

# **Patient Satisfaction in Oncology Ward Settings in Saudi Arabia: A Mixed Methods Study**

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## **DECLARATION**

I declare that this thesis is my own work and has submitted only for the degree of PhD in the University of Stirling.

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# ABSTRACT

**Background:** Since the 1980s, Saudi Arabia's socio economic transformation has led to vast social development. As a result there has been increased adoption of behaviours such as smoking and sedentary life styles, which pose a risk to health. It is anticipated that cancer incidence will double over the next two decades and it is thus vital that high quality of care is provided to meet the growing health care demands. Moreover, it is important that patients are satisfied with their care provision. This thesis begins with a narrative synthesis of the existing literature about patient satisfaction in the Saudi context and beyond. An evaluation of the key concepts for understanding patient satisfaction illuminated the lack of evidence about the assessment of patient satisfaction including specific key domains of the structure and process of care. This evaluation also indicated the need to further investigate the Saudi patient perspectives in oncology hospital setting. The aim of my study was to examine the extent to which clinical effectiveness impacts upon patient satisfaction in oncology ward settings in the Kingdom of Saudi Arabia (KSA).

**Methods:** A sequential explanatory mixed methods design was employed. The Donabedian quality framework (1980) and Patient experience model (Reimann and Strech 2010) were used to assess patient satisfaction with quality of care provided. A quantitative phase was followed by a qualitative phase. In the first phase, the European Organisation for Research and Treatment of Cancer (EORTC) IN-PATSAT32 validated questionnaire was used to collect data from 100 adult oncology inpatients at a Cancer Centre in Riyadh. The second qualitative phase involved semi-structured telephone and face to face interviews with 22 adult oncology inpatients who previously answered the questionnaire. Synthesis occurred at the intersection of quantitative Phase 1 and qualitative Phase 2 data. The qualitative Phase 2 thus further explored the satisfaction scores of quantitative Phase1 to deepen the understanding of patient satisfaction in oncology ward settings in KSA.

**Findings:** The main findings were that patient satisfaction levels are influenced by the clinical effectiveness of doctors and nurses, accessibility to health care and socio-demographic factors. Specifically, the interpersonal aspects of care were deemed core to

patient experiences in oncology ward settings in KSA. It emerged that doctor-patient relationships, nurse shortages and language barriers are particular areas where changes could be made to improve care, thereby enhancing patient satisfaction. These findings contribute important new insights into the interpersonal aspects of care in the light of the underlying social and cultural contextual factors that influence patient satisfaction in the KSA.

**Conclusion:** This study has provided new evidence supporting the need for stronger interpersonal relations and a more patient-centred approach in the oncology health system in KSA. In particular, the influential role of cultural issues in influencing patient satisfaction in oncology ward settings was apparent. Evidence provided by this research will make a substantial contribution to policy makers and hospital management teams in the KSA wanting to improve patient satisfaction in oncology wards and in other health care settings.

**Keywords:** Patient satisfaction, patient experience, clinical effectiveness, oncology, Saudi Arabia, hospital wards settings

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# Chapter 1 Introduction

## 1.1 Introduction

Academic definitions of healthcare quality were traditionally based on standard practice. Over the last decade, however, the developing field of patient satisfaction is increasingly impacting upon the perceived breadth and depth of the term. Patient satisfaction is well established as a major indicator of quality of care and as component of clinical effectiveness (Cleary et al.1989; Crow et al. 2002; Atallah et al. 2013; Doyle et al.2013; Batbaatar et al.2015). While the relationship between patient satisfaction and patient experience has been widely explored (Stizia and Wood 1997; Jekinson et al. 2002; Reimann and Strech 2010), the extent to which patient satisfaction impacts upon notions of quality of care presents a more complex problem. This is in part due to the necessarily subjective nature of patient expectations. Furthermore, the extent to which clinical effectiveness can improve patient satisfaction has not been effectively established in this relatively young branch of research.

Existing academic literature therefore presents no definitive model for developing comparable metrics of care quality, and wider notions of quality have been much debated from both qualitative and quantitative perspectives (Hobb 2009; Jagosh et al. 2011). Additionally, as evidenced by the recent Joint Commission International (JCI) accreditation, perceptions of patient satisfaction for health care authorities are gaining increasing traction in the Kingdom of Saudi Arabia (KSA). This thesis examines the extent to which clinical effectiveness impacts upon patient satisfaction in oncology ward settings in the Kingdom of Saudi Arabia (KSA).

The sample for this thesis is taken from adult oncology patients at the Saudi Regional Cancer Centre in Riyadh (SRCC). A sequential explanatory Mixed Methods Research (MMR) design was developed and implemented to develop wider recommendations when assessing the impact of models of patient satisfaction in practice.

## **1.2 Patient Satisfaction and Quality of Care**

Initially it is essential to establish a robust definition of a number of key terms explored throughout this thesis. For example, patient satisfaction requires further explication in order to isolate key features which subsequently impact upon perceptions of quality of care (Donabedian 1980). Developing an understanding of quality of care as a quantifiable phenomenon is complex as it is necessarily contingent upon a range of interpersonal and structural factors (Donabedian 1980). This section provides a theoretical framework through which approaches to clinical effectiveness and patient satisfaction can be explored and integrated through a robust and uniform research strategy.

### **1.2.1 Quality of Care**

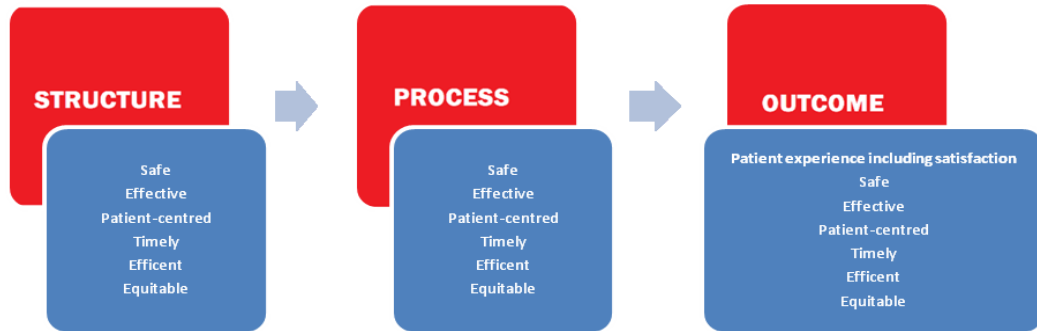
The multi-dimensional nature of perceptions of quality of care has resulted in a number of conflicting academic studies (Chassin and Gavin 1998; Heath et al. 2009). This thesis is based upon an understanding that quality of care is defined and analysed using a combination of the Donabedian model (1980) and the Institute of Medicine's six dimensions of care (IOM 2001). Campbell et al. (2000, p. 1614) defines quality of care as 'whether individuals can access the health structures and processes of care which they need and whether the care received is effective', whilst for Lohr (1990) it is 'the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge' (Lohr 1990, p.65).

Quality of care can be divided into different dimensions according to the aspects of care being assessed. Donabedian's (1980) seminal framework for defining quality of care in healthcare settings has three components: structure, process, and outcomes. Structural components include the context in which care is delivered (including facilities, equipment, and organisational characteristics). Process components include all the actions that make up healthcare (such as diagnosis and treatment), and outcome components include all the

effects of healthcare on patients or populations. The Donabedian care-assessment model has been widely used in international healthcare settings to assess patient satisfaction with quality of care (Ware et al.1988; Campbell et al. 2000; Kringos et al. 2010; Khamis and Njau 2014). The model is an important component of my study framework.

The Institute of Medicine (IOM) (2001) devise six dimensions of health care quality known as: safe, effective, patient-centred, timely, efficient, and equitable. Based on these dimensions, safe includes avoiding harm to patients from the care that is proposed to help them; effective includes provision of services that has its foundation on scientific knowledge to all who could benefit and restrain from providing services to those not likely to benefit which means avoiding the underuse and misuse of resources; patient-centred means providing care that is respectful of and responsive to individual patient preferences, needs, and values and making sure that patients' values are the ones guiding all the clinical decisions made; timely means the reduction of waiting times and often harmful delays for both those who receive and give care; efficient is avoiding waste of resources such as equipment, supplies, ideas, and energy; lastly, equitable is providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, location, and socio-economic status (IOM 2001).

Based on the analysis of both forms of measuring quality of care the Donabedian's model (1980) and IOM's (2001) dimensions of care can be combined to measure and assess quality of care more efficiently (Figure1). Each of the Donabedian's categories of structure, process and outcome can be subdivided to include the six dimensions of quality to examine if the stages are executed effectively to derive inferences about the quality of care in the oncology ward settings in KSA in this study.



**FIGURE 1- COMBINATION OF DONABEDIAN' MODEL OF CARE AND IOM'S 6 DIMENSIONS OF CARE**

Quality of care can therefore be defined as access to necessary, effective health structures and service processes. Patient satisfaction with the quality of care correlates, in turn, with clinical effectiveness. That is, patient satisfaction largely depends on the confluence of healthcare providers' practices, skills and competence, in specific contexts of time and location. The objective of these practices is to improve the patient experience in order to provide satisfaction through improving quality of care in order to attain positive outcomes from healthcare delivery. Interpersonal factors that can have a significant influence on patient satisfaction include the nurses' and doctors' communication with patients, whilst significant structural factors include the size of the hospital and ward (Donabedian 1980).

Although researchers disagree on which indicators of healthcare quality are most valid, the most frequently cited dimensions of quality of care include: safety, effectiveness, equity, efficiency, timeliness, and patient-centeredness (IOM 2001; Doyle et al. 2013; Beattie et al. 2015). The last of these, patient-centeredness, has developed as a particularly fruitful area of inquiry, with researchers discovering that the doctor-patient relationship can be therapeutic (Krupat et al. 2001; Street et al. 2009; Kenny et al. 2010). The patient-centred

approach also provides an avenue for exploring subjectively important factors that might impact upon an individual's expectation of quality of care, such as individual spiritual/religious needs (Williamson and Harrison 2010).

