Exploring patient centred care at St.Luke`s Hospital

A dissertation submitted in partial fulfilment of the Master of Health Science (Health Service Management) degree, Institute of Health Care, University of Malta.

June, 2005

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Declaration

I certify that this dissertation is entirely my own work carried out as a requirement for the degree of Master of Health Science (Health Service Management) Institute of Health Care, University of Malta

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June 2005
Acknowledgements

I would like to express my sincere thanks to all those who assisted me throughout my studies especially my fiancée Aloisia. In particular, I would like to thank my supervisor Dr. Kenneth Grech for his constant support and guidance throughout the study. My thanks also go to Dr. Saviour Cilia and Mr. Carmelo Camilleri for their advice and critique. I am also indebted to Mr. Liberato Camilleri and Dr. Neville Calleja for their assistance with certain statistical tests. Finally, I would like to express my sincere gratitude to all those individuals who participated in this study, without which this study would not have been possible.
Executive Summary

This study aimed to explore the issue of patient centred care in the main hospital of the Maltese Islands. To reach such an aim, the researcher opted for the use of three tools, a survey, interviews and an observation phase. With this choice it was possible to perform triangulation of findings and have better and more reliable results. The survey consisted in querying recently discharged patients about various aspects of their experience within the hospital. The interviews performed were of the elite type and investigated how the organisation perceived the patient centred care agenda with all its interlinking aspects. The observation phase was performed within the ward setting of the hospital, to observe the organisational climate as regards patient centred care and document various interactions, related with this type of care.

The main findings of this study were that patient centred care is practiced at a moderate level within St.Luke's Hospital (SLH). Findings seem to indicate that such care is affected by the age of the patient and also the speciality with which the patient had contact whilst in hospital. It was noted that orthopaedic wards faired better then surgical and medical wards in that order. Also, statistical significance was found between the age of the patients and their relative perception as regards patient centred care. Results indicated that the older the age of the patient, the less the perception that they were receiving patient centred care.

From the results of the interviews, it was concluded that organisational members had a good knowledge of the term patient centred care but each gave a personalised interpretation of the concept which most often reflected the professional background of the respondent. When queried about the commitment towards this agenda, the respondents sustained that there is commitment towards patient centred care within SLH. However, from the interviews it was noted that barriers exist for this type of care which were identified as being of multiple nature. The main ones which were given prominence by the respondents included, overcrowding problems, lack of coordination between professions, ward environment, financial issues and barriers constituted by cultural aspects.
The observation phase confirmed most barriers identified by the respondents and documented the day by day work of the staff within four different wards for a total observation time of sixteen hours. Various aspects of the wards were documented with the main themes being that of the actual physical environment of the wards and also the interaction between the staff of the ward, mainly doctors and nurses with the patients. It was observed that certain aspects of the physical environment hinder patient centred care, whilst overall the interaction between staff and the patients was satisfactory.

Given the findings, various recommendations to management were proposed with the main ones being a needs assessment to analyse the problem of over-demand at SLH, the setting up of a Customer Care Department and also a substantial improvement in the physical environment of the wards. Only after such recommendations are put into practice can the agenda of patient centred care be given sufficient impetus within SLH to effect policies and strategic managerial decisions.
Table of Contents

Title Page i

Declaration ii

Acknowledgment iii

Executive Summary iv

Table of Contents vi

Chapter 1 Introduction

1.1 Introduction 1
1.2 Background to patient centred care 1
1.3 Selection of the topic 3
1.4 Statement of the problem 3
1.5 Aims and objectives 4
1.6 Implications to management and policy making 4
1.7 Conclusion 5

Chapter 2 Literature Review

2.1 Introduction 6
2.2 The changing health systems 6
2.3 Patient centred care 7
2.4 The conceptual framework 9
Chapter 3 Methodology

3.1 Introduction 22
3.2 Time schedule of study 22
3.3 Aims and objectives of the study 22
3.4 Theoretical framework 23
3.5 Research design 23
3.6 The research setting 23
3.7 Gaining access 24
3.8 The research instruments 24
3.8.1 Observations 24
3.8.2 Survey 25
3.8.3 Interviews 27
3.9 Ethical considerations 27
3.10 The pilot study 28
3.11 Data collecting procedures 28
Chapter 4 Results

4.1 Introduction

4.2 Questionnaire results
4.2.1 Results of the questionnaire
4.2.2 Descriptive statistics
4.2.3 Inferential statistics
4.2.3.1 Patient centeredness against age
4.2.3.2 Patient centeredness against different specialities
4.2.3.3 Illness experience against different specialities
4.2.3.4 Level of concordance with age
4.2.3.5 Level of concordance in different specialities
4.2.3.6 Understanding the whole person compared to age
4.2.3.7 Understanding the whole person against specialities
4.2.3.8 Treatment and care aspect against different specialities
4.2.3.9 Quality of staff communication with patients
4.2.3.10 Staff responsiveness towards the needs of the patients
4.2.3.11 Patients being ignored by staff
4.2.3.12 Comparison of overall manners of doctors and nurses with the different specialities
4.2.3.13 Quality of information delivery by staff in different specialities
4.2.3.14 Comparison of family support with the different specialities
4.2.4 Questionnaire conclusions

4.3 Interviews results
4.3.1 Answers to question 1
4.3.1.1 Holistic aspect
4.3.1.2 Understanding the whole person
4.3.1.3 Exploring the disease and illness experience
4.3.1.4 Promoting of health and risk avoidance
4.3.1.5 Multidisciplinary approach
<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.3.1.6 Informed consent and respect for patients desires</td>
<td>55</td>
</tr>
<tr>
<td>4.3.1.7 Diversity of meaning of patient centred care</td>
<td>55</td>
</tr>
<tr>
<td>4.3.2 Answers to question 2</td>
<td>55</td>
</tr>
<tr>
<td>4.3.3 Answers to question 3</td>
<td>57</td>
</tr>
<tr>
<td>4.3.4 Answers to question 4</td>
<td>58</td>
</tr>
<tr>
<td>4.3.4.1 Overloading/overcrowding problems</td>
<td>59</td>
</tr>
<tr>
<td>4.3.4.2 Lack of coordination between professions</td>
<td>60</td>
</tr>
<tr>
<td>4.3.4.3 Ward Environment</td>
<td>61</td>
</tr>
<tr>
<td>4.3.4.4 Financial Issues</td>
<td>62</td>
</tr>
<tr>
<td>4.3.4.5 Cultural barriers</td>
<td>62</td>
</tr>
<tr>
<td>4.3.4.6 Barriers constituted by management</td>
<td>62</td>
</tr>
<tr>
<td>4.3.4.7 Conclusion of interviews</td>
<td>63</td>
</tr>
<tr>
<td>4.4 Observation results</td>
<td>63</td>
</tr>
<tr>
<td>4.4.1 Ward ambient and environment</td>
<td>63</td>
</tr>
<tr>
<td>4.4.1.1 General impression</td>
<td>63</td>
</tr>
<tr>
<td>4.4.1.2 Ward organization</td>
<td>64</td>
</tr>
<tr>
<td>4.4.1.3 Noise level</td>
<td>64</td>
</tr>
<tr>
<td>4.4.1.4 Cleanliness</td>
<td>65</td>
</tr>
<tr>
<td>4.4.1.5 Decoration and lighting</td>
<td>65</td>
</tr>
<tr>
<td>4.4.1.6 Ward and patient security</td>
<td>65</td>
</tr>
<tr>
<td>4.4.1.7 Ward facilities for patients</td>
<td>66</td>
</tr>
<tr>
<td>4.4.1.8 Beds and sleeping facilities</td>
<td>66</td>
</tr>
<tr>
<td>4.4.1.9 Toilets and sanitary facilities</td>
<td>67</td>
</tr>
<tr>
<td>4.4.1.10 Complaint facilities</td>
<td>67</td>
</tr>
<tr>
<td>4.4.1.11 Patients visitors</td>
<td>67</td>
</tr>
<tr>
<td>4.4.1.12 Miscellaneous facilities</td>
<td>67</td>
</tr>
<tr>
<td>4.4.2 Patient support by ward staff</td>
<td>68</td>
</tr>
<tr>
<td>4.4.2.1 General comments</td>
<td>68</td>
</tr>
<tr>
<td>4.4.2.2 Ward organization and routine</td>
<td>68</td>
</tr>
<tr>
<td>4.4.2.3 Approach towards patients</td>
<td>69</td>
</tr>
<tr>
<td>4.4.2.4 Responsiveness of nurses</td>
<td>69</td>
</tr>
<tr>
<td>4.4.3 Patient care and the medical staff</td>
<td>70</td>
</tr>
</tbody>
</table>
4.4.3.1 Patients care and medical doctors 70
4.4.3.2 Approach of medical students 71
4.4.3.3 Conclusion of observation phase 71
4.4.3.4 Conclusion 71

Chapter 5 Discussion

5.1 Patient centred care as perceived by the patient 72
5.2 Difference amongst specialities 73
5.3 Differences with age 75
5.4 Differences in various aspects of patients care 75
5.5 Patient centred care as perceived by the organisation 76
5.6 Level of commitment to patient centred care 78
5.7 Promotion of patient centred care 79
5.8 Barriers to patient centred care 80
5.8.1 Ward overcrowding 80
5.8.2 Lack of coordination between professions 81
5.8.3 Ward Environment 81
5.8.4 Funding 82
5.8.5 Culture 82
5.9 Organisational climate 82
5.9.1 Physical Environment 83
5.9.2 Staff interaction with patients 84
5.10 Limitations of the study and sources of bias 85
5.11 Conclusion 86
Chapter 6 Main conclusions and recommendations

6.1 Introduction 87
6.2 Main conclusions of the study 87
6.3 Recommendations to management 87
6.3.1 Fluctuation in demand 88
6.3.2 Interprofessional antagonism 89
6.3.3 Cultural barriers 90
6.3.4 Undergraduate education and training 91
6.3.5 Customer care department 91
6.3.6 Physical environment 92
6.4 Suggestions for further studies 92
6.5 Dissemination of change 92
6.6 Conclusion 93

References 119
Chapter 1

1.1. INTRODUCTION

In most developed nations, health care systems have advanced considerably over the last four decades, such that the quality of care has become as important as the quantity of care. One consequence of quality improvement is that increasingly health care is being customised to meet patients' needs. Customised care is challenging policy-makers and health care providers to redesign processes of health care in order to enhance delivery of patient-centred care. This study explores the concept of patient-centred care in the hospital setting with the aim to describe the factors that influence the quality of care provided.

This chapter will introduce the concept of patient-centred care and provide the rationale for choosing this topic. Further sections will include the aims and objectives of this study, and concludes by analysing its relevance in the local context.

1.2. BACKGROUND TO PATIENT-CENTRED CARE

The concept of patient-centred care originated from the Universal Declaration of Human Rights, in 1948, and was further developed by the EU Declaration of Patient Rights in 1994. Following this declaration, many nations and hospitals started developing patient charters according to local needs and resources.

Numerous authors have written about patient-centred care, and many policy-makers and administrators have implemented their version of patient-centred care, that it is impossible to provide a universally accepted definition. According to MacStravic (2004) it means putting patients at the head of the line and the centre of the circle, with providers arrayed behind or around patients when designing, operating, evaluating and improving patient care. It is frequently allied with the Planetree model of care, where patients and their family members are empowered to have a far greater say in their individual hospital experiences than has been the traditional approach to patient care (MacStravic 2004). According to Stewart et al (2001), patient-centred care expands on the disease-oriented model by incorporating the
patient's experience of illness, the psychosocial context, and shared decision-making. This type of care has been adopted as a model of medical practice by many health professionals and medical educators.

Elements of patient-centred care have been described since antiquity (Epstein 2002). Providing care to the ill has always been associated with individuals who touched by the sufferings of their fellows, dedicated their life to relieving suffering and provide care. These individuals were precursors of modern-day nurses and doctors. Although different authors have used different nomenclature, the fundamental idea is that healing depends on knowing the patients as persons, in addition to accurately diagnosing their disease. Evidence that elements of a patient-centred approach improve important outcomes of care is abundant in the literature (Ward 2004).

The fact that patient-centred care improves health outcomes is very important knowledge for policy-makers and hospital administrators worldwide. If this knowledge is true, as implied by abundant scientific literature, health costs could be reduced and customer satisfaction could be improved. Unfortunately, most hospitals have not fully adopted either the Planetree model or patient-centred care philosophies (MacStravic 2004).

A national health care system that has long recognized the value of patient-centred care is without doubt the NHS of the United Kingdom. According to the Commission of Health Improvement (NHS): “Listening to patients’ views is recognized as essential to delivering the commitments given in ‘The NHS Plan’ to provide a patient-centred health service…” The U.K. government through the NHS has already committed itself to provide “a patient-centred health service” and surely many other nations are going to follow suit. In particular, one has to acknowledge the partnership the NHS has struck with the Picker Institute of Research that more than highlights the importance the organisation gives to patient-centred care. After extensive research, Picker Institute (UK) has come up with eight core dimensions of patient-centred care that have led to the development of tools to assess the extent of such care in various hospitals in the NHS.

Health systems worldwide have never felt more compelled to understand, and reach out to their customers for a variety of reasons. One reason being the increased patients’ health
awareness and expectations, and the fact that patients are demanding more customised care. This has augmented the need to capture the voice of the patient using a more structured approach which has become an essential element of policy planning. This study can be used by health service providers to ensure that the principle of patient-centeredness becomes an increasingly important feature of how health services are planned and delivered.

A significant trend in the development of modern healthcare delivery is the involvement of patients in the management of their care and treatment. In implementing this development it is important to acknowledge that the personal experiences of health care by the patients vary considerably. Some may have an occasional intervention while others have a more permanent and long-term relationship with a service provider depending on the nature and extent of their need. Patient-centred care respects the dignity and the value of each person. It is highly desirable and proper that the views of patients should be sought and their experiences and expectations of health care valued. Feedback from patients provides valuable data for health need assessment, it can influence and direct the quality improvement agenda and provide an opportunity for learning and development. It provides crucial information on patient’s expectations and patients’ perspective of health care that may be different from that of health care providers.

1.3. SELECTION OF THE TOPIC

The topic of patient-centred care was chosen mainly because it is emerging as a central concept within healthcare planning and management, as demonstrated in the literature. This has occurred for a number of reasons, but mainly because there is a growing body of evidence that consumer feedback and participation in decision-making will improve health outcomes thus leading to reduced health costs (Flach 2004).

1.4. STATEMENT OF THE PROBLEM

The study addressed the problem of informational void on patient-centred care in the local hospital setting. By evaluating the organisation, work practices, and patients’ perception, knowledge was created which will provide hospital management and ward staff the necessary
tools to assess the current situation regarding patient-centred care and to plan quality improvement for the future.

1.5. AIMS AND OBJECTIVES

The aims of this study were to explore patient-centred care at St. Luke’s Hospital (SLH) by:

- Describing patient-centred care as perceived by the patient
- Exploring patient-centred care as perceived by the organisation
- Describing the organisational “climate” towards patient-centred care

In addition, finding answers to the following six questions were the objectives:

- To what extent is patient-centricity developed at SLH?
- How do patients perceive such centricity in their care?
- Does hospital staff perceive themselves as being patient-centred?
- Are these two perspectives synchronous?
- Is there room for improving patient-centred care?
- Is the hospital management receptive of the need for improvement in patient-centred care?

1.6. IMPLICATIONS TO MANAGEMENT AND POLICY-MAKING

The study could have many implications such as identification of problems in the perception of patients’ experience in the hospital, or lacunae in the hospital care. Various research studies have indicated that patient-centred practice is potentially associated with improved patients’ health status and increased efficiency of care (reduced diagnostic tests and referrals). The associations found in various studies may imply a potentially important pathway or process through which patient-centred care influences patients’ health. Sobel (2005) suggested a pathway explaining patients’ perceptions of the care and health outcomes. Sobel and others stress the critical role of patients’ perceptions in the healing process, which highlight that a person’s subjective experience influences biology. For the health manager
this has particular relevance; lack of patient-centred care could lead to increased bed occupancy and longer stay. Another important aspect of patient-centred care is its association with increased efficiency of care by reducing diagnostic tests and referrals (Stewart 2000). This type of care increases participation by the patients and thus helped in reducing patients’ anxiety and their perceived need to be investigated or referred.

Alternatively, patients' perception that the physician had not understood their problem may provoke insecurities resulting in a request for further medical interventions. Moreover, if patients openly express their discontent with the lack of patient-centred care, there may be an increase in physicians' anxiety and a lowering of their threshold for diagnostic uncertainty, resulting in further investigations and referrals (Stewart 2000). Certainly, such a finding is of major concern to health managers. With limited health resources and the need for effective resource allocation, it is appreciated that lack of patient-centred care should be unacceptable for health managers.

1.7. CONCLUSION

In this introduction, the importance of patient-centred care for quality health care as established in the literature was described. However, it was queried why patient-centred care was not universally implemented in many hospitals. Finally, the implications and challenges to hospital organisation and management were mentioned. The next chapter will focus on the literature review on the topic, which will expand the above-mentioned issues and will provide the perspective of the currently available knowledge of patient-centred care.
Chapter 2

Literature review

2.1. INTRODUCTION

The available literature was searched in detail in order to build the necessary knowledge on, and have a better understanding of the term patient-centred care. An in depth search was done using the following electronic indexes: the Biomed, Cochrane library, British nursing index, CINAHL, and SOSIG, for articles containing the terms “patient care” “patient-centred care”, and “patient centeredness”. A search was also performed for books and websites related to the topic, as well as periodicals and documents on Maltese health care. What follows is a discussion on the changing health systems, the developments in the concept of patient-centred care and how this affects management issues. Only after such an exercise, can one propose a model of this type of care, which then can be applied at SLH.

2.2. THE CHANGING HEALTH SYSTEMS

The driving forces behind developments in modern national health services are accessibility, cost effectiveness, and improved quality of care. According to Hyman (2003), this is attributable to a variety of factors including restriction of financial resources, highly educated and more demanding patients, and the need for healthy individuals to sustain economic development. With limited health funds and increasing health demands, health care services are becoming more costly with advancing scientific knowledge (Cap Gemini 2000). Therefore, the proper and effective use of health funds has become a pressing issue in health care delivery. Also, there has been a gradual change in the behaviour of the consumers in the developed nations. With increasing standard of education and the widespread access to information technology consumers have become more knowledgeable and more informed on their health care needs and rights. These ‘new’ empowered patients are much more demanding and have higher expectations than the traditional patients. Nowadays, patients
are pressing and challenging healthcare systems for better quality and customised health care services (Hibbard 2004). The same pressures and challenges are being passed on to policy-makers, health managers and health care providers alike; necessitating a change in the traditional roles of these stakeholders and more trained and expert caregivers than in previous decades.

These developments have created a new healthcare marketplace, where the need to be competitive and the costs associated with competitive failure have never been higher and open to public scrutiny. In such an environment, health organisations are rethinking and redesigning health plans to better satisfy the needs and desires of their key customers: the patients (Wasson 2003). These changes are also being experienced by other non-health related organizations. These organizations are responding to these changes by adopting “customer centric strategies,” aimed to focus all their efforts around their customer; thus creating “a working relationship”.

Such a relationship serves to understand better the needs of the customer, respond better to such needs, and ultimately will result in improved quality of the service. In response to such needs, health systems around the world are reassessing health needs to become more customer-centric or rather patient-centred in their approach to care delivery. This raises two important questions, “What was health care centred on before? and “What does it mean to be patient-centred in health care? (Ponte 2003).

2.3. PATIENT-CENTRED CARE

In the last three decades, extensive literature has accumulated advocating patient-centred care. The term was introduced by Balint et al (1969), who contrasted it with “illness-centred medicine”. Patient-centred medicine tries to understand patients’ complaints, and the associated symptoms and signs, not only in term of illnesses, but also as expressions of the patients’ unique individuality, their tensions, conflicts and problems. Byrne and Long (1976) stated that this type of care implies the use by the physician, of the knowledge imparted by the patients, to guide the overall direction of the interaction. During this time, a gradual shift
of terms begun to occur in the literature where this type of care begun to be referred to more as an approach incorporating various aspects of healthcare rather then only care. This occurred mainly due to the influence of other non-medical professions who gave a different interpretation to the meaning of patient-centred care. To this extent, McWhinney (1989) in the need to transform the clinical method describes the patient-centred approach as one where the physician tries to enter the patient's world, to see through the patient's eyes.

Various other definitions have been suggested to patient-centred care by various researchers, (Dieppe 2002, Gray 2002). Many of these definitions have highlighted aspects such as involving patients in decision-making, and giving information to patients. However, Stewart (2001) argues that many such definitions are: "Oversimplifications which help in teaching and research but fail to capture the indivisible whole of a healing relationship." In addition, Stewart (2001) highlights the fact that currently there is no universally accepted definition of patient-centred care. This sentiment is also echoed in Mead et al (2000), who mention the fact that this lack of global definition has hampered conceptual and empirical developments in the field.

