health care system (Rimal, 2001). Hence, patient satisfaction has been extensively valued.

The results of this study yielded actionable results that can be used by hospital management to address those areas within doctor-patient interaction that require improvement. The health care organisation considers patient satisfaction to be as important as other quality and cost indicators and it uses information on patient satisfaction as a part of its planning strategy. Furthermore, the patient satisfaction assessment can be used as a benchmarking strategy for other specialities within the healthcare system.
5.2 The quality of and satisfaction with doctor interactions

Each question/statement of the patient questionnaire was analysed independently to obtain a clear understanding of how the clients/patients, in general, perceive the quality of doctor communication. Results show that the majority of patients (70.6%) had a previous hospitalisation experience and this enabled the study to be a very positive and satisfactory one. Most of these 70.6% of patients have rated the quality of service equally high, which indicates that different categories of patients do not have different expectations and do not perceive different levels of satisfaction. Shelton (2000) states that customers perceive service in their own unique, end-of-the-day and totally human terms, while Crosby (1979), argues that service quality is evaluated solely on the outcome whereas Parchman et al. (2005) stressed on accessibility, availability and convenience of care. The results of this study are indicative that the doctor-patient communication in Mater Dei Hospital is performing to the clients' expectations. However, in order to support this statement, one may perhaps explore this issue further by surveying different patients and in different settings, as suggested by Zeithaml et al. (1990) and see what the outcome is.

Swartz and Brown (1989), argue that a gap between what customers expect and what they get might always exist, while Desatrick and Bennett (1977) stresses that 96% of unhappy clients never complain about rude or discourteous treatment. In this study, clients showed that they are happy with the service provided, as indicated in the close-ended questions/statements, although there were comments that identified areas for improvement, the commonest being the tight approach practiced by a minority group of doctors. However, Scambler (2003) argues that doctor-patient relationship is influenced not only by the medical condition of the patient but also by the expectations of the doctor.
and of the patient and the structural context of the consultation so one should be cautious before interpreting doctors' behaviours.

It is also a fact that the number of clients accessing the hospital services have increased over the last few years since the opening of the new Mater Dei Hospital (Hospital Activity Report, 2009). This reality could lead to more stress and work overload on health care professionals which in turn according to Roland (2005) could translate in unfriendly behaviour towards patients during ward rounds. According to Scambler (2003), sometimes this might be perceived as rude due to doctors using different relationship models that would need to match with situation at hand that may be based on values, norms and processes.

5.3 Comments about findings from demographic data

The demographic data obtained both from the patient questionnaire and the direct observations on doctors was analysed in order to give a picture of the sample of patients and doctors during the study. The demographic data was also used to examine if respondents with different factors have different perceptions of care and could be used to design targeted quality improvement efforts in the doctor-patient communication and information giving. Some evidence suggests that age, socioeconomic status, health status, and related variables (e.g. education) may be the most important variables that make a difference in one's expectations and perceptions of the way doctors communicate with their patients during ward rounds and overall hospital experience (Dube, Trudeau & Belanger, 1994; Young, et al., 2000). However this study is more in tune with the study by Beach et al. (2006) where positive provider affect and information sharing are
associated with respect and familiarity with patients rather than patient race, gender and patient education.

5.4 Patients' age and gender

Research examining comparisons of patient satisfaction has focused primarily on socio-demographic variables. Foss (2002), found that age and gender are consistently related to patient satisfaction, with women and older individuals reporting higher satisfaction rates. In fact, the above mentioned study was found to be similar to the present study where the elder and female patients rated most of the questionnaire statements in connection with the overall doctor relationship as satisfied and very satisfied. This may be due to the fact that female patients tend to report more detailed symptoms (Clark, Potter, & McKinlay, 1991) and receive more information than male patients (Hall et al., 1994) mainly because they request more information than male patients (Speedling & Rose, 1985). However the findings of the present study showed that there were no response differences between male and female patients with regards to written information and medicinal information given by doctors as these were still ranked equally low. Again this is in line with Crosby (1979) where patients rate their satisfaction according to the outcome and so the issue of being older and female does not make any difference if it directly affects the patients.

Furthermore, in a recent study related to gender differences in hospitalised patient perception of involvement in myocardial infarction care by Arnetz & Arnetz (2009), it came out that women were more dissatisfied than males with hospitalisation and discharge planning involvement.
5.5 Patient education

This study was compatible with another study carried out by Thi et al. (2002), where a significant correlation between persons with level of education and positive satisfaction with the care they received was found. While some studies find no relationship between satisfaction and education level (Brown et al., 2009), this study indicates that patients with lower education reported greater satisfaction. On the other hand, patients are increasingly becoming better educated about the care they receive due to more available health information especially through the media (Feldman-Stewart et al., 2005). In fact Messner (2005) insists that due to this impact, patients will continue to demand higher expectations on patient care. Results of this study also indicate that it can be suspected that persons with higher levels of education tend to have higher expectations on the care they receive. The hospital administrators, thus, need to carefully consider changing patient expectations by keeping up with high quality information standards.

5.6 Hospital length of stay

The author found that patients who had longer hospital stays had lower satisfaction than patients who had a shorter hospital stay. It can be understood that the longer hospital stay may affect the level of patient satisfaction. Patients in the longest length of stay group were significantly less satisfied with some patient satisfaction variables. This conforms to a study performed by Tokunaga (2002) on the influence of length of stay on patient satisfaction, where he concluded that according to the length of stay, unique items could determine the achievement of overall patient satisfaction. This is in fact consistent with the other studies, where in general, more sick patients tended to be less satisfied (Young, et al., 2000; Thi, et al., 2002; Sahin et al., 2006).
In a study of patients hospitalised for minor procedures, like for example an endoscopic procedure for inserting a Percutaneous Gastrostomy (PEG), Clarke (1996) found out that short stays did not seem to be associated with any adverse outcomes, and they did result in modest financial savings to the health care system. Together with this study’s findings, this may imply that there is potential for the greater use of early discharge, provided that more effort has to be directed towards changing doctors’ behaviour, particularly at the point of patient education and empowerment in planning discharge. This Consensus model as also suggested by Scambler (2003) is ideal but greatly depends on the patients’ willingness to learn and comply.

5.7 Length of Consultations during ward rounds

The average length of the eighty consultations being observed by the author was 11.7 minutes. On the other hand the average consultation time achieved from the patients’ questionnaire was that of 8.04 minutes, while that of the perceptions of ward managers during interviews was that of 3.9 minutes.

Two possible explanations for this difference is first of all that the direct observations were made in a different setting that is the Admission Wards (as this was considered as part of the doctor-patient communication process, admission till discharge) from that of the other two sub-studies, and secondly the observations on consultants were made while the latter were seeing their patients for the first time on their admission to hospital. This of course could justify the lengthier visit as the doctors would have devoted more time to address issues like taking a complete history of the patient and more questioning to the
patient in order to acquire a good diagnosis. Another thing to keep in consideration is the individual condition with which patients present as this determines the amount of time dedicated and needed for each patient.

With regards to the consultation time of the other two sub-studies namely patient satisfaction questionnaire and structured interviews with ward managers, their results might have been shorter because these studies were conducted when the patients were in a more stable condition in the medical and surgical wards. However, there seems to be a considerable difference in consultation time between these last two groups of participants (patients and ward managers). Possible explanations for this discrepancy could be either that the patients are saying the truth and therefore being honest or else that some patients could fear that their doctor might get to know and that perhaps they would not get the proper attention or treatment from their doctor if they reveal or complain about consultation time. In fact this issue was brought by Wolf et al. (2008) in which they declared that even when there was lack of communication, the patients’ self-report data demonstrated that the patients’ concerns were completely addressed.

In the case of ward managers, they stressed out that doctors might underestimate the consultation time due to their busy working routine. This might have provoked ward managers to express such statements not realising that time runs out quickly on the wards so this might have triggered them to rate consultation time as short. However there are different circumstances to consider. Comments achieved from ward managers during interviews revealed that:

'With regards to communication with the patient: there's a long way to go.'

The way in which the ward round is conducted; the ward round is carried out
in very limited time, sometimes the doctor seems as if he or she is in a great hurry therefore does not dedicate enough time with the patient, they would only take from 1 to 2 minutes with the patient.’

(Ward Manager 1)

‘Consultation time depends on the nature of the condition of the patient. There were consultations where they took only 2 minutes and there were others that took over 10 minutes. It depends …..’

(Ward Manager 3)

‘Consultation time depends on who is the patient and the condition of the patient. It depends also on the consultant, there are consultants that take 15 minutes and there are others who take 5 minutes. The average is 5-10mins because if the patients stay there just listening and not speaking, like for example a stroke patient, there will be no two way communication so the consultation time would be very short.’

(Ward Manager 4)

‘Doctor communication is not always the same. Sometimes the surgical round is so hectic that the patient concerns are not always met. Sometimes a ward round is done in no time “minuta mexxi mexxi” ....fluids.., nil by mouth..., stop..., bowel sounds... “mexxi”.’

(Ward Manager 6)

‘Consultation time in my opinion would take around 4 minutes and this is very vague as this depends on the condition of the patient. If it is easy going, yes, it would take about 2 to 4 minutes.’

(Ward Manager 7)

In fact Britt et al. (2002) declare that consultation time is affected by many issues such as the number and complexity of problems drawn out and addressed, the degree of psychosocial distress, and the sex and age of the patient and also of the doctor. In other
countries with health care systems like that of Malta, deciding how much time is needed to provide quality care is a subject of ongoing research that often yield to contradicting results (Freeman et al., 2002; Wilson et al., 2002). Although Epstein et al. (2005) suggest that better communication takes more time, Cape (2002) argues that more time does not guarantee better communication and yet poor communication was established to be present in very long consultation period (Scheitel et al., 1996).

This study compares well with that of Epstein et al. (2005) where they affirm that there are other health system factors that need to be considered like available resources and environmental factors besides the duration of the overall doctor-patient encounter. In fact as with human resources, the Maltese healthcare system is experiencing a shortage in health care professionals such as doctors. With regards to environmental factors, one could easily mention that albeit the huge structure of Mater Dei Hospital itself, bed problems still exist and these are causing the dispersion of patients by being allocated in wards that specialise in interventions other than that for which the patient is admitted. This is far more different from being admitted in the consultant’s ward as the case should be. In reality this may stand to reason how most of the consultants could fritter away valuable time by visiting patients in too many different wards within Mater Dei Hospital. The time spent moving from ward to ward might be one of the reasons for which consultation length is short. In fact ward managers commented on such issue.

‘Consultation time is very short. Nowadays it is worst than before because doctors need to run around all the hospital – a marathon that needs to be accomplished otherwise they would not manage to see all the patients. Yes they will take only around 2 minutes for each patient.’

(Ward Manager 5)
From this study, an average Maltese medical consultation lasts around 7 minutes (The average of the mean times for the three methods used – direct observations on doctors, patient questionnaires and structured interviews with ward managers). According to the author, this duration is shorter than American medical interviews of 16 minutes and longer than British medical interviews of 5-6 minutes as stated by Roter et al. (1988).

It is argued that this situation may be an expedient way to extract information from patients but it is not without a cost; the information may be incomplete. As a result, imbalance exists between this study and that of Roter & Hall (2009) in which they emphasize the consumption of more time with the patient during consultations. With important information missing, the diagnosis may be incorrect and treatment ineffective, which could prove costly to both the patient and the health care system.

5.8 Doctor interpersonal skills

The professional responsibility with which the doctors carry out their duties, cannot be stressed enough when one analyses the trust patients put in these professionals. One critical aspect of interpersonal competence is the doctor's ability to convey an attitude of respect. Respectful doctors are likely to be perceived as trustworthy. This aspect has been heeded adequately with patients in this study and in fact compares well with findings by Reinbach et al (1996) and Powell et al (1994). Comments directed to doctors were relatively very positive and encouraging from every participant's point of view (as is clearly shown in the feedback received), however patients have expressed some kind of inadequacy from the doctors especially when it came to provision of privacy during
physical examinations. The results of this study show that doctors were more aware of privacy with female patients than with male patients (p-value 0.036). Although the bed station is usually curtained up, the need for more respect of intimacy (present in only 1 patient out of 10) appears to be manifested by patients being seen naked as a result of lack of discretion from the part of some doctors and even more if consent is not requested from the patient to be exposed in front of other doctors and medical students present during ward rounds. The patient is usually subordinated and in a weak position with regard to the rules, regulation and 'norms' of hospitalization that, at times, fails to respect their intimacy and privacy. This outcome was also emerged during the structured interviews with ward managers. The results of these interviews showed that only 40% of the doctors adhered to full privacy. Most of the ward managers declared that patient privacy during ward rounds depends mainly on their role as nurses rather than that of the doctors. Some of the comments that came out of this issue were:

'With regards to privacy it has to be the nurse to close the curtain. I think they expect the nurse to do it.'

(Ward Manager 3)

'Regarding privacy during ward round, the doctor respects privacy but it is us nurses to close the curtain. The consultant never runs the curtain around the beds of the patients; it is our duty and culture to do that.'

(Ward Manager 4)

'Privacy is not always respected by the doctors and for the majority of times it has to be the nurse who will curtail the area for privacy.'

(Ward Manager 7)
Another aspect in lack of privacy may also be due to the physical structure in most of the public hospitals. Providing privacy between patients by closing a curtain around the bed does not mean guaranteeing confidentiality as words can still be clearly heard by other patients within the same room. Some ward managers noted that:

'However from behind this simple curtain everyone could here you just the same and so you cannot practice privacy hundred percent’

(Ward Manager 1)

'Ok the curtain is closed but rest assured that if the patient next to the one being seen by the doctor is watching television, then he switches it off to make sure he hears what the doctor says to the patient next to him.'

(Ward Manager 3)

The thing is and I do not agree with this, that when a doctor needs to give bad news to the patient about his condition, the doctor just says it no matter who is listening behind the curtain (other patients and relatives would hear almost everything).

(Ward Manager 8)

Doctors need to be more careful in keeping their voices down while communicating with their patients as long as patients do not suffer from hearing problems. On the other hand one should be reasonable enough to understand that it is not feasible to build an entire public hospital that is equipped only with single rooms.

Other variables concerning doctors’ interpersonal skills with which the patients were not convincingly satisfied were ‘eye contact’ (17% of patients) and ‘encouragement to speak’ (12% of patients). This corresponds well to studies by Hornsten et al. (2005) and Hudak et al. (2008) where they concluded that eye contact with fewer gazes would lead to better
doctor-patient relationship satisfaction whereas doctors also need to engage and encourage the patients in a discussion of preferences for decision-making in order to obtain the role each patient wants to play in any given decision. These variables were also mentioned during the interviews by ward managers:

'Eye contact is not always practiced but mostly yes. Some of the doctors are more inclined to direct their attention to the students rather than to the patients.'

(Ward Manager 7)

'Doctors do practice eye contact but sometimes I wonder if the doctors’ focus is really on the patient or on the notes that they have in front of them.'

(Ward Manager 10)

However according to Ridsdale and Hudd (1994), in such instances patients feel that they are not ignored by writing during ward rounds as long as the doctor continues to use verbal skills, and maintain eye contact with them during consultations.

In correspondence with the results of the open ended questions, comments of patients with regards to interpersonal aspects, the doctors at times performed in a very professional way, although for instance, friendliness and politeness were being respected at times and less respected at other times. This issue also coincides with most of the ward managers’ views during their interviews. Although most of these interviewees commented that the majority of doctors have very good interpersonal skills, some ward managers remarked:

'Bed side manners vary from one person to another and from one firm to another; there may be different characters involved and also previous encounters. For example, if a patient knows the doctor personally or if the
patient goes to visit the doctor at a private clinic, the doctor's approach with that patient would be different from that of another patient.'

(Ward Manager 9)

'Interaction depends on the individual characters of the doctors as well as patients of course. There are doctors and doctors. This depends on how hurried the doctor is and in fact this depends on the time spent during consultations. Often, this is the main problem to good interactions.'

(Ward Manager 2)

'Yes doctors do care about the needs of the patients. Although they have more errands to do in this hospital, but they are still available as much as the patient needs.'

(Ward Manager 3)

Communication skills, which according to Hellriegel (1999) is vital to an organisation as the blood stream is to human beings, still lack at times especially when the demand increases and time constraints become evident. On the whole the large majority of patients were very pleased with the doctor presentation and interpersonal skills.

5.9 Facilitation and Listening skills

In addition to question-asking, other categories of speech which corroborate the claim that doctors control the content and direction of the consultation are the 'facilitation and 'orientation' speech composites. By using facilitative speech (back-channelling, bids for repetition, asking the patient for his/her opinion, checking for understanding, and changing the subject), the doctor navigates the conversation in order to obtain an adequate amount
of information to make an accurate diagnosis, while at the same time allowing them to steer the conversation in a different direction if information is not needed.

Although the patients declared to be satisfied with the doctors’ facilitation skills, there seemed to be an imbalance in the conversation between the doctor and patient during the ward rounds. This was experienced by the author during the direct observations on doctors, and could be considered in line with past research (Waitzkin, 1985). By not asking questions, patients do not participate in the medical consultation as much as they should (Meeuwesen, Schaap & VanDerStaak, 1991). During their interviews, ward managers stated that patients sometimes refrain from asking questions because they are frightened of the doctor.

‘Patients sometimes would be so anxious that they do not understand the doctor and 60% of the patients have a problem; they get anxious when the doctor talks to them’

(Ward Manager 2)

On the other hand, the high proportion of doctor question-asking and facilitation indicates that the consultations were more likely to be doctor-centred, yet not paternalistic as suggested by Parsons (1975). Doctors exerted control over the direction and content of the consultation, but at the same time facilitated and encouraged patients to talk about their psychosocial concerns especially in the elderly. This may have taken place due to the relatively large number of patients listed as social cases who are blocking the beds at Mater Dei Hospital while they await accommodation in nursing homes.

Other studies affirm that patients hold back on asking questions (Scambler, 2003) to their doctors during ward rounds. West and Frankel (1991) found that doctors initiated between
91% and 99% of the total questions asked in the medical interaction and patients engaged in very little question asking during the medical visit (Roter & Frankel, 1992). Roter (1984) reported that in the entire medical consultation there were very few (3%) direct medical questions initiated by the patient. Moreover, most questions asked by the doctor were close-ended in form (Roter & Frankel, 1992), which allowed for little elaboration by the patient. However, even when doctors did ask open ended questions, patients’ attitude with involvement was very weakly felt (Rao et al., 2007).

Roter (1984) provided several explanations for the lack of patient question-asking. First, patients may perceive their question-asking as bothering their doctor, thus refraining from asking questions. Second, doctors may have conveyed non-verbal cues to discourage patients from asking questions, and third, some questions may be answered by the doctor before the patient had a chance to ask. At Mater Dei Hospital it could also be due to the fact that most doctors approach their patients in an active way and so patients perhaps would fear to speak to them. The issue of time constraints with the doctors was repeated several times both by patients’ feedback and also by the ward managers’ views.

‘Doctors not always speak in simple terms with their patients. I admit they try to get down to patient's level but in my opinion it is not enough and they need to work harder on this. May be they do not have enough time to communicate more or may be that the patient is finding it hard to understand. Then the information has to be explained again by us.’

(Ward Manager 7)

It is further possible that patients with chronic health conditions need to ask fewer questions, because they are familiar with their condition and are experts in their conditions as declared also by Brown (2008).
Other researchers found that even when patients did not understand their doctor, they still would not explicitly ask the doctor to repeat (Speedling & Rose, 1985). Some patients would rather keep their uncertainty to themselves than asking their doctor for clarifications (Beisecker & Beisecker, 1990). This is also consistent with a statement given by a ward manager saying that:

'Nowadays ward rounds are very hurried and doctors' time is very limited. Doctor interaction with the patient needs to be improved of course. Moreover when doctors speak to the patients it is not always understandable and quite often patients come to us and tell us to explain what the doctor has meant.'

(Ward Manager 10)

In fact this study holds with that of Longo et al. (2006) stating that although patients valued shared decision making, they are much inclined to the doctors’ listening skills and would take a passive role (Scambler, 2003).

In this study, patients seemed to be rather hesitant with various variables contributing to doctors’ facilitation skills such as ‘doctor explained plan’, ‘doctor gave useful and good information’ and ‘the care improved patients’ condition’ resulting in one in five patients feeling indecisive. Goodlin et al. (2008) concluded that doctors need to discuss their care plan to the patient as this can decrease anxiety and promote shared decision-making. There was a big response for this issue with ward mangers and some of them stated that:

'The doctors’ plan is normally conveyed by the nurses. Doctors do however explain to the patient but sometimes patients find it very difficult to understand. Doctors also communicate with other health care professionals like specialist nurses according to the condition of the patient and they work
as a team – yes there is networking and I like it. I wish this could be more elaborated and practiced in the future.'