### **1.2.2 Patient Satisfaction**

It must be noted, however, that patient-centeredness does not necessarily guarantee greater patient satisfaction (Kupfer and Bond 2012). Patient satisfaction is generally defined as the patient's experience of the healthcare process impacted by the extent and assurance of quality developed through clinical effectiveness. Patient satisfaction questionnaires predominantly require respondents to contribute a personal reflection based on subjective notions of quality of care. Some surveys, however, are distributed to medical professionals, such as doctors and nurses to receive their opinion on the perceived level of satisfaction of patients towards health care delivery.

Top-line definitions of patient satisfaction include "a health care recipient's reaction to salient aspects of context, process and results of their service experience" (Pascoe 1983 p.186). This is clearly and inextricably linked to the quality of care (Cleary et al. 1989; Stewart 2001; Fitzpatrick 1997; Fitzpatrick and Coulter 2000; Batbaatar et al. 2015), and although an important indicator of quality care, the formal assessment of such satisfaction is a complex process (Cleary 1998; Al-Rubaiee and Alkaaida 2011).

There are a number of variant factors that have an impact on specific patients and their responses to the quality of their healthcare, including their personal characteristics, attitudes, and prior experience (Oberst 1984; Blanchard et al. 1990). A hospital may be well organised, ideally located, and well-equipped, but low patient satisfaction may still indicate it is failing to provide effective healthcare (Donabedian 1988; Draper et al. 2001; Turhal et al. 2002; Barlesi et al. 2005). The enhancement of patient experiences of healthcare services is a key goal of improvement initiatives (Tsianakas et al. 2012; Health Foundation 2013).



These are perceived as the best quality indicator tools in hospital-based care settings (Ervin 2006; Lynn et al. 2007; Groene et al. 2008; Copnell et al. 2009; Batbaatar et al.2015).

Studies of patient satisfaction are usually conducted through hospital self-assessment. This method of measuring patient satisfaction uses a set of questions which assess the functions, procedures, and capability of the hospital infrastructure, staff, and policies. The results of the hospital assessment survey are then used to measure the delivery of health care and predict patient satisfaction.

Of note is the fact that problems with patient satisfaction surveys has led to an emphasis on measuring patients' experience rather than satisfaction (Jekinson et al. 2002). According to Coulter et al. (2009) patient satisfaction ratings are a reflection of at least four factors including the personal preferences of the patient, the patient's expectations, response tendencies due to personal characteristics and the quality of the care received.

In contrast to satisfaction, patient experience focuses more on what actually occurred, rather than the patient's evaluation of what occurred. This requires researchers to ask patients to report in detail about their experiences of a particular service, hospital episode, general practice, or clinician, rather than to rate their care using general evaluation categories (excellent, very good, good, fair, poor) (Coulter et al. 2009). A disadvantage of this approach, which is pertinent to this study, is that my colleagues and policy makers in KSA can readily relate to and understand the concept of patient satisfaction, rather than experiences, and satisfaction remains a frequently measured performance indicator in Saudi research. Accordingly, the use of a patient satisfaction survey would be preferable for use in this study. The aim of this study was therefore to focus on patient satisfaction, however, during the interviews in Phase 2, there was be an opportunity to explore patients' experiences of their care in some depth.

Over the last 20 years patient satisfaction surveys have played an increasingly important role in identifying quality of care gaps and developing effective response plans from healthcare organisations (Al-Abri and Al-Balushi 2012). While a broad consensus exists positing a link between patient satisfaction and perceptions of quality of care (Batbaatar et al.2015), the exact nature of this relationship continues to be contested.

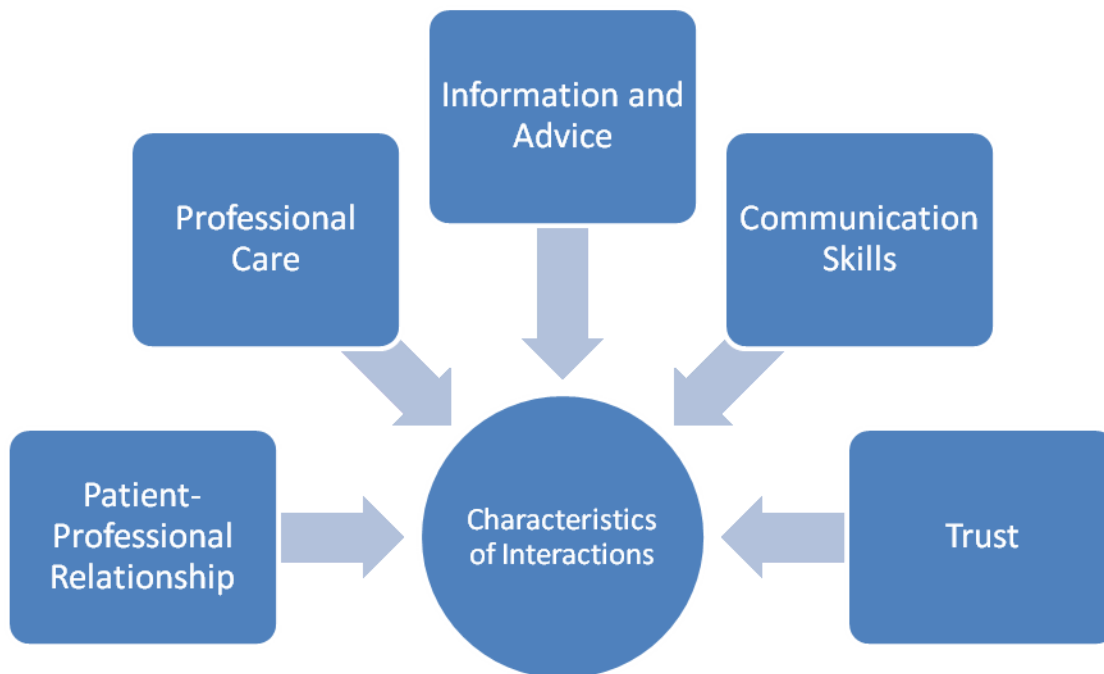
For example, while a number of studies identify a relationship between patient satisfaction and positive health outcomes (IOM, 2001; Bertakis and Azari 2011) this has not been universally accepted (Fisher et al. 2003; Chang et al. 2006). Indeed, Fenton et al. (2012) indicate that a study of over 50,000 adult patients indicated that the most satisfied patients were 26% more likely to die than those less satisfied (2012, p.153). The extent to which patient satisfaction can present a stable indicator of quality of care, therefore, necessarily depends on individual patient expectations and contexts. Academics are divided, therefore, as to the impact of patient satisfaction upon healthcare outcomes, and a universally accepted model by which patient satisfaction can be quantified has not been developed.

Furthermore, a number of studies have also highlighted that patient satisfaction has been high regardless of clinical effectiveness and quality of care (Sait et al. 2014, Stavropoulou, 2010; Al-Sakkak et al. 2008). Stavropoulou (2010) suggests that this may be due to low literacy among respondents and inadequate understanding of the survey requirements. This does not necessitate a rejection of satisfaction as a useful indicator of quality of care, however. Rather, it foregrounds the subjective nature of patient data inputs, and further highlights the requirement of qualitative data sets to produce robust results and recommendations.

Patient satisfaction therefore presents a crucial metric by which clinical effectiveness can be identified as impacting upon a patient's overall perception of quality of care. While existing studies have yielded contradictory results, and one umbrella model has not been developed by which pan-contextual examples of universal satisfaction ratings can be implemented, the clear interconnectivity of satisfaction and quality of care requires further detailed analysis.

### 1.2.3 Patient Experience

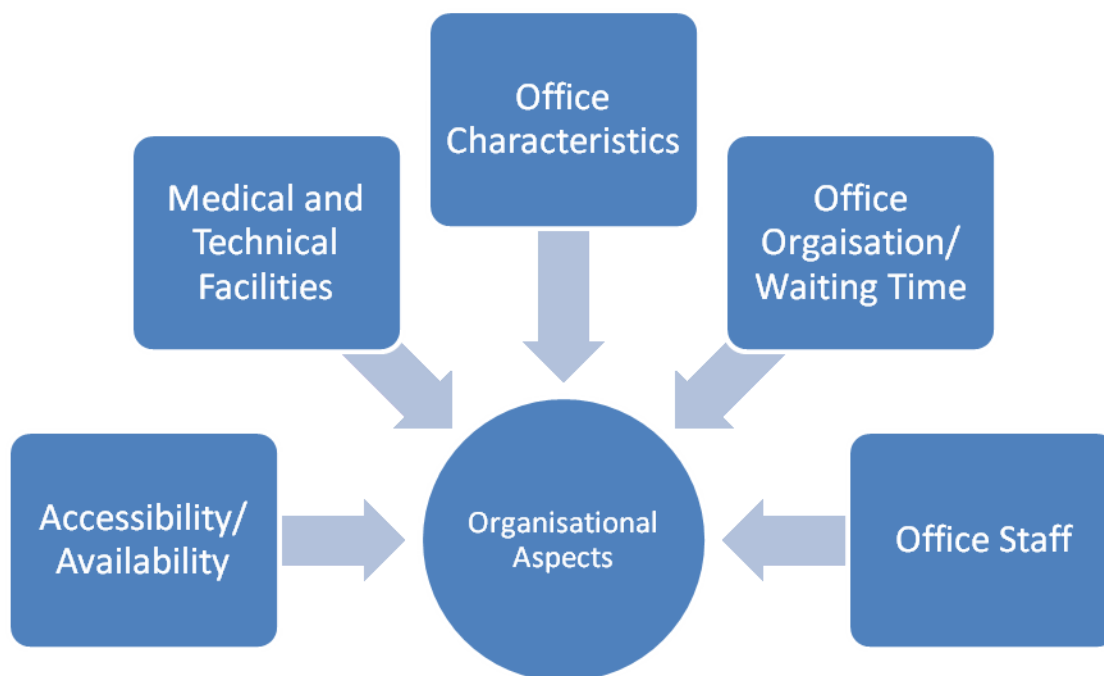
The relationship between patient satisfaction and patient experience is complex, and requires detailed examination (Tsianakas et al. 2012; Beattie et al. 2015). The Health Foundation (2013, p.28) note, for example, that ‘people can report high levels of satisfaction, for example, at the same time as describing experiences that are less than optimal’. This is an important consideration as it throws into sharper focus the impact that previous expectations of quality of care can have upon patient satisfaction. As noted by the Health Foundation (2013) it is important to initially define what is being measured, and to isolate the independent aspects of experience, expectation and satisfaction. As such, Reimann and Strech (2010) have identified 13 core components of patient experience, detailed in Figures 2-4:



**FIGURE 2 - CHARACTERISTICS OF INTERACTIONS (REIMANN & STRECH 2010, P.240)**

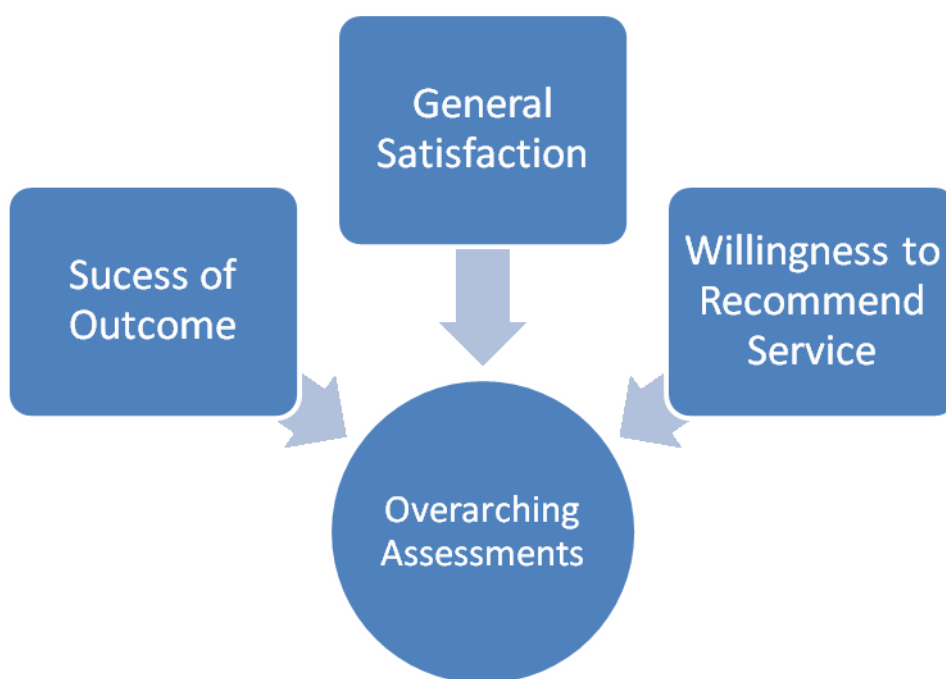
Figure 2 indicates the centrality of interactions in determining patient experience. Building upon Donabedian's (1980) model (Figure 1), therefore; it is evident that aspects of process

directly impact upon the overall experience of the patient receiving care. Figure 3 indicates elements of organisational structure which can additionally impact patient experience:



**FIGURE 3 - ORGANISATIONAL ASPECTS (REIMANN & STRECH 2010, P.241)**

Figure 3 demonstrates a contention at the heart of the definitional differences between expectation and satisfaction. Here, for example, medical facilities could be inaccessible and poorly maintained; and waiting times long; and the healthcare organisation could still register positive patient satisfaction ratings. This is caused by the context and culture-specific nature of each study. Necessarily, expectations of care will be different in the KSA from the USA, for example, and as such experience metrics should be synergised within the existing cultural and economic context of the nation being examined.



**FIGURE 4 - OVERARCHING ASSESSMENTS (REIMANN & STRECH 2010, P.240)**

Figure 4 indicates broader overarching factors which impact upon patient expectation. These are broad, and provide no metric framework for robust analysis; however this figure does highlight wider considerations regarding patient experience. For example, patient satisfaction is placed here within a wider context of overall experience, and this is helpful for the forthcoming structure of the research methodology. By identifying satisfaction as a contingent aspect of a wider study of patient experience, a wider range of applicable practical results can be developed.

As evidenced by Figure 2-4, clarity of measurement is necessary to determine the local contexts and expectations patients have and isolate the cultural factors impacting upon patient experience. As noted by Lau et al. (2012) “the differences between the types of measure and reasons for collecting data on them are not semantic....measures of satisfaction have a common-sense and political appeal’.

As noted by Lau et al. (2012) patient experience can therefore be considered in terms of three key factors: (1) determinants of experience, (2) components of experience (3) outcomes of experience. As with Donabedian's three-part model of quality of care; here a tripartite approach to patient experience can be outlined utilising structural determinants, process-based components and broader outcomes – both projected and actualised. This model contextualises the importance and impact of clinical effectiveness, as this important area of research is consequently impacted by satisfaction, experience, and previous expectation.

#### **1.2.4 Clinical Effectiveness**

Clinical effectiveness is closely related to quality of care and patient experience, but refers specifically to the efficacy of care delivered by practitioners. Clinical effectiveness can be defined as 'the right person doing the right thing (evidence-based practice) in the right way (skills and competence) at the right time (providing treatment and service when patients needs them), in the right place (location of treatment and service) with the right result (clinical effectiveness/health gain' (NHS QIS 2005).

Methods for measuring and assessing clinical effectiveness are discussed further in Chapter 2. The evidence found in the literature suggests that there is a positive association between patient experience and clinical effectiveness (Doyle et al. 2013). In the context of the KSA, there is a lack of evidence of assessment of patient experience including satisfaction from the clinical effectiveness perspective.

#### **1.2.5 Perceptions of Care Quality in KSA Context**

The 13 point approach to patient experience (Reimann and Strech 2010) previously described indicates the centrality of my study context as a contingent factor in determining patient expectations, satisfaction levels, quality of care ratings, perceptions of clinical effectiveness and overall experience. As such, it is therefore essential to explore the

contextual complexities of the KSA case study; and identify the impact that prevailing political and socio-economic factors may have upon key determinants of patient experience.

In the context of the KSA, the measurement of healthcare quality in general and of patient satisfaction in particular, is even more complicated than in Western nations. This is because the models for assessing healthcare were developed in and for Western healthcare systems (particularly in Europe and North America) and they do not translate neatly to the KSA. However, the KSA's healthcare system is at present growing increasingly Westernised, although the residue of the old system persists—including a subordinate role for women, language barriers between providers and patients, and the practice of limiting information disclosure to patients (Younge et al. 1997; Al-Shahri 2002). The main areas of the Westernisation of the KSA healthcare system include health policy, standards of care, and the education of healthcare providers. In addition, KSA hospitals are seeking accreditation with major international bodies. The World Health Organisation is targeting health improvement in the KSA, and the health sector is collaborating with international bodies such as international research centres and the academic sector (WHO 2009; Al-Khenizan and Shaw 2011; Al-Malki et al. 2011). This prevailing environment of increased international cooperation means that it is now possible to explore the measures of patient satisfaction that were derived in the West in the context of the KSA. Indeed, there are certain features of the KSA's healthcare system that make this issue both urgent and complex, since they can significantly impact the quality of care, including gender politics, non-disclosure practices, and language barriers between providers and patients.

### **1.2.6 Summary**

The previous section introduced a number of key terms pertaining to this thesis. While outlining the increasing relevance of patient satisfaction questionnaires within the KSA, a number of academic notions are evidenced and critiqued. Patient satisfaction is highlighted as an inherently subjective notion contingent upon the expectations of the individual patient prior to undergoing care. These are determined by a number of factors including wealth, religion and condition. Quality of care is also evidenced as a fluid process, rather than a

fixed metric against which all institutions can be held accountable. Additionally, clinical effectiveness represents the ability of medical institutions to effectively treat the patient; and this too is impacted by perceptions of satisfaction, expectation and quality. The location of the study within the KSA presents further complications, as quality of care in the KSA is culturally distinct from Western standards.

### **1.3 Research Aims and Research Questions**

This thesis aims at examining the extent to which clinical effectiveness impacts upon patient satisfaction and perceptions of quality of care among adult cancer patients in oncology wards at the Saudi Regional Cancer Centre in Riyadh (SRCC), in the Kingdom of Saudi Arabia.

The primary research question (RQ) emergent from this primary aim was to explore:

RQ: What factors contribute to or hinder patient satisfaction with care in oncology ward settings in the SRCC?

This primary research question was subsequently broken into three more specific sub-questions to be answered during Phase 1 of the research:

SRQ1: What are the socio-demographic characteristics of adult oncology inpatients at the SRCC in Riyadh?

SRQ2: Does the clinical effectiveness of health care (doctors' and nurses' skills, information provision, availability) influence adult oncology inpatients' satisfaction with care at the SRCC in Riyadh?

SRQ3: Does accessibility to health care (service organisation) influence adult oncology inpatients' satisfaction with care at the SRCC in Riyadh?



Informed by the responses in Phase 1, another series of specific questions was asked during Phase 2 of the research:

SRQ4: How do interpersonal aspects of care influence adult oncology inpatients' satisfaction with care at the SRCC in Riyadh?

SRQ5: How do socio-cultural communication factors influence adult oncology inpatients' satisfaction with care at the SRCC in Riyadh?

The specific aims of the research were as follows:

1. To describe the characteristics of patients in adult oncology ward settings in SRCC.
2. To determine the likelihood that clinical effectiveness is associated with patient satisfaction in adult oncology ward settings in SRCC.
3. To determine how likely the accessibility to health care is associated with patient satisfaction in adult oncology ward settings in SRCC.
4. To explore the extent to which interpersonal aspects of care influence patient satisfaction in adult oncology ward settings in SRCC.
5. To provide recommendations for enhancing patient satisfaction in oncology ward settings in KSA.

## **1.4 Significance of Research**

This research is significant in the following ways:

- (a) This study is the one of the first in the context of the KSA to explore patient satisfaction within a hospital context to investigate clinical effectiveness.
- (b) Outside a Western context (Western Europe and North America) there has been little research conducted internationally on patient satisfaction using the mixed methods approach (Hyrkas et al. 2000; Merkouris et al. 2004).

(c) By illuminating the doctor-patient and nurse-patient relationship in the KSA, my study contributes to the understanding of how these relationships operate in Gulf Cooperation Council (GCC) area. This includes Bahrain, Kuwait, Oman, Qatar, Saudi Arabia, and United Arab Emirates, and other Arab countries (in relation to religious beliefs, cultural beliefs and patriarchal culture).