However, Little et al (2001) attempted to give a meaning to patient-centred care and ask if patients want this type of care. Congruent with findings in similar studies (Mallinger et al 2005), the response was that patients want and need this type of care. The components identified by Little et al (2001) compare well with other models of patient-centred care, in particular with the conceptual framework developed by Stewart and colleagues. The method consists of six interconnecting components:

- exploring both the disease and the illness experience
- understanding the whole person
- finding common ground
- incorporating prevention and health promotion
- enhancing the patient–doctor relationship
- and being realistic
A large number of studies suggest that patient-centeredness represents the most effective and satisfying way of communication between the patient and doctor. Mallinger et al (2005) and Mead (2000) identified five dimensions of patient-centred care:

- Biopsychosocial perspective.
- The patient as person - understanding the individual experience of illness
- Sharing power and responsibility
- The therapeutic alliance - based on care, sensitivity and empathy
- and the physician as person - self awareness

Dawood (2005) defined the patient-centred concept as a focus on the patient as a human being with an illness rather than a focus on the disease itself. According to Jacobson (2004), although many of the ideas have origins in the social and behavioural sciences, most development of the patient-centeredness concept has occurred in general medical practice. However, interest in patient-centred medicine is rapidly emerging in other medical disciplines and in other fields of healthcare (Redman 2004). This may explain the increasing body of evidence suggesting that such interpersonal aspects of care incorporated within patient's centricity, are key determinants of patient satisfaction (Redman 2004).

2.4. THE CONCEPTUAL FRAMEWORK

2.4.1. The biomedical model of health care

The concept of patient-centeredness has its roots in the perceived limitations in the conventional way of doing medicine described as the ‘biomedical model’ (Friedson 1970). This model incorporates various broad concepts, which have been described by various researchers (Cassel 1982, Engel 1977) that put emphasis on the content and style of the relationship between the doctor and the patient (Neighbour 1987).

Mead et al (2000) sustain that patient-centred medicine differs from the biomedical model in terms of the five key dimensions, with each dimension representing a particular facet of the
relation between the doctor and the patient. This is congruent with the findings of other researchers (Stewart et al 1996) although the latter describe six components instead of five.

2.4.2. Biopsychosocial model of health care

According to Bain, Bassett & Haines (1973) many illnesses which present in the community cannot be assigned to conventional disease classification. Sometimes reassuring patients that they have nothing wrong makes them even more apprehensive. On the contrary, persons who do not feel that they are ill may in fact harbour pathology worthy of medical treatment. In addition, according to Rogers, Hassell and Nicolaas, (1999) seeking help in response to feeling ill bears little relation to the type of pathology or its clinical severity.

This fact challenges the main assumption of the biomedical model. According to Mead (2000), this limitation has in part encouraged the application of a wider explanatory framework by doctors in their interaction with patients. A combined biological, psychological, and social perspective are regarded necessary to enshrine the full range of patient complaints. This view is concordant with the 'biopsychosocial model' of Engel's (1977, 1980).

Several literature publications advocate the biopsychosocial perspective as the central theme in patient-centeredness. Stewart et al (1995), state that the patient-centred model requires a "willingness to become involved in the full range of difficulties patients bring to their doctors, and not just their biomedical problems." Bonnar (2004) emphasises the importance of being receptive to the patient's hidden agenda. According to Grol et al (1990), the patient-centred professional must feel responsible for non-medical aspects of problems that the patient might have, thus patient-centeredness gives medicine a broader scope then the more traditional ways.

2.4.3. The patient as an individual

According to Armstrong (1979), the biopsychosocial perspective is not enough for a complete understanding of the patient's experience of illness. Much depends on the individuality of the patient as pathology may have different connotations to different
individuals. Similarly, medical treatment can be perceived differently by patients having the same pathology (Cassell 1982, Mead 2000). The implication is that in order to understand illness and alleviate suffering, the health professional must first understand the personal meaning of illness for the patient.

The social and behavioural sciences have contributed significantly to the understanding of how individuals interpret illness. From the psychodynamic perspective, Balint et al (1964), states that sensitivity to the patients psychological world is crucial for insight into whatever unconscious motivations the patient may have for presenting and for understanding "the patient's attitude towards his illness which is of paramount importance for any therapy" (Balint 1964).

Therefore, patient-centred medicine perceives the patient as an experiencing individual, and the consequent interpretation of symptoms and signs must be performed, not only in the terms of the underlying illness but as an expression of the individual (Lomas 2004). In essence, patients cannot be wholly characterised by a diagnostic label, whatever the nature of such label. To develop full understanding of the patient's needs and provide effective management, the health professional must understand the patient in a holistic perspective, which lies within his or her unique context (Bower 1998).

2.4.4. Shared responsibility and therapeutic alliance

The concept of shared responsibility in health care was first introduced by Byrne and Long (1976). This shift from the 'paternalistic' model of Parsons (1951) towards a more symmetric patient-centred way of practicing medicine, respects patients' autonomy in their care. Tuckett et al (1985) argued that non-compliance and dissatisfaction with care was attributable to a paternalistic way of healthcare.

Kaplan, Greenfield and Ware (1989) sustain that patients must be regarded as active 'consumers' of their health with all its consequences. The same authors have reported positive associations with health outcomes when patients were so treated and Grol et al (1990) suggests that information, which comes from a symmetric patient-doctor relationship, enables patients to take greater responsibility for their health.
Crow et al (1999) and Roth and Fonagy (1996) suggest therapeutic alliance as a special relationship required for patient-centeredness. This describes how the health professional interacts on a personal level with the patient. Attitudes, traditionally not acceptable in medical care, such as caring, sensitivity, empathy, and sympathy are deemed essential to enhance not only compliance but also increase patient satisfaction with the care received (Cappuzzo 2005).

2.4.5. The health professional as person

The last concept of patient-centeredness is concerned with the health professional as a person. Whereas in the biomedical model, emphasis was placed on the diagnosis and therapeutic aspects of care, patient-centeredness recognises that each healthcare professional has personal attributes that affect the relationship with the patient. Whereas, traditionally, the health professional was expected to be completely objective and not to be influenced by his personal attributes in decision-making, nowadays it is recognized that this may not always be possible and it is not absolutely necessary for good doctor-patient relationship. The recognition and acceptance of such state of affairs is essential for the successful building of the therapeutic alliance (Larson 2005)

2.5 HEALTH SERVICE MANAGEMENT

According to Wensing et al (1998), lack of patient-centred care in a particular setting can have adverse consequences. Such evidence might have serious repercussions on the role of the health service management. Patient dissatisfaction due to lack of patient-centred care might result in repeated visits to hospitals, unnecessary referrals and insufficient handling of self-care. Consequently, each unsuccessful encounter between the patient and the professional might generate increased economic burden for an already strained health sector. Furthermore, if health care professionals take a traditional, professional-centred approach instead of the patient-centred approach, there is a risk for the patient to be objectified.
According to Byers (2000) "a frustrated and angry patient may make inappropriate time and service demands and ultimately drop out of care completely because of failed expectations."

According to various studies, there seems to be a gap between what patients want from health care and professionals' view of their task (Laing 2002). A recurrent complaint by patients is that doctors and nurses do not listen to them (Wright 2004). If the health professionals are unsuccessful in their encounter with their patients, patients will inevitably be dissatisfied with the care received and their problem might not surface. A patient-centred approach on the other hand offers an opportunity to increase the patient's autonomy and involvement in decision-making, care and treatment.

The health service manager might experience several problems when trying to introduce patient-centred policies in his organization. Many organizations want to become more patients responsive but are somehow unable to reach this goal (Ponte 2003). This could be attributable to various factors; lack of attitude, lack of commitment or lack of momentum from the organisation. The attitude must be such that it accepts patient-centeredness, secondly there must be a commitment at all levels of the organization to make the changes necessary, and lastly, there must be sufficient enthusiasm to maintain such changes even when these become difficult to maintain. The role of the health service manager is to align all three factors to help the organisation achieve the patient-centred approach. Such an approach must be reinforced continually through the many processes that go on within the organization such as performance appraisal.

However, it must be noted that, patient-centred systems can fail easily if they are not owned by those who operate them. The role of management is to give strategic leadership and to ensure that ownership does happen. Most often, staff perceives patient-centred care policies as another excuse to achieve greater economies. It is within the domain of health service manager to ensure that these tensions are resolved and that such policies are in fact implemented (Ponte 2003).
2.6. PATIENT-CENTRED CARE AND ORGANISATIONAL ISSUES

According to Shortell, Gillies et al (1995), organisations wishing to adopt the philosophy of patient-centred care, need to shift and re-align their focus on two major issues. According to the researchers the first shift must be that related with the clinical interventions provided, which must aim on promoting health and a continued advancement in the services provided. Secondly, the organisational structures and processes must be re-engineered to support convenience of access for the patient with an emphasis on quality improvement and new roles for professionals.

Organisational development and change is not a new concept in patient-centred care. As early as 1992, the Board of Kingston Hospital (NHS) was already implementing such a patient focused approach after showing that the hospital’s services were fragmented, decentralised and was not at all patient centric. Nowadays, patient-centred care is being achieved at Kingston Hospital following radical reorganization based on the principles that patient services should be closer to the bedside, staff must be multi-skilled and patient focused, and that care should be coordinated.

Lynn, M., et al. (1999) sustain that for the development of a patient-centred care organisation, two interconnecting components of organisational and clinical integration are necessary. Organisational changes necessary for integrated care focuses on the development of networks of health care professionals and services, new roles and skills for managers and health professionals as well as performance measurement and tracking of clinical effectiveness. In a study assessing various health care organizations, Lynn, M., et al. (1999) identified four distinct levels of organizational transformation leading to patient-centred service delivery. The researchers concluded that higher levels of change correlated with a more comprehensive patient-centred care delivery from the respective organizations. The levels were described as follows:

Level 1: Reorganisation at the department of service level - systems at this level of change are characterised by redesigned jobs and functions within singular services. Organisational change such as multidisciplinary collaboration, emerging co-ordinator roles, and process improvement and utilisation review are implemented during this phase.
Level 2: Intermediate restructuring across services - this level of change is characterised by reorganisation across direct patient-care service units that involve multiple departments and services. Interdisciplinary critical paths and multi-skilled workers are developed to improve the continuum of care and expand varieties of services brought directly to the patient. Initially costs rise with new skills and services investments, however decreases in cost of care are realised in time.

Level 3: Re-engineering to integrate clinical and administrative functions - organisations expand the scope of service and start reaching into the community. The continuum of care bridges inpatient and outpatient settings, supported by interdisciplinary structures, processes and roles for patient-care service production.

Level 4: Complete change to patient centred care - organisations at this level of organisational change evolve into seamless community based health care systems. The mission, vision and philosophy of patient centred care delivery are realised in this phase.

2.7 THE PATIENT-CENTRED RELATIONSHIP

According to MacStravic (2004), if the concept of patient-centeredness is extended to a relationship, beyond the “within the walls” experiences to which most current applications are limited, it will greatly change the way hospitals behave. The same author also states that a truly patient-centred relationship will require beginning with the patient, and each patient's whole health and life situation. It will mean reversing, the traditional approach health care providers employ whenever they even look beyond the walls, and adopting an outside-in approach.

Gordon (2002) has addressed this concept and concluded that to achieve this, hospitals must forego their interest priorities and instead concentrate on individual patients, who, by definition, will be consumers, not patients. This will require learning about individual consumer's health and health-related quality of life (HRQoL) problems, and working with each to design, plan and implement solutions that will enable them to optimize the protection and enhancement of their HRQoL.
MacStravic (2004) and Gordon (2002) agree that in addition to a shift from a restricted view of the patient’s experience within the hospital, a patient-centred relationship will also mean looking beyond the provider’s own capabilities and interests. In addition, health service managers will have to play entirely new roles in vetting potential partners, tracking, and evaluating their performance to decide what is best for the patient centric organisations.

Just as providers are appropriately shifting to patient-centred care, in response to their own convictions and consumers' demands, so they need to shift to “consumer-centred care” that extends beyond their walls, beyond their “experience management” efforts, to the complete person, complete health, and complete lifetime relationships that will be the focus of health care in the future (MacStravic 2004).

2.8 THE PATIENT-CENTRED HOSPITAL

Every organisation, including hospitals, has a reputation that is the direct product of its interactions with its customers. With increasing media scrutiny, what happens within the hospital is immediately transmitted to the outside society with the inevitable result of judgment and unjustified criticism. In this environment, which is sometimes hostile, hospitals find themselves competing against patients’ considerations of which hospital to attend (Perlin 2004).

According to Gerteis (1999), there are characteristics that make a hospital more patient-centred than others. These characteristics have been identified during the Picker Commonwealth Survey, conducted on a national scale in the US in the early 90's. The first aspect that came out of the Picker Commonwealth survey is that: "The quality of patient centred care is an institutional characteristic that transcends any particular program or characteristic." The researchers concluded that each hospital has its strength and weaknesses in certain areas but all hospitals tended to fare comparatively better or worse across all dimensions of care. They stated that while visited hospitals boasted many imaginative programs, such programmes on their own were rarely sufficient to augment performance. According to Roberts (1993) and Gerteis (1999), hospital patient-centredness is much more than the sum of its parts, but a direct function of the hospital’s overall culture, mission, system design, and operation. Cleary
(1992) agrees with this argument and adds that implementing patient-centred care goes beyond replicating good practices in hospitals.

The second aspect highlighted in the Picker Commonwealth survey is that: “Some environments are more conducive to patient-centred care then others.” A striking conclusion of this survey is that most patient-centred hospitals were invariably non-teaching hospitals, or hospitals with small teaching programs. Furthermore, Gerteis (1999), points out that this fact went parallel with the physical location, size, and management of the hospital with the smaller hospitals faring better than the large city located ones. According to Roberts (1993), this is attributable to a variety of reasons but mainly to the size of an organization. It is easier to coordinate care and communicate effectively in a small hospital and it is easier to be sympathetic towards patients, which share the same cultural background as the staff.

2.9 THE CULTURE OF A PATIENT-CENTRED HOSPITAL

The concept of “culture” as an attribute of organisations has attracted much attention in the management field in recent years. Many have tried to define organisational culture. Langfield-Smith K (1995) argues that there are two major schools of taught influencing thinking on organisational culture. The ideationists school, adopt the view that culture is commonly held believes, attitudes and values that give meaning to organizational life for its members and provide them with rules for behaviour. The second school described by Langfield-Smith K (1995), is that of the adaptationists, where culture is viewed as what is directly observable, such as behaviour and speech of the members of the society.

Other definitions bring together the two schools of thought such as Brown (1995) who defined culture as “shared philosophies, ideologies, values, assumptions, beliefs, expectations, attitudes and norms that knit a community together”. According to Gerteis et al (1993), patient-centeredness in the hospitals they visited was an expression of organisational culture. The hospitals that fared well exhibited a clear-cut mission, which was clearly articulated by top managers, which then helped to instil a culture based on the mission of the hospital. The researchers compare this fact with other findings in the same studies which indicate that larger hospitals, serving
more than one constituency exhibit obvious conflicts arising between the demands of clinical teaching and those of patient care.

To this extent, researchers such as Cooke and Rosseu (1988), Schein (1985), and Shortell et al (1991), state that the greater degree of specialization and bureaucratic complexity of the hospital, the more numerous and complex loyalties and cultures become. In fact large organisations have not one organisational culture, but various ones, each shaped by different values and interests (Runy 2005).

2.10 HUMAN RESOURCES

Another important factor, which enables a hospital to be truly patient-centred and create a culture focused on this principle, is its ability to attract, retain, and motivate the staff. During the Picker Commonwealth survey, top managers attributed their success as patient-centred hospitals to a solid work ethics, which was associated with community values outside and inside the hospital.

According to Gerteis (1993), the differences in the qualities of work forces are not simply attributable to the social environment. The successful hospitals, during the survey, whatever their location, “clearly invested time and energy recruiting and screening new job applicants”. Example of these policies are also found in the NHS where much time is spent on recruitment and appraisal of staff especially after these policies have become obligatory within the NHS framework to promote patient centred care. During the Picker survey, it was noted that some hospitals even went to extremes as leaving vacant posts, rather then employing the wrong individual. To the this extent, selective hiring is by definition discriminating, but when it is done properly it allows managers to re-assess skill mixes and staffing ratios they need, and helps them avoid the cultural stereotypes or superficial judgments in hiring that lead to discrimination in the negative sense (Schlesinger and Heskett 1991).

Investing in human resources means more than heaping praise upon employees to improve their attitude (Deming 1986). It requires a commitment from top to down management towards training and education that gives workers both the skill they need to do their job and the opportunity to develop personally (Casha 2002). In this sense, workers are attracted
to those institutions whose values and working styles are consistent with their own. This aspect forms a solid basis for a culture conducive of patient centred care.

2.11 DELIVERY OF HEALTH CARE SERVICES

A reliable test to assess patients' centricity of a hospital is to ask patients to evaluate service performance (Sofaer 2005). Secondly, managers must understand that performance depends upon those who deliver it. What matters most from the patients' perspective, is the frontline service, and personal care at the bedside, apart from clinical treatment. Data from the Picker institute survey suggests that while patients may be apt to forgive when they are not well informed about daily procedures, the same cannot be said for failure in meeting basic needs such as answering a call button or helping them go to the bathroom. Patients reporting problems in this area, have stated that they where four times unlikely to attend the hospital, and nine times less likely to recommend it then patients who had no problems in this same area.

2.12 THE LOCAL CONTEXT

With the Health Vision 2000 document (DH 1995), the health department emphasized its commitment to improve not only the health status of Maltese population, but also to improve the cost-effectiveness of its operations. However, this was not to happen at the detriment of the patients as discussed in the document “Towards best practice in Customer Relations” (Office of Review in 2002). In this document, the Hon. Dr.L.Deguara, the minister of health, wrote:

“Government's agenda for a number of years was predominantly focused on improving efficiency and “back room” operations. Recently however we have seen a change with a strong intention to ensure that all projects and initiatives keep the customer as the principal focus with customer satisfaction as the main objective.”

Implying that customer centricity is a priority objective for the local Health Department although bound by budget constraints and with increased demands.
St. Luke’s Hospital (SLH) is the single public general hospital of the Maltese islands. With a capacity of 884 beds, it incorporates most specialties and supra specialties, it is by far the largest hospital of the Maltese Islands (Annual HIA Report 2004). Services are free of charge at the point of use. As regards running costs, SLH competes with other entities for a share of the Ministry of Health annual budget. In November 2003, the management team of Mater Dei Hospital took over operations at SLH. According to the annual report of Institutional Health (2004), problems where encountered during this shift of responsibility, mainly due to the three fundamental problems which were lack of perceived authority, restraints due to civil service norms and the intervention of unions and also lack of staff.

According to the same report, during 2004, there was reduction of staff, and increased workload leading to several management problems. This aspect is also reflected into the adoption of an over bedding policy by SLH which became active in January 2005, to counter act the over-demand that the hospital was currently experiencing. Although considered a migrating hospital, various activities are currently taking place at SLH. Of note is the extensive work being undertaken on hospital policies such as admission, discharge, and transferring. SLH is also active internationally by means of the International Benchmarking System.

In 2004, the total number of ward admissions in SLH was 81,270. There were 55,722 (68.6%) in-patient admissions, 13,024 (16.0%) day cases and 12,524 (15.4%) dialysis sessions. 48% were males, and 52% were females. The mean length of stay for in-patients was 4.6 days. The average number of new ward admissions daily was 152.7. The hospital had a mean bed occupancy rate of 85.4%. The overall throughput was 67.3 patients per available bed. The turnover interval was 0.8 days. The daily turnover rate was 18.4% (Annual Institutional Report 2004). During 2004, the main problem at SLH remained was one of overcrowding, in particular the presence of social cases within the hospital. This was given ample media attention during the first three months of 2005, with no less than twenty articles in the local newspapers. (Source AP 2005). Another initiative at SLH was setup of Customer Care Service team, with the aim to provide efficient customer care functions. In addition, an in-patient, outpatient, and radiology satisfaction survey was conducted in the last part of 2004, as part of this initiative.
2.13 CONCLUSION

This literature review has shown that patient centricity and patient-centred care have various interlinking aspects, which together form such concepts. In today's health care environment it is not enough to have satisfied patients, but rather, the underlying aim of any provider must be to centre his operations around his customer. As clearly demonstrated, this concept is not a new idea in the local context, which signifies that the environment is receptive to patient centricity. However, several potential problems may hinder such concepts to actually take place. It is the health services manager role to counteract these problems and provide viable solutions. In the local context, these problems are further amplified by an increase in workload as shown by the yearly statistics of 2004 for SLH. This study will explore the extent of patient centricity of SLH albeit all the problems mentioned, to provide management with a clear picture of what needs to be done to achieve such a goal, and also to learn valuable lessons vis-à-vis a successful migration to the new hospital, Mater Dei.
Chapter 3

Methodology

3.1. INTRODUCTION

The study consisted of three phases. The initial phase was an exploration of the main issues concerning patient-centred care through an observational study carried out on four wards of three different specialities. The second phase consisted of semi-structured interviews with elite personnel involved in the management of the hospital. The third phase was a descriptive study through a questionnaire to patients recently discharged from hospital.