(Ward Manager 6)

'I have seen patients who were referred to Boffa Hospital (Oncology Hospital) without them knowing about the referral and why they were going there. Tests results are not always revealed to the concerned patients by the doctors. Patients only come to know about their condition when the name Boffa Hospital is mentioned as this is related to cancer. Doctors need to be clearer and open with the patients while planning their treatment intervention.'

(Ward Manager 8)

With regards to useful and good information, Epstein and Peters (2009) declared that different patients mean different information giving and doctors must gauge the appropriate amount of information for each patient. There were two out of ten interviewees who have identified the above need.

'With regards to written information, we have a website and we give this website to our patients so that patients would go straight to reliable and approved information. We also make printouts of the information if the patient prefers, according to his individual condition. This has been done since the engagement of two new consultants.'

(Ward Manager 8)

'Not all patients react the same to the information given and so the doctors tailor their information according to the patient. You can find patients with whom you can talk and in turn they cope well. There are others who get upset when certain information is given to them and could worsen their condition. There are patients who literally shut down and the relatives have to deal with the situation. I believe that the giving out of information must be packaged according to the patient.'

(Ward Manager 6)
The need for more dialogue, noted and expressed by around half of the patients and ward managers, emphasize the importance of communication and listening skills necessary for selecting information considered relevant by patients. The doctor-patient relationship should, therefore, encompass and integrate listening more attentively to these expressed needs, and the provision of clear information. It needs to be a connection between the world of disease and a world of the same disease as 'a lived experience' (illness). It is within this kind of relationship that the patients will find greater assurance. It will allow the patient to feel that the doctor is nearer to him/her about any future eventuality.

5.10 Medical and Healthy living information

Another main purpose of medical communication is promoting the exchange of information between the doctor and the patient. This includes information-giving and information seeking, which can be seen as a contribution by both parties to the verbal interactions and ease the mechanism for a patient-centred approach (Beck et al., 2002).

This study shows that doctors' medical and healthy living information was mostly rated as unsatisfied in one out of three hospitalized patients. Most of the unsatisfied patients preferred to receive more information both about their future conditions (this is the most expressed need, reported by 60% of these patients) and their diagnosis (40% of patients). Strengthening the documented presence of these two needs and the importance of information in the doctor-patient relationship, some studies have underlined the necessity that doctors help patients to understand information (Hudak et al., 2008; Bar-Anan, Wilson, & Gilbert, 2009).
The patients’ desire to know more about their own diagnosis and future conditions does not necessarily mean that the patients ask for an active role in medical decision-making like for example the Consumerist model by Scambler (2003). However the way in which doctors manage their interactions with patients does not offer a promising future for patient centeredness. More than a third of the patients expressed the lack of opportunity being offered by doctors for deeper involvement in therapeutic choices. This issue was also brought up by most of the ward mangers during the interviews:

'Patients are being left out by certain doctors from decisions regarding their own health – this is not fair for patients because there might be patients who wish to refuse to undergo certain procedures or treatments being suggested by the doctors. There might be patients who are already dealing with their problem privately with their private doctor, so the lack of communication between the ward doctor and the patient would result in wasting useful resources.'

(Ward Manager 8)

This goes beyond Winkler’s study (2009) where he insisted that the successful management of chronic diseases depends on the active involvement of the patient. This was also evidenced during the author’s observations on doctors where only one third of the patients 33.1% (27) were given the appropriate medical information by the doctors during ward rounds. Gattellari et al., (2001) suggest that encouraging participation in decision making may be the best standard approach. They concluded that patient satisfaction was at best when the patients were involved in decision-making, while patients were least satisfied when a decision was taken for them. Trying to outweigh this problem, Stevenson et al., (2000) declared that doctors identified a number of barriers to share decision making, including time pressures, and the doctors’ perception that patients would
not understand medical language and concepts. In fact this is in line with the present study as ward managers revealed that they often witnessed such concepts.

‘In front of the patients, doctors do discuss what they are going to do but it is obvious that certain patients do not understand a word of what is being said to them. It is clearly visible that doctors need to explain in more simple terms.’

(Ward Manager 7)

‘We have two consultants that go down to the level of the patient. Another consultant gives information to the patient but his way of speaking and wording is difficult for the patient to understand. The fourth consultant however explains in such a rush that the patients do not understand a thing; however the latter does offer patients to explain further if they request him to do so.’

(Ward Manager 9)

In order to find a balance to this problem, Street et al., (2005) suggest that doctors could more effectively facilitate patient involvement by more frequently using partnership building and supportive communication.

During the direct observations on doctors, the author noted that the doctors were somewhat lacking the direction for managing doctor-patient relationships. This study is consistent with that of Epstein and Peters (2009) suggesting that the basis of a new clearer and “shared” model has yet to be found. This also conforms to the study by Brown (2008) who states that since some patients are rightly said to be experts in their conditions, this could lead them to the development of a new and more egalitarian (mutual) relationship with the doctor. Doctors need, therefore, consider the meanings (explicit and implicit) contained in a request for more information and therefore reducing the problem of
uncertainty within the patient which according to two separate studies (Bar-Anan, Wilson, & Gilbert, 2009; Lee et al., 2009), if not resolved could lead to lack of concentration or anxiety, which in turn can block effective communication. Furthermore, Fröjd et al. (2008) state that doctors should equip patients with information that matches the individual patients’ needs and preferences as this could relate to health related quality of life, anxiety and depression. Some of the comments taken from ward managers were:

‘No they do not give enough information to the patient; they normally give the information to the relatives. We are still not in a culture of telling the patient the truth about his/her illness, the plan, and direction. The patient is the least person who is involved....and than the patient starts to ask and when he/she starts to ask may be the patient would get some sort of information and would be lucky to get the full information’

(Ward Manager 1)

‘Information on the condition of the patient is not always given to the patient and in fact only half of our consultants give this sort of information to our patients.’

(Ward Manager 10)

‘Doctors do not give written information on the patients’ disease apart from that of the discharge letter, the latter being a brief history of what has happened during the patients’ stay in hospital.’

(Ward Manager 10)

‘Other type of written information is not given by doctors. They just give them the prescription forms and discharge letters.’

(Ward Manager 5)
In a way it does not mean that this infirmity is coming hundred per cent from doctors. Ward managers also commented how within the Maltese culture most of the time it is the relatives who manipulate the quantity and type of information being delivered to the patient by the doctors.

‘If there is a cancer of the lungs, the doctor just tells the patient that he has an inflammation and he will see what this inflammation is. The routine way of doing things around here is that the same doctors do not tell the patient what the reality is but if the patient corners the doctor perhaps he/she will get some information but normally the doctors ask the relatives first before giving such information. This means that the wife, children and everyone will know about the condition except the patient. Sometimes you see the patient’s wife standing behind the patient making signs to the doctor not to tell the patient. The theory behind this is that the doctors want their patients to keep on fighting the disease and they believe that if you tell the patients what they have they might give up and die. This does not mean that everyone is the same. I have talked to many patients who have accepted their condition. I mean why keeping the patient in the dark when you can give the patient a chance to make certain arrangements while he or she is still alive. By the way, this kind of behaviour is practiced by most of the doctors working in this ward.’

(Ward Manager 2)

‘Giving out information is not always possible when the relatives interfere with doctors demanding to do otherwise. However the doctors inform the relatives that this is unethical. If the patient asks specifically for information, the doctor always tell the information requested but in a more subtle way.’

(Ward Manager 3)

‘Doctors do not like it when a relative approaches them and asks them to keep information away from the patient. The doctors would reply that they will take it into consideration but if the patient asks they are obliged to give the information requested. They will explain to the relatives that it is not fair to keep information away from the patient. When doctors do give information to
Research suggests that patients report that realistic prognostic discussions can be blunt and sometimes brutal (Lagarde et al., 2008). However Hagerty et al. (2005) state that evidence indicates that patients value both expertise and openness when bad news is being broken. Furthermore Parker et al. (2001) found out that patients want their doctor to be up to date on the facts, but also to take time to answer questions completely, and to be honest about the severity of the situation. On the other hand, Barnett (2002) reveals that delivering the real information to these patients may produce psychological harm. In fact according to Fried, Bradley and O'Leary (2003), roughly 20% of patients, especially those with complex metastatic disease, do not want thorough information about their prognosis.

However there were other ward managers’ comments on doctors’ information giving:

‘Doctors always give information to patients on their condition. They are usually very delicate in the way they give information but they always give it. Sometimes doctors use certain terminology in giving out information like for example bad tissue instead of cancer. On the other hand for some patients it is all they want to hear and would be happy with that as long as the word cancer is not mentioned.’

(Ward Manager 9)

‘Not all patients react the same to the information given and so the doctors tailor their information according to the patient.’

(Ward Manager 6)
'With regards to written information, we have a website and we give this website to our patients so that patients would go straight to reliable and approved information. We also make printouts of the information if the patient prefers, according to his individual condition.

(Ward Manager 8)

The analysis of qualitative data of the study shows that the need for more information on the patients' future conditions does not mean for patients “knowing all there is to know about prognosis”. According to most of the ward managers, the patients' principal need appears to be receiving more information about the impact of their illness and treatment on their daily lives, with particular attention being paid to the realistic ability to carry out such activities; in brief “what will the patient be able to do or not do?”, “what does the patient will or will not be able to eat?”, “will the patient be able to move, work, love, have children and if “yes”, how?”. One important dimension, therefore, is to regard the quality of life remaining.

Other information seeking on the part of the doctor that has been poorly realised was the doctors' inquiry about patients' diet, risky habits (like smoking or alcohol consumption) and advice on healthy lifestyle. Both patient's feedback and ward managers' comments reveal that most of the doctors need to improve and adapt to this inquiry. Back in 1977, two separate authors, Illich and Lever argued that medicine should not be considered as the only source to cure patients but the best alternative is to prevent illness by educating the patients. This corresponds well with Fröjd et al. (2008) where they insist that besides taking measures in high quality medical care, doctors need to promote health with information related to various aspects depending on the patient's condition (for example: smoking cessation, exercise, nutrition, safe sexual behaviour, and so on). In fact ward managers remarked:
'No the doctors never inquire on patients’ diet. There were times where the doctor just points out a packet of biscuits on the bed table and tells the patient to avoid eating lots of biscuits. Otherwise I have never heard them telling the patient do not take this or that.'

(Ward Manager 4)

'Risky habits are inquired mostly in cardiacs and biliary and even in intestinal problems where they explain in simple terms.'

(Ward Manager 6)

'Inquiry about diet is not always done. It depends on the case. If the doctors feel that he needs to ask because of the condition yes but on the whole no. It depends on the condition the patient has been admitted with.'

(Ward Manager 7)

'Risky habits like smoking and alcohol are not discussed. May be this was discussed on the first visit and I cannot expect the doctor asks the same questions in every ward round.'

(Ward Manager 7)

'Doctors do give healthy eating information to our patients but most of the time this confuses the patients as the doctors do not know the actual food to suggest and would be very vague. For example they simply say high fibre; most of the patients do not even know what fibre is. There were times when we gave the information ourselves to the patients and there were times when we referred the patient to a dietician.'

(Ward Manager 9)

'Doctors inquire patients about diet only if the condition affects metabolic changes with their conditions. Otherwise doctors never get involved into diet plans. However they do involve in risky habits particularly smoking, alcohol and hard drugs especially if they are affecting the condition of the patient.'

(Ward Manager 10)
The findings also revealed other points with regards to medical and healthy living information between doctors and patients in Mater Dei Hospital. Besides the aspects that were lacking like encouraging the patients to participate in the medical dialogue, express concerns and sharing or transferring the medical information, participants of this study also felt that doctors needed to recall if patients understood. This indicates that especially the way in which information is provided to patients could be improved. All interviewees (ward managers) and patients’ comments stated that information needs to be offered in an individualised and a structured manner in which the most important, personally relevant information needs to be summarized and repeated. One ward manager declared that:

‘There are patients who get anxious and upset when certain information is given to them. There are other patients who just shut down and the relatives have to deal with the situation. I believe that the giving out of information must be packaged according to the patient.’

(Ward Manager 6)

Furthermore, information is required to be offered step-by-step, to enable patients to let the information sink in, to consider the personal relevance and make him or herself familiar with it. This is especially important for older patients, and as Kessels (2003) confirms, they often are less educated than younger patients and their cognitive functions decrease with age. Another key factor that affects comprehension of the information is the language level used to convey the message. In fact this feature was remarked positively by patients and ward managers:

‘With regards to language, the doctors adapt very well according to the needs and understanding of the patient. If the patient speaks Maltese they speak in Maltese, if the patient speaks English, they speak in English. If the doctor is a
foreigner and speaks English, he/she would ask someone to translate to the patient in Maltese.'

(Ward Manager 1)

'Yes doctors explain well in layman's terms to the patient and try to be simple in their explanations.'

(Ward Manager 6)

The only way to know if a message is understood and can be recalled is for the doctor to ask patients to repeat the message. A ward manager said:

'I can still remember an instance in which a doctor had sat down near the patient and had a good talk with the patient; making sure that the patient understood everything, making sure that the nurse took notes of what has been said and re-checked whether the patient understood.'

(Ward Manager 1)

Combining different methods of offering information (e.g. providing patients with additional written information) might improve the patient's ability to understand and recall the message. This study shows that encouraging the patient to bring a (younger) person to be present during ward round is considered an effective way to express their needs, address specific subjects to discuss and improve remembering. Literature suggests that a supportive accompanying individual may enhance communication when a complicated procedure or treatment regimen is being described, if the accompanying individual is present at the patient's request and provides positive support to the patient and accurate information to the health care provider (Greene & Adelman, 2003). Having the opportunities to receive information and discuss concerns might also be useful for caring relatives to enable them to be more confident and effective in their caring role (Beaver & Witham, 2007). This was also suggested by Illich (1977) where he argued that the
The medical community should reverse the social trend towards dependency that exists on them by restoring the value of personal responsibility of patients. Ultimately this trend may improve their perceptions, motivation and self-management at home and may also lead to relatives being more willing to take patients home earlier thus reducing the length of stay in hospital.

5.11 Treatment and medicinal information

As with doctor medical information giving, this domain was also found to be slightly lacking within the doctors' communication skills. Much of these have already occurred elsewhere and findings correspond to those from earlier research. One of the doctors' weaknesses here is that they take the patient for granted by not requesting consent from patient for the initiation of new treatment and also disregarding inclusion for patient to be involved in decision-making. One particular ward manager revealed that:

'Characters vary from one doctor to another. More yes than no, patients have less information about their condition and treatment. We had consultations for patients to be seen by gynaecologists without the patient being aware of what is happening and why they had been referred to Gynae. They only came to know when we were going to escort them to the Gynae Ward.'

(Ward Manager 8)

Results of this study were very clear with 31.4% of the patients declaring their dissatisfaction with the lack of involvement in decision-making while another 24.7% of patients preferred not to comment on the issue which can be indicative of a negative answer as well. This conforms perfectly with another study by Guadagnoli and Ward.
(1998) where they concluded that generally patients want to be informed of treatment alternatives and to be involved in treatment decisions. Gattellari et al. (2001), reported that patients were most satisfied with the consultation when they were involved in decision-making, and those patients who reported that the decision was taken entirely by themselves or by the doctor were least satisfied. On the other hand, Stevenson et al. (2000) revealed that doctors identified a number of barriers to sharing decision making, including time pressures, and the doctors’ perception that patients would not understand medical language and concepts. This issue was also brought up by the ward managers during interviews:

_The doctors’ plan is normally conveyed to the patients by the nurses. Doctors do however explain to the patient but sometimes patients find it very difficult to understand._

(Ward Manager 6)

However, Lyndon (2006) suggests that including the patients in decision making is the key to patient safety. Furthermore, Vick and Scott (1998) found that “being able to express the feelings to the doctor” was more important than other attributes such as involvement in decision making and the type of explanation received.

Another two weak points in doctors’ treatment and medicinal information skills were found to be their lack of specifying the possible side effects of treatment to the patients and the lack of information given to patients on what to do in case of adverse events due to medicines being prescribed. In fact results of the patient questionnaires showed that patients’ dissatisfaction with the lack of information on side effects to medicines reached 41% while 26.7% of the patients did not comment on this issue. This shows that the majority of patients were disappointed with the lack of information on treatment side
effects. On the other hand, results on patients’ feedback indicate that the majority of patients (48.2%) stated that they disagreed and strongly disagreed with statements saying that doctors expressed what to do in case of adverse events to medicines. More so, 23.9% of the patients did not comment on this statement which may also imply an inclination to dissatisfaction. As with ward managers views there were lots of comments on this issue.

‘With regards to new treatment, yes they do explain to the patient about the new treatment but they never tell them about side effects of the medicines nor do they explain what to do in case adverse events happen.’

(Ward Manager 3)

‘With regards to side effects of medicines no; in the surgical areas they do not tell patients about such information. Only a few doctors would do it but normally no they would not even dream about it. However in the medical specialities yes as they have a pharmacist present during ward rounds. And the pharmacist gives advice both to the patient and consultant of what is the right choice and cost effectiveness of treatment being prescribed. During medical wards rounds, the pharmacists would take care and prepare everything in connection with treatment for the patient. They would even take care of the schedule V and give full explanation to the patient.’

(Ward Manager 1)

‘Side effects are explained only in certain cases where the doctors considers it as unsafe on using that medicine in the long term especially when complications are likely to arise as with Aspirin or NSAIDs for example.’

(Ward Manager 6)

These results are consistent with a study conducted by Richard and Lussier (2003) where they stated that doctors hardly discussed treatment risks and side-effects with their patients. The same was confirmed by Elwyn et al. (1999) but they declared that the main reason for doctors not giving out information was that they were concerned about sharing
the uncertainties about the outcomes of medical treatments, and causing anxiety by exposing patients to the fact that data are often unavailable or unknown. The doctors in Elwyn et al.'s study admitted that they use 'friendly persuasion' as their usual practice.

However other ward managers admitted that on their ward, doctors do give detailed information about the treatment that has been prescribed to them. Very few interviewees reported that patients have a good relationship and extensive discussions with their doctors before beginning treatment such as chemotherapy about not only basic aspects of their illness and oncology treatments but also the adverse events that might occur. However, serious adverse events such as fever and chills and low white blood cell counts are discussed less frequently than events such as nausea, tiredness, and weakness. Three ward managers from different clinical departments said:

'With regards to new treatment, yes they tell their patients when they start them on new treatment. They also explain the risks being carried by certain medicines especially if the medicines are risky like for example chemotherapy or steroids. This happens mostly in young and female patients for example during the fertility age telling the patient not to have children during treatment for example.'

(Ward Manager 4)

'They do tell patients how to use the medicine and the side effects that are expected. Doctors also tell their patients what to do in case of adverse events to medicine and in fact sometimes antidotes are also given to our patients to take with them at home just in case.'

(Ward Manager 8)

'Doctors do tackle adverse events due to certain medicines with their patients especially when the patient is being discharged and specialist nurse would
also be involved to give more detailed information according to the speciality. The role of the clinical pharmacist also comes in here where the latter would prepare separate written information for the patient. I do not believe this happens in wards where clinical pharmacists are not available.’

(Ward Manager 10)

In line with this study, Lee (2001) stressed the need for doctors to ask patients what they expect from treatment choices, especially when high risks are involved. Even if this discussion does not change their desire to undergo treatment, it may help patients and their families better prepare themselves for the challenges ahead. Also, a study by Makoul et al (1995) resulted that doctors overestimated the extent to which they accomplished key tasks in explanation and planning. Key objectives included discussing the risks of medication, discussing the patient’s capacity to follow the treatment plan and drawing out the patient’s opinion about medication prescribed. Communicating risks and adverse events of treatment is of supreme importance for an improved patient preparedness to side effects, patient health status and compliance as well as for the patients’ satisfaction and can be regarded as a mediator of health care quality and safety (Rao et al., 2007) hence preventing unnecessary re-admissions in hospital.

5.12 Technical and empathy skills by doctors

Results of this study indicate that the patients have a very good impression and are very satisfied with the technical capabilities possessed by doctors working at Mater Dei Hospital. In fact this study proves that the Maltese doctors master both interpersonal and technical skills. This was in fact even strengthened during the ward managers’ interviews stating that the Maltese doctors are amongst the best in Europe.
'Yes Maltese doctors are very competent; they also had great successes even abroad.'

(Ward Manager 1)

'Honestly our doctors are the best when it comes to technical competency and some of them do act in a friendly manner.'

(Ward Manager 2)

'Doctors are very courteous with patients and have a very good reputation with regards to their competencies. A good percentage of our doctors are very competent in their work.'