The research findings will be able to influence future practices, education, and research on patient satisfaction and experiences that are held with healthcare providers in oncology wards throughout the Kingdom of Saudi Arabia.

## **1.5 Overview of Study Context**

This section examines a number of existing socio-political factors impacting upon contemporary healthcare treatment in the KSA. It provides a number of critical contextual insights into the development of this thesis to ensure a culturally-synergised research approach.

### **1.5.1 History and Background of the Kingdom of Saudi Arabia**

The Kingdom of Saudi Arabia (KSA) was unified and established as an Islamic state in 1932. The country occupies an influential political position in the Middle East and the wider Muslim world owing to the presence of the two holy mosques (Makkah and Madinah). The 2010 census found that the KSA had a population of 29.9 million, of whom 73% were Saudi citizens (CDSI 2010). There is substantial employment of non-Saudis in a number of sectors, including healthcare.

Riyadh, the capital and the largest city in the KSA, has a population of just over seven million and accounts for 24% of the population of the Kingdom (World Population Review 2014). To place this in a global context, the city has a population of almost two million more

than the population of Scotland, which currently stands at just over five million (Scotland National Statistics 2014).

Religion is an important aspect of Saudi society, and its culture and social norms are drawn from the Sunnah (a set of documents held to represent a model of life, detailing the actions and the sayings of the Prophet Muhammad [*peace be upon him, pbuh*]). In effect, observant words and actions ensure that daily life fits the teachings of the Prophet of Islam, Muhammad. Specifically, the Sunnah school of thought is a reflection of the Prophet Muhammad's public actions and private behaviour. Essentially, religion sets the boundaries for what is allowed and tolerated.

The KSA is overseen by the monarchy, which dominates Saudi politics, with the King and Royal Family effectively running the state. The KSA, therefore, demonstrates a cultural homogeneity that is reflected through a common Arabic language, adherence to the Sunni Hanbali school of Islam, and a common sense of a national culture.

### **1.5.2 The KSA Culture**

Within the cultural context of the KSA, Islam not only represents a religious ideology but also forms the basis for a social system that defines various aspects of people's lives. There are, however, divergences in understanding and interpretation within Islam that lead to diversity in compliance with the traditional structures of the Islamic regulatory system and levels of adherence to Islamic ideology. Beling (1980) explains that this diversity within Islamic culture is a result of differences between urban and nomadic characteristics, tribal and non-tribal features, city-dwellers and villagers, and other aspects, such as whether individuals are literate or illiterate, open-minded or conservative.

The KSA has a patriarchal social system, characterised by masculine authority over kinship family groups. This culture affords men control over women, who are considered the 'inferior

gender', largely due to values attached to the masculine gender as providers and protectors. A lot of emphasis within the social context is placed on the need for individuals to understand and recognise the welfare of others. Saudi social lifestyles are also characterised by specific socially defined ideals for dignity and honour (Beling 1980).

### **1.5.3 The Process of 'Saudisation'**

One predominant socio-cultural trend which requires acknowledgement at this stage is 'Saudisation'. For over a decade, the Saudi government has been attempting to address the imbalance of foreign versus Saudi nationals in the workforce (Ministry of Planning 2002b). This is an issue that is found among a number of the GCC states, such as Qatar and the UAE, where very significant 'expatriate' (non-national) populations have developed due to migrant labourers being brought in to fill skills gaps in key employment areas. In comparison with the UAE and Qatar, where the non-national populations are as high as 70-85%, the Saudi population imbalance is relatively moderate at only 27%. It has, however, been identified by the government as requiring a resolution.

A Saudisation programme, which focuses on increasing education opportunities and thus employment for Saudi nationals, was introduced with the goal of reducing and reversing over-reliance on foreign workers, and recapturing and reinvesting the kingdom's income (Looney 2004). The Saudisation process has been slow, and in 2011, Saudi Arabia's Ministry of Labour introduced the *Nitaqat* ('zones') programme as a driving force towards replacing expatriate workers with Saudis in the private sector (Ministry of Labour 2009). The programme categorises companies based on their success at nationalising their workforce, and those companies failing to meet Saudisation targets are penalised (Ministry of Labour 2009). Despite the introduction of the Nitaqat programme, change remains slow. Saudi patients still receive their care within a multi-cultural environment, largely from non-Saudi (and non-Arabic speaking) healthcare workers.

## **1.6 Healthcare within the KSA**

Saudi nationals are entitled to public healthcare, which is generally free. The Saudi Arabian Health System is provided by the Ministry of Health centres and hospitals, in conjunction with the King Faisal Specialist Hospital and Research Centre (KFSH&RC), universities, and portions of the military (MOH 2006). Relatively low numbers of Saudis are part of the Saudi Arabian healthcare workforce, which is instead heavily dependent upon workers from other countries, including India, the Philippines, South Africa, the US, and the UK (Al-Dossary et al. 2008).

There is, however, a substantial volume of literature that criticises the level of care provided to patients in the KSA, including fluctuations in facilities, insufficient access to cancer management drugs, substantial communication issues, resource challenges, and difficulties in handling necessary organisational restructuring (Almuzaini et al. 1998; Al-Eid and Manalo 2007; Elkum et al. 2007; Brown et al. 2009; Shamieh et al. 2010). Alongside this, healthcare costs in the KSA have been increasing since 1990, and a significant result of this is a shortage of resources and variations in the quality of healthcare provided (Akhtar and Nadrah 2005; Al-Ahmadi and Roland 2005; Walston 2008; WHO 2009).

These issues can partly be explained by the significant socio-economic and infrastructure transformations that the KSA has faced over the last 30-40 years, and the change in its epidemiological profile from infectious diseases and nutritional deficiencies to the 'age of degenerative and man-made diseases' such as cancer and heart and cerebrovascular disease (Younge et al. 1997, p. 309).

### **1.6.1 The Doctor-Patient Relationship and Disclosure**

Doctor-patient relationships and disclosures are considered influential factors that impact upon patient satisfaction and experience. The central practice in healthcare revolves around the doctor-patient relationship and this has become an imperative component to ensure the delivery high quality health care. Kelley et al. (2014) note “it is absolutely necessary that the patient has confidence in the competence of their doctor and the patient needs to feel comfortable enough to confide in their doctor” (2014, p.36). The relationship is not one conducted between two equal partners; however, with the doctor occupying superior knowledge and experience of diagnosis and prognosis to the patient due to their extensive knowledge and credentials in the medical field (Goodyear-Smith and Buetow 2001).

The nature of this relationship, and the private nature of the material concerned, necessitates complete confidentiality on behalf of the healthcare professional. Disclosure of patient’s medical information without consent leads to a breach in confidentiality which can be tried by law depending on the laws and ethics of various countries.

The doctor-patient relationship in KSA is completely different to the ethically set standards of many Western countries. It is commonly found that many doctors practicing in KSA do not abide by the status-quo of the ethical values that are embraced within doctor-patient relationships in neo-liberal Western nations. This commonly includes a breach in confidentiality through casually disclosing patient health information. There are also instances of doctors in KSA feeling extremely superior to their patients causing them to not include the patients in the decision-making process regarding their own health. An in-depth discussion of this relationship takes place in Section 2.5.2.

### **1.6.2 Cancer Prevalence and Care of Oncology Patients in the KSA**

The rate of cancer diagnoses has been rising in the KSA in recent years, and as such patient satisfaction is becoming an increasing concern across the nation's oncology wards.

The most recent Saudi Cancer Registry (SCR) reports on cancer prevalence and rates indicate that the total number of reported cases was 13,706 in 2010 (Saudi Cancer Registry 2010). This rate is relatively evenly divided in terms of gender, with 48% of those affected being male (6,579 cases) and 52% being female (7,127 cases). Men were found to have an increased rate (up to 1.5 times the normal rate) of cancer after the age of 64, and the median ages of sufferers were calculated to be 51 years for women and 58 years for men. The report also disclosed a geographical division, with Riyadh (central), Tabuk (northwest), Makkah and the Eastern Province having the highest rates, which were measured as 115.00, 92.00, 77.00 and 116.00 (all per 100,000), respectively in 2010 (Saudi Cancer Registry 2010). Further information from the Saudi Cancer Registry's 2010 report is presented in Appendix 1.

The top five types of cancer affecting males and females, as reported by the age-standardised incidence rate (ASR), have historically been lower in the KSA compared to the USA, such differences will, according to Ibrahim et al. (2008), be less evident in the future. Ibrahim et al. (2008) indicate increasing obesity rates, smoking and alcohol abuse as key concerns in this area relating to the rise in malignant cancer diagnoses. Additionally, the aging population adds to future concerns of growing cancer rates (Jazieh 2012). Moreover, a recent publication discussing the burden of breast cancer in KSA anticipates that the incidence and mortality of cases is to increase by about 350% and 160%, respectively, over a ten-year period by 2025 (Ibrahim et al. 2008). The reason for such a large increase in these variables may be due to an anticipated prevalence of reproductive factors associated with the increased risk of breast cancer, including early menarche, late child bearing, fewer pregnancies, use of menopausal hormone therapy, as well as increased detection through mammography, as witnessed in developed countries (Parkin and Fernandez 2006; Zuhl et al. 2008). Projected increases in cancer diagnoses increase the pressure on quality standards across a number of oncology wards in the KSA (WHO, 2009), and raise concerns regarding the maintenance of current standards of care, regardless of the requisite

improvements to meet future demand. Consequently, there is a need for research to examine, inform and make a contribution towards improving the quality of care to meet these anticipated increasing demands. In this regard, my study addresses patient satisfaction interfaced with the current quality of care received within oncology ward settings in the KSA.

It has also been reported that resources for cancer control in the KSA are inadequate and directed almost exclusively to treatment, with little focus on prevention and screening for early detection (Rastogi et al. 2004). In recognition of the problems posed by cancer, and to alleviate the suffering of people and improve their quality of life in the future, an initiative was launched in 2010 in Riyadh with the stated goal of 'Improving Cancer Care in the Arab World' (ICCAW 2010). This high-profile collaboration between the National Guard Health Affairs Oncology Department and the Arab Medical Association Against Cancer also includes the participation of a number of other national and international bodies. The collaboration examined a wide range of themes associated with comprehensive cancer care and control, including the role of service organisations. It was agreed to formulate a strategic planning process for the next ten years, dedicated to implementing improvements to services and planning, and exploring other issues affecting medical reform.