3.2. TIME SCHEDULE OF STUDY

The study was spread over ten months, starting in August 2004 and lasting till June 2005. The literature review was performed during the whole study period. In October 2004, the study design was planned and discussed with collaborators, the questionnaire was formulated, and a pilot study carried out. The recruitment of participants and collection of data was done systematically over two periods; from October to December 2004 and from March to April 2005. Also during the month of April, analysis of both the observations and the survey were conducted. Information and knowledge gained through the analysis was then utilised for the semi-structured interviews, which ensued during the latter part of April 2005. Finally, during May 2005, all the data were collated and analysed and the write up of the study carried out.

3.3 AIMS AND OBJECTIVES OF THE STUDY

Evidence that the patient-centred approach improves health care outcomes is abundant in the literature. However, implementation of such an approach in hospital care has been very slow and incomplete. This fact has prompted the researcher to explore patient-centred care
at the local general hospital from the patient's perspective and the organisation's perspective with the aims and objectives as described in the introduction of this study. (Pg 4 sec 1.5)

3.4 THEORETICAL FRAMEWORK

The theoretical framework on which this study was based is described in Chapter 2, Sections 2.3 and 2.4. Patient-centred medicine tries to understand the patients, and their complaints, the symptoms and signs, not only in term of illnesses, but also as expressions of the patients' unique individuality. In addition, the patients should be allowed to take a more active role in the decision-making and the management of their health problems.

3.5 RESEARCH DESIGN

This study was designed to explore the level of patient-centeredness at a general hospital through quantitative and qualitative research. The three research tools used were a patient-centeredness questionnaire to discharged patients, observation of staff and patient interaction on the wards and semi-structured interviews with elite managerial personnel. Through the three research tools, the design allowed for triangulation, complementation, development, initiation, and expansion (Creswell 2003) of the findings and thus making the conclusions more powerful. This study tried to avoid the pit fall of most of the single method studies that lacked depth because of the using solely quantitative method or being restricted to patients' perception (Cleary 2004, Greene et al 1989). In addition, a pilot study was conducted as to test the questionnaire used to survey the patients.

3.6 THE RESEARCH SETTING

The study was conducted at St. Luke's Hospital (SLH), the only public, general acute hospital of Malta that had to cater for a population of about 400,000. The hospital had a bed capacity of about 884 beds that could be expanded even more at times of over-demand. The management team consisted of various hierarchical levels with the top level being occupied
by the Chief executive officer (CEO). The hospital provided most specialities and supra specialities, but for the purpose of this study only wards from the general medical, general surgical and orthopaedic specialities were included. This amounted to eight medical wards, four surgical wards and three orthopaedic wards. The total patient population in these wards amounted to 586 patients. The observation phase of the study was conducted in four wards, which were selected at random by the researcher from the above-mentioned wards.

3.7 GAINING ACCESS

Several approvals had to be sought in order to approach patients and gain access to the wards. A research proposal was submitted to the Research and Ethics Committee of the Institute of Healthcare in order to be granted ethical approval. Approval was also granted by the medical superintendent of SLH in order to perform the study at the hospital. In order to perform the observations on the wards, permission was obtained from the Manager of Nursing Services of SLH, and from the deputy nursing managers in charge of the wards. The individual nursing officers of the wards were also informed of the study. During the study, due to Data Protection issues the researcher could not make use of information found in the Patient Administration System of the hospital, but had to identify each patient personally using convenience sampling.

3.8 THE RESEARCH INSTRUMENTS

The research instruments consisted of three tools: the observations, the survey to the patients and the interviews to the staff.

3.8.1 Observations

In order to explore and document the organisational “climate” regarding patient-centred care an observational design was chosen. This tool aimed to explore the cultural climate affecting patient-centred care and served to support the findings of the other two tools. The observations were performed during the last three weeks of March 2005. They were conducted by the researcher himself during different time of the day to document actions,
activities, and interactions normally occurring at different time. In total, there were sixteen hours of observation in four different wards of the three specialities.

The observational process underwent some modification from the initiation of the observations till the end. At the start, the observations conducted on the wards were overt in type, consisted in taking of field notes, and a general and unfocused approach was adopted. Particular note was taken of the ward setting, physical environment of the wards, and activities and interactions of staff and patients present on the wards. As the observer gained more experience, a more focused approach was adapted to the observations. Note was taken of particular elements of the ward setting which emerged from the previous observations that were more relevant for the study. Data collection continued until repetition of findings begun to occur at which stage the observations were terminated. The data generated by this phase was forwarded to a researcher in the field for analysis and thematic selection. This was done to limit the researcher’s bias as regards the observation analysis to a minimum.

3.8.2 Survey

In order to assess patient views on patient-centred care a questionnaire was formulated, consisting of 18 questions which aimed to explore the experience of the patient in the hospital retrospectively (see appendix B). The questionnaire was created by the merging of the relevant sections of two ‘parent’ surveys. The first survey was a 14-item patient questionnaire named “Patient Perception of Patient Centeredness” by Dr. Moira Stewart. This tool aimed to score the perception of patient centeredness during encounters with doctors. The second survey was designed by Picker Instrument as a measurement of patient-centred care as perceived by the patient. For the purpose of this study, key questions were identified from the tool, which amounted to a total of twelve, which are directly related to patient-centred care. This was made possible, with the permission of the Picker Institute. The resultant tool of this merger was piloted prior to its use in this study to assess the feasibility, accessibility, and acceptability in the local context.
After this phase, the need was felt that the questionnaire should be translated into Maltese to ease its understandability and acceptability by the Maltese patients. The Maltese version of the questionnaire was used throughout the study. Also prior to administration of this tool, face validity was performed by six experts in the field, and a back translation was performed of the tool, which compared well with the original tools. However, some minor amendments had to be made due to difference in language between Maltese and English.

The total population of the wards under study was 586 patients. This data was obtained from the hospital activity analysis report for the month of December 2004 and excluded the use of beds located in corridors during the same period. For the purpose of this study a representative sample at 90% confidence interval and one degree of freedom at .5 was calculated which amounts to 186 patients.

Inclusion criteria for the survey were:

- Must be older than 18 years and able to give consent
- Maltese residents
- Recently discharged from one of the wards being studied.

Exclusion criteria for the survey were:

- Patients that were too ill or disabled
- Patients that were cognitively impaired

A database of the patients that were on the wards under study was compiled by the researcher. A computer program was then used to randomly generate numbers from this database. The researcher contacted the randomly selected patients asking them to participate in the study and to give more details. A thorough explanation was given to the patients and they were allowed to reflect if they wanted to participate or not. Eligible and willing patients were approached by the researcher a second time after being discharged from hospital, in a completely random order, and the survey was administered either over the telephone or face to face. In every stage of this procedure, it was underlined to the patient the fact that they
can retire from the study at any stage and that anonymity and confidentiality was to be protected in every possible way.

3.8.3. Interviews

Qualitative research in the form of semi-structured interviews was conducted by the researcher (see appendix D), to establish the perception of the organization towards patient-centred care. The researcher used purposive sampling as described by Polit and Hungler (1991). The semi-structured interviews were of the topic type, in order to delve beyond the superficial responses the researcher used probes (Bowling 2001).

The interviews were conducted by the researcher himself, with six elite personnel that included the Director of Institutional Health, Manager Nursing Services of SLH, Manager Customer Services of SLH, and an individual from each specialty under study, which held either a consultant or senior registrar post. Each interview lasted between twenty to forty minutes. Of the six interviewees, only two accepted to be tape-recorded, the rest were hand written. An interviewee asked for an independent observer during the interview. All interviewees were left free to choose their language with which to conduct the interview and all were assured of confidentiality and anonymity.

3.9. ETHICAL CONSIDERATIONS

This study abided by the principles set forth by the APA ethical guidelines (2003). Permission to carry out the study was sought from the Medical Administrator of SLH and the data controller of SLH. During both the pilot testing and the actual study, it was ensured that anonymity and confidentiality for all participants was to be upheld. Any data that was generated by the study itself and other data concerning the participants were kept in a secure place by the researcher. Any queries that arose during or before the study were addressed by the researcher in a comprehensive manner. This included explaining carefully to the participants all the phases of the study and also underlining the fact that participation is not obligatory and that anyone could retire from the study at any stage.
3.10. THE PILOT STUDY

Since both the ‘parent’ surveys, used for the formulation of the final questionnaire, originated abroad, the researcher felt the need to pilot the tool prior to its use in the study. This was necessary so that it could be ascertained if the tool had any section, which could hinder its effectiveness. Six experts in the field were consulted and problems were identified as regards the wording of the questions in two instances. These were reworded and re-submitted to the experts. Subsequently an expert remarked that it would be useful to re-translate the tool from the Maltese version, which had been translated from the original English language, back to its original language. This was done to assess the validity of the tool after translation. By means of a professional translator, this was done, and good correlation was found between the two versions.

The final questionnaire was then submitted to fifteen individuals by telephone conversation. These were advised beforehand that they were to receive such a call and were chosen by convenience sampling. The test-re-test method was used and the tool was administered twice. Results concluded that the questionnaires were effective and reliable.

3.11 DATA COLLECTING PROCEDURES

Data was collected during the surveys by either face-to-face interaction with the patient or over telephone. All patients who were contacted were discharged from hospital shortly prior to the commencement of the study. This was deemed necessary so that recall bias was minimized. Although the direct interaction with the researcher could have provided an additional bias as regards the answers of the patients, such a method was deemed necessary, due to time constraints and information constraints as previously mentioned.

Quantitative data was analysed with the help of two statisticians, one general, and the other a medical statistician. The SPSS for windows package was used with the researcher forming the main template for the statistical analysis. Both parametric and non-parametric tests were used in the analysis of the questionnaire responses. In addition, distinct values were
computed from the questionnaires using calculations that originated from the original tools and enabled the researcher to quantify certain aspects of care. The main variables, which were used in the data analysis, were gender, speciality, length of stay and age. The observational data were transcribed fully and passed to an independent analyser for analysis. The data were coded to facilitate analysis and subsequently were analysed by means of identification of frequently occurring items that formed categories and major themes, using the inductive approach of the grounded theory. The links and relationships between the different categories and themes suggested theoretical prepositions.

The interviews were transcribed verbatim and then analysed by the researcher thematically and content analysis was performed using the inductive approach of the grounded theory. Categorisation was performed by the researcher by means of computer word processing.

3.12. CONCLUSION

This chapter was a thorough description of the research design and the three research tools used. Details were given of how they were developed, how they were utilised to generate the raw data and how the data was subsequently analysed to provide useful knowledge. The design is sufficiently robust to give relevant, valid, and powerful finding; however, barriers that hindered the development of an even more robust design were also described.
Chapter 4

Results

4.1. INTRODUCTION

This chapter will present the results of both the qualitative and quantitative data analysis. Section 4.2 presents the results obtained by the questionnaire, whereas section 4.3 illustrates the results of the elite interviews and section 4.4 presents the analysis of the observations. Tables and graphs are included to facilitate the presentation of findings.

4.2. QUESTIONNAIRE RESULTS

For the exploratory phase, a questionnaire had been formulated using relevant sections of two questionnaires: one developed and validated by Stewart et al (2000) and another by Picker Institute. It consisted of eighteen questions (see Appendix B). For the statistical analysis of data, the answers to the first ten questions were given a range from 1 to 4, with 1 being the most positive and 4 the most negative. In the remaining 12-18 questions, the answers were given a range from 1 to 3 and a fourth neutral answer that was considered as missing data.

The statistical analysis of the factors influencing patient centeredness was performed as shown in table 1. The first ten questions of the questionnaire were used to compute overall patient-centeredness. This was performed by adding up the scores from each question and computing the mean overall score as suggested by Dr Wayne Weston (Stewart et al 2000). The sub-score of patients' perception of their illness experience had been explored was calculated by computing the mean score of questions 1 to 3. Patients' perception of the patient and doctor concordance was computed by the mean scores of questions 4 to 9.

The sub-score of patients' perception on understanding the whole person was calculated by the mean score of question 10. While patients' perception regarding the quality of treatment and care received was calculated by the mean scores of questions 6 to 8. Other important
scores included communicating with the patient (questions 12 and 15), responsiveness to the patients' needs (question 13), patients perception of being ignored by staff (question 14), overall manners of doctors and nurses (question 16), information delivery by staff (question 17), and family support (question 18).

Table 1: Questionnaire scores and sub-scores

<table>
<thead>
<tr>
<th>Scores and sub-scores of patients' perception</th>
<th>Question number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Patient centeredness</td>
<td>1-10</td>
</tr>
<tr>
<td>2 Patients' experience of illness</td>
<td>1-3</td>
</tr>
<tr>
<td>3 Patient and doctor concordance</td>
<td>4-9</td>
</tr>
<tr>
<td>4 Holistic understanding of patient</td>
<td>10</td>
</tr>
<tr>
<td>5 Quality of treatment and care received</td>
<td>6-8</td>
</tr>
<tr>
<td>6 Communicating with the patient</td>
<td>12 and 15</td>
</tr>
<tr>
<td>7 Responsiveness towards the needs of the patient</td>
<td>13</td>
</tr>
<tr>
<td>8 Patient being ignored by staff</td>
<td>14</td>
</tr>
<tr>
<td>9 Overall manners of doctors and nurses</td>
<td>16</td>
</tr>
<tr>
<td>10 Information delivery by staff</td>
<td>17</td>
</tr>
<tr>
<td>11 Family Support</td>
<td>18</td>
</tr>
</tbody>
</table>

4.2.1. Results of the questionnaire

A total of 186 patients were chosen randomly from a total eligible population of 600 patients. The response rate was of 55.9 %, whereas 35.3% refused to be interviewed and 8.8% were unable to participate either due to re-hospitalised or to death. Statistical analysis of the data from the questionnaire was performed using SPSS software.
4.2.2. Descriptive statistics

Descriptive statistics was performed on the four main factors that were the age, gender, speciality, and length of stay. The mean age of the participants was 58.6 years, with a range of 71 years; the youngest being 19 year old and the oldest being 90 years old. The percentage distribution according to gender was 55.8% females and 44.2% males. When the respondents were subdivided into the three different specialties, the following distribution was obtained:

- 44 patients were from the medical wards; 25 females and 19 males,
- 26 patients were from the orthopaedic wards; 13 females and 13 males,
- 34 patients were from the surgical wards; 20 females and 14 males.

The mean length of stay of the whole study population was of 9.17 days, with a minimum stay of one day and a maximum stay of 120 days. The mean length of stay per speciality, corrected for outliers was 7.04 days for the medical wards, 5.56 days for the surgical wards and 4.34 days for the orthopaedic wards. For each of the 104 completed questionnaires the mean score for patient centeredness was calculated and the frequency distribution worked out as illustrated in graph 1. Patient centeredness had a non-parametric distribution with a mean patient centeredness score of 2.09, and a score range between the minimum score of 1.00 and maximum of 3.90.

Graph 1: Overall Patient Centred Scores Distribution
4.2.3. Inferential statistics

Inferential statistics was performed on four variables, which were the age, gender, speciality, and length of stay. (see table 2). Significance testing was performed using ANOVA tests, Kruskal-Wallis test, and Fisher’s exact test. For the purpose of this study, the null hypothesis was accepted or rejected at a significance level 5% and p-value of less than 0.05. Correlation was tested using the Pearson product moment correlation. All other remaining scores were statistically analysed against speciality. The only statistically significant result was obtained for question 16, which asked the respondents about the overall manners of doctors and nurses. The other questions showed no statistically significant results. Statistically relevant results are explained in more detail in the following sections.

<table>
<thead>
<tr>
<th>Score vs. Variable</th>
<th>Statistically significant result (p-value)</th>
<th>Statistically not significant result (p-value)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient centeredness vs. Age</td>
<td>0.45</td>
<td></td>
</tr>
<tr>
<td>Patient centeredness vs. Gender</td>
<td>0.858</td>
<td></td>
</tr>
<tr>
<td>Patient centeredness vs. Speciality</td>
<td>0.001</td>
<td></td>
</tr>
<tr>
<td>Patient centeredness vs. Length of stay</td>
<td>0.650</td>
<td></td>
</tr>
<tr>
<td>Sub score of illness experience vs. Age</td>
<td>0.121</td>
<td></td>
</tr>
<tr>
<td>Sub-score of illness experience vs. Gender</td>
<td>0.161</td>
<td></td>
</tr>
<tr>
<td>Sub-score of illness experience vs. Speciality</td>
<td>0.000 *</td>
<td></td>
</tr>
<tr>
<td>Sub-score of illness experience vs. Length of stay</td>
<td>0.777</td>
<td></td>
</tr>
<tr>
<td>Concordance vs. Age</td>
<td>0.064 (border)</td>
<td></td>
</tr>
<tr>
<td>--------------------------</td>
<td>---------------</td>
<td>-------</td>
</tr>
<tr>
<td>Concordance vs. Gender</td>
<td></td>
<td>0.567</td>
</tr>
<tr>
<td>Concordance vs. Speciality</td>
<td>0.000 *</td>
<td></td>
</tr>
<tr>
<td>Concordance vs. Length of stay</td>
<td>0.555</td>
<td></td>
</tr>
<tr>
<td>Understanding the whole person vs. age</td>
<td>0.048</td>
<td></td>
</tr>
<tr>
<td>Understanding the whole person vs. Gender</td>
<td></td>
<td>0.722</td>
</tr>
<tr>
<td>Understanding the whole person vs. Speciality</td>
<td>0.000 *</td>
<td></td>
</tr>
<tr>
<td>Understanding the whole person vs. Length of stay</td>
<td></td>
<td>0.683</td>
</tr>
<tr>
<td>Treatment (care) aspect vs. Age</td>
<td></td>
<td>0.178</td>
</tr>
<tr>
<td>Treatment (care) aspect vs. Gender</td>
<td></td>
<td>0.328</td>
</tr>
<tr>
<td>Treatment (care) aspect vs. Speciality</td>
<td>0.001</td>
<td></td>
</tr>
<tr>
<td>Treatment (care) aspect vs. Length of stay</td>
<td></td>
<td>0.508</td>
</tr>
<tr>
<td>Family support vs. Speciality</td>
<td>0.000 *</td>
<td></td>
</tr>
<tr>
<td>Family support vs. Length of stay</td>
<td></td>
<td>0.302</td>
</tr>
</tbody>
</table>

(*) --infinitely small number
(border) --borderline score
4.2.3.1 Patient centeredness against age

One of the questions this study tried to answer was whether patient centeredness is dependent on age. The following hypothesis was postulated:

\[ H_0 - \text{Patient centeredness is not affected by the age of the patient} \]
\[ H_1 - \text{Patient centeredness is affected by the age of the patient} \]

Since the p-value was calculated to be 0.045 the null hypothesis should be rejected and the alternative hypothesis accepted. This implies that there was a statistically significant relationship between patient centeredness and age. The statistical measure used to analyse the strength of this relationship was the correlation coefficient obtained by the Pearson product moment correlation test. The correlation coefficient between the centeredness score and age was 0.197 (table 3), which denotes a weak positive relationship. From graph 2, it can be deduced that the older a patient gets, the less the perception of patient centricity experienced (higher scores denote less patient centricity).

Table 3: Correlation of patient centeredness score and age

<table>
<thead>
<tr>
<th></th>
<th>Centredness</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>Centredness Pearson Correlation</td>
<td>1</td>
<td>.197*</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td></td>
<td>.045</td>
</tr>
<tr>
<td>Age</td>
<td>Pearson Correlation</td>
<td>.197*</td>
</tr>
<tr>
<td>Sig. (2-tailed)</td>
<td></td>
<td>.045</td>
</tr>
</tbody>
</table>

* Correlation is significant at the 0.05 level (2-tailed).

Graph 2: Patient centeredness score and age
4.2.3.2 Patient centeredness against different specialities

Another question this study tried to answer was whether patient centeredness is dependent on speciality. The following hypothesis was postulated:

\[ H_0 \text{--- There is no difference between patient centred scores of different specialities} \]

\[ H_1 \text{--- Patient centred scores differ significantly between specialities} \]

The test that was used to analyse this relationship was the one-way ANOVA test. This was used to compare the means of several independent groups.

Table 4: Descriptive Analysis of patient centeredness against different specialities

<table>
<thead>
<tr>
<th>Descriptives</th>
<th>95% Confidence Interval for Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Lower Bound</td>
</tr>
<tr>
<td>N</td>
<td>Mean</td>
</tr>
<tr>
<td>---</td>
<td>-----</td>
</tr>
<tr>
<td>Medical</td>
<td>44</td>
</tr>
<tr>
<td>Surgical</td>
<td>34</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>26</td>
</tr>
</tbody>
</table>

Table 5: Relation patient centeredness vs. specialities

<table>
<thead>
<tr>
<th>ANOVA</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Sum of Squares</td>
<td>df</td>
<td>Mean Square</td>
<td>F</td>
</tr>
<tr>
<td>Between Groups</td>
<td>11.602</td>
<td>2</td>
<td>5.801</td>
<td>13.678</td>
</tr>
<tr>
<td>Within Groups</td>
<td>42.835</td>
<td>101</td>
<td>.424</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>54.437</td>
<td>103</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The p-value for the null hypothesis was found to be much less than the level of significance (.000), implying that the mean patient centeredness score differed significantly amongst speciality. It was evident from the confidence intervals in table 4, that the mean patient centeredness score was significantly higher for the medical speciality (higher scores denote less patient centricity) and significantly lower for the orthopaedic speciality. This difference can be generalized because it was not attributable to chance. The 95% confident interval for
the medical speciality lay between 2.236 and 2.695. This confidence interval did not overlap with the confidence intervals of the surgical and orthopaedic specialities, explaining why the one-way ANOVA gave a significant result. Thus it can concluded that patient centricity is related to speciality in St. Luke's Hospital, with the highest level of patient centricity being experienced on the orthopaedic wards, followed by the surgical and least on the medical wards.