(Ward Manager 8)

'They are very competent but they need to focus on bedside manners.'

(Ward Manager 9)

This does not correspond with the study performed by Oriel (2006) who states that the traditional prominence on technical expertise in the education of healthcare workers leaves little room for instruction and practice on interpersonal skills like the development of relationships with their patients as in this study both skills were highly rated by the participants.

Empathy scores were rated very high in the patient questionnaires. According to Roter & Hall (2009) this is indicative that patients adhere well to treatment and consequently improving their health status. Furthermore, as reported by Wilson & Child (2002), satisfaction with empathy skills reflects the patients’ better reliance on their doctor. This may have been achieved perhaps because the doctors may have used ‘friendly persuasion’ as their usual practice as found in Elwyn et al.’s study (1999).
However there seems to be a perforation in this empathy being practiced by doctors. When looking deeper into the results, it has been noted that patients were not completely fulfilled with empathy skills rendered by doctors. In the patients’ opinion the issue of the doctor showing empathy by asking whether help was needed at home when the patient is discharged was absent for a large number of patients. In fact only half of the patients expressed an agreement with this issue, the other half were reluctant and showed their disappointment. This indicates that the study is not consistent with that of Heritage & Maynard (2006) where they insist that empathy involves not only illness issues but factors that represent the context within which a patient lives and/or employment issues that influence the patient’s health and well-being. This was also projected by 50% of ward managers who within their statements on the doctors’ concerns for the patients’ needs at home were conflicting.

‘Another thing with regards to discharging of patients home is that some doctors do not even want to know what problems the patient is going to be faced with at home, they just want them to leave hospital at once to make space for other patients. In such cases the doctors would not even want to listen nor making compromises. Once I have brought the attention of one particular consultant saying that such behaviour with the patient is not right even for his own and the hospital’s reputation.’

(Ward Manager 1)

‘Before discharging a patient, the doctor never asks about the patients needs at home but it would be up to us to take care of that. As a ward we nurses, physiotherapists, occupational therapists and pharmacists meet every Friday at 10am to discuss issues on each patient. I am afraid to say that doctors never attend in these meetings they say because of work overload and time constraints.’

(Ward Manager 3)
However positive responses on doctors’ concerns were also received by ward managers.

‘Patients’ needs at home are asked from day one so that doctors could plan their discharge and they just give patients an indication of when they are going to be discharged.’

(Ward Manager 6)

‘On discharge, doctors do ask the patients if they need anything while being at home and they are doing it more often nowadays. Then obviously the doctors come to us with the problems and we arrange everything for the patient...social worker, community nurse etc.’

(Ward Manager 7)

It is important to note that according to Bar-Anan, Wilson and Gilbert (2009), the provision of relevant information to address patient concerns about symptoms that may create episodic uncertainty after being discharged home is considered as empathetic.

According to the ward managers, showing empathy and support is an important aspect of patient education. It makes the patient (and relative) feel understood and creates a trustful environment, both during and after the ward round, which is a prerequisite for reflection on the information provided and the decision to undergo treatment. The results suggest that doctors need to try to adapt to patients’ emotional needs by providing more information apart from showing empathy and emotional support, as information was considered particularly important and much appreciated by all participants in this study.
5.13 Direct Observations

Doctor communication characteristics were observed against different patient variables such as gender, status, residence, education level, being nursed in single room and whether the patient suffered from chronic diseases. As testified by the author himself, the doctors’ interactions with patients on the whole were satisfactory. When comparing doctor attitudes with patient gender, results showed that there were differences in p-values in two out of five doctor communication characteristics when interaction occurred between male and female patients. Otherwise, doctors resulted to have collaborated better with female patients than with male patients. These results are conformable with a study by Meeuwesen et al. (1991) where female patients have been shown to be more involved with the interaction than male patients while Stewart (1995) found that doctors were more likely to ask opinions or feelings of female patients than male patients. However Weijts (1994) stated that the concerns of female patients were not taken as seriously thus resulting that the doctors’ responses to these concerns were of lower quality. One of the most visible difference in doctor communication attitudes towards patients was the assurance of privacy amongst male and female patients. This variable resulted in a p-value of 0.036 and is indicative that doctors were more cautious of ensuring privacy with female patients than with male patients.

Another two doctor communication variables which although were very weakly practiced on patients (mean = 28% on males and 8.1% on females), still showed differences in doctor interaction amongst male and female patients. These two variables were doctors’ inquiry on patients’ risky habits and advising healthy lifestyle to patients. These resulted in p-values of 0.013 and 0.04 respectively with both variables directed mostly to male patients. With regards to risky habits, these findings correspond well with that of Helman.
(1994) where he identified that doctors might have neglected to ask about risky habits such as smoking and alcohol to both genders. He also states that besides this being a deficiency in itself, the doctors are being more inclined to ask male patients about risky habits. According to Helman (1994), it could also be related to cultural beliefs about behaviour appropriate to each gender, such as alcohol consumption and smoking being regarded as natural for men, but not as much for women. However in this present study it was not clear if the patients had been questioned on these issues during previous interactions with doctors mainly at their first contact in casualty.

As seen from the results, with regards to doctors’ advice on healthy lifestyle, it is a clear fact that doctors are not persisting enough to instil awareness on patients’ healthy lifestyle. This was also uncovered during a conference entitled “A Strategy for the Prevention and Control of Noncommunicable Diseases in Malta” held by the Maltese Ministry for Health, Elderly and Community Care (2010) during the introduction of this strategy. It was also emphasised that doctors and other health care professionals need to focus more on patients’ awareness to healthy lifestyle by devoting more explanations to their patients especially on healthy eating (Cachia, 2010). Such simple and effective interventions will help to significantly reduce the burden of premature death and disease (Illich, 1977), and will bring significant health and economic gains to Malta especially in the long term (Cachia, 2010). This could also help in increasing the emphasis on health promotion and disease prevention in Malta (Cassar, 2010).

With respect to doctor communication attitudes towards patients nursed in single rooms against those nursed in common areas, the author did not find any inconsistencies except to the fact that doctors inquired more on patients’ diet compliance with those patients in
single rooms. This variable gave rise to a p-value of 0.002 meaning that the difference in doctors’ attitudes between patients in single rooms over patients in common areas were very clearly evident. Although never acknowledged, since some few years ago when the acute cases were still accommodated at St. Luke’s Hospital, single rooms were dedicated either for severely ill patients or for the elite people. The latter factor could have led to unfair situations in the doctor-patient relationship, which according to Cooper (2008), can be manifested in doctors showing unconscious biases towards their patients and treating them according to their background. However bed management is no longer managed by consultants at Mater Dei Hospital and so the above statement should be used discretely and with caution. A more significant reason for doctors to be more focussed on patients nursed in single rooms could be that as was mentioned, single rooms are nowadays more than before reserved exclusively for critically ill patients (due to strict policies implemented on the use of single rooms) and so doctors tend to be more caring and cautious in dealing with these patients.

The author’s impression on the doctors’ relationship during the observation study was quite satisfactory. This was marked especially with the last association test being the doctors’ communication characteristics towards patients suffering with chronic illnesses and patients with temporary or acute conditions. Most of the variables in this association resulted to having no significant differences in doctors’ behaviour between the two groups of patients. But still there were three important variables that emerged prominently producing p-values of 0.033, 0.017, and 0.004. These variables were doctors’ medical communication, inquiring on allergic reactions to medicines, and explaining how to use the medicine to patients, respectively. In all of these variables, doctors were more focussed on patients suffering from chronic illnesses. This might have happened because
patients with chronic diseases are more prone to ask questions because as Brown (2008) affirms, these type of patients can rightly be said to be experts in their conditions so they try to discover more about their illness. The results of this study seem to be in line with that of Rao et al. (2007) were it could be indicative that the doctors at Mater Dei Hospital believe that promotion with patient participation in health care could be regarded as best practice because this leads to better care and outcomes. Adding to this, doctors could be realising that since there has been an increase in the prevalence of chronic diseases, as Winkler (2009) suggests, it is widely accepted that their successful management depends on the active involvement of the patient.

5.14 Limitations of the Study

The following is a brief discussion of the limitations of the study and how the researcher tried to mitigate them.

- The author is aware of the literacy bias arising from the use of a questionnaire particularly in Malta where 12% of the Maltese population is illiterate. However to maintain equality with everyone, the author also included in this study those patients who when asked to participate, declared that they were not able to read and write. Of course this had entailed loads of hidden costs in view of patience and time consumption for the author in reading and explaining every detail in the questionnaire without exerting any influence on the participant. The author believed that this manoeuvre was worth doing as it allowed a much more representativeness, transparency and more robust results.
• As already stated above, the author was very meticulous in achieving a very good representation of the three different sample populations under study (260 patient questionnaires, 80 doctor observations, and 10 interviews with ward managers). However, the author was constricted to use convenience sampling because of the selection criteria being set up in order to achieve the most real and true feedback from all participants in view of the sensitivity of the subject being studied. On using convenience sampling instead of random sampling, the normal distribution may have been affected when statistical tests like ANOVA and student t-test were used.

• The author preferred to select patients who were making use of the hospital for the first time to minimize the possibility of any previous biased perceptions. However, this target was rather difficult to achieve and in fact the majority of the patients were not admitted in hospital for the first time. Besides that, one needs not to forget that this was a cross-sectional study and so all patients with the specified criteria had to be accepted within the stipulated period of time.

• A certain degree of observational bias is possible in this study as all observations were made by only one individual. However some advantages of fusing only one observer are that all observations are made in a similar way. Furthermore one would argue the possibility of a Hawthorne effect following an observation study. Actually this was not the case for a number of reasons. In spite of the fact that the consultants through the consent letter knew that there was going to be a direct observation study on their communication skills with patients, they were not told
when this was going to take place. In fact the author handed out the consent forms four months earlier than they had actually been undertaken. This was done purposely so as to allow enough time for the consultants not to recall the whole thing. Besides this, the consent letters were not given to the consultants by the author but by an external person. This manoeuvre was undertaken in order to hide the identity of the author from the consultants and also helped them to forget the event more easily. However, the majority of the consultants knew personally the author as he happened to make part of the health care team as whose name was clearly written on the consent form. To tackle this problem the author took advantage of his position as a deputy nursing officer to attend ward rounds with these consultants at the above specified wards saying that he was making part of the ward’s staff for that day (indirectly making them believe that he was working overtime). This was only embarked after establishing an agreement with the ward managers concerned.

- Another limitation is that no data were collected on the diagnostic outcome of the patients, which according to Scambler (2003) may have determined doctors’ attitudes and also influenced patient satisfaction with doctor-patient communication and information giving. Therefore interpretation of the associations between patient responses categories and patient satisfaction should be cautious.
5.15 Conclusion

Given these discussions and limitations, the study gave some insight into the quality of care within the doctor-patient communication and information giving at Mater Dei Hospital and identified areas which have management implications for improvement. The strength of this project is that the author sought to elicit not only the patients' perspectives on the information they receive but also from other different angles being that of ward managers and self observations on doctors' practices. This knowledge, in turn, puts the author in a better position to capitalize on those sources that patients find most useful, in an effort to increase adherence, and ultimately, outcomes. The next section includes a summary of the overall results and recommendations.
CHAPTER 6

Conclusion and Recommendations
Chapter 6  CONCLUSION and RECOMMENDATIONS

6.1  Introduction

This cross sectional qualitative and quantitative research included a triangulation method to collect, analyse and manage the data. The triangulation comprised a questionnaire relating to patient satisfaction with doctor communication, direct observations on doctors and structured interviews with ward managers.

The three methods used in data collection were quite supportive to each other and revealed similar findings, thus supporting the study interpretations. Satisfaction surveys in health care are often the structural mechanism through which patients can alert providers to their concerns, needs, and perceptions of the service being offered. At the same time achieving hands-on information both from ward managers through everyday working experiences with doctors, and the author's lived experience with doctor practices, made the results of this study even more robust. This study showed that participants' feedback with doctor-patient interaction is also important to the quality assessment process since it helped doctors to identify potential areas for improvement.

As Jehn, Northcraft, and Neale (1999) argue, the success of healthcare organisations is not only dependent on doctors' abilities to perform their tasks but also on doctors' abilities to manage their interactions with patients. It is through communication that individual perspectives and expertise are shared, concerns are heard, work efforts are coordinated, and collaborative decision making ultimately may be achieved. Lyndon (2006) even suggests that communication is the key to patient safety.
6.2 Today’s patient

Although in this study the patients perceived doctor-patient communication as being satisfactory, it is important that patients’ satisfaction is looked at from various aspects, since at face value patients indicated satisfaction and when one investigates deeper, other issues indicated dissatisfaction.

According to the patients, the general outcome of the doctor-patient relationship appears to be an acceptable one and very encouraging. However, in this study it was indicated that a gap between the ward managers’ perception and the patients’ perception exists around this issue. This may be due to the fact that health care providers normally tend to concentrate more at the technicalities, whereas clients focus mainly on the physical and interpersonal relationships, although it does not necessarily mean that they do not agree, since the patient wants the technical skills too (Donabedian, 1987). However the care provider, in this case the doctor, could make the situation better by recognizing the patients’ views and moving closer to them without diminishing quality and the level of medical care given.

The patient has become much more educated in terms of quality expectations. Patients are advising each other to “educate yourself and ask questions” thus, in order to ensure health care success, health care professionals must undergo a complete organizational convergence on exceeding patient expectation by continuously improving the quality of their service and safeguarding high standards of care. Patient satisfaction with their care rests heavily on how successfully this transition is accomplished. Ready access to quality information and thoughtful patient-doctor discussions should be at the fulcrum of this revolution.
As a focal point of contact between a health care organisation and its clients, health care professionals particularly doctors are an invaluable resource base. As such there needs to be a much more open and flexible line of communication between the clients, other health care professionals and the hospital management.

6.3 Conclusion

As we entered the 21st century, the nature of the patient-doctor relationship appears to be more complex. Continuous changes within and outside the health care sector such as the growing amount of chronic illnesses, new medical technologies, the Internet, government regulations, rising costs and changing social norms, are constantly moulding patient and doctor behaviour. There is an augmented concern in researching patient-doctor communication and acknowledging the need to teach and assign this specific clinical skill. The results indicate that directing towards interpersonal and communication skills would result in an effective information exchange and teaming with patients, their families, and other health professionals. It has been accepted that difficulties in the effective delivery of health care can emerge from problems in communication between patient and provider rather than from any deficiency in the technical aspects of medical care. Therefore improvements in doctor-patient communication can have favourable effects on health outcomes.

The results of this study showed that for a successful and humanistic encounter during ward round visits, the doctor needs to make sure that the patient's key interests have been directly and specifically solicited and tackled. To be effective, the doctor must attain an understanding of the patient's perspective on his or her illness as long as the patient is capable and has the knowledge required to do so (Scambler, 2003). Patient concerns can
be widely extended, including fear of death, amputation, and disability; threatening attribution to pain symptoms; doubt of the medical profession; concern about loss of integrity, job, status, or autonomy; negation of reality of medical problems; mental suffering and other uniquely personal issues.

Patient values, cultures, and preferences need to be investigated as this leads direction to the various models and determinants of doctor-patient relationships. Ensuring key issues that are declared in an open manner is essential to effective patient-doctor communication. The doctor needs to be wary not to be subjective or admonishing because this may quickly close down communication. Sometimes the patient acquires therapeutic benefit just from expressing concerns in a safe environment with a caring doctor. The correct reassurance or practical connotations to help with working out a correct solution and setting up a structured technique of action may be a significant share of the patient care that is needed however the process itself should also be a shared two way relationship and not dependable only on the doctor.

Doctors need to produce written information on patients’ specific diseases so that each patient is guided through the correct path of progress and improvement of his/her condition, while motivating the patients to be more self-caring at home as also has been suggested by Illich back in 1977. Adding to this, giving advice on unhealthy or risky behaviours is a meaningful communication skill that should be part of the health care plan as also suggested Illich (1977) and very recently by the Minister for Health, the Elderly & Community Care during the introduction for the Strategy for the Prevention and Control of Noncommunicable Diseases in Malta (April, 2010).
Reasoning out the psychology of behavioural change and setting up a systematic framework for such interventions, which includes assessing, advising, agreeing, assisting and arranging, are actions toward ensuring effective patient-doctor communication. Consideration of patient care as a system of intervention (a continuum), rather than discrete encounters, may lead to identification of effective collaborative strategies.

6.4 Recommendations

Despite the limitations mentioned in the previous chapter, the author still believes that this study can offer several implications to improve doctor-patient communication and information giving in the acute hospital setting in Malta. Health services authorities need to create a better environment in Mater Dei Hospital to facilitate patients in expressing their preferences and appropriate resources need to be made available to support the patients' decisions.

- Doctors need to discuss their plans so as to more accurately understand each patient's preferences regarding his/her roles in the decision-making process and the amount of information being transferred to them. As proposed by Bruera et al. (2002), patient preferences need to be assessed on a prospective basis by directly asking the patient rather than assuming that the existing level of communication will allow the doctor to predict strategy as suggested by Scambler (2003) in his Strategic Interaction model. This is important as evident from the results which suggest that doctors, even those highly experienced in communication skills, need to be equipped to predict patient preferences regarding their role in decision-making and information acquired.
• Healthcare professionals need to inform the patients that they should express their preferences regarding their role in the decision-making process more explicitly. However, the doctor needs to make sure that the patient is capable in taking an active role. For this purpose, one needs to explore the reasons why some patients have a sense of resignation in contrast to those who become more assertive in expressing their preferences after unsatisfactory experiences related to decision-making.

• Doctors could more effectively facilitate patient involvement by frequently using partnership building and supportive communication as stated by Scambler (2003). This shall include the provision of information-giving, information-seeking and the medical information they need to make shared decision-making. Furthermore, if patients are given the opportunity to express "ownership" in the health care process, they would engage in more self-care behaviours and demonstrate greater adherence to medical recommendations, resulting in less hospitalisation days and readmission rates.

• Patients need to be provided with detailed information on their illness and the available treatment options. Patients also need to be given sufficient time to think and deliberate on the options before being required to make a decision. Moreover, doctors should be aware that merely attempting to involve patients into treatment-related decision-making without adequate information exchange and deliberation on the options can result in dissatisfaction on the part of the patients. Further, doctors need to be advised on how to effectively utilise the available educational
material to increase their patients’ understanding of the disease and treatment options.

- Doctors need to explain medical information in simple terms and confirm patients’ understanding. Whatever the methods of information transfer is used, it is important that doctors make sure to ask the patient what he or she has understood.

- There is the need to focus on the role of communication training in medical curricula and the medical profession shall aim to acquire and develop it. Vocational training programmes in general practice and continuous medical education schemes have already been developed in Malta (and are still being developed). The acquisition of communication skills by medical students and postgraduate doctors is vital and so the setting of standards by regulatory bodies must include interpersonal skills and a robust system needs to be in place to assess these skills for health care professionals. Regular training courses are essential in developing and improving interpersonal skills for all members of the medical profession and not only for junior doctors. If all is in place then greater patient satisfaction will be achieved.

- Doctors as well as other health care professionals have to be motivated, committed and persistent. A healthcare system that supports effective teamwork can improve the quality of patient care, enhance patient safety, and reduce workload issues that cause burnout among healthcare professionals. Owing to their dynamic nature of work, doctors need to involve more and work alongside other healthcare professionals mostly ward nurses, specialist nurses, pharmacists, and dietitians so
that work related to patient communication could be managed more efficiently and evenly distributed. In such cases, high quality working relationships are fundamentally important within the team, between teams and with other health care professionals. This may be achieved by the introduction of regular meetings with other health care professionals so that one can define mostly the weaknesses and further develop their strengths within the whole organisation. All this shall bring about a culture of putting the patient at the centre of activity.

- Patient expectations need to be managed to improve perceptions and the best way to achieve this is to detail service specifications, making it clear what patients can and should expect from the service being offered to them. Patients need to be encouraged to participate effectively. They need to be more oriented on the service and how to participate in their daily care. Patients also need to be given information about their condition and how each healthcare professional including the doctor will contribute to their care so that responsibility and accountability will be respected within the team.

- The aging of the Maltese population portends a shift from the acute care to one aimed at maintaining or improving the health and functioning of an increasing number of patients with chronic medical conditions. This shift in focus necessitates increasing emphasis on biopsychosocial aspects of health care (Engel, 1977). Simultaneously, the continuing trend toward cost containment mandates efficiency. Therefore, even small improvements in the health of patients with chronic conditions that result from simple changes in the health care delivery process, as observed in this study, are noteworthy because of their potential
population wide impact. Consideration needs to be given to incorporate the essential features of this intervention into the primary care of patients especially with chronic medical conditions.