This huge initiative takes a holistic view, examining a range of topics, including funding, detection and screening, access to medication, and human resources development, as well as the establishment of population-based registries across all Arab countries as part of a newly developed National Cancer Control Program to enhance oncology care, generally. By illuminating the doctor-patient and nurse-patient relationship in the KSA, my study contributes to understanding of how these relationships operate in the KSA in particular, and Arab countries in general, with their distinct cultural beliefs.



### **1.6.3 Personal Research Rationale**

As a former head nurse within an oncology unit in the KSA, I was at the cutting edge of healthcare in the country prior to undertaking this research. I dealt with a wide range of care being delivered to cancer patients on a daily basis, and through my hands-on experience, I witnessed areas which I believe could be changed to improve the quality of the care that patients receive. In particular, I believe that the circumstances and complexities of each patient should be considered. These practical experiences demonstrate the benefits of patient-centeredness as a means to help remove barriers to top-quality care and to empower patients through the process of diagnosis and care. This is achieved by allowing their opinions, feelings, religion-cultural views and perspectives to be taken into account.

The value of patient-centeredness, however, must be recognised before it can be effectively implemented and have a positive impact on healthcare quality. Consequently, there is need for further research in the field to expand the knowledge base and to interpret the relationship between patient experience, patient satisfaction, and quality of care. These personal perspectives and experiences have been a driving force in motivating this research.

## **1.7 Outline of Thesis**

This thesis is organised in six chapters, as outlined below:

Chapter 1 introduces the development of robust research aims, based around existing literature regarding perceptions of clinical effectiveness, quality of care and patient satisfaction; and applying these notions to the KSA oncology ward sample.

Chapter 2 consists of a review of relevant literature relating to the key terms outlined in the research question. These include: quality of care (including Donabedian's model), patient

satisfaction (including definitions, influences, and approaches to measurement), and KSA-specific studies on patient experience or satisfaction.

Chapter 3 describes the chosen research methodology and methods, and provides the rationale for adopting a sequential mixed-methods approach. This chapter also includes the processes/methods by which the research for this study was conducted.

The research findings are presented in the subsequent two chapters: Chapter 4 details the results from the quantitative phase of the study, and Chapter 5 presents the findings from the qualitative phase.

One particular challenge in a mixed-methods approach is to integrate the different strands; this is achieved in the final discussion and conclusions found in Chapter 6, which pulls together and evaluates all of the results, considers the success and limitations of the research, and offers recommendations for further study along with the contributions that this study makes to the field of patient satisfaction in particular to the KSA healthcare setting.

Chapter 6 also provides insight into the significance of the study along with the various contributions produced to improve patient satisfaction within healthcare delivery in the Saudi Arabian context. The recommendations produced by the study contribute to the improvement of healthcare systems in Saudi Arabia.

## **Chapter 2 Literature Review**

### **2.1 Introduction**

This literature review begins with a description of the methodology used in the literature search strategy, and the narrative synthesis method that is used to combine or pool the results of research studies with a range of different research designs (Coughlan et al. 2013). The chapter subsequently examines (a) the Donabedian model (1980) and quality of care; (b) patient satisfaction and evaluation of the quality of care and (c) the assessment of patient satisfaction and quality of care in the KSA based on the patient experience.

A thorough appraisal is then made of the selected literature regarding patient satisfaction in oncology settings in the KSA. A careful assessment of the most robust evidence and a detailed exploration of important and relevant themes emerging from the studies are then offered. The review concludes by identifying the limitations of existing patient satisfaction studies. These limitations are subsequently used to help formulate the research question adopted for this study, and help to articulate the research question and the research design.

### **2.2 Methodology for Literature Review**

#### **2.2.1 Narrative Synthesis**

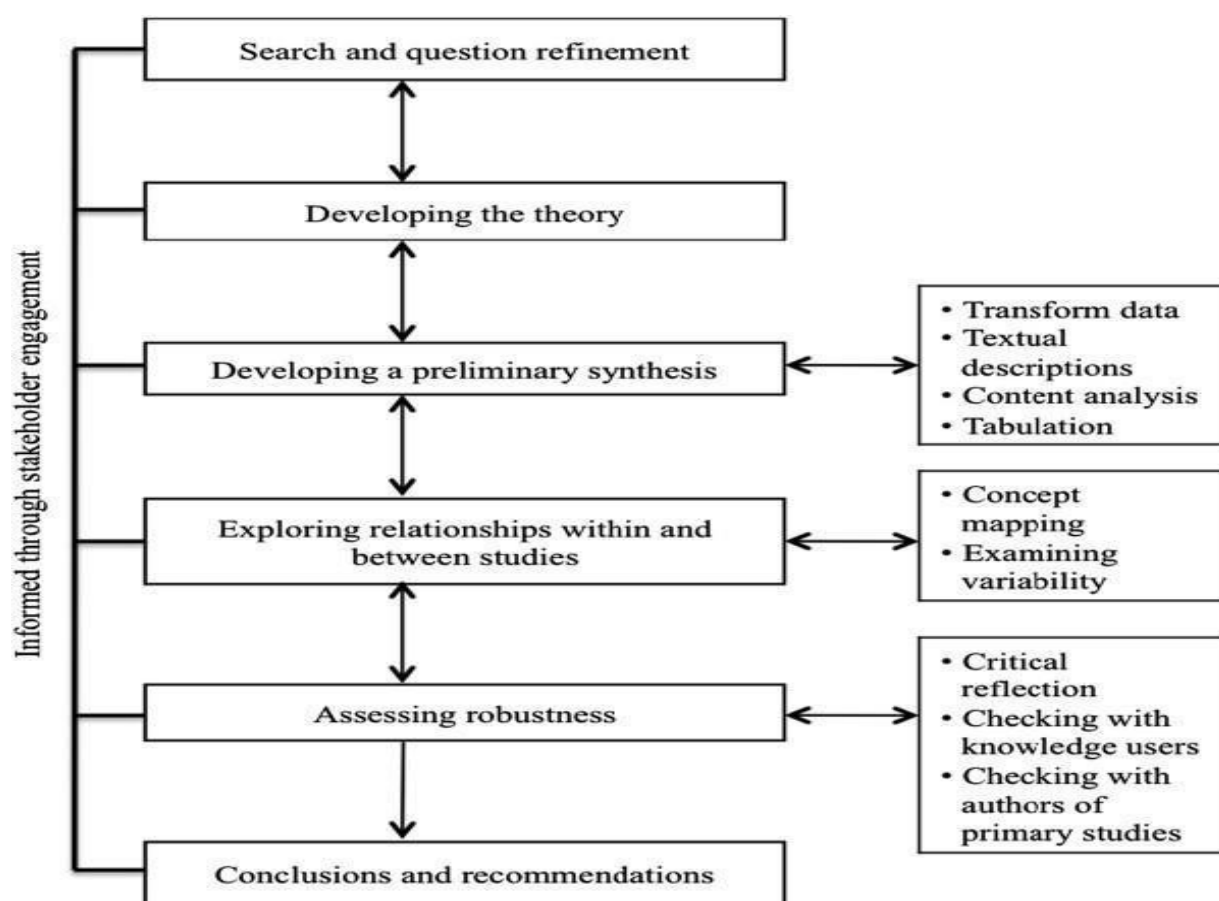
This section provides a narrative synthesis of existing relevant literature in the KSA and beyond, focusing primarily on publications from the last three decades. As a relatively new field of research there is limited published material on patient satisfaction, quality of care and clinical efficiency from before 1980. The method of narrative synthesis has been chosen because it relies primarily on extant text to summarise, interpret and correlate a wide range of findings, and synergise these within the context of the research question. This is a

particularly useful method for facilitating evidence-informed policy development internationally (Snilstveit et al. 2012).

Popay et al. (2006) define narrative synthesis as an approach to the “systematic review and synthesis of findings from multiple studies that relies primarily on the use of words and text to summarize and explain – to ‘tell the story’ – of the findings of multiple studies” (2006, p.5). The narrative approach to synthesis of research evidence involves critical appraisal of large bodies of evidence, which can employ different research designs, including qualitative and/or quantitative, or a combination of both in mixed methods. It is particularly relevant to synthesise diverse evidence from a range of study designs, as is the case here. It is noteworthy that unlike the commonly used specialist synthesis methods, narrative synthesis has not been well developed. For example, one particular weakness of narrative synthesis mentioned in the literature is the lack of transparency (Dixon-Woods et al. 2005) and the lack of clarity on methods and guidance on how to conduct such a synthesis (Mays et al. 2005).

Nevertheless, within the past decade, extensive work by Popay et al. (2006) has culminated in published guidance on the conduct of narrative synthesis. This guidance shows researchers precisely how to conduct narrative synthesis in a systematic and transparent way by focusing on the synthesis of evidence, effectiveness of interventions, and factors determining the implementation of interventions. This guidance has been tested by other researchers and found to be robust and transparent (Arai et al. 2007; Rodgers et al. 2009), and unlike existing models quantifying quality of care, for example, it is based on an objective research perspective; and is therefore applicable to a number of research contexts and methodologies. It has, however, been emphasised that researchers should ensure their narrative synthesis is aimed at producing a reflective account, rather than simply providing a summary of research findings (Rodgers et al. 2009). This interpretive element to the process emphasises the importance of contextual specificity to the research; a specificity that is required for such a complex and intricate research proposition as care quality in the KSA.

Applying this guidance to my research ensured effective implementation of the technique as demonstrated below. Specific tools to assist in the synthesis were adopted, and the narrative synthesis was followed. First, the approach involved setting out the adopted search strategy and describing the reasons for including particular articles. Second, theories were developed and a preliminary synthesis of the most robust research evidence was performed. This was then followed by an evaluation and a reflective account of those articles selected for inclusion. Finally, conclusions and recommendations are offered. The process is evidenced in Figure 5:



**FIGURE 5 - INTEGRATIVE NARRATIVE SYNTHESIS PROCESS (ADAPTED FROM POPAY ET AL. 2006)**

### **2.2.2 Literature Search Strategy**

The selection criteria used for this review were applied in two stages. The initial selection of studies was followed by a final selection of the studies after an appraisal of quality. As previously mentioned, the literature search was kept within the date range of 1980-2015, as there is little published material on the topic before 1980. This also covers the period during which there was substantial socio-economic change in the KSA, as discussed previously.