4.2.3. Illness experience against different specialities

A third question this questionnaire tried to answer was whether patient experience of illness is dependent on the type of speciality. The following hypothesis was postulated:

\[ H_0 \text{--- There is no difference between the illness experiences of among different specialities} \]

\[ H_1 \text{--- Illness experience differs significantly between specialities} \]

This hypothesis was tested using the one-way ANOVA. As can be deduced from the tables 6 and 7, the p-value was less than 0.005, thus null hypothesis was rejected and H1 accepted. The illness experience was much better for the orthopaedic wards then for the surgical and medical wards, in that order, as demonstrated by the confidence intervals (table 6).

Table 6: Descriptive statistics of illness experience against different specialities

<table>
<thead>
<tr>
<th>Speciality</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error</th>
<th>95% Confidence Interval for Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>44</td>
<td>2.21970</td>
<td>.859491</td>
<td>.129573</td>
<td>1.95839 to 2.48101</td>
</tr>
<tr>
<td>Surgical</td>
<td>34</td>
<td>1.70588</td>
<td>.660398</td>
<td>.113257</td>
<td>1.47546 to 1.93631</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>26</td>
<td>1.50000</td>
<td>.620036</td>
<td>.121599</td>
<td>1.24956 to 1.75044</td>
</tr>
</tbody>
</table>

37
Table 7: Relation Illness experience vs. specialities

ANOVA

<table>
<thead>
<tr>
<th>ILLNESS</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Groups</td>
<td>9.856</td>
<td>2</td>
<td>4.928</td>
<td>8.924</td>
<td>.000</td>
</tr>
<tr>
<td>Within Groups</td>
<td>55.768</td>
<td>101</td>
<td>.552</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>65.624</td>
<td>103</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

4.2.3.4 Level of concordance with age

The study tried to analyse the level of agreement between staff and patients and patients' age. The following hypothesis was postulated:

\[ H_0: \text{There is no relation between the level of concordance and age} \]

\[ H_1: \text{The level of concordance and age are related} \]

With the p-value of 0.064, the null hypothesis was accepted. However, from the values in table 8, it can be deduced that although the relationship between the level of concordance and age was not statistically significant, yet there was a weak relationship between concordance and age. This relationship was further analysed using the Pearson product moment correlation test. The correlation coefficient between the concordance score and age was 0.182 so it was weakly positive (table 8)

Table 8: Correlation level of concordance with age

<table>
<thead>
<tr>
<th>Correlations</th>
<th>COMMON_G</th>
<th>AGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>COMMON_G</td>
<td>Pearson Correlation</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.064</td>
</tr>
<tr>
<td>AGE</td>
<td>Pearson Correlation</td>
<td>.182</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>.064</td>
</tr>
</tbody>
</table>
4.2.3.5 Level of concordance in different specialities

A further analysis was done on the level of agreement between staff and patients and the different specialities. The following hypothesis was postulated:

\[ H_0 --- \text{There is no relation between the level of concordance and different specialities} \]
\[ H_1 --- \text{Level of concordance and speciality are related} \]

The test used to analyse this relationship was the one way ANOVA and the Pearson product moment correlation test. It can be deduced from the tables 9 and 10, the p-value was less then 0.005 (.000), thus H0 was rejected and H1 accepted. Patients’ perception of concordance (common ground) was much better for the orthopaedic wards then for the surgical and medical wards, in this order. This was inferred by the confidence intervals in table 9. This relationship was further analysed using Pearson product moment correlation test (table 11); the two variables exhibited a negative and medium high correlation coefficient of -0.428, which was significant at the 0.01 level.

Table 9: Descriptive statistics of level of concordance between different specialities

<table>
<thead>
<tr>
<th>COMMON_G</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error</th>
<th>95% Confidence Interval for Mean</th>
<th>Lower Bound</th>
<th>Upper Bound</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>44</td>
<td>2.60006</td>
<td>.843037</td>
<td>.127093</td>
<td>2.34975</td>
<td>2.86237</td>
<td></td>
</tr>
<tr>
<td>Surgical</td>
<td>24</td>
<td>2.08824</td>
<td>.749901</td>
<td>.128453</td>
<td>1.82690</td>
<td>2.34957</td>
<td></td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>26</td>
<td>1.73718</td>
<td>.604011</td>
<td>.118456</td>
<td>1.49321</td>
<td>1.98114</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>104</td>
<td>2.21955</td>
<td>.832616</td>
<td>.081644</td>
<td>2.05783</td>
<td>2.38147</td>
<td></td>
</tr>
</tbody>
</table>

Table 10: Relation level of concordance with specialities

<table>
<thead>
<tr>
<th>COMMON_G</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Groups</td>
<td>13.209</td>
<td>2</td>
<td>6.605</td>
<td>11.463</td>
<td>.000</td>
</tr>
<tr>
<td>Within Groups</td>
<td>58.194</td>
<td>101</td>
<td>.576</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>71.404</td>
<td>103</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4.2.3.6 **Understanding the whole person compared to age**

One question this study tried to answer was if patients were being treated differently according to their age. The following hypothesis was postulated:

\[ H_0: \text{There is no relation between the understanding the whole person and age} \]
\[ H_1: \text{Understanding of whole person and age are related} \]

Since the p-value was 0.048 (table 12), the null hypothesis was rejected and the alternative hypothesis accepted. This implies that understanding the whole person and age were statistically related. The older one gets, the less the perception that he or she was being understood as a whole person. The test used to analyse this relationship was the Pearson product moment correlation test. It can be deduced from table 12, the correlation coefficient between understanding the whole person score and age was 0.194, thus weakly positive.

Table 12: Correlation understanding the whole person to age

<table>
<thead>
<tr>
<th>Correlations</th>
<th>( q10 )</th>
<th>Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>( q10 )</td>
<td>Pearson Correlation</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>( N )</td>
<td>104</td>
</tr>
<tr>
<td>( Age )</td>
<td>Pearson Correlation</td>
<td>( 0.194^* )</td>
</tr>
<tr>
<td></td>
<td>Sig. (2-tailed)</td>
<td>0.048</td>
</tr>
<tr>
<td></td>
<td>( N )</td>
<td>104</td>
</tr>
</tbody>
</table>

* Correlation is significant at the 0.05 level (2-tailed).
4.2.3.7 Understanding the whole person against specialities

Another question this study tried to answer was if patients were being treated differently by different specialities. The following hypothesis was postulated:

$H_0$: There is no relation between understanding the whole person and speciality

$H_1$: Understanding the whole person sub-score and speciality are related

The test used to assess this relationship was the one way ANOVA. It can be deduced from tables 14 and 15, the p-value was less than 0.005 (.000), thus $H_0$ was rejected and $H_1$ accepted. The confidence intervals were very similar for the surgical and orthopaedic wards signifying that understanding the whole person scores for these specialties were very similar. However, the confidence intervals for the medical wards did not overlap with the other specialities implying a strong difference from the other specialities. It can be concluded that for both the orthopaedic wards and surgical wards there was a high level of understanding the whole person, which was very similar, whilst for the medical wards there was a lower level of this aspect.

Table 14: Descriptive analysis of understanding the whole person scores

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error</th>
<th>95% Confidence Interval for Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Lower Bound</td>
</tr>
<tr>
<td>Medical</td>
<td>44</td>
<td>2.36</td>
<td>.885</td>
<td>.130</td>
<td>2.18</td>
</tr>
<tr>
<td>Surgical</td>
<td>24</td>
<td>1.74</td>
<td>.710</td>
<td>.122</td>
<td>1.49</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>28</td>
<td>1.77</td>
<td>.514</td>
<td>.101</td>
<td>1.56</td>
</tr>
</tbody>
</table>

Table 15: Relation understanding the whole person and specialties

<table>
<thead>
<tr>
<th></th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Groups</td>
<td>9.576</td>
<td>2</td>
<td>4.788</td>
<td>8.726</td>
<td>.000</td>
</tr>
<tr>
<td>Within Groups</td>
<td>55.415</td>
<td>101</td>
<td>.549</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>64.990</td>
<td>103</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
In this study, it was asked if patients receive the same quality of treatment and care by the different specialities. The following hypotheses were postulated:

- $H_0$: There is no relation between treatment and care aspect sub score and speciality
- $H_1$: Treatment and care aspect sub score and speciality are related

The test used to analyse this relationship was the one way ANOVA. It can be deduced from tables 16 and 17, the p-value was less than 0.005, therefore, rejecting the $H_0$ and accepting $H_1$. There was a statistically significant difference in the treatment aspect scores of all specialities; however, as can be seen by the various confidence intervals there was overlap. The results indicated that the highest scores are achieved by the orthopaedic speciality, followed by the surgical and medical specialities respectively.

**Table 16: Descriptive analysis of treatment and care aspect**

<table>
<thead>
<tr>
<th>CURE</th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error</th>
<th>95% Confidence Interval for Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Lower Bound</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Upper Bound</td>
</tr>
<tr>
<td>Medical</td>
<td>44</td>
<td>3.03788</td>
<td>.994080</td>
<td>.149963</td>
<td>2.73565</td>
</tr>
<tr>
<td>Surgical</td>
<td>34</td>
<td>2.51961</td>
<td>1.101548</td>
<td>.188914</td>
<td>2.13526</td>
</tr>
<tr>
<td>Orthopaedic</td>
<td>26</td>
<td>2.03846</td>
<td>.980296</td>
<td>.194213</td>
<td>1.63847</td>
</tr>
<tr>
<td>Total</td>
<td>104</td>
<td>2.61859</td>
<td>1.086644</td>
<td>.107535</td>
<td>2.40532</td>
</tr>
</tbody>
</table>

**Table 17: Relation treatment and care aspect and specialities**

<table>
<thead>
<tr>
<th>CURE</th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Groups</td>
<td>16.819</td>
<td>2</td>
<td>8.409</td>
<td>7.934</td>
<td>.001</td>
</tr>
<tr>
<td>Within Groups</td>
<td>107.052</td>
<td>101</td>
<td>1.060</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>123.871</td>
<td>103</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
4.2.3.9 Quality of staff communication with the patients

This particular aspect was explored by means of questions 12 and 15. Question 12 asked respondents if they had received satisfactory and comprehensive responses to their queries while in hospital. Question 15 asked respondents about the availability of staff to answer questions. The following hypothesis was postulated:

\[ H_0 \] -- The quality of staff communication with the patients does not differ with speciality

\[ H_1 \] -- The quality of communication with the patients differs with speciality

Both sets of answers were statistically analysed by means of the Fisher exact test to see if there were differences in the perception of respondents from different specialities. Results showed that no such relation existed, that is, the quality of staff communication with patients was not dependent on the originating specialities. In both cases the Fisher's exact test yielded a p value of 0.271 and 0.250 and thus one rejects any association. Another important aspect to note was that the only respondents who reported problems in this area were coming from medical and surgical specialties (as shown in the graphs 3 and 4 in the 'no' section). In addition, a large number of respondents in both questions stated that they had no need to ask questions, which was shown in the graphs as missing data.

Table 18:

<table>
<thead>
<tr>
<th>Fisher's exact test question 12</th>
<th>Value</th>
<th>Exact Sig. (2-sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fisher's Exact Test</td>
<td>5.173</td>
<td>.271</td>
</tr>
</tbody>
</table>

Table 19:

<table>
<thead>
<tr>
<th>Fisher's exact test question 15</th>
<th>Value</th>
<th>Exact Sig. (2-sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fisher's Exact Test</td>
<td>5.169</td>
<td>.250</td>
</tr>
</tbody>
</table>
Graph 3: Question 12 answers

Graph 4: Question 15 answers

4.2.3.10 Staff responsiveness towards the needs of the patients

In this part, respondents were asked if they had found staff that was ready to discuss at length anything that was worrying the patients whilst in hospital. For this question, the following hypothesis was proposed:

\( H_0 \) --- Responsiveness does not differ with speciality

\( H_1 \) --- Responsiveness differs with speciality
This hypothesis was tested by means of the Fisher's exact test. It can be seen from table 20, that there was no association between the answers of the respondents and the speciality of origin. Many respondents stated that they always found staff ready for discussion when needed. However, the majority of respondents stated that they did not need to discuss anything whilst in hospital. This was shown in graph 5 as missing data. In all three specialities, only a minority of respondents had problems as shown in graph 5.

Table 20:

<table>
<thead>
<tr>
<th></th>
<th>Fisher's exact test question 13</th>
<th>Exact Sig. (2-sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fisher's Exact Test</td>
<td>5.833</td>
<td>.190</td>
</tr>
</tbody>
</table>

Graph 5: Answers to question 13
4.2.3.11 Patients being ignored by staff

Question 14 asked patients if during their stay in hospital, doctors or nurses were perceived talking about them, in their presence, as if they were not there. For this question, the following hypothesis was proposed:

H₀ --- Perception by patients of being ignored by staff do not differ with speciality
H₁ --- Perception by patients of being ignored by staff differ with speciality

This association was tested by means of the Fisher's exact test. A statistical association was sought between the answers to this question and the specialities of the respondents. As it can be seen from the results in table 22, no association was found between the answers of the respondents and their specialities. However, it can be noted that the major problem was on the medical wards. As demonstrated by graph 6, respondents from medical wards who reported “frequently” as their answer were in the great majority when compared with the other two specialities. The majority of respondents answering this question stated that they never experienced such an occurrence during their stay in hospital.

Table 21:

<table>
<thead>
<tr>
<th>Fisher's Exact Test question 14</th>
<th>Value</th>
<th>Exact Sig. (2-sided)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fisher's Exact Test</td>
<td>6.252</td>
<td>.391</td>
</tr>
</tbody>
</table>

Graph 6: Answers question 14
4.2.3.12 Comparison of overall manners of doctors and nurses with the different specialities

One would expect that since doctors and nurses receive the same training and come from the same background there would be no difference in their manners towards the patients on different wards of different specialities. The following hypothesis was postulated:

$$H_0$$---Overall manners scores do not differ with speciality
$$H_1$$---Overall manners scores differ with speciality

This hypothesis was tested using the Fisher’s exact test. The null hypothesis was rejected and the alternative hypothesis was accepted, as the p value was less than 0.05. Therefore, there was a significant difference in the manners of the doctors and nurses in the different specialities. The general results are presented in the graph 7. The largest number of unfavourable responses was given for the medical wards, followed by the orthopaedic wards and surgical wards in that order. The great majority of respondents from all categories had given a ‘good’ response.

Table 22: Statistical Analysis Question 16

<table>
<thead>
<tr>
<th>Chi-Square Tests</th>
<th>Value</th>
<th>df</th>
<th>Asymp. Sig. (2-sided)</th>
<th>Exact Sig. (2-sided)</th>
<th>Exact Sig. (1-sided)</th>
<th>Point Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Chi-Square</td>
<td>14.656</td>
<td>6</td>
<td>.023</td>
<td>.021</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fisher's Exact Test</td>
<td>14.293</td>
<td>6</td>
<td>.021</td>
<td>.021</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Linear-by-Linear Association</td>
<td>5.208</td>
<td>1</td>
<td>.022</td>
<td>.025</td>
<td>.013</td>
<td>.004</td>
</tr>
</tbody>
</table>

Graph 7: Answers Question 16
4.2.3.13 Quality of information delivery by Staff in different specialities

Different specialities and different professions within the same specialty may give apparent or actual conflicting information to patients. This question asked respondents if sometimes members of the staff disagreed as regard to information given to them. The following hypothesis was postulated:

\[ H_0 \text{--- Quality of information delivery does not differ with speciality} \]
\[ H_1 \text{--- Quality of information delivery differs with speciality} \]

This relationship was analysed using the Fisher exact test. The results presented in table 23 demonstrate the p-value was greater then 0.05 (0.911) thus, the null hypothesis was accepted as there was no difference in information delivery amongst specialties. Most respondents, as shown by the graph 8, stated that they never experienced any disagreement of information amongst staff.

Table 23: Statistical Analysis Question 17

<table>
<thead>
<tr>
<th></th>
<th>Value</th>
<th>df</th>
<th>Asymp. Sig. (2-sided)</th>
<th>Exact Sig. (2-sided)</th>
<th>Exact Sig. (1-sided)</th>
<th>Point Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Chi-Square</td>
<td>1.262</td>
<td>4</td>
<td>.868</td>
<td>.885</td>
<td>.911</td>
<td>.885</td>
</tr>
<tr>
<td>Fisher's Exact Test</td>
<td>1.295</td>
<td>4</td>
<td></td>
<td>.911</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Linear-by-Linear Association</td>
<td>.443</td>
<td>1</td>
<td>.506</td>
<td>.580</td>
<td>.294</td>
<td>.072</td>
</tr>
</tbody>
</table>

Graph 8: Answers Question 17
4.2.3.14 Comparison of family support with the different specialities

Patients' care and support by their relatives and family although very important, was not equally present on all the wards of different specialties. The following hypothesis was postulated:

- $H_0$—Family support sub-score does not differ amongst specialties
- $H_1$—Family support sub-score differs amongst specialties

This hypothesis was tested using the one-way ANOVA and the Fisher's exact test. It can be appreciated from tables 24, 25, and 26; the null hypothesis was rejected as there was a statistically significant difference in family support amongst the different specialties. The difference was statistically significant as demonstrated by the p-value (quote value). In addition, the Fisher's exact test indicated that such significance was not attributable to chance. Family support was more pronounced on the orthopaedic and on the surgical wards than on the medical wards. Interesting to note was that only on the medical wards a considerable number of respondents declared that they had no support at all (see graph 9).

**Table 24: Descriptive analysis Question 18**

<table>
<thead>
<tr>
<th></th>
<th>N</th>
<th>Mean</th>
<th>Std. Deviation</th>
<th>Std. Error</th>
<th>95% Confidence Interval for Mean</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Lower Bound</td>
<td>Upper Bound</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical</td>
<td>20</td>
<td>1.95</td>
<td>.759</td>
<td>.170</td>
<td>1.59</td>
</tr>
<tr>
<td>Surgical</td>
<td>23</td>
<td>1.43</td>
<td>.507</td>
<td>.106</td>
<td>1.22</td>
</tr>
<tr>
<td>Orthopedic</td>
<td>15</td>
<td>1.13</td>
<td>.352</td>
<td>.091</td>
<td>.94</td>
</tr>
</tbody>
</table>

**Table 25: Relation family support with different specialties**

<table>
<thead>
<tr>
<th></th>
<th>Sum of Squares</th>
<th>df</th>
<th>Mean Square</th>
<th>F</th>
<th>Sig.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Between Groups</td>
<td>6.096</td>
<td>2</td>
<td>3.048</td>
<td>9.142</td>
<td>.000</td>
</tr>
<tr>
<td>Within Groups</td>
<td>18.336</td>
<td>55</td>
<td>.333</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>24.431</td>
<td>57</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Table 26: Chi square tests question 18

<table>
<thead>
<tr>
<th></th>
<th>Value</th>
<th>df</th>
<th>Asymp. Sig. (2-sided)</th>
<th>Exact Sig. (2-sided)</th>
<th>Exact Sig. (1-sided)</th>
<th>Point Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pearson Chi-Square</td>
<td>17.432</td>
<td>4</td>
<td>.002</td>
<td>.001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Likelihood Ratio</td>
<td>19.284</td>
<td>4</td>
<td>.001</td>
<td>.001</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fisher's Exact Test</td>
<td>15.133</td>
<td></td>
<td>.002</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Linear-by-Linear</td>
<td>13.855</td>
<td>1</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
<td>.000</td>
</tr>
<tr>
<td>Association</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N of Valid Cases</td>
<td>58</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

a. 3 cells (33.3%) have expected count less than 5. The minimum expected count is 1.29.

b. The standardized statistic is -3.722.

Graph 9: Graphical Representation of Results Question 18

4.2.4 Questionnaire conclusions

From the questionnaire it turned out that, the speciality was the single factor that had the greatest influence on patient centeredness. Speciality had statistically significant influence on overall patient centeredness, on illness experience, on concordance, on holistic understanding of the patients, on the quality of treatment and care, and the quality of family support. The other factor that had some statistical significant influence on patient centeredness was age. Age had statistically significant influence on overall patient
centeredness, on concordance (statistical not significant), and on holistic understanding of the patients. The other factors, gender, and length of stay had a statistically significant influence on patient centeredness.

4.3 INTERVIEWS RESULTS

Six elite interviews were conducted; Table 28 illustrates the participants of the interviewees together with their position and code used for the purpose of this study.