6.5 Recommendations for further studies

- Following the results of this study and exploring the needs in doctor-patient communication and information giving, one may need to ask whether perhaps this has been derived from a health care system where the doctor is not paid directly by the patient. Considering that most of the consultants working in Mater Dei Hospital also work privately in clinics around Malta, perhaps the idea of conducting a similar study in a private setting would justify the doctors' true need for more training as recommended by the author, or whether the doctors being 'self employed' is a motivating factor. Apart from this, one of the ward managers stated that most of the doctors take many investigations in order to find out what is going wrong with the patient which according to him/her, these investigations are being taken with no expense in mind. Perhaps this factor could be analysed and compared with that in the private sector as well.

- As doctors have a dynamic nature, further studies in productivity trends and the changing nature of its contributing factors is strongly desirable.

- To investigate the views of the doctors themselves by identifying what training and further development need to be done so as to upgrade their practices and optimise quality of health care service.
Furthermore, it is recommended that comparative studies be carried out separately between different specialities and/or departments (Medical, Surgical, Cardiac, ENT etc) within Mater Dei Hospital with similar quantitative and qualitative studies so that the real doctor-patient approach would emerge for the individual clinical department. This is being suggested because since the present study took an overview of doctor-patient relationship within all clinical departments, the author felt that it would be fairer to assess doctor behaviour within specific clinical departments as their attitudes may differ according to their different practices, physical and human resources available, and workload.

Presently, this study could be conducted in other settings outside Mater Dei Hospital like Health Centres to evaluate and assess the quality of service and amount of output per capita being delivered by doctors working in these Health Centres. The result could be needed and used for future management planning.

In the near future when the Primary Health Care Reform would be in place, a similar study with doctors working in Health Centres could be taken concurrently with doctors practising the Personal Primary Health Care System. This could be beneficial in comparing their performances and also creating trends (if study is taken routinely). This could help health services authorities by measuring efficiency and effectiveness between both services so that they could make favourable choices towards the best interests of the Maltese population.

Maybe exploring with a different study instrument such as a structured interview in focus groups so as to encourage participants to open up and discuss more.
- Future research also needs to investigate what are the actual benefits that patients perceive from having a doctor that has transferred tailored education to them and also has an extended knowledge about them.
"Communicate unto the other person that which you would want him to communicate unto you if your positions were reversed."

Aaron Goldman
REFERENCES


Wortzel, E.M. (2002). Practicing patient-centred medicine each day won’t keep the lawyers away. Archives of Internal Medicine, 161(22), 2631.


APPENDICES
APPENDIX 1

Letters of Approval

- The Board of Ethics formed by the Institute of Health Care (University of Malta).
- The Medical Superintendent (Mater Dei Hospital).
- The Chairman of Surgery.
- The Chairman of Medicine.
- The Consultants
- The Director Nursing Services (Mater Dei Hospital).
- The Departmental Nursing Managers allocated to the wards involved in the study.
Check list to be included with UREC proposal form

Please make sure to tick ALL the items. Incomplete forms will not be accepted.

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Received by Faculty office on 04/03/09

Discussed by Faculty Research Ethics Committee on 02/06/09

Discussed by university Research Ethics Committee on 3/7/09
UNIVERSITY OF MALTA

Request for Approval of Human Subjects Research
Please type, or print legibly with black pen. You may follow this format on separate sheets or use additional pages if necessary.

FROM: Jesmond Seychell
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COURSE AND YEAR: MSc. HSM Oct. 2008

PROJECT TITLE:
“Doctor-Patient Communication and Information Giving in an Acute General Hospital in Malta”

ANTICIPATED FUNDING SOURCE: Self funded

FACULTY SUPERVISOR’S NAME: Mr. Michael Bezzina

DURATION OF ENTIRE PROJECT: from June 2009 to May 2010

1. Please give a brief summary of the purpose of the research, in non-technical language.

The heart of medicine is the personal encounter: the coming together of doctor and patient with the aim to relieve suffering and ideally heal the whole patient. But all too often the forces of modern medicine conspire against this ideal, narrowing the doctor's role to that of expert on the body and leaving no room for a curious and compassionate connection, clear instruction, or even the extra second of attentive listening that might lead to a more informed diagnosis.

Effective doctor-patient communication has been tied to better adherence to treatment, shorter hospital stays, better efficiency and cost effectiveness, enhance quality of care, helping patients and doctors use time wisely, decreased risk of malpractice claims, and not surprisingly, increased doctor and patient satisfaction.

Failure to give information or providing unwanted information can cause harm. Information may be poor because doctors might underestimate patients’ needs, overestimate the amount of information they give, lack the necessary skills, or use jargon.

The aim of this study is to explore doctor-patient communication and information giving in the medical and surgical wards in an acute general hospital in Malta.
2. Give details of procedures that relate to subjects’ participation
(a) How are subjects recruited? What inducement is offered? (Append copy of letter or advertisement or poster, if any.)
A cross-sectional explorative study will be performed at Mater Dei Hospital through triangulated, unobtrusive methods to enhance the validity of the findings. The three steps will consist of:

1.) DIRECT OBSERVATION STUDY
A direct observation study of randomly selected medical and surgical doctors working in the Medical Admissions Unit and Surgical Admissions Unit at Mater Dei Hospital during their consultations with newly admitted patients and an assessment on their performance will be made. These two units were particularly chosen because most of the medical and surgical patients will be admitted in these wards (most of the consultant firms will be involved) and then transferred to the acute medical and surgical wards. This assessment will be evaluated against a checklist which is developed by the applicant and which possesses a good internal validity (a copy of this check-list can be found in the appendix list).

2.) IN-DEPTH INTERVIEWS
A qualitative study consisting of in-depth interviews with key personnel such as Nursing Officers and Nursing Managers to identify how the impact of communication on behalf of the doctors towards patients could affect the running of Mater Dei Hospital wards and the health service in general. A maximum of ten interviews will be performed and the subjects will be selected according to the higher level of in-service seniority (experience). These subjects will be recruited from the surgical and medical wards during October 2009. The duration of each interview will be limited to one hour. The same common set of four questions will be asked to each participant and this will mainly ask for their opinions, views, likes, dislikes and suggestions for future recommendations (a copy of these guide questions for the face to face interview with key personnel can be found in the appendix list). This set of guide questions for key personnel was also created by the applicant and was based on the literature findings.

3.) PATIENT SATISFACTION QUESTIONNAIRE
The last method is a questionnaire for inpatients that had experienced doctor interaction at Mater Dei Hospital during their hospitalisation. A survey questionnaire that possesses psychometric properties measuring patient satisfaction was created by the applicant (a copy of the questionnaire in both Maltese and English versions are found in the appendix list) and so it will be quick to complete (approximately 10 minutes). Potential dimensions of patient satisfaction with doctor-patient interaction such as technical competence, facilitation skills, presentation skills, interpersonal skills, empathy, friendliness, confidentiality, listening skills, eye contact, medical information, medicinal information and others will be included in the questionnaire. Such dimensions were extracted from the review of the literature. All adult patients whose hospital stay in Mater Dei Hospital’s medical and surgical wards exceeds more than 4 days will be eligible to participate in the questionnaire. The 4 day criteria was established in order to obtain a feasible number of patients. A list of patients with the above inclusion/exclusion criteria will be obtained on a daily basis for eight weeks. Patients on this list will be approached during their
hospital stay and will be asked whether they would want to participate in the
questionnaire. The questionnaires together with enclosed envelopes will be delivered personally
to the patients and is done a day prior to their discharge. This will give the
patients enough time to experience and be able to form an opinion with their
interaction with the doctor. The questionnaires will be completed and sealed in
the envelopes by the patients themselves.

An explanation regarding the research aims, anonymity, confidentiality and
voluntary participation in this study, will be given to the patients and clinical
staff. In fact a letter of consent about this issue will be handed to and signed by
each participant before taking part in the study.

There will be no inducements to be offered in any of the three methods
mentioned above.

(b) Salient characteristics of subjects—number who will participate, age range, sex, institutional
affiliation, other special criteria:

1.) DIRECT OBSERVATION STUDY
This direct observation study on doctors will be held during a 2 week period in
which 4 doctors from each unit (medical and surgical admitting units) will be
selected daily at random. This is done by taking the first 4 admitted patients
from 8am till noon from the Medical Admitting Unit and the first 4 patients from
1pm till 5pm from the Surgical Admitting Unit. Whoever doctor comes to visit
these patients will be observed according to the pre mentioned check list. There
should be around 60 subjects (doctors) under study and will be performed after
approval is granted from all consultants of the wards involved in this study and
each individual doctor visiting the patients.

2.) IN-DEPTH INTERVIEWS
A qualitative study consisting of in-depth interviews with key personnel such as
Nursing Officers and Nursing Managers will be done to identify how the impact
of communication on behalf of doctors towards patients could affect the running
of Mater Dei Hospital wards and the health service in general. A maximum of 10
interviews will be performed and the subjects will be selected according to the
higher level of in-service seniority. These subjects are selected from the surgical
and medical wards within the acute Mater Dei Hospital during October 2009.
The duration of each interview will be limited to one hour. The same common
set of four questions will be asked to each participant and this will mainly ask for
their opinions, views, likes, dislikes and suggestions for future recommendations
(a copy of these guide questions for the face to face interview with key personnel
can be found in the appendix list). This set of guide questions for key personnel
was also created by the applicant and was based on the literature findings.

3.) PATIENT SATISFACTION QUESTIONNAIRE
During an 8 week study period, all adult patients whose hospital stay in the acute
Mater Dei Hospital’s medical and surgical wards exceed more than 4 days will
be eligible to participate in the questionnaire. Exclusions from this study will be those patients who, for physical or mental reasons cannot take part in the questionnaire (e.g. CVA, Huntington's chorea, mentally disabled persons etc.). This will be done because the applicant is interested to achieve the real views of the patients and not those of the relatives. For such reason the Paediatric wards were also excluded from this study.

During this 8 week period, the estimated number of participants for this questionnaire is expected to be that of around 300.

(c) Describe how permission has been obtained from cooperating institution(s)—school, hospital, organization, prison, or other relevant organization. (Append letters.) Is the approval of another Research Ethics Committee required?

Permissions have been obtained from hospital authorities since the study concerns inpatients in medical and surgical wards at Mater Dei Hospital. Please find attached the letters of approval from:

Acting Superintendent of Mater Dei Hospital, Chairman of Dept. of Medicine, Chairman of Dept. of Surgery, Director Nursing Services of Mater Dei Hospital, Dept. Nursing Managers (Medical), Dept. Nursing Managers (Surgical), Dept. Nursing Manager (Specialist Nurse Services).

There will be no need for approval from another Research Ethics Committee.

(d) What do subjects do, or what is done to them, or what information is gathered? (Append copies of instructions or tests or questionnaires.) How many times will observations, tests, etc., be conducted? How long will their participation take?

1.) DIRECT OBSERVATION STUDY ON DOCTORS
A direct observation study for medical and surgical doctors working in the Medical Admitting Unit and the Surgical Admitting Unit in Mater Dei Hospital during their consultations with the newly admitted patients and an assessment on their performance will be made. This assessment will be evaluated against a check-list which is developed by the applicant and which possesses a good internal validity and containing 19 variables of good doctor communication qualities (a copy of this check-list can be found in the appendix list). Each direct observation duration time depends mainly on the doctor visiting the patient and how much the patient questions the doctor but usually it would not take more than 15 minutes. These observations will be conducted once for each doctor but overall 60 will be conducted (30 from each unit).

2.) IN-DEPTH INTERVIEWS WITH KEY PERSONNEL
A qualitative study consisting of in-depth interviews with key personnel such as Nursing Officers and Nursing Managers to identify how the impact of communication on behalf of doctors towards patients could affect the running of Mater Dei Hospital wards and the health service in general. The duration of each interview will be limited to one hour. The same common set of four questions will be asked to each participant and this will mainly ask for their opinions, views, likes, dislikes and suggestions for future recommendations (a
copy of these guide questions for the face to face interview with key personnel can be found in the appendix list). This set of guide questions for key personnel was also created by the applicant and was based on the literature findings. This kind of interview will be done once for every key personnel and the maximum of interviews will be that of 10. The top 10 with regards to government in-service seniority who will be working in the acute medical and surgical wards at Mater Dei Hospital will be selected.

3.) PATIENT SATISFACTION QUESTIONNAIRE
The tool has been developed by the applicant.
The subjects will fill in a questionnaire either in Maltese or in English (copies are attached in the appendix list).
The questionnaire entitled “Doctor-Patient Communication” will cover potential dimensions of patient satisfaction with doctor-patient interaction such as technical competence, facilitation skills, presentation skills, interpersonal skills, empathy, friendliness, confidentiality, listening skills, eye contact, medical information, medicinal information and others.
This questionnaire will be given to the patients one day prior to their discharge from hospital. The questionnaires will be completed and sealed in the provided envelopes by the patients themselves. These envelopes will be collected later on the same day by the ward manager in a tamper-proof fashion. This feature will ensure that the hospital staff has no access to the completed questionnaire and the applicant will not associate person with answers.
This questionnaire is very simple for the patient to understand and complete.
The questionnaire will be conducted once and it will take from 5 to 10 minutes to be filled.

(e) Which of the following data categories are collected?

<table>
<thead>
<tr>
<th>Data Category</th>
<th>YES / NO</th>
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<tbody>
<tr>
<td>race or ethnic origin</td>
<td>YES</td>
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<tr>
<td>political opinions</td>
<td>YES</td>
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<tr>
<td>religious or philosophical beliefs</td>
<td>YES</td>
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<tr>
<td>trade union memberships</td>
<td>YES</td>
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<td>health</td>
<td>YES</td>
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<tr>
<td>sex life</td>
<td>YES</td>
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<tr>
<td>genetic information</td>
<td>YES</td>
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3. How do you explain the research to subjects and obtain their informed consent to participate? (If in writing, append a copy of consent form.) If subjects are minors, mentally infirm, or otherwise not legally competent to consent to participation, how is their assent obtained and from whom is proxy consent obtained? How is it made clear to subjects that they can quit the study at any time?

Explanation of the research to the subjects and obtaining their informed consent to participate is done in writing. Please find attached a copy of the consent form both in Maltese and English (for patients) and in English for professional staff. Mater Dei Hospital authorities and all medical staff consents have already given approval for this study and a copy of all these are found in the appendix list.
Patients, who for physical or mental reasons cannot take part in the survey, will be excluded from this study (e.g. CVA, Huntington’s chorea, mentally disabled persons etc.). The reason behind this is that the author is interested mostly in the patients’ views and not their relatives’. Normally relatives cannot express exactly what the patient is feeling and/or experiencing.

4. Do subjects risk any harm—physical, psychological, legal, social—by participating in the research? Are the risks necessary? What safeguards do you take to minimize the risks?

There are no risks involved; in fact this is clearly stated in the consent form.

The subjects will not be subjected to any risks.

5. Are subjects deliberately deceived in any way? If so, what is the nature of the deception? Is it likely to be significant to subjects? Is there any other way to conduct the research that would not involve deception, and, if so, why have you not chosen that alternative? What explanation for the deception do you give to subjects following their participation?

There will be no deception involved.
6. How will participation in this research benefit subjects? If subjects will be “debriefed” or receive information about the research project following its conclusion, how do you ensure the educational value of the process? *(Include copies of any debriefing or educational materials)*

The respondents will be informed that they will not receive any remuneration for participating in the study. However, the result of this study (Doctor-Patient communication and information giving in an acute general hospital in Malta) should benefit each participating patient, other future patients, doctors, and health care administrators by:

- Delivering superior quality care across the system through timely access to accurate information and improved decision-making support.
- Enhancing ongoing disease management for chronic and longer-term care by facilitating a higher level of patient involvement and education, and more guideline-compliant treatment.
- Ensuring the system’s long-term sustainability through enhanced performance management of cost, quality, and access, as well as management of critical resources.
- Enabling patient self-care and community care.
- Controlling system risks to the population from pandemics or other health issues through adequate information.
TERMS AND CONDITIONS FOR APPROVAL IN TERMS OF THE DATA PROTECTION ACT

- Personal data shall only be collected and processed for the specific research purpose.
- The data shall be adequate, relevant and not excessive in relation to the processing purpose.
- All reasonable measures shall be taken to ensure the correctness of personal data.
- Personal data shall not be disclosed to third parties and may only be required by the University or the supervisor for verification purposes. All necessary measures shall be implemented to ensure confidentiality and where possible, data shall be anonymised.
- Unless otherwise authorised by the University Research Ethics Committee, the researcher shall obtain the consent from the data subject (respondent) and provide him with the following information: The researcher's identity and habitual residence, the purpose of processing and the recipients to whom personal data may be disclosed. The data subject shall also be informed about his rights to access, rectify, and where applicable erase the data concerning him.

I, the undersigned hereby **undertake** to abide by the terms and conditions for approval as attached to this application.

I, the undersigned, also give my consent to the University of Malta’s Research Ethics Committee to process my personal data for the purpose of evaluating my request and other matters related to this application. I also understand that, I can request in writing a copy of my personal information. I shall also request rectification, blocking or erasure of such personal data that has not been processed in accordance with the Act.

Signature: [Signature]

APPLICANT'S SIGNATURE: [Signature]  
DATE: 30.4.09

FACULTY SPONSOR'S SIGNATURE: [Signature]  
DATE: 30 April 09

ATTACHMENTS:
* Recruitment letter, poster
* Tests or questionnaires
* Written consent form (or script)
* Other institutional approval
* Information sheets or debriefing materials
* Other

*Return the completed application to your faculty Research Ethics Committee*
To be completed by Faculty Research Ethics Committee

We have examined the above proposal and advise

Acceptance Refusal Conditional acceptance

For the following reason/s:

Signature Date 02.06.09

To be completed by University Research Ethics Committee

We have examined the above proposal and grant

Acceptance Refusal Conditional acceptance

For the following reason/s:

Signature Date 07.09
Dr. Lina Janulova
A/Medical Administrator,
Mater Dei Hospital,
Tal-Qroqq, Msida.

Dear Dr. Janulova,

I am a part-time student reading for Masters in Health Services Management at the University of Malta (Institute of Health Care). I am going to do my final research project on “Doctor-Patient Communication and Information Giving in the Acute Medical and Surgical Wards”, which will be carried out at Mater Dei Hospital.

For this study I will need to ask some questions in a form of questionnaire to a number of clients who are inpatients at Mater Dei Hospital. I will also need to interview and observe clinical staff. The questions will be related to patient satisfaction with their relationship with doctors during hospitalisation. Views on this aspect are essential to facilitate a higher level of patient involvement and education, and more guideline-compliant treatment thus achieving better adherence to treatment, shorter hospital stays, better efficiency and cost effectiveness, enhance quality of care, helping patients and doctors use time wisely, decrease risk of malpractice claims, and increase doctor and patient satisfaction.

I am writing this letter for your approval to allow me to ask clients and clinical staff at Mater Dei Hospital to participate for my research. I shall be explaining to the patients as well as the staff that their participation will be voluntary and that they have the right to refuse. I shall inform them also that their participation will be anonymous and that their participation or no participation will have no effect on services that they receive from their ward or any other service within Mater Dei Hospital.

Your approval will be highly appreciated.

Yours faithfully,

Jesmond Seychell

attached signature
Dear Prof. Laferla,

I am a part-time student reading for Masters in Health Services Management at the University of Malta (Institute of Health Care). I am going to do my final research project on "Doctor-Patient Communication and Information Giving in Acute Medical and Surgical Wards", which will be carried out at Mater Dei Hospital.

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Your approval will be highly appreciated.

Yours faithfully,

Jesmond Seychell

Jesmond Seychell
Dr. Mario Vassallo  
Chairman of Medicine,  
Mater Dei Hospital,  
Tal-Qroqq, Msida.

Dear Dr. Vassallo,

I am a part-time student reading for Masters in Health Services Management at the University of Malta (Institute of Health Care). I am going to do my final research project on “Doctor-Patient Communication and Information Giving in Acute Medical and Surgical Wards”, which will be carried out at Mater Dei Hospital.

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Yours faithfully,

Jesmond Seychell

Approved / Not approved

To inform consultants and get written approval from consultant.
Dear Dr. Vassallo,

I am a part-time student reading for a Master's Degree in Health Services Management at the University of Malta (Institute of Health Care). I am going to do my final research project on "Doctor-Patient Communication and Information Giving in the Acute Medical and Surgical Wards", which will be carried out at Mater Dei Hospital and under the supervision of Mr. Michael Bezzina. This study will be carried out in October, 2009.