Multiple databases were searched, including: Science Direct; CINAHL (Cumulative Index to Nursing and Allied Health Literature); Web of Knowledge (multiple data bases, including Medline); and Google Scholar. Combinations of search terms were used through Boolean operator, including: 'patient satisfaction AND quality of care', 'patient satisfaction AND Saudi', 'Saudi patient satisfaction' AND 'quality of care, Saudi Cancer patient satisfaction AND quality care', 'quality health care AND Saudi', 'Doctor Communication AND Saudi AND cancer care', 'Communication AND Saudi Cancer care'. This search strategy facilitated capture of all articles pertaining to quality care issues in health care, both globally and in the KSA, with specific focus on oncology patients. In addition to this database search, other documents and reports were accessed via the Saudi Ministry of Health, and Saudi Cancer Registry websites. A total of 93 papers were retrieved following this search (see Appendix 2 for search and screening process).

### **2.2.3 Inclusion and Exclusion of all Search Outcomes**

Following the initial search, the next stage of the selection process narrowed down the articles by reading through the abstracts and removing those not directly related to this study. The inclusion and exclusion criteria used for this selection are shown in Appendix 3. After this secondary review was complete, a total of 69 articles were selected for full review. The importance and value of hand searching during systematic reviews is demonstrated by Armstrong et al. (2005) who uses the same criteria as described for this study. Therefore, a further 21 additional articles were selected by hand searching the citations from the initially

selected articles, and identifying those articles considered of relevance. These were subsequently narrowed down to nine. Accordingly, a total of 78 papers were ultimately collated and subjected to quality appraisal.

#### **2.2.4 Quality Appraisal**

In order to determine the quality of these extracted papers, all of the 78 identified primary studies were further subjected to rigorous quality appraisal using the method devised by Dixon-Woods et al. (2005). This approach does not exclude weaker studies, but gauges the overall quality of both quantitative and qualitative papers to be graded together using the following five criteria: (1) aims and objectives, (2) research design, (3) methodology, (4) findings, and (5) interpretations and conclusions (see Appendix 4). One point is given for each of these aspects, and a research paper's quality is judged in terms of the total score obtained out of five. Of the 78 papers, those obtaining the highest quality appraisal were included in the final review (a rating of 3-5). These papers were scored in the following way: 3, if they omitted a robust explanation of the methods used such as the sampling strategy or the instrument definition; 4, if only a clear interpretation of the results were missing; and 5, if they clearly addressed study aims, methods and findings. As a consequence of this screening, a total of 58 papers were selected for use in this review.

### **2.3 Overview of Studies**

This section presents an overview of the studies reviewed. The details of the 58 papers that were selected and critically reviewed can be found in Appendix 5. Appendix 5 includes a summary of study aims, sample population, methods, key findings and limitations of the studies for each paper. A preliminary synthesis helped develop theories regarding patient satisfaction; further critical review then allowed exploration of relationships within and between studies. This iterative process identified a number of common themes and allowed for categorisation of a number of identified variations. The rest of this chapter presents the narrative synthesis of the research on quality of care, patient satisfaction, and healthcare in the KSA.

### **2.3.1 Quality of Care: Definition and Measurement**

Quality of care is an increasingly important concept in health care. However, developing a transferable measurement model has proven very difficult owing to the highly subjective nature of each individual study (Cleary 1998; Campbell et al. 2000; Ladhari 2009; Beattie et al. 2015). In lieu of such a universal model, there is a requirement for a working definition that can capture the multidimensional nature and reflect the differing perceptions of what comprises quality of care. The Institute of Medicine IOM (2001) define quality as 'the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge' (IOM 2001, p.65). This definition suggests that if patients can access the services they need and if the services provided are useful then quality is guaranteed. Service provision and access therefore form key components of effective quality as defined in this thesis.

It is also important to identify perceptions of quality of care as part of a transient process that do not occupy uniform or fixed positions within medical practice. Practical attitudes towards quality of care have particularly developed in recent years. Formerly, a traditional method of measuring quality of health care was achieved by assessing if the care or treatment being provided had achieved its goal, for example, was the illness cured, did the patient recover (Payne et al. 2001). In more contemporary practice an increasingly holistic approach is taken to the issue of quality of care. The Institute of Medicine (2001) cite quality of care as ultimately determined by patients' reflection upon their experiences in a health setting. If a patient constructs their reflections of care in a positive way, then consequently positive quality of care has been achieved. In recent academic discourse, therefore, it is possible to evidence a movement in focus from disease/cure based perceptions of care quality, to patient-driven analyses of wider experience (Tsianakas et al. 2012; Manary et al. 2013; Beattie et al. 2015). In contemporary discourse quality of care is therefore ultimately determined by the patient and this is crucial to a patient-centred approach (IOM 2001).



Through a broader analysis of the chronology of academic perceptions of care quality it is clear that perceptions of indicators of quality shift in focus over time. This raises the issues of the identity of the indicators we need to consider as essentially linked to the measurement of quality in order to assess patient satisfaction. It is possible to identify some central recurring features across a broader analysis of academic literature. The most frequently identified dimensions of quality in the literature are: safety, effectiveness, efficiency, equity, patient centeredness and timeliness (IOM 2001; Copnell et al. 2009; Doyle et al. 2013; Beattie et al. 2015) all of which are reviewed next.

#### **2.3.1.1 Donabedian Model (1980)**

The Donabedian model (1980) provides a framework for understanding quality of care in a health care setting. It does not claim to offer how an organisation can improve the quality of care, or even present a definition of what quality of care is, but rather it should be seen as a means of helping to evaluate the existing context. The Donabedian model offers a way of analysing a health care environment or a treatment method in order to determine what can be done to understand the level of quality of care of patients. Information on patients' satisfaction with the quality of care can be assessed with the help of information captured under three domains (1) process, (2) structure, and (3) outcome.

Process refers to the various actions and initiatives taken in the treatment of a patient and includes all the actions involved in the care of a patient from diagnosis to after care. It includes clinical and interpersonal aspects of care during delivery of medical treatment or intervention. Outcome refers to the series of consequences and effects of the treatment on a patient. This is possibly the most important of all the concepts in the Donabedian Model (1980). It is ultimately the main criteria for a patient's level of satisfaction with the care received.

There is a strong relationship between all three domains as suggested by Donabedian (1980) and all need to be explored together (Khmais and Njau 2014, p. 6). For example, the Donabedian Model was used as a basis to construct reliable findings on patients' satisfaction in an outpatient setting in Dar Es Salem, Tanzania (Khamis and Njau 2014). The model has been widely used as basis for identifying quality in international healthcare settings (Tarlov et al. 1989; Irvine and Donaldson, 1993; Campbell et al. 2000; Kringos et al. 2010). The model has been used to generate data and insights into patients' quality of care and provides concepts useful in identifying factors that influence patients' satisfaction through a wider examination of patient experience of process, structure and outcome.

### **2.3.2 Patient Satisfaction and Expectations**

This section discusses the literature on patient satisfaction, including (1) the varying definitions of the construct of patient satisfaction, together with (2) the wide array of factors that have been shown to influence it, and (3) the various approaches that can be used to attempt to measure it.

#### **2.3.2.1 Definitions**

The concept of patient satisfaction has evolved over the years as different definitions have been applied to the concept. Linder-Pelz (1982) defined patient satisfaction as an evaluation of distinct health care dimensions. Pascoe (1983, p. 189), on the other hand, defined it as a 'comparative process involving both cognitive evaluation of care and an affective response that may include both structure process and outcomes of services'. This is important as it provides a framework by which clinical effectiveness can be directly related to patient-centred analyses of satisfaction and quality of care.

While the relationship between the central elements of patient experience and satisfaction, quality of care and clinical effectiveness is highlighted by the above definition, it is not quantified by existing definitions of patient satisfaction. For example, Keith (1998, p. 1122) defined patient satisfaction 'as a complicated multidimensional concept whose measurement and application are anything but simple'. A more recent definition by Al-Rubaiee and

Alkaaida (2011) refers to it as a psychological notion that is easily understood but difficult to define. Patient satisfaction is considered to be imperative and generally used as an indicator for measuring the quality of healthcare delivery. Prakash (2010) has argued that patient satisfaction impacts clinical outcomes, patient retention, and medical malpractice claims. Furthermore, it is known to affect the judicious, efficient, and patient-centred delivery of quality health care (Prakash 2010). Patient satisfaction is also considered a very effective indicator used to measure the success of doctors and hospitals.

The definitions found in the literature, (Linder-Pelz 1982; Pascoe 1983; Keith 1998; Prakash 2010; Al-Rubaiee and Alkaaida 2011) identify patient satisfaction as a multidimensional concept determined by the individual views of patients asked to complete a questionnaire evaluating the adequacy of care services they have received. Traditionally, patient satisfaction is largely determined by patients' evaluation of their experiences, across a range of key variables, especially outcomes. This view of patient satisfaction is often regarded as a flawed concept, if it is simply based upon perceptions of quality of care. More recent research on patient satisfaction is now increasingly linked to how they constructed their experiences (Bjertnaes et al. 2012; Anhang Price et al. 2014). Patient satisfaction is no longer just based upon patients' ratings of their care but how they have conceptualised it. That is, how they have configured their experiences into a belief or idea that their experiences were positive or negative. This construction involves 'their multiple satisfactions with various objects and encounters that comprise their care' (Singh, 1989, p. 177).