Table 28 Interview Participants with relevant code

<table>
<thead>
<tr>
<th>Position</th>
<th>Code used for the purpose of the study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consultant Medicine SLH</td>
<td>CM</td>
</tr>
<tr>
<td>Consultant Surgical SLH</td>
<td>CS</td>
</tr>
<tr>
<td>Orthopaedic Surgeon SLH</td>
<td>OS</td>
</tr>
<tr>
<td>Management Nursing Services SLH</td>
<td>MN</td>
</tr>
<tr>
<td>Management Customer Services SLH</td>
<td>MC</td>
</tr>
<tr>
<td>Director Ministry of Health</td>
<td>DH</td>
</tr>
</tbody>
</table>

The sample for this part of the study was selected by means of purposive sampling. The focus of such a selection was on elite members of staff; staff which were involved in translating the concept of patient centred care from theory to practice. The interviewees were selected from the surgical, orthopaedic, and medical specialities, together with members from the nursing management, customer care services, and the Ministry of Health.

The interviews were of the semi-structured type; the key questions were as follows:

1) What do you understand by the term “patient centred care”?
2) In your opinion, do you think that there is a commitment to promote patient centred care by your organisation (SLH)?
3) What is currently being done to promote such an agenda?
4) What are the barriers to the provision of patient centred care within your organization, in particular to your work place and role within SLH?
5) Other comments

4.3.1. Answers to question 1 "What do you understand by the term "patient centred care"?"

The respondents showed several diverse responses to this question. These themes emerged from the various answers:-

- Holistic aspect, including family, social background
- Understanding the whole person
- Exploring both the disease and illness experience
- Promotion of health and risk avoidance
- Multidisciplinary approach to healthcare
- Informed Consent
- Respecting the patient and his desires

DH stated that:

"For me patient-centred care means, organizing everything which concerns the patients, from the cleaning services to the operations around the needs and preferences of the patient."

From the range of answers to this first question, it was noted that every respondent to some extent showed a personalized understanding of patient-centred care. The answers to this question reflected the different backgrounds of each respondent. Whilst the doctors in the sample emphasized the holistic approach and exploring both the disease and illness experience, from a managerial perspective the need to respond to patients needs and desires as a prime factor in the delivery of patient-centred care was highlighted.
4.3.1.1 Holistic Aspect

Four of the interviewees referred directly to this term as being part and parcel of patient-centred care. By holistic approach, it was understood that care towards the patient should involve every aspect related to him:

"by care I understand all aspects which pertain to the patient not only his condition, but also his family, his social background, religion etc." MN continued to elaborate on this point and stated that: "for me patient centred care is acting compassionately."

It is interesting to note that only MN, which comes from a nursing background, felt the need to express the term “compassion” in her definition of patient-centred care. None of the other respondents included this term in their definition.

However, DH remarked that:

"I think that the most important aspect of this concept is the patient, I quote people before me who said "His Majesty the patient."

DH continued to elaborate on these lines and added that every healthcare worker should deal with his patients as if he is dealing with a relative or close friend. Patient centred care should be a focused and intelligent approach to the delivery of health.

4.3.1.2 Understanding the whole person

This term was mentioned by three respondents directly. Although the other respondents alluded in general terms to this concept, it was not well articulated.

4.3.1.3 Exploring the disease and illness experience

Four respondents felt the need to include “exploring both the disease and illness experience” in their answer. This shows that practically all respondents consider this aspect as a core part of patient centred care. CM elaborated on this and stated that:
"one should address the fears and worries of the patient"

whilst exploring the disease and illness experience. Another interesting point that comes out from this part of the answer is that respondents perceive a difference in terms as regards "illness" and "disease". These are not perceived as being the same as regards the patient.

4.3.1.4 Promotion of health and risk avoidance

Only one respondent included health promotion and risk avoidance as part of the definition of patient centred care:

"for me patient centred care ..., promoting health whilst highlighting to the patient how to avoid risk and how to reduce it."

A point of interest, and congruent with previous findings, the only respondent to mention this aspect of patient centred care is MN, which comes from a nursing background. From this it can be inferred that MN has a broader concept of patient centred care, then her colleagues.

4.3.1.5 Multidisciplinary approach

This aspect of patient centred care was mentioned by two respondents, with the two being doctors. This more then highlights the fact that the answers that the respondents gave reflected mostly their professional affiliation and work background. OS stated that:

"by the term patient centred care I understand, a multidisciplinary approach towards medicine, with the centre of operations being the patients".
4.3.1.6 Informed Consent and respect for patients desires

Whilst informed consent was mentioned by only one respondent (OS), respect for patients' desires was mentioned by all the respondents interviewed. This showed a clear agreement and moderate understanding of this concept within the respondent group. However, DH also emphasises the importance to focus on the real needs of the patient and distinguishes real needs from other needs of the patient.

"We must put first and foremost the needs of our patients. I am not speaking about the frivolous needs but the real needs of the patient."

4.3.1.7 Diversity of meaning of patient-centred care

As can be appreciated from the above section the responses varied from one respondent to another and these reflected their professional background. No respondent mentioned finding common ground as part of patient-centred care. In addition, no reference was made to the patient physician relationship directly although some respondents mentioned it indirectly without going into detail. However, despite the differences in answers to this question, the researcher noted that there was a distinct difference between the medical profession and the other professions interviewed as regards the answer provided. There was a tendency from the medical profession to emphasis on the treatment aspect of patient centred care whilst the other respondents were more apt to describe other aspects of the care.

4.3.2. Answers to question 2 “In your opinion, do you think that there is a commitment to promote patient centred care by your organisation (SLH)?”

All the respondents, except one agreed that there is a commitment at SLH as an organisation. The deviant respondent stated that:
"I do not feel that there is a commitment towards this in SLH...the recent cancellations of operations reflect this."

Despite this answer, the other respondents stated that there is commitment but all then expressed reservations on this aspect. A particular respondent stated that:

"it is my impression that the general direction of the organisation is towards that, but I feel that there is lack of commitment from top management in this respect."

This view is challenged by a respondent, which states that:

"this is not totally attributable to the organisation of SLH"

All respondents express reservations on the commitment and all give reasons for this. The main reasons cited by the respondents were:

- Barriers within and outside the organisation
- Overcrowding issues
- Underlying issues and agendas within SLH
- Lack of finance

Two respondents agree that although there is commitment of SLH as an organisation towards patient-centred care, this commitment cannot be attributable to the whole organisation, and is described as 'patchy'.

"In my opinion I think that the commitment to promote patient centred care at SLH is very patchy. There are areas where commitment is pronounced and areas were patient centred care is less pronounced."

All respondents identify barriers to the commitment, irrelevant if they agree or not that the commitment is present. Also all challenge the totality of the extent of the commitment within SLH.
4.3.3. Answers to question 3 "What is currently being done to promote such an agenda?"

The answers to this question reflected, yet again, the different backgrounds of the respondents. Promotion of such an agenda was perceived differently by different members of staff. Only one respondent, coherent with the answer given in question two, stated that there is nothing, which is being done to promote such an agenda. According to CM:

"The administration is promoting the teamwork concept."

Moreover, this was seen as enhancing patient centricity in SLH. Also the same respondent went on to say that:

"Various health care professionals have developed a higher level of expertise which enables them to promote patient centred care in the long term."

This respondent felt the need to include the education aspect in his answer. Asked to elaborate on this, the respondent replied that a more expert workforce, in his opinion, can promote more patient centred care because it can provide a higher level of clinical and emotional care which ultimately is for the benefit of the patient.

MN corroborated with her previous answer, the statement of CM, and stated that from a nursing perspective, nurses are becoming more knowledgeable. However she went on to state that:

"They (the nurses) have still to achieve in patient centred care. Being a good nurse and being patient centric should be a synchronous process."

However, MN did not agree with CM’s statement as regards the organisational role in promoting such an agenda. In her opinion:
"From an organisational perspective not much is being done to promote such an agenda, in the sense that certain directives that we receive are not very patient centred."

However, MN acknowledged that the problem was not totally attributable to the organisation but rather was a broader problem, which was coming from a governmental level:

"I think that the government's agenda is still out of focus as regards the needs of the elderly, and this is leaving its repercussions on SLH".

Two further respondents identified the promotion of such an agenda in the setting up and operations of the customer care service unit within SLH. The respondents however did not articulate such an answer.

The straightest and most articulated answer to this question was provided by DH who stated that:

"What I can say is that patient centred care is the main philosophy in the agenda of reform to the management system of the health sector as envisaged and planned by government."

DH continued on these lines and stated that this more then highlights the commitment of the organisation to promote such an agenda. However, DH admitted that there are several problems to this. DH stated that:

"The problem however is how that agenda is going to cascade down to the frontlines of the service so that the point of service is really patient centric."

4.3.4. Answers to question 4 "What are the barriers to the provision of patient centred care within your organization, in particular to your work place and role within SLH?"

Various barriers to patient-centred care were identified by the respondents. These were grouped in themes to ease evaluation:
• Overloading/overcrowding problems
• Lack of coordination between professions (teamwork approach)
• Ward Environment
• Financial issues
• Cultural barrier
• Barriers contributed by management

4.3.4.1 Overloading/overcrowding problems

Five respondents identified this barrier as a major obstacle to the delivery of patient-centred care. However, congruent with the other answers to the previous questions, these were interpreted by the various respondents from the point of view of their professional affiliation.

In his answer CM emphasised that 50% of the barriers were all included in overcrowding problems in SLH. When trying to identify the source of this problem CM pointed out to the presence of social cases within his wards of competence. Due to overcrowding issues, CM stated:

"the contact time with the patient has been reduced significantly due to this state of affairs."

This view was also embraced by CS who stated that the time to interact with the patients had been reduced. CM continued to elaborate on his previous statement by saying that the current pressure of work was too much and this was a very serious barrier to consider.

"You become business like in your work”

MN also mentioned overcrowding problems and stated that this was affecting negatively the nursing staff. However, this was attributed by the respondent to demographic problems, which Malta was experiencing at the current time.
“Older people require longer and repeated length of stays in hospital, and this coupled with the increase in social cases contributes to the overcrowding issue.”

OS stated that the overcrowding was not only preventing patient-centred care to be practiced but was also affecting staff negatively:

“Frequently my staff are not enough for the daily workload and I feel that the general apathy which is gradually taking over is part to blame for the lack of patient centricity....how can one practice patient centricity with an outpatient clinic bursting with people....I just go through them that’s all!!”

4.3.4.2 Lack of coordination between the professions

Five respondents mentioned lack of coordination between the professions as a major barrier to the delivery of patient-centred care. CM stated that SLH suffered from lack of coordination not only between professions but also between the different specialities. CM stated that:

“I feel, and this is my general impression....that we don’t cater for patients as a total package but rather, each speciality is only concerned with its area of interest.”

Such a view was also expressed by MN who stated that sometimes the medical staff suffered from ‘myopia’ in treating patients and:

“From the nursing side, I feel that although nurses are fast becoming better professionals everyday, as exemplified by the emergence of specialist nursing....they are being hindered by antagonism from the consultants and their subordinates.”

Reference was made to this point also in CM interview but from a diametrically different perspective. CM stated that:
"I believe that all healthcare professionals should embrace the teamwork approach in order to deliver patient centred care. However this does not mean that one should debate the fact that doctors and especially consultants must have the leadership role in this respect."

OS and MS did not debate the role of the doctor within the healthcare team but OS in particular stated that:

"a very big barrier to the practice of patient centred care in this hospital is the attitude of some doctors, not only towards complimentary professions but also towards the patient"

DH also remarked about this barrier and stated that this is attributable to staff at SLH losing the esprit de corps;

"I believe very much in this concept ....but it is very lacking in our hospital."

DH was aware that certain professions accepted complimentary services but did not tolerate teamwork. DH position on this aspect was clear:

"If we do not tolerate teamwork, we cannot be patient-centred, because patient centricity means that if the patient needs more the social worker then the psychiatrist, the latter should step back for the good of the patient."

4.3.4.3 Ward environment

Of significance is the fact that only one respondent (MN) mentioned the environment of the wards as a barrier to the practice of patient centred care.

"Some wards are lacking structurally and this is directly affecting the provision of patient centred care in SLH."
4.3.4.4 Financial issues

These issues were brought up and defined as barriers by two respondents. Interesting was to note that a common denominator of these two respondents was the fact that both came from a background which was primarily involved in interventional aspects of healthcare delivery within SLH, although from different specialities. CS stated that:

"due to lack of funds we are not performing the recent developed procedures which first of all would benefit the patient and secondly would result in various benefits to the organization."

4.3.4.5 Cultural barriers

Only one respondent mentioned the cultural issue as a barrier to patient centred care. DH stated that:

"the first barrier is the cultural barrier, the Mediterranean culture."

DH elaborated on this statement and declared that this barrier was represented by the inherent attitude of staff, which came from their background or culture, which in his opinion:

"makes staff reluctant to embark in new organisational solutions"

It was the opinion of DH that this also prevented delivery of patient centred care as regards courtesy and bedside manners towards the patients.

4.3.4.6 Barriers constituted by management

Three respondents attributed barriers to the management structure of SLH. MN stated that:

"another part which contributes to the barriers is management, which I say that it has not yet enforced the culture of patient centred care in the policies that emerge from them."
A concordant view, but from a slightly different perspective was provided by MN which stated that certain directives which were aimed to minimize problems at SLH were not in themselves patient centric.

4.3.4.7 Conclusion of interviews

From this part of the study, various themes have emerged relevant to the topic under study. The organisation seems to perceive patient-centred care from various viewpoints, each reflective of the position of the individual within the organisational framework. Also the respondents identified various barriers to patient centred care which will be discussed in the next chapter.

4.4. OBSERVATION RESULTS

For this part of the study, the entire observational transcript was analysed and various categories and sub categories were identified. For ease of evaluation, the product of such an analysis is presented here. The processing of the observational transcript in its entirety can be found in appendix C.

4.4.1 Ward ambient and environment

4.4.1.1 General impression

In general, wards that were recently refurbished received positive comments whereas wards that have not been refurbished received negative comments. The refurbished wards were observed as being well organized, of very good quality, in good condition, and presenting a pleasant experience. The other wards were observed as being overcrowded, disorganised and not to the satisfaction of the patients. In both cases, the external environment of the wards was described as "leaving much to be desired."
4.4.1.2 Ward organization

Wards layout consisted of two big halls, two four beds rooms, and one to two single bedrooms. The beds were separated with partitions, of glass, aluminium or retractable curtains. It was an established practice that when patient admission on the ward exceeded ward capacity, additional beds were inserted in between existing beds and even in the main corridor.

While some wards were observed as being well organized, wards that were overcrowded with patients were observed as being disorganized and chaotic. Factors that were identified as reflecting to disorganisation were the presence of beds, patient medical files, filing trolleys, stretchers, trays and feeding utensils and piles of dirty linen in the corridors.

In every ward there were other rooms such as nursing office, consultant offices, treatment room, staff rest room, and a storeroom.

4.4.1.3 Noise level

On the wards, most of the time, the overall environment was observed as being very noisy. There appear to be a lack of self-consciousness among staff on the amount of noise they produce. Staff was observed as speaking out loud, discussing patients loudly, and whenever there was some activity on the ward the noise became pronounced. The only periods of silence on the wards was when there was no activity at all such as in the afternoon. Another identified source of noise and confusion on the ward were the relatives and visitors of the patients. Visitors were described as being present on most wards at any time of the day and very often in large numbers. They were described by the patients themselves as being numerous, noisy, inconvenient and causing confusion on the ward.
4.4.1.4 Cleanliness

Maintenance of cleanliness appeared to be a problem in some wards. This was a frequent reason for complaint by many patients and their relatives. What seemed worse was the fact that staff on such wards behaved indifferently to the lack of cleanliness. In contrast, other wards were described as maintaining very good and more than satisfactory level of hygiene. Dirty, messy, and cluttered floors were the main reason for uncleanliness. Piles of dirty linen lying on the floor were frequently described in various places of the ward such as the corridors, the pantry, and the toilets.

4.4.1.5 Decoration and lighting

The general impression was that wards decoration was at a minimum and a simple, minimalist, and reductionist setup was maintained. The walls of wards that were recently refurbished were nicely painted in light colours, however, the walls of the rest of the wards were in grave need of redecoration as the wall paint was dull and old and was observed as: "Walls and the furnishing of the ward were not very well kept." Windows on some wards had curtains while others were without curtains. The curtains were described as being old and need to be changed. The only other form of decoration observed were picture frames hang on the walls of the main corridors of most wards and on the walls of few big halls. In the observations, it was identified that proper use of natural lighting creates a nice atmosphere on the ward. However, on most wards very often there was excessive use of artificial light of the fluorescent type, while the windows were kept closed with shutters.

4.4.1.6 Ward and patients' security

Ward, patients and staff security seems to be a very serious issue at St. Luke's hospital. With the exception of a single ward, the main door was always wide open and there was free access for anyone. "The staff did not seem to be bothered by the presence of foreigners" and "no one asked about entrance of a stranger on the ward." Relatives, patients, and strangers are free to enter or leave the ward at will and without any form of control or checking.
The only security facility that was noticed in the observation was an intercom at the main entrance of a single ward. CCTV, restricted access facilities, and security personnel were never mentioned in the observations. It was not clear if there was any person responsible for the overall security of the ward, the patients and the staff.

**4.4.1.7 Ward facilities for patients**

In general, ward facilities for patients were scarce and not properly maintained. Most space available on the wards was occupied by beds and very little space was left for other purposes. At the entrance of every ward, there was a waiting area for patients and their relatives, containing some chairs and a television set. However, most of the time, the waiting area was found to be locked up and not accessible for the patients.

**4.4.1.8 Beds and sleeping facilities**

In general, the bed capacity of every ward was of about 36; however, at times ward capacity could be extended to 45 beds. The organization of a large ward of 36 beds was a difficult task, and when the ward exceeded its capacity, the overcrowding and disorganization started to be evident.

Single, double and four bedded rooms were very few on every ward and there was a medical purpose for them. The bulk of the patients were situated in the two large halls containing 10 and 20 beds respectively. The separation of beds with partitions or curtains provided very little privacy and comfort. The situation was much worse when corridor beds were inserted in between normal beds or in the main corridors.

Bedside facilities were very rudimentary; a bedside table, overhead lamp and a calling buzzer. At times these facilities were not functioning and very often corridor beds lacked such facilities altogether. Moreover, at times “staff told relatives of patients that there were neither pillows nor pillow cases available at the moment.”
4.4.1.9 Toilets and sanitary facilities

On each ward there were as common bathroom consisting of 4 to 5 showers, 4-5 water closets, and 4 wash hand basins. These facilities had to be shared by all the patients on the ward. The only other bathrooms available on the ward were an en suite toilet in one of the single bedded rooms and another one for the staff.

In general, toilet facilities were found to be clean. However, in some wards they were described as neglected and ill maintained while in others they were found to be of better quality and in perfect condition. A frequent complaint was that the doors of the toilet either could not be closed or were not lockable.

The use of bedpans was very much limited on the wards and very often, “patients were told that there were not bed pans available.” Patients that could not walk to the toilet on their own or were bed bound but continent of urine were still put in diapers. “On admission I was given a nappy, this devastated me.”

4.4.1.10 Complaint facility

Formal complaint facilities and formal complaint processing was practically non existent on the wards. Only one suggestion box was identified on only one ward. Some patients were afraid of retribution by the staff it they complained. Patients admitted that “Because this was a public hospital my expectations are not high.” Some relatives even resorted to complaining on local newspapers instead of voicing complaints to the Customer Care Unit.

4.4.1.11 Patients’ visitors

The presence as well as the absence of visitors and relatives made a pronounce difference to the overall running of the ward. Visitors and relatives were observed on the ward at any time of the day, during visiting hours as well as during non-visiting hours. While on some wards
there were no regulation on visiting times and the presence of visitors appeared not to be controlled, on other wards strict visiting hours were kept and only for exceptional reasons were relative allowed on the ward during out of visiting hours. Visitors were described by the patients themselves as being numerous, noisy, inconvenient and causing confusion on the ward.

4.4.1.12 Miscellaneous facilities

From the observations, it was evident that there was a grave lack of additional facilities for the patients. Apart from kitchenette or a pantry and the small waiting areas that were often found locked up, there was no mention of any recreational facilities or space for relaxation and leisure. The patients were considered purely as sick people and their other social needs where often ignored.

4.4.2. Patient support by ward staff

4.4.2.1 General comments

In general there were relatively few staff members to attend to the large number of patients on the ward (six members of staff for about 45 patients in ward that had a capacity of 36 patients). This would mean that patient support and care by the ward staff had to be very limited and very often prioritised according to the needs of the patients. This situation was often made worse by the presence of several extra beds and overcrowding of patients on the ward. The fact that the maximum number of patients on the ward was not fixed and the number of staff was not matched to the number of patients means that the quality of care patients received would have fluctuated form time to time.

4.4.2.2 Ward organization and routine

In many instances, patients have been woken up during the night and early in the morning repeatedly. This happened because the light of the main wards would be switched on to
enable blood checking of patients. This occurred due to the fact that sometimes the overhead lamp of an individual bed would not work, and the attending doctor would have no option but to switch on the light of the whole ward. Disturbed sleep was a common cause of complaint by many patients: “We have been woken up early in the morning repeatedly”; “In the night she has not managed to sleep decently”; “During the night the ward would be lit up apparently for no reason”.