As part of this study, I would like to ask some questions in the form of a questionnaire to a number of clients who might happen to be under your care as inpatients at Mater Dei Hospital. I would also like to ask permission to attend ward rounds. Approval for this aspect of the study is also being sought from Dr. Lina Janulova, A/Medical Administrator; Prof. Godfrey Lafera, Chairman of Surgery; Dr. Mario Vassallo, Chairman of Medicine; and Mr. Emanuel Bezzina, Director of Nursing.

Approval for this research was given by the IHC Dissertation Panel and following your approval this will then be submitted to the UoM Research Ethics Committee for their approval.

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Your approval will be highly appreciated.

Yours faithfully,

Jesmond Seychell
161567(M)
Dr. Bernard Coleiro  
Rheumatology Consultant,  
Mater Dei Hospital,  
Tal-Qroqq, Msida.

Dear Dr. Coleiro,

I am a part-time student reading for Masters Degree in Health Services Management at the University of Malta (Institute of Health Care). I am going to do my final research project on “Doctor-Patient Communication and Information Giving in the Acute Medical and Surgical Wards”, which will be carried out at Mater Dei Hospital and under the supervision of Mr. Michael Bezzina. This study will be carried out in October, 2009.

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Your approval will be highly appreciated.

Yours faithfully,

Jesmond Seychell  
161567(M)
Dear Dr. Caruana Montalto,

I am a part-time student reading for Masters Degree in Health Services Management at the University of Malta (Institute of Health Care). I am going to do my final research project on “Doctor-Patient Communication and Information Giving in the Acute Medical and Surgical Wards”, which will be carried out at Mater Dei Hospital and under the supervision of Mr. Michael Bezzina. This study will be carried out in October, 2009.

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Yours faithfully,

Jesmond Seychell
161567(M)
Dear Dr. Galea Debono,

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Jesmond Seychell
161567(M)
Dear Dr. Mallia Azzopardi,

I am a part-time student reading for Masters Degree in Health Services Management at the University of Malta (Institute of Health Care). I am going to do my final research project on “Doctor-Patient Communication and Information Giving in the Acute Medical and Surgical Wards”, which will be carried out at Mater Dei Hospital and under the supervision of Mr. Michael Bezzina. This study will be carried out in October, 2009.

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Jesmond Seychell
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Dear Dr. Aquilina,

I am a part-time student reading for Masters Degree in Health Services Management at the University of Malta (Institute of Health Care). I am going to do my final research project on "Doctor-Patient Communication and Information Giving in the Acute Medical and Surgical Wards", which will be carried out at Mater Dei Hospital and under the supervision of Mr. Michael Bezzina. This study will be carried out in October, 2009.

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Your approval will be highly appreciated.

Yours faithfully,

Jesmond Seychell
161567(M)
Dr. Stephen Fava  
Diabetes/Endocrinology Consultant,  
Mater Dei Hospital,  
Tal-Qroqq, Msida.

Dear Dr. Fava,

I am a part-time student reading for Masters Degree in Health Services Management at the University of Malta (Institute of Health Care). I am going to do my final research project on “Doctor-Patient Communication and Information Giving in the Acute Medical and Surgical Wards”, which will be carried out at Mater Dei Hospital and under the supervision of Mr. Michael Bezzina. This study will be carried out in October, 2009.

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I am writing this letter for your approval to allow me to ask clients and clinical staff at Mater Dei Hospital to participate for my research. I shall be explaining to the patients as well as the staff that their participation will be voluntary and that they have the right to refuse. I shall inform them also that their participation will be anonymous and that if they choose not to participate, it will have no effect on services that they receive from their ward or any other service within Mater Dei Hospital.

Your approval will be highly appreciated.

Yours faithfully,

Jesmond Seychell  
161567(M)
Dear Dr. Camilleri,

I am a part-time student reading for Masters Degree in Health Services Management at the University of Malta (Institute of Health Care). I am going to do my final research project on "Doctor-Patient Communication and Information Giving in the Acute Medical and Surgical Wards", which will be carried out at Mater Dei Hospital and under the supervision of Mr. Michael Bezzina. This study will be carried out in October, 2009.

As part of this study, I would like to ask some questions in a form of questionnaire to a number of clients who might happen to be under your care as inpatients at Mater Dei Hospital. I would also like to ask permission to attend ward rounds. Approval for this aspect of the study is also being sought from Dr. Lina Janulova, A/Medical Administrator; Prof. Godfrey Lafera, Chairman of Surgery; Dr. Mario Vassallo, Chairman of Medicine; and Mr. Emanuel Bezzina, Director of Nursing.

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Your approval will be highly appreciated.

Yours faithfully,

Jesmond Seychell
161567(M)
Dear Dr. Vella,

I am a part-time student reading for Masters Degree in Health Services Management at the University of Malta (Institute of Health Care). I am going to do my final research project on "Doctor-Patient Communication and Information Giving in the Acute Medical and Surgical Wards", which will be carried out at Mater Dei Hospital and under the supervision of Mr. Michael Bezzina. This study will be carried out in October, 2009.

As part of this study, I would like to ask some questions in a form of questionnaire to a number of clients who might happen to be under your care as inpatients at Mater Dei Hospital. I would also like to ask permission to attend ward rounds. Approval for this aspect of the study is also being sought from Dr. Lina Janulova, A/Medical Administrator; Prof. Godfrey Lafera, Chairman of Surgery; Dr. Mario Vassallo, Chairman of Medicine; and Mr. Emanuel Bezzina, Director of Nursing.

Approval for this research was given by the IHC Dissertation Panel and following your approval this will then be submitted to the UoM Research Ethics Committee for their approval.

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Yours faithfully,

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161567(M)
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As part of this study, I would like to ask some questions in a form of questionnaire to a number of clients who might happen to be under your care as inpatients at Mater Dei Hospital. I would also like to ask permission to attend ward rounds. Approval for this aspect of the study is also being sought from Dr. Lina Janulova, A/Medical Administrator; Prof. Godfrey Lafera, Chairman of Surgery; Dr. Mario Vassallo, Chairman of Medicine; and Mr. Emanuel Bezzina, Director of Nursing.

Approval for this research was given by the IHC Dissertation Panel and following your approval this will then be submitted to the UoM Research Ethics Committee for their approval.

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Your approval will be highly appreciated.

Yours faithfully,

Jesmond Seychell
161567(M)
Dear Dr. Piscopo,

I am a part-time student reading for Masters Degree in Health Services Management at the University of Malta (Institute of Health Care). I am going to do my final research project on “Doctor-Patient Communication and Information Giving in the Acute Medical and Surgical Wards”, which will be carried out at Mater Dei Hospital and under the supervision of Mr. Michael Bezzina. This study will be carried out in October, 2009.

As part of this study, I would like to ask some questions in a form of questionnaire to a number of clients who might happen to be under your care as inpatients at Mater Dei Hospital. I would also like to ask permission to attend ward rounds. Approval for this aspect of the study is also being sought from Dr. Lina Janulova, A/Medical Administrator; Prof. Godfrey Lafera, Chairman of Surgery; Dr. Mario Vassallo, Chairman of Medicine; and Mr. Emanuel Bezzina, Director of Nursing.

Approval for this research was given by the IHC Dissertation Panel and following your approval this will then be submitted to the UoM Research Ethics Committee for their approval.

I am writing this letter for your approval to allow me to ask clients and clinical staff at Mater Dei Hospital to participate for my research. I shall be explaining to the patients as well as the staff that their participation will be voluntary and that they have the right to refuse. I shall inform them also that their participation will be anonymous and that if they choose not to participate, it will have no effect on services that they receive from their ward or any other service within Mater Dei Hospital.

Your approval will be highly appreciated.

Yours faithfully,

Jesmond Seychell
151567(M)
Dear Dr. Pocock,

I am a part-time student reading for Masters Degree in Health Services Management at the University of Malta (Institute of Health Care). I am going to do my final research project on “Doctor-Patient Communication and Information Giving in the Acute Medical and Surgical Wards”, which will be carried out at Mater Dei Hospital and under the supervision of Mr. Michael Bezzina. This study will be carried out in October, 2009.

As part of this study, I would like to ask some questions in a form of questionnaire to a number of clients who might happen to be under your care as inpatients at Mater Dei Hospital. I would also like to ask permission to attend ward rounds. Approval for this aspect of the study is also being sought from Dr. Lina Janulova, A/Medical Administrator; Prof. Godfrey Lafera, Chairman of Surgery; Dr. Mario Vassallo, Chairman of Medicine; and Mr. Emanuel Bezzina, Director of Nursing.

Approval for this research was given by the IHC Dissertation Panel and following your approval this will then be submitted to the UoM Research Ethics Committee for their approval.

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Your approval will be highly appreciated.

Yours faithfully,

Jesmond Seychell
161567(M)
Dear Dr. Cassar,

I am a part-time student reading for Masters Degree in Health Services Management at the University of Malta (Institute of Health Care). I am going to do my final research project on “Doctor-Patient Communication and Information Giving in the Acute Medical and Surgical Wards”, which will be carried out at Mater Dei Hospital and under the supervision of Mr. Michael Bezzina. This study will be carried out in October, 2009.

As part of this study, I would like to ask some questions in a form of questionnaire to a number of clients who might happen to be under your care as inpatients at Mater Dei Hospital. I would also like to ask permission to attend ward rounds. Approval for this aspect of the study is also being sought from Dr. Lina Janulova, A/Medical Administrator; Prof. Godfrey Lafera, Chairman of Surgery; Dr. Mario Vassallo, Chairman of Medicine; and Mr. Emanuel Bezzina, Director of Nursing.

Approval for this research was given by the IHC Dissertation Panel and following your approval this will then be submitted to the UoM Research Ethics Committee for their approval.

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Your approval will be highly appreciated.

Yours faithfully,

Jesmond Seychell
161567(M)
Dear Dr. Cachia,

I am a part-time student reading for Masters Degree in Health Services Management at the University of Malta (Institute of Health Care). I am going to do my final research project on "Doctor-Patient Communication and Information Giving in the Acute Medical and Surgical Wards", which will be carried out at Mater Dei Hospital and under the supervision of Mr. Michael Bezzina. This study will be carried out in October, 2009.

As part of this study, I would like to ask some questions in a form of questionnaire to a number of clients who might happen to be under your care as inpatients at Mater Dei Hospital. I would also like to ask permission to attend ward rounds. Approval for this aspect of the study is also being sought from Dr. Lina Janulova, A/Medical Administrator; Prof. Godfrey Lafera, Chairman of Surgery; Dr. Mario Vassallo, Chairman of Medicine; and Mr. Emanuel Bezzina, Director of Nursing.

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Your approval will be highly appreciated.

Yours faithfully,

Jesmond Seychell
161567(M)
Dear Prof. Vassallo,

I am a part-time student reading for Masters Degree in Health Services Management at the University of Malta (Institute of Health Care). I am going to do my final research project on "Doctor-Patient Communication and Information Giving in the Acute Medical and Surgical Wards", which will be carried out at Mater Dei Hospital and under the supervision of Mr. Michael Bezzina. This study will be carried out in October, 2009.

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Approval for this research was given by the IHC Dissertation Panel and following your approval this will then be submitted to the UoM Research Ethics Committee for their approval.

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Your approval will be highly appreciated.

Yours faithfully,

Jesmond Seychell

Prof. Josanne Vassallo
Diabetes/Endocrinology Consultant,
Mater Dei Hospital,
Tal-Qroqq, Msida.

27th April, 2009.
Dr. Edgar Pullicino  
Gastroenterology Consultant,  
Mater Dei Hospital,  
Tal-Qroqq, Msida.

Dear Dr. Pullicino,

I am a part-time student reading for Masters Degree in Health Services Management at the University of Malta (Institute of Health Care). I am going to do my final research project on “Doctor-Patient Communication and Information Giving in the Acute Medical and Surgical Wards”, which will be carried out at Mater Dei Hospital and under the supervision of Mr. Michael Bezzina. This study will be carried out in October, 2009.

As part of this study, I would like to ask some questions in a form of questionnaire to a number of clients who might happen to be under your care as inpatients at Mater Dei Hospital. I would also like to ask permission to attend ward rounds. Approval for this aspect of the study is also being sought from Dr. Lina Janulova, A/Medical Administrator; Prof. Godfrey Lafera, Chairman of Surgery; Dr. Mario Vassallo, Chairman of Medicine; and Mr. Emanuel Bezzina, Director of Nursing.

Approval for this research was given by the IHC Dissertation Panel and following your approval this will then be submitted to the UoM Research Ethics Committee for their approval.

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Your approval will be highly appreciated.

Yours faithfully,

Jesmond Seychell  
161567(M)  
27th April, 2009.
Dear Dr. Balzan,

I am a part-time student reading for Masters Degree in Health Services Management at the University of Malta (Institute of Health Care). I am going to do my final research project on “Doctor-Patient Communication and Information Giving in the Acute Medical and Surgical Wards”, which will be carried out at Mater Dei Hospital and under the supervision of Mr. Michael Bezzina. This study will be carried out in October, 2009.

As part of this study, I would like to ask some questions in a form of questionnaire to a number of clients who might happen to be under your care as inpatients at Mater Dei Hospital. I would also like to ask permission to attend ward rounds. Approval for this aspect of the study is also being sought from Dr. Lina Janulova, A/Medical Administrator; Prof. Godfrey Lafera, Chairman of Surgery; Dr. Mario Vassallo, Chairman of Medicine; and Mr. Emanuel Bezzina, Director of Nursing.

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Your approval will be highly appreciated.

Yours faithfully,

Jesmond Seychell
161567(M)
Dear Dr. Borg,

I am a part-time student reading for Masters Degree in Health Services Management at the University of Malta (Institute of Health Care). I am going to do my final research project on “Doctor-Patient Communication and Information Giving in the Acute Medical and Surgical Wards”, which will be carried out at Mater Dei Hospital and under the supervision of Mr. Michael Bezzina. This study will be carried out in October, 2009.

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Your approval will be highly appreciated.

Yours faithfully,

Jesmond Seychell
161567(M)
Dear Prof. Montfort,

I am a part-time student reading for Masters Degree in Health Services Management at the University of Malta (Institute of Health Care). I am going to do my final research project on "Doctor-Patient Communication and Information Giving in the Acute Medical and Surgical Wards", which will be carried out at Mater Dei Hospital and under the supervision of Mr. Michael Bezzina. This study will be carried out in October, 2009.

As part of this study, I would like to ask some questions in a form of questionnaire to a number of clients who might happen to be under your care as inpatients at Mater Dei Hospital. I would also like to ask permission to attend ward rounds. Approval for this aspect of the study is also being sought from Dr. Lina Janulova, A/Medical Administrator; Prof. Godfrey Lafera, Chairman of Surgery; Dr. Mario Vassallo, Chairman of Medicine; and Mr. Emanuel Bezzina, Director of Nursing.

Approval for this research was given by the IHC Dissertation Panel and following your approval this will then be submitted to the UoM Research Ethics Committee for their approval.

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Your approval will be highly appreciated.

Yours faithfully,

Jesmond Seychell
161567(M)
Dear Dr. Buhagiar,

I am a part-time student reading for Masters Degree in Health Services Management at the University of Malta (Institute of Health Care). I am going to do my final research project on "Doctor-Patient Communication and Information Giving in the Acute Medical and Surgical Wards", which will be carried out at Mater Dei Hospital and under the supervision of Mr. Michael Bezzina. This study will be carried out in October, 2009.

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Your approval will be highly appreciated.

Yours faithfully,

Jesmond Seychell

161567(M)

27th April, 2009.

Dr. Louis Buhagiar
Nephrology Consultant,
Mater Dei Hospital,
Tal-Qroqq, Msida.

Jesmond Seychell
St. Michael Farmhouse,
Zabbar Road,
Zejtun. ZTN 3806

Approval granted

Dr. Louis Buhagiar

27th April, 2009.
Dear Dr. Farrugia,

I am a part-time student reading for Masters Degree in Health Services Management at the University of Malta (Institute of Health Care). I am going to do my final research project on "Doctor-Patient Communication and Information Giving in the Acute Medical and Surgical Wards", which will be carried out at Mater Dei Hospital and under the supervision of Mr. Michael Bezzina. This study will be carried out in October, 2009.

As part of this study, I would like to ask some questions in a form of questionnaire to a number of clients who might happen to be under your care as inpatients at Mater Dei Hospital. I would also like to ask permission to attend ward rounds. Approval for this aspect of the study is also being sought from Dr. Lina Janulova, A/Medical Administrator; Prof. Godfrey Lafera, Chairman of Surgery; Dr. Mario Vassallo, Chairman of Medicine; and Mr. Emanuel Bezzina, Director of Nursing.

Approval for this research was given by the IHC Dissertation Panel and following your approval this will then be submitted to the UoM Research Ethics Committee for their approval.

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Your approval will be highly appreciated.

Yours faithfully,

Jesmond Seychell
161567(M)
Dr. Mario P. Vella  
Nephrology Consultant,  
Mater Dei Hospital,  
Tal-Qroqq, Msida.

Dear Dr. Vella,

I am a part-time student reading for Masters Degree in Health Services Management at the University of Malta (Institute of Health Care). I am going to do my final research project on “Doctor-Patient Communication and Information Giving in the Acute Medical and Surgical Wards”, which will be carried out at Mater Dei Hospital and under the supervision of Mr. Michael Bezzina. This study will be carried out in October, 2009.

As part of this study, I would like to ask some questions in a form of questionnaire to a number of clients who might happen to be under your care as inpatients at Mater Dei Hospital. I would also like to ask permission to attend ward rounds. Approval for this aspect of the study is also being sought from Dr. Lina Janulova, A/Medical Administrator; Prof. Godfrey Lafera, Chairman of Surgery; Dr. Mario Vassallo, Chairman of Medicine; and Mr. Emanuel Bezzina, Director of Nursing.

Approval for this research was given by the IHC Dissertation Panel and following your approval this will then be submitted to the UoM Research Ethics Committee for their approval.

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Your approval will be highly appreciated.

Yours faithfully,

Jesmond Seychell  
161567(M)

Jesmond Seychell  
St. Michael Farmhouse,  
Zabbar Road,  
Zejtun. ZTN 3806

27th April, 2009.
Dear Mr. Bezzina,

I am a part-time student reading for Masters Degree in Health Services Management at the University of Malta (Institute of Health Care). I am going to do my final research project on “Doctor-Patient Communication and Information Giving in the Acute Medical and Surgical Wards”, which will be carried out at Mater Dei Hospital and under the supervision of Mr. Michael Bezzina.

As part of a triangulation study, I would like to interview 10 Nursing Officers from the Medical and Surgical wards at Mater Dei Hospital. This shall take place in October 2009 and the questions asked will explore these nurses’ opinion on doctors’ communication attitudes towards patients and whether they think doctors are giving enough explanation to the patients about their illness.

A questionnaire to inpatients and a direct observation study on doctors both at Mater Dei Hospital will also make part of this research study. The questionnaire will be related to patient satisfaction with their relationship with doctors during hospitalisation. Approval for this aspect of the study is also being sought from Dr. Lina. Janulova, A/Medical Administrator.

All the tools that will be used in this study were created by the researcher and are based on the literature review. Approval for this research was given by the IHC Dissertation Panel and following your approval this will then be submitted to the UoM Research Ethics Committee for their approval.

I am writing this letter for your approval to allow me to ask clients and nurses at Mater Dei Hospital to participate for my research. I shall be explaining to the patients as well as the staff that their participation will be voluntary and that they have the right to refuse. I shall inform them also that their participation will be anonymous and that if they choose not to participate, it will have no effect on services that they receive from their ward or any other service within Mater Dei Hospital.

Your approval will be highly appreciated.

Yours faithfully,

Jesmond Seychell

ID No. 161567(M)
Ms. Catherine Micallef  
Departmental Nursing Manager,  
Mater Dei Hospital.  

Dear Ms. Micallef,

I am a part-time student reading for Masters in Health Services Management at the University of Malta (Institute of Health Care). I am going to do my final research project on “Doctor-Patient Communication and Information Giving in Acute Medical and Surgical Wards”, which will be carried out at Mater Dei Hospital.

For this study I will need to ask some questions in a form of questionnaire to a number of clients who are inpatients at Mater Dei Hospital. I will also need to interview and observe clinical staff. These questions will be related to patient satisfaction with their relationship with doctors during hospitalisation. Views on this aspect are essential to facilitate a higher level of patient involvement and education, and more guideline-compliant treatment thus achieving better adherence to treatment, shorter hospital stays, better efficiency and cost effectiveness, enhance quality of care, helping patients and doctors use time wisely, decreased risk of malpractice claims, and increased doctor and patient satisfaction.

I am writing this letter for your approval to allow me to ask clients and staff at Mater Dei Hospital to participate for my research. I shall be explaining to the patients as well as the staff that their participation will be voluntary and that they have the right to refuse. I shall inform them also that their participation will be anonymous and that their participation or no participation will have no effect on services that they receive from their ward or any other service within Mater Dei Hospital.