Patient satisfaction is, therefore, the conceptualisation of their experiences as good or bad and the extent to which this concept is positive or negative determines their level of satisfaction. Patient satisfaction is distinct from their experiences, although dependent upon those experiences. Patients' experiences relate to their encounters with health care professionals in a healthcare setting. In other words, 'it is the sum of all interactions that are shaped by a healthcare organisation's culture, that influence the patient perceptions throughout the continuum of care' (Beryl Institute 2014). Satisfaction is the conceptualisation of the totality of their experiences in a health care setting which is influenced, but not determined, by one experience. Patient satisfaction is thus defined as the evaluation of the

conceptualisation of their experiences and the extent to which it has satisfied their needs and has delivered the expected outcomes (Jekinson et al. 2002). This working definition is adopted throughout the thesis.

Central to patient satisfaction are patient expectations. Satisfaction in the clinical setting can be defined simply as the desirable outcome of care, while perceived service quality refers to the process where the consumer (in this case the patient) compares his/her expectations with the service he/she has received, which, in this case, is a subjective measure (Gronroos, 2000). Smith (1992) likewise recognises the subjective nature of patients' evaluation of care, thus illustrating the complex interrelationship between perceived need, expectation of care, and the experience of care. Indeed, patients' expectations of care are known to be influenced by several factors, including patient characteristics, prior experience and characteristics of the situation, as well as environmental factors (Oberst 1984). Expectations predispose a patient to have a positive or a negative experience. Satisfaction levels are related to whether a patient's expectations are met when they encounter the health care system (Bowling et al. 2013). The extent to which a patient's expectations have been acted upon or not influence the development of their experience in a healthcare setting which later significantly influences their development of a specific level of satisfaction (Bjertnaes et al. 2012; Bowling et al. 2013).

Customer and patient satisfaction constructs are only similar in that they both value the process by which services are delivered. For a patient, service delivery includes medical care as well as provision of comfort, emotional support and education (Kupfer and Bond 2012). Also, there is a suggestion that, to satisfy patients on a continuous basis, there is a need for physicians to incorporate patient perspectives into the clinical decision-making process. Patient satisfaction can be misinterpreted as there is more to it than a health service provider offering high standards of care and ignoring individuals' perspectives. Good quality health care by itself does not guarantee that patients evaluate their experiences in a positive light. Findings in the literature recognise the need to differentiate between the two concepts of quality health care and patient satisfaction (Cleary 1998; Haddad et al. 2000). Al-Rubaiee and Alkaaida (2011) describe satisfaction as a moving target that must be

monitored in order to understand the content of patient expectations and ensure health care providers respond proactively to enhance the standard of care provided to patients.

Review of the literature has shown that patient satisfaction is affected by the model of patient-centred care adopted (Mead and Bower 2000), and evidence has suggested that the underlying notion of what patient-centred care means has implications for patient satisfaction (Michie et al. 2003; McCormack et al. 2011; Kupfer and Bond 2012). However, there is a dearth of literature related to patient-centred care in the KSA. The literature that does exist suggests that the adoption of patient-centred care in the KSA could help to bridge the gaps related to information provision resulting from cultural beliefs (Younge et al. 1997; Al-Ahwal 1998; Aljubran 2010).

### **2.3.2.2 Influences upon Patient Satisfaction**

There are manifold factors which influence an individual patient's overall satisfaction and perception of quality of care including: duration and efficiency of care, and the empathy and communication that health care providers give. Kenny et al. (2010) asserts that patient satisfaction is seen to be favoured by a good doctor-patient relationship. Clever et al. (2008) has argued that patients who are well-informed about the process and procedures within a clinical encounter and the amount of time that the processes will take are generally seen to be more satisfied with the service even if they must wait longer. Bensing et al. (2013) also argue that one of the most influencing factors of patient satisfaction is the job satisfaction that is experienced by doctors.

Extant research suggests that a variety of different factors influence patients' perceptions of their experiences in a health care setting, although patient satisfaction is generally difficult to isolate from overall clinical outcomes. This section starts by discussing several cultural and demographic influences more generally, and then focuses on specific influences that are found consistently in the patient satisfaction literature: disclosure practices, the doctor-patient relationship, and the practice of patient-centred care.

It is important to highlight that influences on patient satisfaction are difficult to separate from overall clinical outcomes. According to Jackson et al. (2001), the psychological determinants that may lead patients to express themselves as being relatively satisfied or dissatisfied remain largely unknown, a point reiterated throughout the literature reviewed in this section. In order to attempt to bring some clarity to these important areas, Jackson et al. (2001) set out to establish which characteristics of patients (and physicians) correlate with expressions of satisfaction, what the contribution of the many satisfaction variables identified in previous studies may be, and the extent to which the co-relationships remained constant over time. They found that patients over sixty-five years old are more likely to be generally satisfied; however, the most important predictor of satisfaction, according to them, was the meeting of expectations. This supports the findings of Hall and Dornan (1990), who found that higher levels of satisfaction were associated with increased age.

Indeed, considerable research exists indicating older patients tend to be more satisfied with their health care, a phenomenon which is consistent across cultures and nations (Campbell et al. 2001; Crow et al. 2002; Jaipaul and Rosenthal, 2003; Sofaer and Firminger, 2005; Moret et al. 2007; Quintana et al. 2006; Bleich et al. 2009; Rahmqvist and Bara, 2010; Lyratzopoulos et al. 2012). This may arise from older people having lower expectations of the health care system and therefore there is less likelihood of their expectations being unmet. However, some researchers maintain that these findings may be flawed and not a true reflection of reality due to an inherent caution and reluctance of older people to voice their dissatisfaction when questioned about the adequacy of their health services as they are in constant need of it (Bowling, 2002; Bowling et al. 2013).

### **2.3.2.3 Disclosure Practices**

An important cultural issue that may impact patient experiences and their reflections on them is disclosure. Research in Japan by Tanaka et al. (1999) found that patients suffering from terminal cancer wanted clarity on their prognosis so that they could make the best use

of their time. Tanaka et al. (1999) argued that it is a basic human right of an individual to know about his/her own prognosis.

Concealing the diagnosis from cancer patients may lead to poor patient compliance, misinformation of treatment options, and side effects, which could have an adverse impact on the patient's survival and remaining quality of life. However, even where disclosure occurs, cultural barriers can exist because of a reluctance to accept a terminal prognosis. This puts health care providers in a complex situation, as they are expected to be sensitive toward the patients and their needs as well as continue the care, despite their professional judgment (King et al. 2008). In this regard, it is important to have quality palliative care along with effective coordination between the primary, secondary, and tertiary care services.

#### **2.3.2.4 Doctor-Patient Relationship**

Research further suggests that the doctor-patient relationship is an indicator of patient satisfaction. The encounter between practitioner and patient is valuable for defining patient evaluation of quality of care, and can be seen as fundamental to the doctor-patient relationship (Ong et al. 1995). Although patient-centred communication is at the heart of such interactions, there are different levels and types of communication. These have been separated into three areas by Ong et al. (1995): (1) the creation of good inter-personal relations between the doctor and the patient, (2) the exchange of information, and (3) the making of decisions which are related to the treatment. Ong et al. (1995) found that the extent and type of communication used by the doctor and the responsiveness of the patient will subsequently have a strong impact on the levels of satisfaction derived by the patient from the interaction. Improvements in the doctor-patient relationship will directly influence the quality and levels of patient-centred care, and in the long term, improve patient's evaluation of their experiences.

In a study of how to improve health through communication, Street et al. (2009) identify seven pathways for doing so: (1) increased access to care, (2) greater patient knowledge

and shared understanding, (3) higher quality medical decisions, (4) enhanced therapeutic alliances, (5) increased social support, (6) patient agency and empowerment, and (7) better management of emotions. In another study emphasising the importance of doctor-patient communication, Kenny et al. (2010) state that good communication is essential if the notion of 'relationship-centred care' is to be encouraged. Their results show some significant differences between what patients perceive as the communication skills of the doctors and the doctors' own perceptions of those skills. The qualitative research detailed in Jagosh et al. (2011) reveals that doctors' listening to patients is a critical part of the communication process. These results echo the Institute of Medicine's (2001) claims about alignment of care to the 'voice of medicine' as part of the patient-centred care approach.

These studies demonstrate a clear connection between communication and a successful doctor-patient relationship. However, there is also evidence that the effectiveness of this relationship appears to depend on the severity and associated psychological condition of the patient (McWilliam et al. 2000; Ong et al. 2000; Street et al. 2009; Jagosh et al. 2011). In other words, whilst a correlation seems to exist between communication and patients' satisfaction levels, the strength of this correlation remains equivocal and is a subject for further study.

During the past four decades, there has been a transition in the doctor-patient relationship from one in which the decisions of doctors were 'silently complied with', and any information imparted by the doctor was designed to support his or her opinion of the most suitable course of treatment, to one in which the patient has an expectation of being at the centre of the process and anticipates a greater level of "mutual participation" (Kaba and Sooriakumaran, 2007, p. 57). This shifting relationship reflects not only a change in the socially constructed view of how patients should be empowered, but also one which has been encouraged by the 'social system'. This means that a patient-centred approach has become the predominant model in clinical practice today. However, the KSA is just starting to address the need to improve doctor-patient communication (Aljubran, 2010), and this aspect of research forms an important element of my study. The next section discusses patient-centred care in greater detail.



### **2.3.2.5 Patient-Centred Care**

Generally, patients' development of their experiences based upon their care may involve complex processes, and may be influenced by the values and beliefs of each patient, along with other variables such as health status and socio-economic status. A further factor frequently mentioned in the literature on patient satisfaction is patient-centred care (De Silva 2014). Within the UK, the need for a patient-centred health care system is widely accepted, since this approach supports people making informed decisions about their own health and care, hence, facilitating appropriate management of their care (De Silva 2014). The need for patient-centred care is also well-recognised globally (IAPO 2006; WHO 2008), and in 2001, the Institute of Medicine (IOM) highlighted it as a major goal for improving health care in the USA. The IOM report defines patient-centeredness as 'providing care that is respectful of and representative to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions' (IOM 2001, p. 3). Kupfer and Bond (2012, p. 139) describe patient-centred care as 'improving health literacy through information and education, coordination and integration of care, physical comfort, emotional support, and personalised care, which encompasses the concept of shared decision making'. It can be argued that achieving a better experience for a patient and therefore higher patient satisfaction levels involves good patient-centred care (Krupat et al. 2001; McCormack 2003).