The placement of patients on the ward could also be a source of discomfort for the patients. In one particular ward, patients were positioned according to priority of their illness. This necessitated that patients’ positioning had to be changed frequently, creating inconvenience for the patients and chaos on the ward. On other wards, post-operative patients were placed in the same hall. This would mean that patients who have had minor operations would have to stand the moaning and groaning of patients that have had major operations and were in greater pain. Similarly, on other wards, elderly patients were placed with relatively young patients creating discomfort and uneasiness on the latter class of patients. Therefore, it would be more humanly acceptable if other factors such as age, sex, and envisaged hospital stay besides type and severity of illness, are taken into account when considering patients’ placement on the ward.

4.4.2.3 Approach towards patient

Overall, the approach of ward staff towards patients was very positive. The staff was described as being particularly polite and cordial; interacting with patient excellently, and respectful to patients’ needs. However, there where instances where staff approach was very disrespectful. For example patients have recounted instances when the “staff told patients that they were in the wrong ward”

4.4.2.4 Responsiveness of nurses

Overall, nurses were observed as being very responsive to patients’ needs and queries. However, some patients complained that nurses failed to deliver care at times, such as “Called nurses but they did not come”; “Patient left all night vomiting”; “Nurses failed to provide bed pan”;
and “Patients did not receive any help when they wanted to wash up”; “Patient asked for help and nurse told him nurses had many things to do”. Although, at face value this may look as negligence or lack of professionalism on the part of the nurses, there could have been other reasons that made them behave in such a manner. Such reasons could have been: overcrowding on the ward with patients exceeding the full capacity of the ward, shortage of staff, shortage of facilities example lack of bed pans, bed sheets and pillow cases, or nurses could have been following a union directive.

4.4.3. Patient care and the Medical staff

4.4.3.1 Patients’ care and medical doctors

Repeatedly, the interaction between medical staff and patient was described as being very cordial and polite and the communication between the two was very well. Doctors took time to explain procedures clearly, answer any queries, and to reassure the patients. However, there were instances where doctors’ behaviour was not to liking of the patients. For example, a patient recounts an instance when a doctor called out loudly a patient’s name, making the patient feel embarrassed. Another instance of disagreeable behaviour described by a relative was when doctors were discussing openly and loudly amongst themselves issues of quality of life near a dying patient in the presence of the relatives.

Another reason for repeated complaint by patients was the discharge procedure. It was an established practice that patients were informed that they were discharged from the ward early in the morning, their bed would be quickly taken over by another patient and they would be left waiting in the corridor for the issuing of the discharge letter. However, because the medical officers would be busy during the morning doing ward rounds, outpatient sessions or assisting at the operating theatre, discharge letter would only be issued late in the afternoon. This means that either the patient leave the hospital without a discharge letter or else the patient would have to wait for hours in the corridor or waiting area.
4.4.3.2 Approach of medical students

St. Luke's Hospital is a teaching hospital and this entails that patients are frequently seen by medical students and other students like nurses. The observation recounted one of such episodes and clearly described the inconvenience the medical student created to patients. One patient describes how many students go to speak to him, seven groups of students went on him asking the same questions and performing the same examination that day. Although, the patient understood the need for medical students to learn and was very cooperative with them, he admittedly was not amused when seeing another group of students.

4.4.3.3 Conclusion of observation phase

This part of the study concluded when repetition of findings begun to occur. The observations have shown that there might be a problem as regards the overall physical environment within the individual wards.

4.5 Conclusion

The above chapter has illustrated the results obtained from the three tools used in this study. These results are analysed and discussed in the following chapter with the aim of comparing and contrasting the results from the three tools and providing insight in patient centred care within SLH.
Chapter 5

Discussion

This study was designed to investigate the level of patient-centeredness at a general hospital through quantitative and qualitative research. The three research tools used were a patient-centeredness questionnaire, an observation study of staff and patients and semi-structured interviews with elite managerial personnel. The three research tools allowed triangulation of the findings. Starting with the assumption that patient-centred care is vital and desirable by both patients and hospital staff, as suggested by the literature review, the study concentrated on investigating the level of patient-centred care at St. Luke's Hospital (SLH), and attempted to uncover any barriers that may hinder quality improvement and effective patient-centred care. The researcher believes that this study could be a useful tool for providing scientific evidence of the level patient-centeredness achieved in a large general hospital like SLH and provide direction for future improvement in the quality of patient care on the wards of a general hospital.

5.1. PATIENT-CENTRED CARE AS PERCEIVED BY THE PATIENT

The researcher found that despite a high level of awareness about patient-centeredness amongst staff, this was not being transmitted to the patients through quality care. From the first part of the questionnaire it was estimated that the overall patient-centred care had a mean score of 2.09 (1 being the highest, while 4 being the lowest). 57% (N = 64) of the respondents gave a patient centricity score better than average (<2), whereas 43% (N = 45) of the respondents gave a score worse than average (>2). These scores signified that the overall patient-centred care at SLH as perceived by the patients was of moderate level. Statistical analysis of the patient-centeredness scores against the four main independent variables has yielded statistically significant results in only the type of speciality and patients' age, although the latter was to a much lesser degree. Gender and length of stay were shown to have no effect on patient centricity what so ever.
5.2. DIFFERENCE AMONGST SPECIALITIES

In this study, the mean patient-centred care score was statistically superior for the orthopaedic wards compared to the surgical and the medical wards. The observed differences amongst specialties were also present in all other sub-scores, which yielded unequivocal, statistically significant results. There may be several explanations for such results.

One explanation could be that the three specialties have inherent differences in case mix. From the observations, it was noted that the patient demographics of the orthopaedic and surgical wards were different from those of the medical wards. Patients on the wards of the former two specialties, tended to be younger than those on the medical wards. In addition, a gender difference was apparent, on the medical wards female patients significantly outnumbered male patients, whereas on the orthopaedic and surgical wards a more equitable gender mix was observed. These differences in case mix alone could have skewed the results towards the particular health care requirements on the wards. Older patients and female patients might have needs that are more demanding. Moreover, they might have higher and unrealistic expectations.

Another explanation for the differences amongst specialties could be inherent differences in type of health care provision. While on the orthopaedic and surgical wards, there were more patients for elective procedures, on the medical wards, the majority of patients had chronic ailments, requiring frequent re-hospitalization. Health care outcomes, in the orthopaedic and the surgical specialties, tend to produce immediate and tangible improvement in the health status of the patients. On the contrary, health care outcomes in the medical speciality tend to produce limited health improvement that is less tangible for the patients due to the chronicity of the illness. This does not only influence the relative workload but also influence the level of job satisfaction of the staff. Staff working in orthopaedic and surgical specialties might have higher job satisfaction due to a higher rate of 'satisfactory health outcomes'. On one hand, in the medical speciality, this might not be the case due to the type of patient case mix and type of illness present on these wards. Thus there might be the possibility of medical staff to be dissatisfied and demotivated by the apparent poor health care outcome of
their work, which reflects in the quality of care delivered to the patient. These fundamental differences in specialities must all be taken into account when discussing the issues of patient centricity.

Another aspect to be considered is the staff to patient ratio of the different wards and the relative size of the wards. The smallest wards observed in this study were the orthopaedic wards, whereas the biggest were the medical wards. During the study, the wards having the highest patient census were always the medical wards, thus having the lowest staff to patient ratios. Staff working in this environment was perceived as demotivated, with major factors being resource inadequacy and lack of administrative support. Increasing the staff to patient ratio is not an easy task from a management point of view. Over the past decade there have been a number of studies that have reached conclusions regarding the relationship of patient load to staff availability in health care facilities. Actions that reduce the number of patients per staff in hospitals can produce outcomes that are beneficial in a number of ways. Operationally, these benefits are manifested in the quality of care provided to hospital inpatients, reductions in the use of hospital resources, and improvements in the quality of work life for staff.

The reasons for these findings are fairly obvious. Having too many patients reduces the time staff can attend to and observe individual patients, and the extra workload often leads to fatigue, and in combination the two can lead to errors. In addition, understaffing means patients often have to wait longer times for medication or medical procedures, and there is often not enough time to educate patients and their families (Hart 2003). As the relationship between patient-to-staffing levels and quality of patient care has become better documented, research attention in recent years has increasingly focused on specific patient outcomes that are related to staff levels and the costs of these outcomes. The underlying assumption is that the increase in staff performing hands on patient care will result in better quality of care and better patient outcomes. While there are substantial costs associated with increasing staff to reduce the patient-to-staff ratio and to minimize or eliminate staff overtime, better patient centred care and outcomes will pay for themselves through reduced costs associated with complications, adverse events, and reduced patient lengths of stay, not to mention reduced turnover costs.
5.3 DIFFERENCES WITH AGE

The study has demonstrated that there was the tendency for the mean patient-centeredness scores to increase with the age of the patient, showing that the patients' perception of patient centricity decreased with increasing age. Although the relationship between patient centricity and age was not as powerful as that between patient centricity and speciality, this relationship has important implications.

Various researchers have given different reasons for decreased quality in patient care with increasing age. Morgan et al (1997) sustain that patients who are elderly, often present themselves with complex medical problems that are further compounded by their fragile emotional and social state. In a study by Scheuer et al (2002), it was found that older patients have a decreased symptom perception, which most often leads to incongruence between what the patients perceive to be the problem and the clinical diagnosis. This study also provided some evidence that this might be the case. Relating this particular aspect with the previous section, the fact that older patients were observed in the medical speciality might offer yet another possible explanation as regards the decreased patient-centred score in this speciality. During the observation phase, it was noted that such patients were frequently found in overcrowded wards. This fact alone more than compounded the issue of patient centeredness within these wards.

5.4 DIFFERENCES IN VARIOUS ASPECTS OF PATIENTS' CARE

Through the questionnaire, the study also queried respondents on various aspects of care they may have experienced whilst in hospital. The first aspect that was assessed was the overall manners of the staff. The results of the questionnaire pointed to a majority of 'good' responses. Statistical significance was obtained when the responses were compared across specialities, with the orthopaedic wards scoring the highest, followed by the surgical and medical wards. In fact, the major number of negative responses was detected in the medical speciality. This correlated well with the previous analysis of the differences between specialities. Another two aspects that were assessed in the questionnaire were the quality of information delivery by staff and the quality of staff communication. Most respondents were
very positive with regard to communication and responsiveness issues, the majority of respondents did not report any problems, and there were no significant differences between specialities.

However, a large number of respondents stated that they did not need to ask questions during their stay in hospital. This could have several interpretations such as that every aspect of their care was well explained by the staff in advance or that they had no interest to be involved in their care. Whatever the answer, this could have affected the results. The final two aspects of care that have been investigated were staff responsiveness towards their needs whilst in hospital and if there were instances during their stay when they felt ignored by staff. In both instances, no significant relation was found between originating specialities and results. In addition, the majority of respondents sustained that they always found staff open for discussion and that they never experienced being ignored by staff. This reflects the fact that most staff at SLH, in particular, the nursing and medical staff were observed as having good communication skills, and patients perceived this positively. Also, the above findings, seems to suggest that patients’ perception of ward staff was very good and overall ward staff were adequately trained and dedicated to their patients.

5.5 PATIENT-CENTRED CARE AS PERCEIVED BY THE ORGANISATION

There was considerable diversity of the understanding of the term patient-centred care amongst the interviewed senior personnel during this study. Several themes emerged that were congruent with various definitions and theoretical frameworks found in the literature. Seven themes were identified from the various answers to this question: holistic care including family and social background, understanding the whole person, exploring the disease and illness experience, promotion of health and risk avoidance, multidisciplinary approach, informed consent, and, respecting the patients’ concerns and desires. However, despite all these mentioned factors, a common view and common understanding of what should be patient-centred care in a general hospital was lacking. This was similar with the observational findings in the three specialties, which reflected the fact that all the different specialities give a different interpretation of this concept, which is then reflected in their daily activities.
Holistic care was strongly associated with patient-centred care by four of the six interviewees. However, the respondent with nursing background showed the widest understanding of holistic care, where she included amongst other things the religious and spiritual needs of patients as suggested by Rothrock (1994). Understanding the whole person was mentioned by three of the six interviewees. However, the interviewees were unable to elaborate further what they exactly meant by understanding the whole person. All interviewees gave importance to exploring both the illness and disease in their answer. However, health and illness have different definitions and meaning to different persons, as was evident in their answers. Yet again, in this aspect a direct correlation with the observations can be made. Health professionals, working in different backgrounds interpret this concept differently. Consequently, at SLH, the organization lacks a common understanding and agreement of what health is, what illness is, and what care is, that inevitably has a negative effect on the understanding of patient-centred care.

Only one respondent included promotion of health and risk avoidance in the definition of patient-centred care. Patients' health education, promotion, and prevention should start in the community, be reinforced at hospital, and resume in the community. Such vision was not given priority at SLH and there was a deficit in continuity between community (primary care) and hospital care (specialist care). Only two respondents emphasized the need for multidisciplinary approach as an important part of patient-centred care, and this was not well articulated by the respondents. This could have several implications such as the possibility that the multidisciplinary approach amongst hospital staff is not a priority at managerial level. It could also mean that the management team should work more closely with the frontline staff on the wards to provide a working environment more conducive of patient-centred care and at the same time enhance the multidisciplinary approach.

Informed consent was only mentioned by one respondent whilst respect for patients' concerns and desires was mentioned by all respondents. The wishes, desires, and concerns of the patient should be given more importance and more weight in decision-making. Nowadays, it is a recognized fallacy that nurses and doctors always know what is best for the patient.
The interviewees also failed to mention several important issues related to patient-centred care. None of the interviewees mentioned respect of basic human rights and respect of patient's rights of adequate privacy, respect for human dignity, right of expression and ability to make a complaint without being coerced. All these are mentioned in the patient charter of SLH where patient-centred care is declared by hospital management and is made known to the patients, to the staff and to the public. From the analysis of the semi-structured interviews, it was obvious that the individual interviewees focused on different aspects of what patient-centred care might mean, with the consequence that there seemed to be a lack of understanding of what the term really means and lack of clarity. This diversity in meaning could have several important implications such as lack of ownership of the concept and overlooking of important aspects of patient-centred care, which in turn would make implementing policy in this respect very difficult.

5.6 LEVEL OF COMMITMENT TO PATIENT-CENTRED CARE

Five out of six interviewees consider that there was commitment to promote patient centred care at SLH, but all expressed reservations in this respect. Commitment can be considered as a state of attachment that defines the relationship between an organization and its target (Brown 1996). It is essential in the successful delivery of management policies, together with the provision of the necessary time, resources, and positive approach to the policy (Elizur 2001). However, if commitment was being limited, as remarked by some of the respondents, it might be that the policy of patient-centred care within SLH was not given the right priority; therefore, not adequately delivered. In fact that the respondents not only associate the presence of barriers to the commitment, but also sustained that the commitment did not encompass the whole of the organization, but was described as ‘patchy’. This aspect correlates well with the findings of moderate patient centricity shown by the questionnaire.
5.7 PROMOTION OF PATIENT-CENTRED CARE

All the respondents except one sustained that within their organization there were ongoing activities and policies to promote the agenda of patient centred care. Among the activities mentioned by the respondents were the promotion of the teamwork concept, the continued education of staff, the customer service at SLH and other government policies.

It was pointed out that an interdisciplinary approach to health care required health care providers from different disciplines to collaborate and function interdependently to meet the needs of patients and their families. Various benefits of multidisciplinary teamwork were identified such as a more efficient and effective use of human and financial resources through the provision of appropriate health care services, and a reduction in duplication and overlap of services. It was also stated that this concept also encourages each discipline to contribute its unique knowledge to the collaborative process, which provides a broader base for decision-making and a wider range of service options. Also, important positive implications of this concept that were mentioned by the interviewees were increase job satisfaction, promote better understanding of each other, mutual support among team members, reduced interdisciplinary competition, increased knowledge and skill mix, and consumer satisfaction improvement. Respondents have identified an increased knowledge base of healthcare professionals towards a better provision of patient centred care.

This finding was congruent with the findings of Johannessen and Dolva (1994), which identified education, internal training, experience, and specialization as being critical innovation factors. Respondents related the setting up of a customer service unit at SLH as an attempt to promote patient centred care. However, the interviewees were very critical as the patients’ right for complaint was not actively promoted at SLH and complaints were not perceived as a positive issue that could be used as a learning tool that could lead to improvements in health care delivery. The customer-care service department has neither the resources nor the authority to implement necessary changes that are pointed out by patient complaints. Such state of affairs was well documented by the observational study where patients and relatives expressed their frustrations that their complaints were unheeded. These findings correlate well the resulting feedback that emerged in the interview with the manager of customer services of SLH who stated that the customer service department was
currently more concerned with one to one complaint handling, rather then providing feedback essential for future policy-making.

5.8 BARRIERS TO PATIENT-CENTRED CARE

Although the respondents identified six major types of barriers to patient-centred care at SLH, correlation with the observational findings yielded only five such barriers. The sixth barrier that was mentioned by one respondent was not observed, and thus could be the result of a heavily biased point of view. The themes were overworking and overcrowding problems, lack of coordination between professions, poor ward environment, limited financial resources, and cultural barriers.

5.8.1 Ward Overcrowding

All the respondents stated that the most frequent barrier that they encountered on a daily basis was the overcrowding on the wards. Comparing these statements with the Hospital Activity Analysis (HIA) of SLH for 2004, one finds that for that year the medical wards experienced bed occupancy of over 100%, the surgical wards 81.4% and the orthopaedic wards 71.3%. This data was also comparable with the data generated from the observations. From an operational perspective there seemed to be a problem in the handling of demand for beds at SLH. Several factors lead to demand uncertainty in health care delivery.

Vissers et al. (2001) suggest three underlying dimensions of demand uncertainty in health care: size of the population in the catchments area; demographic changes in the population such as the increasing proportion of elderly patients; and changing professional standards that are influenced by higher patient expectations and technological developments. The first two aspects are particularly relevant to the situation at SLH. Apart from the increase of the local population, there has been a demographic shift in the elderly population. This has resulted in an increased demand of services from SLH especially from elderly patients. This study has demonstrated that the overcrowding issue in the wards is one of the primary barriers to the patient centred care agenda. Stakeholders must prioritise such an issue, especially in the light of the current projections as regards demographic changes which the Maltese islands are going to experience in the near future.
5.8.2 Lack of coordination between professions

Lack of coordination between professions was described as a major barrier to the delivery of patient-centred care within SLH. The emphasis on this barrier was made especially on the antagonism that exists between nurses and doctors, which was described as problematic for the hospital management and future development. In the local scenario, this antagonism between the medical and nursing profession has its roots and origin in the educational system of Malta, which segregates potential members of the two professions from the very beginning of their careers that might be the source of such antagonism. Furthermore, antagonism was also described amongst the different specialities as these continuously compete for the limited funds and resources. The split amongst specialities was amply demonstrated in this study as perceived by the interviewees. Evidence of this antagonism and its negative influence on patient-centred care is abundant in the literature (Radcliffe 2000, Blickensderfer 1996).

5.8.3 Ward environment

Only one respondent felt the need to mention poor ward environment as a barrier to patient-centred care. Congruent with the findings in the observational phase, it was noted that environment also plays a significant part, not only in the delivery of patient centred care, but also can serve as a buffer for stress experienced by staff. From the observed wards, it was noted that different wards had different levels of refurbishing. Moreover, orthopaedic wards were observed to have a different layout to other wards, and a smaller number of patients. Relating this to the questionnaire results, one might consider the option of replicating such a setup on other wards and then follow up with an assessment to see if patient centricty on these wards has been affected.
5.8.4 Funding

Various respondents sustained that patient-centred care could not be delivered in the present climate of under funding currently being experienced by the local health care system. This might present the case were the respondents associated this type of care with increased expense. Stewart et al (2000) challenges this concept and states that changes for better patient-centred care delivery can be made within limited resources. However, from the previous results, it has been noted that a certain amount of funds are needed, especially if physical environment changes are considered. In addition, to increase staff to patient ratios, an equivalent increase in funds is needed; nevertheless, as previously discussed, the advantages to this, by far outweigh the economic sacrifice.

5.8.5 Culture

One respondent mentioned that one of the most insurmountable barriers to patient centred care that existed at SLH was the culture of the workforce, which in his opinion restricted the delivery of patient-centred care. Such a statement however did not find any significant correlations with the findings of this study. Staff has been observed as being responsive to the patients needs and the questionnaire results seem to point to that direction also. However gauging organizational culture is a major study in itself and thus if there is a perceived problem, a cultural assessment could be performed to elucidate better the culture within SLH and assess if such a culture is in fact receptive to the patient centred care agenda.