Your approval will be highly appreciated.

Yours faithfully,

Jesmond Seychell

Jesmond Seychell  
St. Michael Farmhouse,  
Zabbar Road,  
Zejtun. ZTN 3806  

22nd April, 2009.
Ms. Isabelle Avallone
Departmental Nursing Manager,
Mater Dei Hospital.

Dear Ms. Avallone,

I am a part-time student reading for Masters in Health Services Management at the University of Malta (Institute of Health Care). I am going to do my final research project on “Doctor-Patient Communication and Information Giving in Acute Medical and Surgical Wards”, which will be carried out at Mater Dei Hospital.

For this study I will need to ask some questions in a form of questionnaire to a number of clients who are inpatients at Mater Dei Hospital. These questions will be related to patient satisfaction with their relationship with doctors during hospitalisation. I will also need to interview and observe clinical staff. Views on this aspect are essential to facilitate a higher level of patient involvement and education, and more guideline-compliant treatment thus achieving better adherence to treatment, shorter hospital stays, better efficiency and cost effectiveness, enhance quality of care, helping patients and doctors use time wisely, decrease risk of malpractice claims, and increase doctor and patient satisfaction.

I am writing this letter for your approval to allow me to ask clients and staff at Mater Dei Hospital to participate for my research. I shall be explaining to the patients as well as the staff that their participation will be voluntary and that they have the right to refuse. I shall inform the patients that their participation will be anonymous and that their participation or no participation will have no effect on services that they receive from their ward or any other service within Mater Dei Hospital. On the other hand the participating clinical staff anonymity and confidentiality will be assured, and that the data that will be provided by them will only be used for the purpose of the research study.

Your approval will be highly appreciated.

Yours faithfully,

Jesmond Seychell

[Signature]

Jesmond Seychell

Approved / Not Approved
Mr. John Cassar  
Departmental Nursing Manager,  
Mater Dei Hospital.

Dear Mr. Cassar,

I am a part-time student reading for Masters in Health Services Management at the University of Malta (Institute of Health Care). I am going to do my final research project on “Doctor-Patient Communication and Information Giving in Acute Medical and Surgical Wards”, which will be carried out at Mater Dei Hospital.

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Your approval will be highly appreciated.

Yours faithfully,

Jesmond Seychell

Approved /Not approved
Ms. Pauline Gatt  
Departmental Nursing Manager,  
Mater Dei Hospital.

Dear Ms. Gatt,

I am a part-time student reading for Masters in Health Services Management at the University of Malta (Institute of Health Care). I am going to do my final research project on "Doctor-Patient Communication and Information Giving in Acute Medical and Surgical Wards", which will be carried out at Mater Dei Hospital.

For this study I will need to ask some questions in a form of questionnaire to a number of clients who are inpatients at Mater Dei Hospital. I will also need to interview and observe clinical staff. These questions will be related to patient satisfaction with their relationship with doctors during hospitalisation. Views on this aspect are essential to facilitate a higher level of patient involvement and education, and more guideline-compliant treatment thus achieving better adherence to treatment, shorter hospital stays, better efficiency and cost effectiveness, enhance quality of care, helping patients and doctors use time wisely, decreased risk of malpractice claims, and increased doctor and patient satisfaction.

I am writing this letter for your approval to allow me to ask clients and staff at Mater Dei Hospital to participate for my research. I shall be explaining to the patients as well as the staff that their participation will be voluntary and that they have the right to refuse. I shall inform them also that their participation will be anonymous and that their participation or no participation will have no effect on services that they receive from their ward or any other service within Mater Dei Hospital.

Your approval will be highly appreciated.

Yours faithfully,

Jesmond Seychell

St. Michael Farmhouse,  
Zabbar Road,  
Zejtun. ZTN 3806

22\textsuperscript{nd} April, 2009.
I am a part-time student reading for Masters in Health Services Management at the University of Malta (Institute of Health Care). I am going to do my final research project on “Doctor-Patient Communication and Information Giving in Acute Medical and Surgical Wards”, which will be carried out at Mater Dei Hospital.

For this study I will need to ask some questions in a form of questionnaire to a number of clients who are inpatients at Mater Dei Hospital. I will also need to interview and observe clinical staff. These questions will be related to patient satisfaction with their relationship with doctors during hospitalisation. Views on this aspect are essential to facilitate a higher level of patient involvement and education, and more guideline-compliant treatment thus achieving better adherence to treatment, shorter hospital stays, better efficiency and cost effectiveness, enhance quality of care, helping patients and doctors use time wisely, decreased risk of malpractice claims, and increased doctor and patient satisfaction.

I am writing this letter for your approval to allow me to ask clients and staff at Mater Dei Hospital to participate for my research. I shall be explaining to the patients as well as the staff that their participation will be voluntary and that they have the right to refuse. I shall inform them also that their participation will be anonymous and that their participation or no participation will have no effect on services that they receive from their ward or any other service within Mater Dei Hospital.

Your approval will be highly appreciated.

Yours faithfully,

Jesmond Seychell
Dear Mr. Bezzina,

I am a part-time student reading for Masters Degree in Health Services Management at the University of Malta (Institute of Health Care). I am going to do my final research project on “Doctor-Patient Communication and Information Giving in the Acute Medical and Surgical Wards”, which will be carried out at Mater Dei Hospital and under the supervision of Mr. Michael Bezzina.

As part of a triangulation study, I would like to interview 10 Nursing Officers from the Medical and Surgical wards at Mater Dei Hospital. This shall take place in October 2009 and the questions asked will explore these nurses’ opinion on doctors’ communication attitudes towards patients and whether they think doctors are giving enough explanation to the patients about their illness.

A questionnaire to inpatients and a direct observation study on doctors both at Mater Dei Hospital will also make part of this research study. The questionnaire will be related to patient satisfaction with their relationship with doctors during hospitalisation. Approval for this aspect of the study is also being sought from Dr. Lina Janulova, A/Medical Administrator.

All the tools that will be used in this study were created by the researcher and are based on the literature review. Approval for this research was given by the IHC Dissertation Panel and following your approval this will then be submitted to the UoM Research Ethics Committee for their approval.

I am writing this letter for your approval to allow me to ask clients and nurses at Mater Dei Hospital to participate for my research. I shall be explaining to the patients as well as the staff that their participation will be voluntary and that they have the right to refuse. I shall inform them also that their participation will be anonymous and that if they choose not to participate, it will have no effect on services that they receive from their ward or any other service within Mater Dei Hospital.

Your approval will be highly appreciated.

Yours faithfully,

Jesmond Seychell
161567(M)
Dear Mr. Bugeja,

I am a part-time student reading for Masters in Health Services Management at the University of Malta (Institute of Health Care). I am going to do my final research project on "Doctor-Patient Communication and Information Giving in an Acute General Hospital in Malta", which will be carried out at Mater Dei Hospital.

For this study I will need to ask some questions in a form of questionnaire to a number of clients who are inpatients at Mater Dei Hospital. I will also need to make a number of in-depth interviews with key personnel such as nursing officers and departmental nursing managers to do my research. These questions will be related to patient satisfaction with their relationship with doctors during hospitalisation. Views on this aspect are essential to facilitate a higher level of patient involvement and education, and more guideline-compliant treatment thus achieving better adherence to treatment, shorter hospital stays, better efficiency and cost effectiveness, enhance quality of care, helping patients and doctors use time wisely, decreased risk of malpractice claims, and not surprisingly, increased doctor and patient satisfaction.

I am writing this letter for your approval to allow me to ask clients attending your unit to fill in my questionnaire. In this phase of the study your patients’ participation is only going to be utilised to test the validity and reliability of the tool and as such the information gathered is not going to be included in the results of the study. I shall be explaining to the patients that their participation will be voluntary and that they have the right to refuse. I shall inform them also that their participation will be confidential and that their participation or no participation will have no effect on services that they receive from their ward or any other service within Mater Dei Hospital.

Your approval will be highly appreciated.

Yours faithfully,

Jesmond Seychell

Approved / Not approved
APPENDIX 2

- Tools used in the study
  - Check list for doctor observation study
  - Communication themes guide and questions used for the structured interviews with ward managers
  - Patient consent form and questionnaire (both in Maltese and English versions)
Checklist for the direct observation study on doctors

1. Friendly welcoming (indicated if doctor: greeting with a smile, called by names or shake hands). Yes □ No □

2. Introductory chat. Yes □ No □

3. Ensured privacy of consultation. Yes □ No □

4. Asked about symptoms. Yes □ No □

5. Inquired about diet compliance. Yes □ No □

6. Inquired about medicine compliance. Yes □ No □

7. Inquired if patient had any adverse events to medicine. Yes □ No □

8. Inquired about risky habits (such as smoking or alcohol consumption). Yes □ No □

9. Performed physical examination. Yes □ No □

10. Encouraged the patient to ask questions. Yes □ No □

11. Paid attention to the patient. Yes □ No □

12. Performed eye contact with the patient while talking. Yes □ No □

13. Did some gestures to encourage patient to continue (such as head nodding, vocal intonation etc.). Yes □ No □

14. Advised on healthy life. Yes □ No □

15. Emphasised on patient’s understanding and follow up. Yes □ No □

16. Emphasised on blood sugar control (if patient is diabetic). Yes □ No □

17. Described how to use medicine. Yes □ No □

18. Friendly closing and fare well. Yes □ No □

19. Consultation length (in minutes) 0-3 min 4-7 min 8-11 min >12 min
Doctor-patient communication theme guide used during the structured interviews with ward managers

<table>
<thead>
<tr>
<th>Interpersonal skills</th>
<th>Welcoming</th>
</tr>
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<tbody>
<tr>
<td>Doctor respects privacy</td>
<td></td>
</tr>
<tr>
<td>Asks patients about their symptoms</td>
<td></td>
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<tr>
<td>Doctor listens carefully to patients</td>
<td></td>
</tr>
<tr>
<td>Doctor performs eye contact</td>
<td></td>
</tr>
<tr>
<td>Doctor encourages patients to speak</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Facilitation skills</th>
<th>Doctor explains his treatment plan to patient</th>
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<tbody>
<tr>
<td>Doctor encourages patient to ask questions</td>
<td></td>
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<tr>
<td>Explains things in a way patient could understand</td>
<td></td>
</tr>
<tr>
<td>Asks patient’s consent for examination in front of students</td>
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</table>

<table>
<thead>
<tr>
<th>Medical &amp; Healthy living information</th>
<th>Doctor inquires about patients’ diet</th>
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<tbody>
<tr>
<td>Doctor inquires about patients’ risky habits</td>
<td></td>
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<tr>
<td>Doctor performs physical examination</td>
<td></td>
</tr>
<tr>
<td>Doctor gives information about patient’s disease</td>
<td></td>
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<tr>
<td>Doctor inquires about home medication</td>
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<table>
<thead>
<tr>
<th>Treatment &amp; Medicine information</th>
<th>Doctor inquires if medicine was taken regularly</th>
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<tbody>
<tr>
<td>Discusses the newly prescribed medicine with patient</td>
<td></td>
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<tr>
<td>Doctor asks if patient was allergic to any medicine</td>
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<tr>
<td>Doctor asks patient’s approval of prescribed medicine</td>
<td></td>
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<tr>
<td>Doctor explains carefully how to use the medicine</td>
<td></td>
</tr>
<tr>
<td>Doctor described the possible side effects</td>
<td></td>
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<tr>
<td>Doctor explains what to do in case of adverse events</td>
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<thead>
<tr>
<th>Technical &amp; Empathy skills</th>
<th>Doctors are polite and courteous</th>
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<tbody>
<tr>
<td>Doctors are very competent in their work</td>
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<tr>
<td>Doctor asks patient whether help is needed at home</td>
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<tr>
<th>Written information</th>
<th>About medication and treatment</th>
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<tr>
<td>How to deal with the illness (if symptoms persist or get worse)</td>
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<tr>
<td>Things to do and what to avoid (Eg. Exercise, diet, altitudes or atmospheric pressures, etc….)</td>
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| Consultation time | How much did the doctor spend near the patient? | Yes / No |
Other questions asked to ward managers during the structured interviews

1. I want you to discuss your opinions and views on the type of communication/interaction that the patients are having with their doctors (with regards to information on their condition, on treatment, partnerships, written information, empathy, and all you could imagine on communication. It is an open interview and I want you to feel at ease and free to talk. I want to hear from you any kind of doctor-patient interaction that you experienced while you were doing ward-rounds with doctors.

2. What did you like and what you did not like?
   (Researcher observation checklist for doctors at hand to check variables for: welcoming, consultation privacy, attention, eye contact, encouraging questions asking, information on diagnosis/disease, consultation length).

3. What is your opinion about the provided care?
   (History taking, physical examination and involvement in the selection of treatment prescribed)

4. What are your suggestions to improve the quality of doctor interaction with the patients during ward rounds?
Formula t’Aċċettazzjoni (Pazjent/Klijent)


Il-partecippazzjoni tiegħek hija waħda volontarja, u int m’għandek l-ebda obbligu li tippartecippa u għandek ukoll id-dritt li tieqaf jekk inti tagħżel hekk anke jekk tkun diġa’ aċċettajt. Li tippartecippa jew le, bl-ebda mod ma jaffettwa s-servizz li int u l-familja tiegħek tirċievu mill-qasam tas-Saħħa.


Firma tar-ričerkatur Data
Il-Komunikazzjoni bejn it-tabib u l-pazjent
Kwestjonarju fuq l-opinjoni tal-pazjent

Sezzjoni A

Billi tagħmel ċirku madwar in-numru maġħżul, għati valur lil kull aspett ta’ komunikazzjoni li inti kellek mat-tabib (fuq skala bejn 1 u 5) meta kont pazjent go dan l-isptar;
Fejn:

1 = Ma naqbilx kompletament
2 = Ma naqbilx
3 = Ma nafx
4 = Naqbel
5 = Naqbel perfettament

Jekk jgħoġbok immarka kif thoss li hu xieraq għalik:

1. It-tabib introduċa lilu nnifsu b’mod dħuli. (indika jekk it-tabib: laqakx bi tbissima, sejjahlekx b’ismek jew ħadlekkx b’idejk)


3. It-tabib ħegġijgni biex nesprimi dak li kont qed inħoss.

4. It-tabib kien attenti għal dak kollu li kont qed ngħidlu.

5. It-tabib interessa ruħu ħafna fuq il-bżonnijiet li kelli.
6. It-tabib kien ihares f'ghajnejja waqt li jien kont inkellmu.

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7. It-tabib kien jagħmel mossi li bihom kien jinkorağġini nkompli nitkellem (ičaqlaq rasu u jkompli miegli).

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10. It-tabib kien isaqsini jekk kellix xi mistoqsijiet fuq dak li kien jghidli.

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11. L-informazzjoni li kien itini t-tabib kienet tqawwini ħafna u kont inħossni ħafna ahjar.

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12. L-informazzjoni li tagħni t-tabib ghenitni biex intaffi ftit mill-problemi tal-mard tieghi.

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1 2 3 4 5

15. Il-kura li rċivejt mingħand it-tabib għenitni biex infieq malajr.

1 2 3 4 5

16. It-tabib ġab ruħu tajjeb.

1 2 3 4 5

17. It-tabib staqsieni fuq it-tip ta’ ikel li kont niekol (ħlewwiet, imluha, xafmijiet etc.).

1 2 3 4 5

18. It-tabib staqsieni jekk kelliex xi vizzji li huma ħżiena għal saħhti (bħal tipjip u xorb żejjed)

1 2 3 4 5

19. It-tabib tagħni parir kif nista’ nghix ħajja b’saħħitha.

1 2 3 4 5

20. It-tabib eżaminani.

1 2 3 4 5


1 2 3 4 5
22. It-tabib staqsieni jekk kontx qed nieħu l-medicina regolari qabel ma dhalt l-isptar.

1 2 3 4 5

23. It-tabib iddiskuta mieghi x’tip ta’ medicina kien ser jordnali.

1 2 3 4 5

24. It-tabib staqsieni jekk xi darba kellix xi tip ta’ allergija kontra xi medicina partikulari.

1 2 3 4 5


1 2 3 4 5


1 2 3 4 5

27. It-tabib spjegali l-effetti ħżina li jista’ jkollhom il-medicini li ordnali.

1 2 3 4 5

28. It-tabib spjegali x’nista’ nagħmel f’każ li l-medicini jahdmu ħażin fuqi.

1 2 3 4 5

29. It-tabib kien prudenti u meqjuż fl-attaqjament tiegħu.

1 2 3 4 5
30. It-tabib kien kompetenti ħafna fix-xogħol tiegħu.

1  2  3  4  5 

31. It-tabib wera' l-htieġa li jien fhimt sew dak li kien qed ġhidli.

1  2  3  4  5 

32. Meta kont l-isptar it-tabib kien jistaqsini jekk kellix l-ghajnuna meħtieġa meta kont se nkun lura d-dar.

1  2  3  4  5 

33. Waqt li kont l-isptar, it-tabib tani informazzjoni bil-miktub dwar is-sintomi u problemi oħra tas-saħħa li jien kelli noqgħod attent/a ġhalhom meta noħрош mill-isptar.

1  2  3  4  5 

34. Xi kemm kienet iddum il-vista tat-tabib?

0-3 minuti  4-7 minuti  8-11 minuti  >12 minuta
Sezzjoni B

35. Fil-fhema tiegħek, inti ħrigt sodisfatt bis-servizz fuq l-aspett ta' komunikazzjoni li kellek mat-tabib?
Jekk jgħoġbok ikkumenta fuq xi aspett jew ġrajjja li gratlek u li marret kontra l-aspektativi tiegħek.

__________________________

__________________________

__________________________

36. Fl-opinjoni tiegħek, x'taħseb li jista' jitranġa jew inkella jigi ntruducut sabiex il-komunikazzjoni bejnek u t-tabib titjieb?

__________________________

__________________________

__________________________
Sezzjoni Ċ

Jekk Jgħoġbok immarka b’ X fejn jaqbel għalik.

37. Eta’: ____________  
38. Sess  
  Raġel: Mara:  
39. Stat  
  Ġuvni/Xebba: Miżżewweġ/a: Armel/Armla:  
40. Kif tgħix id-dar?  
  Waħdek: Mal-familja: Ġo stituzzjoni:  
41. Levell ta’ Edukazzjoni:  
  Primarja: Secondarja: Terzjarja:  
42. Kemm ilek/domit għall-kura fl-isptar? ________________  
43. Meta kont l-aħħar ġo dan l-isptar bħala pazjent/a? ________________  
44. Għandek tabib tal-familja? IVA LE  

GRAZZI HAFNA tal-ħin li ħadt biex timla’ dan il-kwestjonarju.
Consent Form (Patient/Client)

I am Jesmond Seychell, a Health Services Management student and my research project is “Doctor-Patient Communication and Information Giving”. The client is an important part in the evaluation of a service. From this study, the client will provide information that might enable the researcher to identify areas within the service where doctor information delivery can be improved. The information obtained will aid in an attempt to improve the quality of doctor communication by identifying any weaknesses in this aspect and thus improve the satisfaction of our clients.

The appropriate personnel from Mater Dei Hospital and the Board of Studies of the University of Malta have approved the study and its procedures. The study procedures involve no foreseeable risks or harm to you or your family. The procedures include the filling in of a questionnaire which is available in English and Maltese. You are free to ask any question about the study.

Your participation in this study is voluntary; you are under no obligations to participate. You have the right to withdraw at any time. Your participation or non-participation will have no effect on the services you or your family receive from the health care sector.

You may note that the questionnaire contains no identity information and therefore your participation will be anonymous. Moreover, any data collected will be treated in strict anonymity/confidentiality, as applicable and in such a manner that it cannot trace the individual subject. All the study data will be used for the study research purpose only and will be destroyed immediately after publication of the results.

Researcher’s signature and date
Doctor-Patient Communication
Patient Perception Questionnaire

Section A

Please rate the following aspects of doctor communication as experienced by you during your stay in this hospital.
Give each statement a score of between 1 and 5, where:

- ☒ = 1 = Strongly Disagree
- ☐ = 2 = Disagree
- ☐ ☐ = 3 = Do not know
- ☐ ☒ = 4 = Agree
- ☒ ☒ = 5 = Strongly Agree

Please circle the number that you feel appropriate:

1. The doctor had a friendly welcoming *(indicate if doctor: greeted you with a smile, called you by name or shake hands).*
   
   1 2 3 4 5

2. The doctor ensured of my privacy during the consultation *(closed the room or curtain).*
   
   1 2 3 4 5

3. The doctor asked about my symptoms.
   
   1 2 3 4 5

4. The doctor listened carefully to what I had to say.
   
   1 2 3 4 5

5. The doctor was attentive to my needs.
   
   1 2 3 4 5
6. The doctor performed eye contact while I used to talk to him.

7. The doctor did some gestures to encourage me to continue speaking (such as head nodding, vocal innocation etc.).

8. I felt understood by the doctor.

9. The doctor explained his/her plan for helping me to recover.

10. The doctor encouraged me to ask questions.

11. The information received from my doctor improved my attitude and how I feel about myself.

12. The information I received from the doctor has helped me to deal more effectively with my problems.

13. The care I received from the doctor has improved my general health.
14. During my hospitalisation, the doctor explained things in a way I could understand. 

1 2 3 4 5

15. The care I received from the doctor has helped me to recover faster. 

1 2 3 4 5

16. The doctor was well presented. 

1 2 3 4 5

17. The doctor inquired about my diet (carbohydrates, fats, salty food, etc.). 

1 2 3 4 5

18. The doctor inquired about risky habits (such as smoking and alcohol consumption). 

1 2 3 4 5

19. The doctor advised on healthy lifestyle. 

1 2 3 4 5

20. The doctor performed physical examination. 

1 2 3 4 5

21. The doctor inquired if I was taking any medicine. 

1 2 3 4 5
22. The doctor inquired if I was taking my medicine regularly before I was admitted in hospital.

1 2 3 4 5

23. The doctor discussed the type of medicine that s/he was going to prescribe for me.

1 2 3 4 5

24. The doctor inquired if I have ever had any adverse events to a particular kind of medicine.

1 2 3 4 5

25. The doctor asked me if I agreed with the kind of medicine s/he was going to prescribe for me.

1 2 3 4 5

26. The doctor explained to me carefully how to use the medicine he prescribed.

1 2 3 4 5

27. The doctor described the possible side effects of the medicine he prescribed.

1 2 3 4 5

28. The doctor explained to me carefully what I should do in case of an adverse reaction to the medicine.

1 2 3 4 5

29. The doctor was polite and courteous.

1 2 3 4 5
30. The doctor was very competent in doing his/her work.
   
   1  2  3  4  5
   ☑  ☐  ☑  ☑

31. The doctor emphasised on my understanding.
   
   1  2  3  4  5
   ☑  ☐  ☑  ☑

32. During my hospital stay, the doctor talked with me about whether I would have the help I needed when I left the hospital.
   
   1  2  3  4  5
   ☑  ☐  ☑  ☑

33. During my hospital stay, the doctor gave me information in writing about what symptoms or health problems to look out for after I left the hospital.
   
   1  2  3  4  5
   ☑  ☐  ☑  ☑

34. About how much did the consultation with the doctor take?
   
   0-3 minutes  4-7 minutes  8-11 minutes  >12 minutes
Section B

35. As a whole, were you satisfied with the type of communication offered to you by the doctor? Please comment on any aspect or event which went against your expectations during your stay in hospital.

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________

36. In your opinion, is there anything with the doctor-patient communication that could be changed and/or introduced to improve or optimise the interaction?

__________________________________________________________________________

__________________________________________________________________________

__________________________________________________________________________
Section C

Please mark with an 'X' where applicable.

37. Age: ___________

38. Sex

Male: Female:

39. Status

Single: Married: Widow/er:

40. How do you live at home?

Alone: With the family: In an institution:

41. Level of Education:

Primary: Secondary: Tertiary:

42. For how long have you been here in hospital? ___________

43. When was your last hospitalisation? ___________

44. Any regular/family physician? YES NO

THANK YOU
for your time and cooperation in completing this questionnaire.
APPENDIX 3

• Statements derived from the Structured interviews

Communication Themes:
- Interpersonal skills
- Facilitation skills
- Medical information skills
- Treatment information skills
- Technical and empathy skills
- Consultation length
INTERPERSONAL SKILLS

This theme included doctors’ communication characteristics like: welcoming, respecting patients’ privacy, asking patients about their symptoms, listening carefully to patients, performing eye contact, and encouraging patients to speak.

WARD MANAGER 1:

'Some doctors never introduce themselves to the patient. Sometimes I interfere and introduce the patient to the doctor saying this is Mr. so and so. There are some doctors who do not even touch the patient. There were times where the doctors would fool around with the patient.'

‘With regards to privacy if the nurse would not close the curtain, the doctors would not bother to close it, so there is not privacy during ward rounds. For me the priority before the doctor starts to see the patient, is the closing of the curtain around the bed. If the team does not fit inside the bed area it is up to them but the privacy of the patient comes first. The doctor starts to lift up the patient’s clothes before the area is being curtained – if you give him the chance to see the patient in the middle of the corridor he would do so as well’

‘However from behind this simple curtain everyone could hear you just the same and so you cannot practice hundred percent privacy’

When this ward manager was asked whether the doctors ask the patients if it is ok with them, if the doctors examine them in front of the whole team, the answer was:

'No, certainly not. Lately I heard that a patient refused to be examined in front of a number of medical students and the consultant was very angry with her telling her that in that case she would not be seen by the firm. This happened at the out-patients department and she was a breast patient - she had no other alternative but to be seen against her wish.'

‘There is one particular doctor who is very rude and rough; he always shouts during the ward round saying that he is the boss in here – he is only a senior doctor by the way'
WARD MANAGER 2:

'Interaction depends on the individual characters of the doctors. There are doctors and doctors. This depends on how hurried the doctor is and in fact this depends on the time constraints. This is the main problem to good interactions. Only 40% perform a good interaction. The patient sometimes says how the doctor came, told him a few words and left'

'With regards to privacy yes the doctors adhere to privacy and use curtains and I can tell that 85% of the doctors use privacy'

WARD MANAGER 3:

'The doctor does not always introduce himself to the patient, but I will make it a point to introduce the doctor to the patient if this is missing.'

'With regards to privacy it has to be the nurse to close the curtain. I think they expect the nurse to do it. Ok the curtain is closed but rest assured that if the patient next to the one being seen by the doctor is watching tv, then he switches it off to make sure he hears what the doctor says to the patient next to him.'

'Although doctors are more aware on hygiene, it has to be the nurse to remind the doctor.'

'Yes doctors do care about the needs of the patients. Although they have more errands to do in this hospital, but they still are available as much as the patient wants.'

WARD MANAGER 4:

'Doctor characteristics during ward rounds depend on the doctors. For example there are doctors who start shouting at the patients, for example, if the doctor tells the patient not to smoke and the patient continues to smoke, the doctor starts shouting and stamping his feet. There are other doctors who are more diplomatic and speak slowly. On the other
hand, there are consultants that if the patient asks them anything, the doctor feels that he is being threatened. We had a recent event in which a patient, who was somewhat arrogant, told the doctor whether he was going to remain in that situation; that is always taking Panadols and still remaining with headaches. The patient said this a few times to this particular doctor. The doctor called immediately the police. The police were in the ward in no time for nothing (because the patient was neither aggressive nor threatening).

'Yes the doctor introduces himself to the patient most of the time.'

'Regarding privacy during ward round the doctor respects privacy but it is us nurses to close the curtain. The consultant never runs the curtain around the beds of the patients; it is our duty and culture to do that.'

'Yes the doctor listens to the needs of the patient and they do make eye contact with the patient. They also give time for the patient to speak.'

WARD MANAGER 5:

'We are doing a huge role at the moment. I do not want to say that we are ordering doctors to do things but sometimes if nurses do not push the doctors to take certain actions, like for example if we are going to take certain blood investigations for particular patients? Especially for INRs and serum potassium where such patients are being given particular treatments to correct their serum levels. Others could be: Are we going to stop IVI and change to oral fluids? Are we going to stop IV antibiotics and continue on oral treatment?'

WARD MANAGER 6:

'Most of the doctors introduce themselves. If they don't I will do it for them.'

'They make sure that they adhere to privacy, they always close the curtain and is normally done by the SHO. The thing that annoys them is the acute area where they have to move the relatives out of the room all the time. Acute area is disastrous; if you have a psychiatric consultation the others would hear the conversation, so the doctor and patient
move out in a separate room. Even to discuss a surgical case, the doctors do sometimes get the patient out of the acute area to discuss the situation privately."

‘With regards to symptoms and patients’ needs, yes they are very caring.’

‘Eye contact is practiced most of the time.’

‘Checking for patient encouragement to speak up and for his understanding is not always done.’

‘Doctors sometimes act like children; they clash and argue between themselves on simple things like for example on patients who belong to their firm are and others that are not. Junior doctors are more comprehensive perhaps due to the new culture. I just tell them not to change their attitudes whilst they progress in their career.

WARD MANAGER 7:

‘Today doctors are giving a lot of information to the patient on everything; their condition, what is going to happen….everything.’

‘With regards to information and communication, I can tell you that it is more of a problem with us nurses that doctors lack their communication rather than with the patient. Sometimes they just write on the file and that is it. We have to constantly watch what is written in the file. They have to be more collaborative to improve continuity of care.’

‘The doctors do not always introduce themselves to the patients.’

‘Privacy is not always respected by the doctors and for the majority of times it has to be the nurse who will curtain the area for privacy.’

‘Doctors listen to their patients. There are particular patients who are very familiar with the doctors as they are frequently admitted here so the doctors are more confident with them.’
'Eye contact is not always practiced but mostly yes. Some of the doctors are more inclined to direct their attention to the students rather than to the patients.'

'Doctors do ask their patients whether they had understood and ask them to speak up.'

WARD MANAGER 8:

'Most of the time doctors do introduce themselves with the patients. With regards to privacy, doctors use the curtain around the bed. The thing is and I do not agree with this, that when a doctor needs to give bad news to the patient about his condition, the doctor just says it no matter who is listening behind the curtain (other patients and relatives would hear almost everything).'

'When there is a ward round, the consultant goes near the patient and talks with him for a short time but later on the senior doctors would normally take more time near the patient and give him detailed information of what is really happening. I am speaking of my present ward now.'

'There are consultants who do not even look at the patients' eyes when they speak to them. But I admit that the majority of them would look at their patients' eyes while communicating with them.'

'After the senior doctors would have spoken to the patients, these would normally tell the patients that they would return to them in another instant to check for any queries.'

WARD MANAGER 9:

'Bed side manners vary from one person to another and from one firm to another; there may be different characters involved and also previous encounters. For example, if a patient knows the doctor personally or if the patient goes to visit the doctor at a private clinic the approach here at the hospital would be different from that of other patients.'

'During ward rounds not all the doctors introduce themselves to the patients, only half of the consultants do this.'
‘All consultants respect privacy towards patients.’

‘Mostly all doctors listen attentively to the patients. Only one consultant from the four consultants present in this ward does not have the appropriate bedside manners. This particular doctor has the tendency of listening to himself.’

‘They do not often encourage patients to speak, but the majority involve the patients in discussion. Doctors do not only see their symptoms but also explore a bit further. If I see that certain patients are not participating or not understanding I will make sure that this would be taken care of.’

‘With regards to privacy during physical examination, normally the consultant introduces his medical students to the patient. Then the consultant would go ahead examining the patient without requesting consent from patient. It is very rare that the consultant asks for request from the patient before examining her in front of his entourage. There were times where a patient refused to be examined in front of these medical students but this also depends on the patient. Normally it comes automatically that a patient will not object if the consultant simply informs the patient that those students are there to learn.’

‘Once we had a patient who had some complications post procedure. After we sent her home, she had some complications and consulted with her consultant privately from home and was admitted as a direct admission. Desired investigations were taken and because the consultant did not come to the ward, this patient remained with no results of those investigations. In the meantime other complications arose and everyone was involved as things got worse with the patient. I phoned the doctors to inform them about the case and they ignored my request to see the patient. Then I had to put my foot down and told them I am holding them responsible for the condition of the patient. After having said this, they said they will come when they have the chance.’

‘We have similar cases where I feel that it is not fair. Doctors ignore our concerns for the patient as they doubt our assessment on the patient. Sometimes patients end up in intensive care because the doctors ignore the nurses’ concern for the patients.’
WARD MANAGER 10:

‘There are doctors who introduce themselves to patients and there are others who do not. This applies also to privacy and the average of consultants respecting privacy is 40%. The doctor is very limited to listen to the patient. If the patient needs to say something it is not always possible that he is given the opportunity to do so. This is practiced with 60% of consultants.’

‘Doctors do practice eye contact but sometimes I wonder that the doctors’ focus is not actually on the patient but on the notes that they have in front of them. The majority of doctors do eye contact.’
FACILITATION SKILLS

This theme included doctors' communication characteristics like: explaining the treatment plan to the patient, encouraging the patient to ask questions, explaining things in a way the patient could understand, and asking the patient for consent to be examined in front of medical students.

WARD MANAGER 1:

'Once there was a patient with an extensive wound and as soon as the consultant saw her he started shouting saying he needed a chair because he was feeling drowsy and was going to faint. The patient could not see her wound because she had an incision from here to here (participant indicating the area of incision). The consultant told the patient that her wound looked like a shark bite. This scenario obviously caused the patient to get more anxious and distressed'

The consultant said that he would better go and have some coffee. To tell you the truth when I saw this patient I remained like this (participant making facial expressions showing astonishment), but I would never have reacted in that way in front of the patient as we are here to reassure patients and not making them anxious.'

'Sometimes we as nurses would bring the attention of the consultant that the patient is still speaking to him/her and that the patient still needs to clarify some things. Sometimes even when they discharge patients, they would project unclear and incomplete statements, with the patient ending up confused and unsure of what is happening.'

'With regards to language, the doctors adapt very well according to the needs and understanding of the patient. If the patient speaks Maltese they speak Maltese, if the patient speaks in English, they speak in English. If the doctor is foreigner and speaks English, he/she would ask someone to translate to the patient in Maltese.'

'I can only witness one particular doctor who is very diligent. The doctor had sat near the patient and had a good talk with the patient; making sure that the patient understood everything, making sure that the nurse took notes of what has been said, re-checked whether the patient understood. In fact this was a foreign doctor and came here not for our patients, but for patients admitted here as 'outliers'.
WARD MANAGER 3:

‘The majority of doctors clearly explain to their patients what plans they have in mind.’

‘Sometimes the patient continues to say yes, meaning that he is understanding but in fact he is not understanding anything. In instances like this the doctors continue to speak and so some information could be missed out by the patient. However some patients prepare a check list of questions they want to ask to the doctor and in my opinion this is a very convenient way to doing things.’

‘No the consultant never asks consent to the patient in order to examine him in front of medical students. Rather to make things worse they (medical students) even come to visit the patient while the patient is resting or sleeping in the afternoon .......And students come here in dozens to see the same patient especially if it is an interesting case. This is not fair on the patient so I have to intervene especially if the patient does not feel comfortable to refuse.’

WARD MANAGER 4:

‘I have never heard of any doctor asking permission from the patient for the doctor to examine him in front of the medical students.’

WARD MANAGER 6:

‘Nowadays the doctors are more aware of informed consent and in fact they are changing the consent form specifically for all procedures. This is being done to explain more in detail the procedure to the patient.’

‘Yes doctors explain well in layman’s terms to the patient and try to be simple in their explanations.’

Physical examination is done in front of everybody (medical team). Sometimes consultants do ask patients if it would be ok for students to be present during physical
examination – they just say “I have two students do you mind if they stay during examination?” – two students would be ‘per modo di dire.’

WARD MANAGER 7:

‘Doctors not always speak in simple terms with their patients. I admit they try to get down to patient’s level but in my opinion it is not enough and they need to work harder on this. May be they do not have enough time to communicate more or may be that the patient is finding it hard to understand. Then information has to be repeated again by us.’

‘Consent from the patient is never asked by the consultant for physical examination to be held in front of medical students. No I think doctors believe it is their right to do it.’

WARD MANAGER 8:

‘In front of the patients, doctors do discuss what they are going to do but it is obvious that certain patients do not understand a word of what is being said in front of them. It is clearly visible that doctors are excluding their patients from discussions that relate to their own health issues.’

‘Patients are being put aside by the doctors – this is not fair for patients because there might be patients who wish to refuse to undergo certain procedures or treatments being suggested by the doctors. There might be patients that are already dealing with their problem privately with their consultant of choice, so the lack of communication between the ward doctor and the patient would result wasting useful resources.’

‘I have seen patients who were referred to Boffa Hospital (Oncology Hospital) without their knowing about the referral and why they were going there. Tests results are not always revealed to the concerned patients by the doctors. Patients only come to know about their condition when the name Boffa Hospital is mentioned as this is related to cancer. Doctors need to be clearer and open with the patients while planning their treatment intervention.’

‘Doctors do go down to the patients’ level of understanding.’
‘Characters vary from one doctor to another. More yes than no patients have less information about their condition and treatment. We had consultations for patients to be seen by gynaecologists without the patient being aware of what is happening and why they had been referred to Gynae. They only came to know before they were being escorted to the Gynae Ward.’

‘Before examining the patient, the doctor usually asks the patient for consent especially when there are lots of medical students present. Most of the time the patient would not feel comfortable to say yes but because the patient normally feels that he or she is obliged to the doctor as they need their doctor to get cured, then they approve. On the other hand despite doctor asking for consent, they just do it to make it formal in front of students, as in reality consultants pretend that their patients would not object.’

‘The thing is that for the patient to get some sort of information about his condition, it has to be the nurse. Even the relatives, the information which is given to them is very limited. If the relatives and patients do not ask, they would not acquire information. If a patient goes to see a doctor privately he might get the information needed but otherwise one has to repeatedly ask the doctor to get this information.’

WARD MANAGER 9:

‘Doctors do keep their patients up to date on the treatment plan. If it is not a ward round day, the junior doctors will just say to the patients that everything is going to continue the same. They usually wait for the consultant to elaborate on the condition of the patient.’

‘We have two consultants that go down to the level of the patient. Another consultant gives information to the patient but his way of speaking and wording is difficult for the patient to understand. The fourth consultant however explains in such a rush that the patients do not understand anything; however the latter does offer patients to explain further if they request him to do so.’

WARD MANAGER 10:

‘Nowadays ward rounds are very hurried and doctors’ time is very limited. Doctor interaction with patient needs to be improved of course. Moreover when doctors speak to
the patients it is not always understandable and quite often patients come to us and tell us to explain what the doctor meant.'

'The doctor explains to the patient about his condition but does not give the patient the whole picture. Recently there was a patient who was going to be discharged and the patient was the last person to know. Most of the times the junior doctors have a more conscious approach and better ways how to deal with the patients than consultants have.'
MEDICAL INFORMATION SKILLS

This theme included doctors’ communication characteristics like: inquiring about patients’ diet, inquiring about patients’ risky habits, performing physical examination, giving information about patients’ disease, written information, and inquiring about home medication.

WARD MANAGER 1:

‘It depends, sometimes yes and sometimes no. More often the doctors discuss the case with us as nurses on what they are going to do rather than with the patient’

‘No they do not give information to the patient; they normally give the information to the relatives. We are still not in a culture of telling the patient the truth about his/her illness, the plan and direction. The patient is the last person who is involved....and than the patients starts to ask and when he/she starts to ask may be the patient would get some sort of information and he/she would be lucky to get the full information’

‘Another thing is the consent form. Sometimes the patients just sign the consent forms without even knowing what they are signing for. Sometimes this is signed within the last minute just before the patient will be taken to theatre because the doctors forget to do it; meaning that sometimes they do not even explain what they are about to undergo and therefore abstain the patient from reflecting or may be changing his/her mind about the procedure. Another thing about the anaesthetist; he just comes, asks for the patients file and does the pre-op according to the file without even meeting the patient.

‘There is another thing we need to consider: if the doctor has already seen the patient in his private clinic we do not know; perhaps the doctor already explained and gave all the information during the private consultation’

‘About the diet: they just tell the patient how fat they are but at least lately they are suggesting the patients to be seen by nutritionists and also referring them to dieticians – a culture that is slowly growing’
WARD MANAGER 2:

'The doctors never tell the patient that he needs a certain diet and gives it in writing or
tells the nurse to give him a specific diet. Only one doctor has ever told me to give a
patient a diet with a certain amount of calories'

'Usually they refer the patients to a dietician'

'If you have a cancer in your lungs, the doctor just tells the patient that he has an
inflammation and we will see what this inflammation is. The routine way of doing things
around here is that the doctors do not tell the patient what the reality is but if the patient
corners the doctor perhaps he/she will get some information but normally the doctors ask
the relatives first before giving such information. This means that the wife, children and
everyone will know about the condition except the patient. Sometimes you see the
patient's wife standing behind the patient making signs to the doctor not to tell the
patient. The theory behind this is that the doctors want their patients to keep on fighting
the disease and they believe that if you tell the patients what they have they might give up
and die. This does not mean that everyone is the same. I have talked to many patients
who have accepted their condition. I mean why keeping the patient in the dark when you
can give the patient a chance to make certain arrangements while the patient is still alive.
By the way, this kind of behaviour is practiced by all doctors working here.'