5.9 ORGANIZATIONAL CLIMATE

The observational phase explored the climate within the organization as regards patient-centred care. Organizations may have many climates (Langfield Smith 1995), but this study focused on the physical environment and the social interactions, which could be associated to patient-centred care.
5.9.1 Physical Environment

Well thought facility design not only actualizes a philosophy of care, it can also ensure that health care facilities are efficient, orderly, and functional; and at the same time, stress reducing. Falk and Woods (1973) in their study provided the first proof that stress can increase the risk of infection. Just as stress can influence the onset of illness, research also suggests that stress-reducing environments can have a beneficial effect on healing (Ulrich 1992, Malkin 1992, Knapp 1993). This aspect can also be related to the previous discussion as regards the staff to patient's ratios. Stress-reducing environments are not only beneficial to the patients but also to the staff who ultimately must dispense patient centred care. In the observation phase, it was noted that there was a significant difference between recently refurbished wards and other wards. The refurbished wards were described as being well organised, of very good quality, in good condition, and presenting a pleasant experience. The other wards were described as being overcrowded, disorganised and not to the satisfaction of the patients. This reference was made entirely for the medical wards. The open layout of the ward with several beds in large halls mean that if a patient needed attention during the night all the patients would have been disturbed by having to light up the hall or by the noise generated. Relating to this fact, in the observation it was noted that the orthopaedic wards have such a layout. However, this did not affect patient-centeredness scores.

This provides ample evidence that the environment cannot be taken in isolation, but rather all aspects are interrelated. In fact, in orthopaedic wards, although open plan, did not offer inconvenience to the patients, because through a combination of factors, were perceived differently then in other wards. Reducing the amount of noise is also an important factor to be considered in the creation of a healing environment. In the observations, there were several episodes were the noise level in the ward was very high. Sound can be negative if it is perceived as noise; in fact noise is one of the most significantly detrimental environmental factors known to cause physiological changes in the body and effect healing. During the observations, the general impression was that wards decoration was not given much importance and a very simplistic setup was maintained. The lack of decorative elements created a very dull and depressive ambient in some parts of the observed wards. This aspect could be remedied by the use of different colour textures, aimed at minimizing the
institutional and clinical feel of hospital wards. Even the choice of colour in wards must not be a haphazard choice. There is an abundance of research on psychological, biological, and physiological effects of colour. These should be considered when choosing the most appropriate colours for the wards. Natural light connects interior spaces with the world outside, and one key to a pleasant interior is to provide as much natural light as possible. Improper lighting can be a major source of psychological and physical stress on patients. Excessively bright light can cause headaches; lack of light has been known to cause depression. In most wards very often there was excessive use of artificial light of the fluorescent type, while the windows were kept closed. Management has limited control in this respect, due to the inherent architecture of SLH. However, several issues such as wall painting and wall decoration could improve the ward ambient considerably.

A high level of cleanliness and hygiene was not a priority on some wards. What seemed worse was the fact that staff on such wards behaved indifferently to the lack of cleanliness and this could be related to the reduction in morale previously mentioned. It appears that there was lack of established procedure of disposing dirty linen in a more hygienic and sanitary acceptable way. Formal complaint facilities and formal complaint processing was practically non-existent on the wards.

The presence as well as the absence of visitors and relatives made a pronounce difference to the overall running of the ward. Unfortunately, it was evident that the lack of information to and education of the relatives and the lack of space available on the ward negated the potential useful role of the relatives in the care of the patients. Ward, patients and staff security seems to be a non-issue at St. Luke’s hospital. It was not clear if there was any person responsible for the overall security of the ward, the patients, and the staff. On most wards, every person was free to enter or leave the wards unhindered and unquestioned.

5.9.2 Staff interaction with patients

From the observations, it was evident that on the wards, the individual patient did not occupy a central position. In general, ward staff, both medical and nursing staff were very respectful to their patients and did their utmost to provide the best care possible for their patients. Nevertheless, the predominant mentality of the staff followed the medical model of
patient care. Thus, the illness of the patient took precedence over his other needs, resulting in habitual neglect of the social and personal needs of the individual patient. Therefore, there is the need to instil in the mentality of staff the more modern and more acceptable bio-psych-social model of patient centred care. However, the overall approach of ward staff towards patients was positive. In most instances, nurses were described as being very responsive to patients' needs and queries. Repeatedly, the interaction between medical staff and patient was described as being very cordial and polite and the communication between the two was very good. Notwithstanding the fact that the overcrowding and excessive workload meant that patient support and care by the ward staff had to be very limited and very often prioritized according to the needs of the patients.

5.10 LIMITATIONS OF THE STUDY AND SOURCES OF BIAS

The researcher had to overcome numerous barriers; some were dealt with successfully while others could not be resolved. The first limitation of this study is that it was confined to SLH the only general hospital in Malta, which is known to have greater difficulties of work force, overcrowding, and a high proportion of social patients and so these results may not reflect the general experience of general acute hospitals. Other barriers included obtaining permissions to access wards, to access details of discharged patients, and to approach patients and staff to discuss patient-centred care. The researcher was faced with suspicion and lack of cooperation by many ward staff and managerial personnel. Such barriers had imposed limitations on the original design of the study.

The findings of the questionnaire could have been affected by two types of bias. The first is that 33% of the randomly selected patients refused to participate. This could be interpreted in various ways including the possibility that these patients could have been potentially patients who have had a negative experience whilst in hospital. Secondly, patients were contacted for the questionnaires several days after they were discharged, thus it could be that the answers to the questionnaire had a certain amount of recall bias from the part of the patient, which in turn affected the scores positively. Effort from the researcher was made to contact patients early following their discharge to minimize such a bias.
Limitations also existed as regard the semi-structured interview to the elite personnel. The views of the six interviewees are certainly a very subjective opinion. The subjectivity would have been reduced if the number of interviewees was increased considerably, but this was not possible because of the time limit. In addition, the semi-structured interviews were conducted by the researcher himself and this too may have introduced an element of subjectivity and bias.

5.11 CONCLUSION

This study has shown how useful information obtained from the patients, ward staff and managerial personnel can be utilized to describe the situation of patient-centeredness in a general hospital and to evaluate and suggest how these might be improved. The researcher thinks that the significant findings of the study are quite powerful. While caring for the illness and disease was very satisfactory, there were obvious deficiencies in safety, comfort, privacy, and support. The researcher has argued that current deficiencies in patient-centred care are due to the numerous barriers that the key stakeholders may or may not be in a position to resolve. Very often, the solution to such barriers may lie outside the hospital organization. Further research into these barriers is urgently required in order that patient-centred care can be effectively implemented.
Chapter 6

Main conclusions and recommendations

6.1 INTRODUCTION

This chapter starts with the main conclusions to the study in section 6.2. This is followed by recommendations in section 6.3. Suggestions for further studies are presented in section 6.4.

6.2 MAIN CONCLUSIONS OF THE STUDY

The main findings of this study were that patient-centred care is practiced at a moderate level at SLH. Such level of care was significantly influenced by the type of speciality and age of the patient. Several members of the organisation interpret patient-centred care differently according to their organisational role and therefore, there was no common organisational perception of patient-centred care. Whilst there was a significant degree of perceived commitment to this agenda, it was clearly shown that barriers existed within and outside the organisation, which hinder patient-centred care. The observational phase of this study has shown that in some instances the physical and social environment was not always conducive of patient-centred care for a variety of reasons.

6.3 RECOMMENDATIONS TO MANAGEMENT

The researcher recommends that a steering committee is to be setup to address the agenda of patient-centred care at SLH. This committee will be entrusted with the mission to promote patient-centred care throughout the whole organisation. The committee should consist of representatives from every stratum of the organisation, such as senior management, middle management, nursing and paramedical staff. This would ensure that such an agenda is owned by the whole organisation. The committee should seek to acquire support from top management in order to promote a common and understandable notion
of what is patient-centred care and address the current situation were everyone interprets patient-centred care according to the respective role within the organisation. This in turn will result in the possibility of forming common policy as regards patient centred care within the organisation. The committee will also aim to disseminate information with the view for change within the organisation. This could be achieved by various means, such as meetings and seminars with the aim to divulge findings, not only to staff members but also to external stakeholders. This could be done to start a whole cycle of events with the ultimate objective being that of ensuring that the agenda of patient centred care is given impetus for change.

A substantial part of the agenda of this committee must also be devoted to identifying solutions for the barriers for patient centred care identified in this study. It must assess the possibility and viability of an internal re-engineering of the processes within the organization with the aim of making the whole organization more patient-centric. In addition, a cultural assessment would provide the necessary information to the committee to gauge the readiness for change within the organisation. What follows are practical recommendations which can be developed to counter act the identified barriers.

6.3.1 Fluctuation in demand

One of the major barriers to patient-centred care at SLH is the fluctuation in demand and persistent over-demand. During this study, it has been ascertained that demand for health care services at SLH has fluctuated significantly over the last five year period (> 10% per year). Several researchers highlighted the actions organisations can take in such cases to implement a shielding strategy. To reduce demand uncertainty, Fries (1998) suggests that administrators should use a broadened definition of health promotion including chronic disease self-management, risk reduction, and increased self-efficacy.

Secondly, Baker (2000) evaluates several health benefits programs that used interventions at specific ages in order to distribute services to a given population. In the researchers opinion, a needs assessment is needed in this respect to evaluate the current situation and propose viable solutions. Other solutions could include: proactively deploying flexible workforce strategies; relying on technological capabilities that enhance efficiency; and investing in information technologies that enhance organizational performance (Bowen et al. 1990).
Organizations may also use flexible workforce policies that make innovative use of their human resources such as: the deployment of overtime and temporary employees to increase capacity; innovative shift schedules, and creative use of existing employees through cross-training (Bloom 1997). Organizations can also enhance their flexibility by focusing on processes that enhance their efficiency and improve their internal planning and control systems (Chirikos 2000). Some of these efficiency measures include utilization reviews, standard costing, and a focus on improving labor productivity.

6.3.2 Interprofessional antagonism

Another barrier to effective patient centeredness was the lack of coordination between professions. The emphasis on this barrier was made especially on the antagonism that exists between nurses and doctors, which was described as problematic for the hospital management and future development. Evidence of this antagonism and its negative influence on patient-centred care is abundant in the literature (Radcliffe 2000, Blickensderfer 1996). Patient-centred care depends crucially on doctors and nurses working well together. Yet doctors and nurses are trained separately, keep separate patient records, report to different hierarchies, read different journals, and use different jargon. Sometimes these differences result in misery and conflict (Patronis Jones 1996) The professions and, most importantly, patients stand to benefit from closer cooperation, particularly as nurses take on more work that has traditionally been undertaken by doctors. According to Radcliffe (2000), the nursing profession reconstructed itself as an independent profession which sometimes stood up to doctors, so it's not surprising that nurses have turned to the material world of postgraduate recognition, evidence based practice, expanded roles, and mimicking the medical career structure with the creation of specialist nursing and so on.

In the local scenario, this antagonism between the medical and nursing profession has its roots and origin in the educational system of Malta, which segregates potential members of the two professions from the very beginning of their careers. Unintentionally, systematic separation and segregation between the two professions takes place on entry to University. Students who obtain the top grades at post-secondary level are eligible to enter the medical course, whereas those who do not obtain top grades can only make it to the nursing or paramedical courses. Doctors in training go to the medical school, whereas nurses in training
go to the nursing school, they never meet and after 4 to 6 years of segregation they meet again on the ward and they are expected to work as team. In this sense, the committee must liaise with the local educators to find a viable solution to this problem. Various options could be considered such as common subjects and more interaction between the students of the different professions. In addition, a practical recommendation in this respect could be more close cooperation and collaboration between the Medical School and the Institute of Healthcare.

6.3.3 Cultural barriers

Culture can be defined as an amalgamation of the values and beliefs of the people in an organisation. Culture can be felt in the implicit rules and expectations of behaviour in an organisation where, even though the rules are not formally written down employees know what is expected of them. According to Mannion (2002), the management of organisational culture is increasingly viewed as a necessary part of any health system reform. The values and beliefs of hospital staff are those values and beliefs that they were brought up and trained in. If there is a perceived problem as regards the culture of staff at SLH, which is precluding the organization to be patient-centred, management is compelled to act not only to revise such culture but also to try and understand the culture of the organisation and its values, which will then facilitate the initiation, and implementation of context-fitted reforms. According to Brown (1995), organizational culture does not exist in a vacuum, but is affected by the national culture. The problem lies in the fact that health delivery and health care systems have changed drastically and the old values and beliefs have to be changed, as they do not fit in the modern concepts of health. Naturally, hospital staff feels under threat and overwhelmed with uncertainty when faced with these changes. They feel threatened for the simple reason that they were not prepared, educated and trained for such changes. Therefore, the solution for cultural resistance to change can only be resolved by establishing updating courses, re-training programmes and continuing professional development for all the staff.
6.3.4 Undergraduate education and training

Patient centeredness is not something that can be learnt from textbooks or can easily be achieved through experience. Different persons with different personalities and upbringing can be more or less predisposed to be patient-centred. Patient centeredness is an important attitude of every healthcare professional that should be taught and practiced from the initial phases of every education and training structure. By the end of training, patient centeredness should become second nature to every healthcare professional. Therefore, the researcher recommends that the undergraduate courses for medical, nursing, and other related health professions should be redesigned such that patient centeredness will be a core concept of the training curricula. Direct patient contact and training in respecting patients should start from the beginning of the courses and go hand in hand with the academic teaching of the professions.

Training through direct patient contact should be more professionally organized. In the observational study there was mention of how medical students approach patients on the ward to examine them. There should be a more patient-centred way of performing patient clerking and examination. The patients should be informed of such possibility and their consent sought by the teaching organization. There should be guidelines and protocols how doctors and nurses in training should approach patients and whether they should be supervised by trainers or experienced doctors or nurses. In addition, the number of trainees approaching an individual patient should be limited. The problem of numerous students approaching limited number of patient could be solved by offering computer simulated scenarios and situations before experiencing life situations.

6.3.5 Customer Care Department

The researcher strongly recommends that the importance of customer care unit at SLH should be recognised and appreciated even more. It should be elevated to departmental level; its role extended, its resources increased (both financial and human), and it should be given overall responsibility for the implementation of patient-centred care at SLH. The tasks of customer care department should not only be of complaint handling, but also of policy development, staff, patient, and public education, monitor the implementation of the policy
and to liaison with other organisations within or outside the hospital organisation that can affect patient centeredness at SLH.

The customer care department through staff education and information could tackle issues such as lack of common understanding and agreement of what patient-centred care is by the managerial personnel and front-line worker. In addition, this department can liaison with the different sectors of the hospital such as the managers, nurses, and doctors to bridge the cultural barriers that exists and promoted interprofessional teamwork.

6.3.6 Physical environment

From the results of the study, it was noted that the ward environment seemed to affect patient-centred care. This aspect was also reflected in the results of the questionnaire. To this extent, improvement of the physical environment of the affected wards is envisaged to promote a healthier environment conducive of patient-centred care.

6.4 SUGGESTIONS FOR FURTHER STUDIES

Future research could aim to explore the individual barriers to patient-centred care, which was identified in this study. In addition, a replication of this study could be performed on other areas within SLH to see if there is correlation between findings.

6.5 DISSEMINATION OF CHANGE

The finding of this study should be communicated to health professionals, policy-makers, and the public. Dissemination of this research could first take place by presenting the findings at local conferences. Afterwards, a formal paper of the research could be prepared for publication in a local journal. Finally, a series of articles on patient-centred care may be prepared published in the popular press. Further more, the findings of this study may be disseminated by means of meetings and seminars for staff members, managers, and external stakeholders. This could be done to start a whole cycle of events with the ultimate objective
being that of ensuring that the agenda of patient centred care is given impetus from all those concerned.

6.6 CONCLUSION

This study is the first report to explore patient-centred care within the local general hospital setting. By means of triangulation, several aspects of this type of care were explored and several barriers identified. Further studies are required in order to identifying the quality of care and to investigate the various aspects of patient-centred care. Only after a substantial body of evidence is collected can an agenda of patient-centred care be applied to the local hospital and to the whole Maltese health care system.
APPENDIX A

LETTERS OF APPROVAL
Dear student

Please refer to your application submitted to the Research Ethics Committee in connection with your undergraduate dissertation entitled:

EXPLORING PATIENT CENTERED CARE AT ST LUKE’S HOSPITAL

At the last meeting of the Research Ethics Committee held on 12th October, 2004, members reviewed and approved the above-mentioned Protocol.

You are kindly requested to submit to the Research Ethics Committee a brief report on completion of your research.

Yours sincerely

Professor V. Ferrito
Chairman
Research Ethics Committee
Institute of Health Care

cc: Dr Kenneth Grech, Supervisor
Data Protection

SILVIO CAMILLERI
56 BORG FLATS 1
TRIQ IT-TIN
QORMI QR111
Dear Mr Camilleri,

I would like to inform you that at its meeting of the 16th December 2004, the Board of the Institute of Health Care accepted the recommendations of the Board of Studies that you be granted an extension of one month to submit the dissertation.

Kindly note that you will have to submit the dissertation by not later than 24th June 2005.

Yours sincerely,

Jo-Anne Stivala
Administrative Officer

cc:  Dr N. Azzopardi Muscat, Coordinator Health Service Management
From: Bridget Ryan <bryan@uwo.ca>
Sent: Wednesday, October 20, 2004 1:47 PM
To: Evelyn Levy <elevy2@uwo.ca>
CC: Silvio Camilleri <silviocam@hotmail.com>, Moira Stewart <moira@uwo.ca>
Subject: Re: Permission to use Patient centered questions

Attachment: PPCWorkingpaper04-1UVWO.pdf (0.96 MB)

MIME-Version: 1.0
X-Sender: "Bridget Ryan" <bryan@smtp.uwo.ca> (Unverified)
Received: from pony.its.uwo.ca ([129.100.2.63]) by mc7-f30.hotmail.com with Microsoft SMTPSVC(5.0.2195.6824); Wed, 20 Oct 2004 06:48:05 -0700
Received: from spork.its.uwo.ca (ride.its.uwo.ca [10.10.10.10]) by pony.its.uwo.ca (8.12.10/8.12.10) with ESMTP id 9K0093D0D0339for <silviocam@hotmail.com>; Wed, 20 Oct 2004 09:47:53 -0400 (EDT)
Received: from uwo.ca (bryan.Mpru.family.med.uwo.ca [129.100.173.72]) by spork.its.uwo.ca (8.12.10/8.12.10) with ESMTP id 9K0093D0D0339for <silviocam@hotmail.com>; Wed, 20 Oct 2004 09:47:53 -0400 (EDT)
X-Message-Info: i9KDIJdS005339for <<silviocam@hotmail.com>>; Wed, 20 Oct 2004 09:47:53 -0400 (EDT)
Message-ID: <41766C66.B314280@UWO.ca>
Organization: University of Western Ontario
X-Mailer: Mozilla 4.74 [en]C-CCK-MCD {UWO} (Windows NT 5.0; U)
X-Accept-Language: en
References: <BAHY16-F278DY4W0cwaA0002aaf2@hotmail.com> <417668F6.E7F92B63@uwo.ca>
X-Scanned-By: MIMEDefang 2.39
Return-Path: bryan@uwo.ca

Dear Silvio,

We are glad that you have found our measure to be helpful in your work. You have our permission to use the Patient Perception of Patient-Centredness (PPPC) questionnaire that we sent you earlier. I am attaching a copy of our recently produced working paper about the PPC. This is the reference you should cite when using this measure. You also have our permission to translate the PPC into Maltese. We would appreciate receiving any information about this adapted measure once you have developed it. We wish you all the best in your research.

Sincerely,

Bridget

Bridget L. Ryan, M.Sc., Ph.D Candidate
Project Coordinator
Centre for Studies in Family Medicine
The University of Western Ontario
Suite 245, 100 Collip Circle
London, Ontario, N6G 4X8

Direct voice: 519-661-2111, ext. 22053
Department voice: 519-858-5028
Fax: 519-858-5029
E-mail: bryan@uwo.ca

Evelyn Levy wrote:

> Silvio: 
> Bridget Ryan will be responding on behalf of Dr. Stewart. This will be done shortly.
> Evelyn

http://by16fd.bay16.hotmail.msn.com/cgi-bin/getmsg?curmbox=F000000001&a=00d870... 10/20/2004
8 April 2004

Mr Silvio Camilleri
56, Borg Flats 1
Olive Street
Qormi
MALTA QRM11

Dear Silvio,

Thank you for your enquiry of 25 March. Further to your email correspondence with Regula Dent I am pleased to give you permission to use the questions from the Picker Inpatient and Outpatient questionnaires for your thesis to investigate patient-centred care. Please find enclosed copies of the questionnaires. You may also find useful information on survey methodology on the website of the National Advice Centre for the NHS Survey Programme (www.nhssurveys.org).

The questions may be used for this study only and cannot be sold or transferred to any other entity. Any publication of the questions in survey form or other media, or publication of survey results based on the questions, must include attribution to “Picker Institute Europe, Oxford, UK”. You must have written permission from Picker Institute Europe to publish questions in other media, including academic journals or other publications.

The mission of the Picker Institute is to promote the assessment and improvement of services so as to improve care from the patient’s perspective. As a condition of our agreement we require a copy of your final report on findings and a copy of the questionnaire used in your study. We may use this information to suggest ways other providers can improve care using the Picker approach.

Please indicate your agreement with the terms stated above by countersigning below and returning one copy of this letter.

Yours sincerely,

Angela Coulter, PhD
Chief Executive

Email: angela.coulter@pickereurope.ac.uk

Encs

Your signature: .........................................