'What! Written information? The patients need to cry to obtain some kind of
information. If the relatives do not come and ask for any investigation results, no they
would not obtain any information. If the doctor approaches the patient to get some blood
sampling and the patient asks which sort of investigation is being tested, the doctor just
answers, but with regards to result the doctor never gives results unless the patient asks
for it once again. You have to literally push on the doctors to obtain any information.
Written information is out of the question. If the patients want to get information they
just go and search for it but the doctors never give such information'

'I am very sorry to say that there is no individualised care'

'Physical examination – yes they all do a thorough physical examination to the patients.
Doctors obviously differ on physical examination according to the patients' condition.'
WARD MANAGER 3:

‘With regards to doctor-patient communication, nowadays things have changed. Today a doctor passes on more information to the patient and feels obliged to do this as contrary to the past.’

‘This is not possible when the relatives interfere with them demanding to do otherwise. However the doctors inform the relatives that this is unethical. If the patient asks specifically for information, the doctor always gives the information requested but in a more subtle way.’

‘Risky habits, usually yes they ask on risky habits but sometimes they used to miss out on asking patients on risky habits. Once we had a 92yr old patient admitted with pancreatitis, he was up and about and when he was about to be discharged we recommended his relatives that it would be better if he does not drink alcohol. Only then we came to know as the relatives told us that the patient used to drink around a bottle and a half of whisky everyday before he had been admitted to hospital.’

‘About dietary needs the patient is normally referred to the dietician.’

‘About written information the doctors never give written information apart from the discharge letter. If it would be the case we just print out a standard diet for example a fat-free diet or a low protein diet……sometimes we just call the dietician for a referral.’

WARD MANAGER 4:

‘No the doctors never inquire on patients’ diet. There were times where the doctor just points out a packet of biscuits on the bed table and tells the patient to avoid eating lots of biscuits. Otherwise I have never heard them telling the patient do not take this or that.’

‘Yes they tell them about smoking and other risky habits.’

‘Physical examination not always takes place. This depends with what condition the patient had been admitted to hospital. For example if the patient has been admitted with
Diplopia the doctor does not need to examine the whole patient, but he just needs to examine his eyes.’

WARD MANAGER 5:

‘Other type of written information is not given by doctors. They just give them the prescription forms and discharge letters. This is mostly dependable on the social background of the patient. If the patient gives the impression that he or she is knowledgeable, the doctor’s attitude will change and will give his utmost on all the information requested by the patient. But if the patient is quiet and asks nothing then the doctor just moves on without elaborating on information.’

‘Written information on diet and exercise are never given by doctors.’

WARD MANAGER 6:

‘Inquiring about the diet is done by doctors especially for fat free diet.’

‘Risky habits are inquired mostly in cardiacs and biliary and even in intestinal problems where they are explained in simple terms.’

‘Physical examination is performed but the chest is very rarely checked. It is only checked when the patient has a temperature or being on any respiratory treatment for example inhalers.’

‘Doctors do not like it when a relative approaches them and asks them to keep information away from the patient. The doctors would reply that they will take it into consideration but if the patient asks they are obliged to give the information requested. They will explain to the relatives that it is not fair to keep information away from the patient. When doctors do give information to the patient they do not do it so bluntly and just give the information in a fine way by explaining in simple terms.’
'Not all patients react the same to the information given and so the doctors tailor their information according to the patient. It is a pity that we still find people (patients) who are so illiterate and take very long to understand even in the simplest terms. You can find patients with whom you can talk and cope. There are other patients who make things difficult and doctors have to explain why they did this and not that and they still refuse to believe. There are others who get upset when certain information is given to them. There are patients who shut down and the relatives have to deal with the situation. I believe that the giving out of information must be packaged according to the patient.'

'Written information about their illness and how to deal with it is very lacking. They just say it verbally and give patients the contact numbers to call the ward just in case problems arise.'

WARD MANAGER 7:

'There are cases where relatives ask the doctors to be careful how to speak with the patient meaning not to tell the patient the full information.'

'Written information about the patient's disease is not given.'

'Inquiry about diet is not always done. It depends on the case. If the doctors feel that he needs to ask because of the condition yes but on the whole no. It depends on the condition the patient has been admitted with.'

'Risky habits like smoking and alcohol are not discussed. May be this was discussed on the first visit and I cannot expect the doctor to ask the same questions in every ward round.'

'Physical examination is done whenever a patient complains that he is in pain. Otherwise just a few auscultations and abdominal checks and is done. This is basically all doctors do here in our ward with regards to physical examination.'

'Information on the patient's illness is not always explained as long as the patient would not ask. Then the doctor would go in detail with information giving if the patient asks for it.'
WARD MANAGER 8:

'We have two scenarios that normally happen here. We have patients who come here to ask the doctor for a detailed explanation and there are other cases where the relatives come here impeding the doctors from telling the patients the true information about their condition. Hopefully things are really changing now.'

'There are new consent forms for the patients so that they would now exactly which procedures and treatment options are available for them so that they could make choices. This consent form also includes what the patient should expect from their condition and clear explanation of what is going to happen with regards to treatment plan and side effects of the proposed treatment. In the near future this consent is going to be formulated and kneaded according to respective departments and sections within Mater Dei Hospital. However at the moment we are still doing all this without the patient consent. Normally doctors would tell the patients exactly what is going to happen. Besides that, here we have the Haematology Nurse who will continue giving out information in detail to the patients.'

'Doctors do ask patients about risky habits.'

'Physical examination is never done during a ward round in this ward and this is never done by the consultant. It is after the ward round had finished that the senior doctors would do the physical examination.'

'With regards to written information, we have a website and we give this website to our patients so that patients would go straight to reliable and approved information. We also make printouts of the information if the patient prefers, according to his individual condition. This has been done since the engagement of two new consultants.'

WARD MANAGER 9:

'Doctors do give healthy eating information to our patients but most of the time this confuses the patients as the doctors do not know the actual food to suggest and would be very vague. For example they simply say high fibre; most of the patients do not even know what fibre is. There were times when we gave the information ourselves to the patients and there were times when we refer the patient to a dietitian.'
‘The most popular risky habits are inquired by doctors but otherwise no. Delicate issues are not always requested from patient.’

‘Physical examination is always performed.’

‘Doctors always give information to patients on their condition. They are usually very delicate in the way they give information but they always give it. Sometimes doctors use certain terminology in giving out information like for example bad tissue instead of cancer. On the other hand for some patients it is all they want to hear and would be happy with that as long as the word cancer is not mentioned.’

‘The only written information that doctors give to patients consist only of one type of operation. We nurses took the initiative of doing such a consent which in itself includes information of what to expect and be done in that procedure. There are other endoscopy consent forms which include what would happen before the procedure and post-op information. This is available in Maltese and English versions.’

WARD MANAGER 10:

‘Doctors never request the approval of the patient to be examined in front of medical students.’

‘Doctors inquire patients about diet only if the condition affects metabolic changes with their conditions. Otherwise doctors never get involved into diet plans. However they do involve in risky habits particularly smoking, alcohol and hard drugs especially if they are affecting the condition of the patient.’

‘Majority of doctors do physical examination.’

‘Information on the condition of the patient is not always given to the patient and in fact only half of our consultants give this sort of information to our patients.’

‘Doctors do not give written information on the patients’ disease apart from that of the discharge letter, the latter being a brief history of what has happened during the patients’ stay in hospital.’
TREATMENT INFORMATION SKILLS

This theme included doctors' communication characteristics like: inquiring if medicine was taken regularly at home, discussing the newly prescribed medicine with the patient, asking if patient was allergic to any kind of medicine, explaining carefully how to use the medicine, describing the possible side effects of medicine, and explaining what to do in case of adverse events.

WARD MANAGER 1:

'I am going to prescribe a vitamin for you.'

'Yes they ask for allergies.'

'With regards to side effects of medicines no; in the surgical areas they do not tell patients about such information. Only a few doctors would do it but normally no they would not even dream about it. However in the medical specialities yes as they have a pharmacist present during ward rounds. And the pharmacist gives advise both to the patient and consultant of what is the right choice and cost effectiveness of treatment being prescribed. In the medical wards the pharmacists would take care and prepare everything in connection with treatment for the patient. They would even take care of the schedule V and give full explanation to the patient.'

WARD MANAGER 2:

Sarcastically answered: 'There is no need for the doctor to explain to the patient, he just explains to the nurse and that is all. If the doctor had explained this before at the casualty I do not know but here I am sure that they do not'

'patients sometimes would be so anxious that they do not understand the doctor and 60% of the patients have the problem of getting nervous when the doctor talks to them'
WARD MANAGER 3:

'Whether the patient was on any particular medicines the patients may have usually been asked at the casualty.'

'With regards to new treatment, yes they also explain to the patient about the new treatment but they never tell them about side effects of the medicines nor do they explain what to do in case adverse events happen.'

'Only the nurses will explain to the patient how to take the medicines.'

WARD MANAGER 4:

'Yes they do ask the patient about what treatment they had at home and whether they were taking the treatment.'

'With regards to new treatment, yes they tell their patients when they start them on new treatment. They also explain the risks being carried by certain medicines especially if the medicines are risky like for example chemotherapy or steroids. This happens mostly in young and female patients for example during the fertility age telling the patient not to have children during treatment for example.'

'When prescribing new treatment, the doctor just tells the patient that he is going to be given a new drug. No consent has ever been requested from the patient.'

'Explanation is given by doctors on medicines.'

WARD MANAGER 5:

'Yes doctors do ask patients whether they were taking their medicines at home, for example; were you eating before taking your treatment?'
'No; the doctors never explain to patients why their treatment has been prescribed or about the side effects that the treatment may cause. The majority of the doctors never give such information.'

'With regards to how the treatment is to be taken doctors never explain either. Side effects have never been tackled with the patients. The patients just phone here when they find themselves in crisis when they are at home. We try to help them and explain to them but then we just tell them to consult with their GP.'

'About written information, it is the pharmacist that gives this sort of detailed information about treatment to facilitate things at home during their self care.'

WARD MANAGER 6:

'Doctors do inquire if the patient was taking any medicines at home and whether the patient was taking them regularly. Yes for sure they ask. In fact they go "oltre" ...they even ask the patient to tell their relatives to bring the medicines over to see them.'

'New medicines are explained to the patient and even get their consent. They just say that they are going to prescribe a new medicine. They tell the patients that it is available in hospital but there is a better product which you have to buy if you prefer that product. They also ask if they are willing to purchase that kind of medicine. Yes most of the time patients accept to buy these medicines.'

'Doctors do ask for allergic reactions.'

'The use of medicines is explained to the patients but they are told to get information from the pharmacist once again so that they could get the written information.'

'Side effects are explained only in certain cases where the doctors considers it as unsafe on using that medicine in the long term especially when complications are likely to arise like Aspirin for example.'

'What to do in case of adverse events doctors just tell the patient to keep them informed of what will happen rather than telling them what to do.'
WARD MANAGER 7:

'Doctors not always explain to the patients what kind of treatment they are going to prescribe for them or if they do they do it in a way that patients would not understand because straight afterwards the patients always come to us for clarifications.'

'Treatment plan is never discussed with the patient.'

'Written information to facilitate understanding is done by the pharmacist.'

'Sometimes patients do not even know that they had been started on a new treatment. They often get to know when they are actually given the tablets for them to swallow. Then the patients would usually come to us and ask us how they were given those particular pills. This could be either the doctor has not given the patients enough information or may be because the patient did not understand what the doctor had told him/her.'

'With regards to allergies, this is asked by the doctors only on the first interaction during the clerking.'

'Side effects are non existent. I have never heard of any doctor explaining any side effects caused by medications to the patient.'

WARD MANAGER 8:

'Doctors do not always inform their patients of new medicines. Neither do doctors involve the patients with treatment options. However they do tell patients how to use the medicine and the side effects that are expected. Doctors also tell their patients what to do in case of adverse events to medicine and in fact sometimes antidotes are also given to our patients to take with them at home just in case.'
WARD MANAGER 9:

'Doctors do inquire if patients were having any type of medicine at home and if they were taking it regularly, however even if they were not taking it, they still tell the doctor that they did take it.'

'On prescribing a new treatment the doctor does ask for any allergic reaction to that type of medicine and they tell them the reason for what that medicine had been prescribed. However consent from patient is never requested and there is not enough information on how to use the medicine and nearly no information on its side effects.'

WARD MANAGER 10:

'Doctors do inquire patients on whether they were taking any kind of medicine at home and whether the patient was taking the medicine regularly. Yes incompliance is very important.'

'If a doctor comes to prescribe a new medicine, he would tell the patient about that especially if the patient is going to be discharged as this might cause problems later on. However the clinical pharmacist will explain everything to the patient.'

'The doctor never asks the patient whether he agrees with the proposed treatment but just write it down on treatment chart no matter if the patient agrees or not. The doctor just says in one sentence that he is going to prescribe a new medicine.'

'The doctors will only tell the patients about side effects with medicine if that type of medicine is known to have repercussions, interaction with other drugs, rashes and other side effects. Otherwise no, the doctor would not tell anything if he thinks that the medicine is relatively safe.'

'Doctors do tackle adverse events due to certain medicines with their patients especially when the patient is being discharged and specialist nurse would also be involved to give more detailed information according to the speciality. The role of the clinical pharmacist also comes in here where the latter would prepare separate written information for the patient. I do not believe this happens in wards where clinical pharmacists are not available.'
TECHNICAL AND EMPATHY SKILLS

This theme included doctors’ attitude/characteristics like: politeness and courtesy, competency, and asking whether help is needed at home.

WARD MANAGER 1:

'Yes Maltese doctors are very competent; they also have great successes even abroad'

'Junior doctors are very friendly but as soon as they start going up in their career they would no longer practice in a friendly manner with the patients. I have noted the difference between medical and surgical consultants; the medical consultants are much more reserved and are not as friendly as the surgical consultants.'

'Another thing with regards to discharging of patients home is that some doctors do not even want to know what problems the patient is going to be faced with at home, they just want them to leave hospital at once to make space for other patients. In such cases the doctors would not even want to listen nor making compromises. Once I have brought the attention of one particular consultant saying that such behaviour with the patient is not right even for his own and the hospital’s reputation – this doctor is still young and he does not need to act like this.'

WARD MANAGER 2:

'Honestly our doctors are the best when it comes to technical competency and some of them do act in a friendly manner.'

WARD MANAGER 3:

'Maltese doctors are very competent in their work.'
‘Before discharging a patient, the doctor never asks about the patients needs at home but it would be up to us to take care of that. As a unit we nurses, physios, occupational therapists and pharmacists meet every Friday at 10am to discuss issues on each patient. I am afraid to say that doctors never attend these meetings. They say because of work overload and time constraints.’

WARD MANAGER 4:

‘If everything goes well, yes the doctor will be courteous.’

‘Yes the majority of doctors are very competent. However there is a small number of doctors who are competent but they try to shirk their duties just like some of the nurses.’

WARD MANAGER 5:

‘Yes the doctors are courteous with their patients.’

‘With regards to competency, we do sometimes are faced with problems especially with INR results, and also with the type of antibiotics which are going to be prescribed. It happens many times. For example, a patient comes here from casualty with a prescribed antibiotic and the next day the consultant changes the prescribed antibiotic to a different one.’

WARD MANAGER 6:

‘Doctors who are arrogant could be counted on your fingers. The rest are all very courteous and try their best. The ones who are arrogant with the patients are usually annoying even to the nurses.’
'Most of the doctors are very competent and I can give them 8 out of 10 for their competency. They take so many investigations, with no expense in mind, to see what is going wrong.'

'Patients’ needs at home are asked from day one so that doctors could plan their discharge and they just give patients an indication of when they are going to be discharged.'

WARD MANAGER 7:

'On the whole the doctors are courteous towards the patients and yes they are very competent as well.'
'On discharge, doctors do ask the patients if they need anything while being at home and they are doing it more often nowadays. Then obviously the doctors come to us with the problems and we arrange everything for the patient...social worker, community nurse etc.'

WARD MANAGER 8:

'Doctors are very courteous with patients and have a very good reputation with regards to their competencies. A good percentage of our doctors are competent in their work.'

'Help at home is always inquired by the doctors otherwise these patients would not leave here. They apply for Hospice as well so that there would be a continuity of care.'

WARD MANAGER 9:

'The doctors are very courteous with the patients. This depends on the doctors’ relationship with the patients as I said at the beginning. Only one of our consultants is considered to be bit rough. Otherwise they are wonderful. Today a patient arrived from the US who is a terminally ill patient who requested to die in Malta. The patient is saying
that she is already feeling better and she has been repeating that our service and care is far better than where she was staying.

‘They are very competent but they need to focus on bedside manners.’

‘Doctors never ask patients if they need care at home, they just give them an out patient appointment and that is it. If doctors think that it is a case where they might know that there would be problems till the out patients date, they just tell them to call at the ward if something happens to them.’

WARD MANAGER 10:

‘The majority of doctors are courteous and competent.’

‘With regards to patients’ requirements needed at home, the doctors do ask patients but hopefully we would have identified the problem beforehand because this should not come only from the doctor but from the entire multidisciplinary team.’
CONSULTATION LENGTH

Ward managers were asked how much time the consultants usually spend near the patient during ward rounds.

WARD MANAGER 1:

'With regards to communication with the patient: 'there's a long way to go. The way in which the ward round is conducted; the ward round is carried out in very limited time, sometimes the consultant seems as if he or she is in a great hurry therefore does not dedicate enough time with the patient, they would only take from 1 to 2 minutes with the patient.'

'Sometimes they come for the ward round without knowing who is the patient and why the patient had been admitted for. In such cases the senior doctor would brief the consultant with the information. In other words some of the consultants do not even bother to look in the patients' files before presenting themselves in front of the patients.'

'Sometimes we as nurses would bring the attention of the consultant that the patient is still speaking to him/her and that the patient still needs to clarify some things. Sometimes even when they discharge patients, they would project unclear and incomplete statements, with the patient ending up confused and unsure of what is happening.'

'By the way, consultants do their ward rounds twice in a week. One particular consultant sees every patient in his first ward round of the week. During the second ward round he just sees the new admissions. There were instances where the medical superintendent asked the consultant to do a ward round because obviously if patients are not seen they are not even assessed whether they are fit for discharge resulting in a congested hospital. This particular consultant instead of coming for the ward round, just phoned up and did the ward round on the phone – asking me to brief him up on the patients. This is the kind of doctor-patient relationship we have here'
WARD MANAGER 3:

'Consultation time depends on the nature of the condition of the patient. There were consultations where they took only 2 minutes and there were others that took over 10 minutes. It depends .....'

WARD MANAGER 4:

'Consultation time depends on who is the patient and the condition of the patient. It depends also on the consultant, there are consultants that take 15 minutes and there are others who take 5 minutes. The average is 5-10mins because if the patient stay there just listening and not speaking, like for example a stroke patient, there will be no two way communication so the consultation time would be rather short.'

WARD MANAGER 5:

'Consultation time is very short. Nowadays it is worse then before because the doctors need to run around all the hospital – a marathon that needs to be accomplished otherwise they would not manage to see all the patients. Yes they will take only around 2 minutes for each patient.'

WARD MANAGER 6:

'Doctor communication is not always the same. Sometimes the surgical round is so hectic that the patient concerns are not always met. Sometimes a ward round is done in no time “minuta mexxi mexxi” ....fluids..., nil by mouth..., stop..., bowel sounds... “mexxi”.'
WARD MANAGER 7:

'Consultation time in my opinion would take around 4 minutes and this is very vague as this depends on the condition of the patient. If it is easy going, yes, it would take about 2 to 4 minutes.'

'I would suggest that it is important for doctors to give more information to the patient. The things that mostly concern the patient are the treatment especially if they are on loads of treatment. I do not know perhaps doctors are leaving this issue on the pharmacist. But on the whole the doctors' attitudes go down well with the patients. I cannot say that the doctors' relationship with the patients is better than that of ours. Obviously we spend more time with the patient so that is why our relationship is better.'

WARD MANAGER 8:

'With regards to consultation time there is one consultant who just sees the patients and moves on and leaves the more complicated part to the senior doctors. The remaining two consultants go more in depth with their patients. The average consultation time of the latter two is around 5 minutes.'

WARD MANAGER 9:

'Consultation time depends on the condition of the patient. If it is a ward round of five patients it would take around 35 minutes meaning 7 minutes each consultation.'

WARD MANAGER 10:

'A ward round visit would not take longer than 8 minutes for each patient.'
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