Date: ..................
Silvio Camilleri
56, Borg Flats 1,
Triq it-Tin
Qormi QRM 11

20th August 2004

The Superintendent
St.Luke's Hospital
G'Mangia

RE: Permission to undertake Study in various wards and departments in St.Luke's Hospital

I am a qualified radiographer, presently undergoing a course which leads to the award of a Masters degree in Health Service Management. The course programme includes the write up of a dissertation on an approved topic. The degree project I have chosen is titled:

Exploring Patient Centered Care at St.Luke's Hospital

The study aims to explore the dimension of patient centered care within St.Luke's hospital. This new concept in healthcare is being found to have various beneficial consequences as regards quality of care and optimal resource allocation. To this extent my aim as the researcher is to explore this type of care and supply valuable information to be used both by managers and the higher establishment.

In order to obtain the necessary data, I will have to submit a questionnaire to a number of discharged patients and also interview doctors and nurses on the subject from the orthopedic, surgical and medical wards. In order to carry out this study I will need your permission.

Thanking you in anticipation of your assistance in the matter and looking forward to your reply.

Yours sincerely,

Silvio Camilleri
APPENDIX B

QUESTIONNAIRE DISTRIBUTED TO PATIENTS
PATIENT PERCEPTION OF PATIENT-CENTEREDNESS

Please CIRCLE the response that best represents your opinion.

How much were you satisfied with the discussion and explanation (if there were) as regards your problem whilst in hospital?

- Completely
- Mostly
- A little
- Not at all

To what extent did the doctor understand the importance of your reason for coming to hospital?

- Completely
- Mostly
- A little
- Not at all

How well do you think your doctor understood you during your hospital stay?

- Very well
- Well
- Somewhat
- Not at all

To what extent did you agree with the doctor’s opinion about the problem?

- Completely
- Mostly
- A little
- Not at all

How much opportunity did you have to ask your questions?

- Very much
- A fair amount
- A little
- Not at all

To what extent did the doctor ask about your goals for treatment?

- Completely
- Mostly
- A little
- Not at all

To what extent did the doctor explain treatment?

- Very well
- Well
- Somewhat
- Not at all
To what extent did the doctor explore how manageable this (treatment) would be for you? He/she explored this:

<table>
<thead>
<tr>
<th>Completely</th>
<th>Mostly</th>
<th>A little</th>
<th>Not at all</th>
</tr>
</thead>
</table>

Do you think that you were given enough chance to participate in decision regarding your treatment?

<table>
<thead>
<tr>
<th>Completely</th>
<th>Mostly</th>
<th>A little</th>
<th>Not at all</th>
</tr>
</thead>
</table>

How much would you say that the doctor cared about you as a person?

<table>
<thead>
<tr>
<th>Very much</th>
<th>A fair amount</th>
<th>A little</th>
<th>Not at all</th>
</tr>
</thead>
</table>

How long was your hospital stay? _________

When you had important questions to ask to doctors and nurses, did you get answers that you could understand?

<table>
<thead>
<tr>
<th>Yes, always</th>
<th>Yes, sometimes</th>
<th>No</th>
<th>I had no need to ask</th>
</tr>
</thead>
</table>

If you had any worries or fears, did a doctor or nurse discuss them with you?

<table>
<thead>
<tr>
<th>Completely</th>
<th>To some extent</th>
<th>No</th>
<th>I had no need to ask</th>
</tr>
</thead>
</table>

Did doctors or nurses talk in front of you as if you weren’t there?

<table>
<thead>
<tr>
<th>Often</th>
<th>Sometimes</th>
<th>A little</th>
<th>Not at all</th>
</tr>
</thead>
</table>

If you ever needed to talk to doctors or nurses, did you get the opportunity to do so?

<table>
<thead>
<tr>
<th>Always</th>
<th>Sometimes</th>
<th>No</th>
<th>I had no need to talk</th>
</tr>
</thead>
</table>
How would you rate the courtesy of doctors and nurses?

EXCELLENT  GOOD  FAIR  POOR

Sometimes in the hospital, a member of staff will say one thing and another will say something quite different. Did this happen to you?

OFTEN  SOMETIMES  No

If your family or someone else close to you wanted to talk to a member of staff, did they have enough opportunity to do so?

YES, DEFINITELY  YES, TO SOME EXTENT  NO  NO NEED

CONTINUES ON NEXT PAGE

General questions

Are you male or female?

M  F

What was your year of birth? ____________

How many times have you been in hospital in the last twelve months? _______

Which ward were you in?

ORTHOPAEDIC  SURGICAL  MEDICAL
13. JEKK KIEN HEMM XI AFFARIJET LI KIENU QED JINKWETAWK, SIBT TOBBA U NERSIS LI KIENU LESTI LI JIDDISKUTUHOM MIEGHEK?

IVA DEJJEM IVA XI DRABI LE MA KELLHIEX
BŻONN INSAQSI XEJN

14. KIEN HEMM XI DRABI META TOBBA JEW NERSIS BDEW JITKELLMU FUQEK, FIL-PREŻENZA TIEGHEK QISEK INT MA KONTX HEMM?

TA' SPISS XI DRABI FTIT QATT

15. META KELLEK BŻONN LI TITKELLEM MA' TOBBA JEW NURSES, KELLEK ĈANS LI TAGHMEL DAN?

IVA DEJJEM IVA XI DRABI LE MA KELLHIEX
BŻONN NGHID: XEJN

16. KIF TIDDESKRIVI L-MANJIERI TAT-TOBBA U N-NURSES MIEGHEK WAQT LI KONT L-ISPTAR?

EĊCELLENTI TAJBBA INSOMMA FQAR

17. ĠIELI MEMBRI TA' L-ISTAFF MA QABLUX BEJNIETHOM DWAR INFORMAZZJONI LI NGHATAT LILEK?

HAFNA DRABI XI DRABI QATT

18. JEKK XI HADD MILL-FAMILJA TIEGHEK, JEW XI HADD QRIB TIEGHEK XTAQ IKELLEM XI MEMBRU TA' L-ISTAFF, KELLU BIŻJEJED ĈANS JAGHMEL DAN?
IVA, DEJJEM SA ĆERTU PUNT LE MA KIENX HEMM BŻONN

DOMANDI ĠENERALI

a) JEKK JOGHĠBOK INDIKA BĊIRKU S-SESS TIEGHEK M F

b) F'LIEMA SENA TWELIDT _______________

c) KEMM-IL DARBA KONT RIKOVERAT L-ISPTAR DAWN L-AHĦAR TNAX-IL XAHAR?

_____________

d) F'LIEMA TIP TA' SALA KONT FL-ISPTAR?
ORTOPEDIJA KIRURĠIJA MEDIĊINA (AGĦMEL ĈIRKU FEJN JAPPLIKA)

GRAZZI HAFNA TAL-KOPERAZZJONI TIEGHEK
Sinjur/a,


Grazzi hafna ta hinek,

Silvio Camilleri
<table>
<thead>
<tr>
<th>reason</th>
<th>explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>191. complaints as regards the general hygiene of the ward</td>
<td>80. Because this was a public hospital my expectations are not high</td>
</tr>
<tr>
<td>194. external environment in this ward leaves much to be desired.</td>
<td>84. Many relatives with patients</td>
</tr>
<tr>
<td>197. I noticed a high level of activity and noise</td>
<td>85. Many relatives confusion in the ward</td>
</tr>
<tr>
<td>198. some paintings on the wall</td>
<td>86. Inconvenience for the adjacent patients.</td>
</tr>
<tr>
<td>199. the fluorescent lights were all around ward</td>
<td>87. Relatives are loud and are numerous</td>
</tr>
<tr>
<td>203. left the tea tray in the middle of the corridor</td>
<td>196. Waiting area for patients just at the start of the ward was area closed</td>
</tr>
<tr>
<td>208. overcrowding was very much an issue in that ward</td>
<td>128. Waiting area for patients and also a suggestion box</td>
</tr>
<tr>
<td></td>
<td>155. Were no relatives near the patients</td>
</tr>
<tr>
<td></td>
<td>156. No relatives are allowed near the patients except in special cases</td>
</tr>
<tr>
<td></td>
<td>157. Relatives during normal visiting hours</td>
</tr>
<tr>
<td></td>
<td>196. Some relatives near patients although it was not visiting time as yet</td>
</tr>
<tr>
<td></td>
<td>206. Relatives of this patient seem very bothered by this!!!</td>
</tr>
<tr>
<td>173. good level of cleanliness was maintained on this ward</td>
<td>174. The glass panes are dirty</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>-------------------------------</td>
</tr>
<tr>
<td>176. a few humps of dirty linen in various parts of the corridor</td>
<td>177. real chaos that reigns in the ward</td>
</tr>
<tr>
<td>179. walls and the furnishing of the ward were not very well kept</td>
<td>180. they were not completely satisfied of their stay in hospital.</td>
</tr>
<tr>
<td>182. they have been woken up early in the morning repeatedly</td>
<td>183. they have been woken up early in the morning repeatedly</td>
</tr>
<tr>
<td>185. during the night the ward would be lit up apparently for no reason</td>
<td>186. No one of the staff helped to turn stroke patient around</td>
</tr>
<tr>
<td>188. during the night the ward would be lit up apparently for no reason</td>
<td>189. asked a nurse to help me, she refused</td>
</tr>
<tr>
<td>150. Noise level was fluctuating</td>
<td>180. nursing station in the middle of the ward</td>
</tr>
<tr>
<td>---------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>151. level of cleanliness which was more then satisfactory</td>
<td>181. four-bedded room in front of it</td>
</tr>
<tr>
<td>152. I heard a screeching noise coming from the main corridor</td>
<td>182. the pantry and a general utility room.</td>
</tr>
<tr>
<td>154. The noise level now was very high</td>
<td>183. big ward had several aluminum dividing partitions</td>
</tr>
<tr>
<td>159. experience on this ward was pleasant</td>
<td>195. room was used as a store for various equipment of the ward such as beds etc.</td>
</tr>
<tr>
<td>160. Everything was well organized</td>
<td>200. sanitary facilities were clean but one of the WC doors did not close.</td>
</tr>
<tr>
<td>163. environment seemed well kept and in good condition</td>
<td>208. overcrowding was very much an issue in that ward</td>
</tr>
<tr>
<td>166. high noise level that was present.</td>
<td>209. 6 members of staff for about 45 patients</td>
</tr>
<tr>
<td>167. two beds which laid in the corridor.</td>
<td>210. demotivation of staff</td>
</tr>
<tr>
<td>172. this ward was that it's overcrowded!!</td>
<td></td>
</tr>
<tr>
<td>130. At the entrance there was also a nursing station</td>
<td>138. toilet facilities were in perfect state and clean</td>
</tr>
<tr>
<td>133. a second nursing station in this section</td>
<td>140. kitchenette</td>
</tr>
<tr>
<td>15. walls were all painted with a light colour</td>
<td>141. female wing of the ward, TV was hung up high on the wall</td>
</tr>
<tr>
<td>136. the lights were of the fluorescent type</td>
<td>144. beds in this section could also be separated by retractable curtains</td>
</tr>
<tr>
<td>137. All the windows have curtains and</td>
<td>148. toilet facilities were of better quality</td>
</tr>
<tr>
<td>138. toilet facilities were in perfect state and clean</td>
<td>149. were metal bars in some toilet</td>
</tr>
<tr>
<td>143. second nursing station readily accessible for the patients</td>
<td>168. waiting room which was locked up</td>
</tr>
<tr>
<td>145. very good quality of the environment in ward</td>
<td>169. least two corridor beds with patients</td>
</tr>
<tr>
<td>146. ward recently refurbished</td>
<td>170. other beds in the main corridor further on</td>
</tr>
<tr>
<td>147. proper use of natural lighting created a nice atmosphere</td>
<td>172. this ward was that it's overcrowded!!</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
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<td>---</td>
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</tr>
<tr>
<td>55. Environment was very loud now</td>
<td>88. I was given a nappy, this devastated me</td>
</tr>
<tr>
<td>61. There was a stretcher in the main corridor</td>
<td>89. told that these were not bed pans available</td>
</tr>
<tr>
<td>68. uncleanness in the ward</td>
<td>91. neither pillows nor pillow cases were available</td>
</tr>
<tr>
<td>83. Glass panes dirty in some wards</td>
<td>100. ward had a capacity of 36 patients</td>
</tr>
<tr>
<td>94. ward was that it was very silent</td>
<td>102. doors leading to the toilet could not be locked</td>
</tr>
<tr>
<td>95. ward was much better than the previous ward as regards wall paint etc.</td>
<td>103. toilet facilities were clean</td>
</tr>
<tr>
<td>97. Walls were painted of a violet color with paintings on the wall</td>
<td>107. overhead lamp did not work and no buzzer near this bed</td>
</tr>
<tr>
<td>101. floor was a bit dirty</td>
<td>129. big statue of a Madonna was adorned with fresh flowers</td>
</tr>
<tr>
<td>104. the ward was very quite</td>
<td>131. several beds which can be separated from each other by means of partitions</td>
</tr>
<tr>
<td>111. ward quite organized</td>
<td>133. a one bedded room</td>
</tr>
<tr>
<td>126. they were refurbished recently.</td>
<td>134. TV was available in this section</td>
</tr>
</tbody>
</table>
Observational Transcript

<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td>4. environment very noisy</td>
<td>2. main door wide open</td>
<td>15. Waiting area and TV, chairs</td>
<td>5. few staff members</td>
<td>31. 3 medical students</td>
</tr>
<tr>
<td>6 poor cleanliness</td>
<td>13. main door wide</td>
<td>18. a single bedded room</td>
<td>8. talkative staff</td>
<td>32. patient in question was fast asleep students waking him up</td>
</tr>
<tr>
<td>7. floor was quite a mess</td>
<td>3. I entered the ward undisturbed</td>
<td>19. two other adjacent rooms which contain four beds</td>
<td>33. Phone no one to pick it up - phone stops ringing</td>
<td>33. barrage of questions followed</td>
</tr>
<tr>
<td>12. noise level down</td>
<td>9. staff not bothered by presence of foreigners</td>
<td>20. nursing station was situated centrally</td>
<td>36. patient in question was fast asleep students waking him up</td>
<td>34. thanked the patient and left</td>
</tr>
<tr>
<td>16. pile of dirty linen</td>
<td>92. door of the ward was wide open</td>
<td>22. doors of the WC could not be closed</td>
<td>33. barrage of questions followed</td>
<td>35. not that amused at seeing me</td>
</tr>
<tr>
<td>21. Patient files - two separate trolleys - in the corridor</td>
<td>93. no one asked me about my entrance on the ward</td>
<td>24. WC facilities seemed much neglected.</td>
<td>34. thanked the patient and left</td>
<td>46. patient very cooperative</td>
</tr>
<tr>
<td>23. another pile of dirty linen</td>
<td>121. this ward was locked</td>
<td>30. end of this ward - kind of store</td>
<td>44. discussion between staff seems to be very loud</td>
<td>37. many students that come to speak to him</td>
</tr>
<tr>
<td>25. only Natural lighting in this ward was the windows</td>
<td>122. I had to push a button of the intercom to be attended to</td>
<td>44. overhead lamp and buzzer for patients was not working</td>
<td>45. health assistant was preparing tea/coffee</td>
<td>38. seven groups of students - the same questions</td>
</tr>
<tr>
<td>26. some pictures on the walls of main corridor</td>
<td>123. promptly a voice asked me what I needed</td>
<td>62. Bell was not working</td>
<td>46. problem concerning a patient</td>
<td>39. he understands - for them to learn</td>
</tr>
<tr>
<td>27. no pictures on the wall of the big wards</td>
<td>121. this ward was locked</td>
<td>66. Some patients afraid to complain</td>
<td>47. One of the staff tells me that the central line of this patient was apparently blocked.</td>
<td>49. 5 minutes pass by before the MO arrives.</td>
</tr>
<tr>
<td>28. Lighting of the ward all of the fluorescent type.</td>
<td>165. the main door was wide open</td>
<td>69. When complained, I was not spoken to neither by nurses or the doctors</td>
<td>48. member of staff phones medical officer</td>
<td>50. MO convinced two anaesthetists to see patient</td>
</tr>
<tr>
<td>41. Wall was in need of a paint</td>
<td></td>
<td>82. Humped mattresses</td>
<td>54. nurse has come to assist the doctors</td>
<td>51. interaction between medical staff and patient polite</td>
</tr>
</tbody>
</table>
CONSENT FORM

I am a Maltese citizen and am over eighteen (18) year of age.

I have been asked to participate in a research study entitled:

The purpose and details of the study have been explained to me by ____________ and any difficulties which I raised have been adequately clarified.

I give my consent to the Principal Investigator and his delegate either make the appropriate observations/tests or both or take the necessary samples. I am aware of the inconveniences which this will cause.

I understand that the results of this study may be used for medical or scientific purposes and that the results achieved from this study in which I am participating may be reported or published: however, I shall not be personally identified in any way, either individually or collectively, without my express written permission.

I am under no obligation to participate in this study and am doing so voluntarily.

I may withdraw from the study at any time, without giving any reason. This will not influence in any way the care and attention and treatment normally given to me (applicable only in case of patients receiving treatment).

I understand that any complications and/or adverse effects which may arise during or as a consequence of the study will be recorded and any treatment which this may entail will be given within the Government Health Services.

I am/I am not receiving any remuneration for participating in this study.

In case of queries during the study I may contact ________________ Tel No

Signature of participant ______________________________

Name of participant ________________________________

Id. No.: ____________________________________________ (in block letters)

Signature of Chief Investigator/Investigator ________________________________

Name of Chief Investigator/Investigator ________________________________ (in block letters)

Id. No.: ____________________________________________

DATE ________________________________

* delete where applicable
Kwestjonarju Fuq X.Jahseb il-Pazjent Rigward it-Tip ta’ Kura Li Nghatat Lilu Wagt il-Perjodu Rikoverat l-Isptar

Jekk Joghjbok Aghmel Ćirku mar-Risposta li Tahseb Taqbel Maghha Int.

1. Kemm Kont Sodisfatt Bid-Diskussjoni u Spjegazzjoni (jekk Kiem Hemm) Rigward il-Problema Tieghek Wagt Li Kont l-Isptar?

Sodisfatt Hafna Sodisfatt Ftit Li Xejn Miux Sodisfatt

2. Kemm Tahseb Li T-Tabib Fehem l-Importanza Tar-Raguni Tieghek Ghalfejn Ġejt l-Isptar?

Kompletament L-Bičċa l-Kbira Ftit Xejn

3. Kemm Tahseb Li T-Tabib Gharaf Jifhmek Tajjeb Wagt Li Kont l-Isptar?

Tajjeb Hafna Hafna Ftit Xejn

4. Kemm Qbitl Ma l-Opinjoni Tat-Tabib Rigward il-Problema Tieghek?

Kompletament L-Bičċa l-Kbira Ftit Xejn

5. Kemm Tawk Ċans Issaqsi Domandi Wagt Li Kont l-Isptar?

Kompletament L-Bičċa l-Kbira Ftit Xejn
6. XI KEMM STAQSIK IT-TABIB RIGWARD X TISTENNA INT MIL-KURA LI KONT SER TIRCIIEVI?

KOMPLETAMENT L-BIĊĊA L-KBIRA FTIT XEJN

7. XI KEMM SPJEGALEK IT-TABIB DWAR IL-KURA LI KONT SER TIEHU?

KOMPLETAMENT L-BIĊĊA L-KBIRA FTIT XEJN

8. XI KEMM SPJEGALEK IT-TABIB KEMM DIN IL-KURA SE TKUN DIFFIĊLI GHALIK?
SPJEGALEK:

KOMPLETAMENT L-BIĊĊA L-KBIRA FTIT XEJN

9. TAHSEB LI KONT MOGHTI CANS BIZZEJED LI TIEHU SEHEM FID-DECIZJONIJET DWAR IL-KURA TIEGHEK?

KOMPLETAMENT L-BIĊĊA L-KBIRA FTIT XEJN

10. XI KEMM TGHID LI T-TABIB/TOBBA LI RAWK FL-ISPTAR IHOSSU GHALIK BHALA PERSUNA?

HAFNA NORMALI FTIT XEJN

11. KEMM DOMT L-ISPTAR ? _______________ (IKTEB IN-NUMRU TA' GRANET)

12. META KELLEK DOMANDI IMPORTANTI X'TAGHMEI LIT-TOBBA U N-NERSIS LI KIENU QED IDURU BIK, IRĊEVEJT RISPOSTI LI STAJT TIFHIMHOM?

IVA DEJJEM IVA XI DRABI LE MA KELLHIEX BŻONN INSAQSI XEJN
APPENDIX D

INTERVIEW SCHEDULE
Interview Questions Schedule – Elite

Thesis title – Exploring Patient Centred Care at St. Luke’s Hospital

Researcher – Mr. Silvio Camilleri

1) What do you understand by the term “patient centred care”?

2) In your opinion, do you think that there is a commitment to promote patient centred care by your organisation (SLH)?

3) What is currently being done to promote such an agenda?

4) What are the barriers to the provision of patient centred care within your organization, in particular to your work place and role within SLH?

5) Other comments
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