The ascent of patient-centred care in recent years has been driven by the recognition that care can often be more effective when it is tailored to specific patients' needs (Kitson et al. 2013). Patient-centred care in the literature is very much focused on the individual, the delivery of whole person-care and communication. This form of care encourages the participation of the patient and their family in the decision making process with regard to treatment. Although researchers disagree on what exactly constitutes patient-centred care, and its influence on patient satisfaction has not been firmly established, ample evidence does suggest that patient-centeredness leads to patients reflecting upon their experiences in a health care setting in a positive way. Patient-centred care is still fairly new in the Saudi

healthcare delivery system due to societal norms that influence doctors and nurses perceptions.

Indeed, the literature reveals the existence of a number of definitions for patient-centred care and, as such, there are a range of approaches available for measuring patient-centred care. Most take a holistic view, or measure specific subcomponents such as shared decision-making or communication (De Silva 2014).

#### **2.3.2.6 Measurement of Patient Satisfaction**

Patient satisfaction is frequently used as a performance indicator, and commonly measured in self-reporting studies and at times particular kinds of customer satisfaction metrics (Farley et al. 2014). William (1994) and Farley et al. (2014) have countered the effectiveness of patient satisfaction as a useful tool of measurement by arguing that often self-reporting assessments are unable to measure the extent to which a patient may be content with the healthcare that they are receiving. They argued that the metrics implemented may not be valid as patients may be dissatisfied with healthcare which improves their health or satisfied with healthcare which does not. Various studies have failed to identify the relationship between satisfaction and healthcare quality including Schneider et al. (2001); Avery et al. (2006); Clarke et al. (2006); Chang et al. (2006) and Sack et al. (2011).

Patient satisfaction measures are therefore widely used to assess quality of care (Jagosh et al. 2011; Batbaatar et al. 2015), however, researchers lack consensus on how best to measure the construct. This difficulty seems inevitable given that it is challenging even to define the construct. A patient's perceptions of their care are difficult to measure. Patient satisfaction is known to be related to their perceptions of hospital care and other issues, and certain validated and reliable questionnaires have been developed to measure it. There is no one agreed questionnaire or instrument for data collection on the subject. There is also the issue of construct validity, that is, is the researcher able to measure what they claim to be measuring. The problem with measuring patients' conceptualisations of their experiences

is not so much concerned with determining the factors that influence their views. As previously indicated, such factors are well known and established. The key challenge is to find a way for researchers to measure the patients' attitudes to these identified factors in a reliable and agreed way. Therefore, in studying the relationship between patient satisfaction and perceptions of quality of care, it is essential to utilise robust, validated, and reliable questionnaires.

Patient satisfaction is fundamentally different in health care settings compared to consumer marketing constructs, in which service experience approximates to expectations. The patient in a clinical setting tends to be indifferent with respect to service quality and satisfaction, their focus is mainly on their treatment outcomes. It is only when expectations are not met that the patient is likely to judge the service quality as low (Kupfer and Bond 2012).

Indeed, 'satisfaction' is a difficult concept to measure in any context. Against a background which sees the achievement of patient satisfaction as an important aspect of health care outcomes, Williams (1994) expresses concerns about the extent to which 'satisfaction' can be measured, let alone adequately defined. He argues that 'satisfaction surveys provide only an illusion of consumerism, producing results which tend only to endorse the status quo' (Williams 1994, p. 809). In effect, he suggests such surveys provide a veneer of patient involvement which may yield results that fail to reflect reality. In order for the meaningful experiences and perceptions of patients to be elicited, it is necessary that service providers first identify and isolate factors which provide true satisfaction to patients. In this regard, investigating practitioner skills and how they relate to patient satisfaction is critical for understanding the rationale for delivering good, patient-centred care. The design of this thesis has been built upon this assumption. One of the aims of my study was to look at comprehending clinical effectiveness of health care (doctors' and nurses' skills, information provision, availability) effect on adult oncology inpatients' satisfaction with care.

Some issues of major concern for researchers in this field have to do with the validity and reliability of results arising from satisfaction measurements. DuFrene (2000) suggests a solution to problems with validity and reliability in patient satisfaction measurements, namely, to adopt an extended survey to capture the opinions of patients. Merkouris et al. (2004), meanwhile, recommend using mixed methods, as they did in their study conducted in two large Greek hospitals. Interestingly, these two studies came to broadly similar conclusions: the highest levels of satisfaction were related to technical aspects of care, while the lowest had to do with information delivery.

Gill and White (2009) criticise the majority of research performed on patient satisfaction, questioning the validity of instruments used and highlighting associated underlying weaknesses and the subjective nature of patient satisfaction constructs. They indicate that using patient satisfaction as the measure of service quality is a flawed approach, which could hinder effective understanding of the quality of health services from patients' perspectives. These researchers emphasise the need to focus on perceived service quality, differentiating it from satisfaction, and letting this inform the improvement of the delivery process in health care services. However, patient satisfaction measurements are still being used as a proxy for patient assessments of service quality (Turris 2005). For this reason, it is important to conduct further research on how best to define and measure patient satisfaction in healthcare settings.

There are common features of a patient's experience that are influential in the conceptualisation of their satisfaction, such as outcomes and communication. Patients' attitudes to these can provide a good indication of how they conceptualise their experiences, given that the data collection method is reliable to ensure a high degree of construct validity in the measurement of patient's satisfaction. Promising instruments for assessing patient satisfaction have been developed. Whereas earlier studies on patient satisfaction were compromised by the use of invalid approaches to measurement, such as poorly established psychometric testing (William et al. 1998), recent studies have found that certain satisfaction questionnaires/instruments have a well-grounded validity, indicating that developing reliable measures of satisfaction and perceived quality is possible. A good example is the measures

of perceived quality described by Rao et al. (2006), which include medicine availability, medical information, staff behaviour, doctor behaviour, and hospital infrastructure.

These dimensions provide direct measurement of 'structure' and 'process' of care. One important issue, mentioned earlier, regarding measurement of the satisfaction concept and quality of care, is the fact that evaluation of quality by the patient is difficult, especially with regards to technical competence. For example, a physician who is perceived as action-orientated (for example requesting frequent bloods or diagnostic tests) may be mistakenly viewed highly favourably (Kupfer and Bond 2012). In this research, I recognise such limitations of patient satisfaction surveys, and recommend adopting appropriate and evidence-based approaches.

In summary, there is considerable evidence demonstrating that patient satisfaction measures are being extensively used as indicators of quality of care (Bredart et al. 2007; Jagosh et al. 2011; Kupfer and Bond, 2012). The availability of different constructs of patient satisfaction is evidence of how complicated and challenging patient satisfaction is to measure. Patient satisfaction is very much related to patients' perceptions of hospital care, and, in studying the relationships between these two constructs, it is important to utilise robust, validated, and reliable questionnaires, which evaluate such constructs as separate dimensions.

### **2.3.3 Clinical Effectiveness**

While discussions focussing on establishing working definitions for patient satisfaction and quality of care are drawn from a predominantly patient-focus; notions of clinical effectiveness have wider implications for the structures and processes of the individual healthcare organisation in which the patient is receiving care. Measuring clinical effectiveness presents a number of problems for our existing models regarding patient satisfaction and quality of care assessment. In the next section definitions of clinical effectiveness; and subsequently

posits adaptations to the Donabedian model of patient satisfaction to incorporate more detailed understandings of clinical effectiveness metrics are explored.

### **2.3.1.1 Definition**

Clinical effectiveness is defined as ‘the right person doing the right thing (evidence-based practice) in the right way (skills and competence) at the right time (providing treatment and service when patient needs them), in the right place (location of treatment and service) with the right result (clinical effectiveness/health gain’ (NHS QIS 2005). Clinical effectiveness can therefore be understood to relate to the effectiveness of the processes which facilitate greater patient interaction and care, and is necessarily examined from the perspectives of both stakeholders in the doctor-patient discourse. Nevertheless, it is important to recognise the requirement for patient input and comprehension of notions of clinical effectiveness; as with consumer satisfaction and element of patient-driven contributions to effectiveness measurement is required.

### **2.3.1.2 Measuring Clinical Effectiveness**

Measuring clinical effectiveness has a number of implications for the application of the Donabedian model of quality of care in practice and an outcomes focus presents a number of weaknesses inherent with the model in its current iteration. For example, much of the debate relating to the findings produced in a number of studies by the Donabedian model centres on the service structures and processes of healthcare organisations, in addition to the skills and availability of doctors and nurses (Chassin and Gavin 1998; Copnell et al. 2009).

Research suggests that the structural aspects of healthcare have implications for patient satisfaction. Structure of care refers to ‘the organisational factors that define the health system under which care is provided’ (Campbell et al. 2000 pp. 1612). A key domain of a health care delivery system is how it is structured to involve service organisations or access

to services in the health care facility (Donabedian 1980; Davies and Crombie 1995; Campbell et al. 2000; Sizmur and Redding 2009). This includes the ease and rate of the movement of patients from one facility to another, the availability of services, such as screening and testing, the effectiveness and organisation of the schedule that the patients have to follow, and the overall experience of the patients during their time in health care. Patients' experiences of access to services, which include service organisations and structures, can significantly contribute to patient satisfaction, which is one of the key indicators of quality of care. Hence, assessing access to services represents a further dimension needed to meet the aims of my study.

Research further suggests that the processes by which healthcare is delivered are related to patient satisfaction. According to Campbell et al. (2000), Donabedian's process of care 'involves interactions between users and the health care structure; in essence, what is done to or with users' (p.1612). Of fundamental importance to processes of care is clinical effectiveness, an important criterion for patient satisfaction (Campbell et al. 2000; Copnell et al. 2009; Farley et al. 2014). Clinical effectiveness is the delivery of suitable patient care in a suitable manner by health professional with the best outcome possible for the patient and their wellbeing (Doyle et al. 2013).

Studies by Cleary and Edjman-Levitan (1997), Chassin and Gavin (1998), and Campbell et al. (2000) describe a plethora of different quality indicators with little standardisation. A study, undertaken by Bredart et al. (2007), using the EORTC IN-PATSAT32 questionnaire, found that the most relevant indicators of quality were the interpersonal skills and availability of nurses and doctors, and information provision. The EORTC IN-PATSAT32 tool is a cross-culturally validated tool, and is therefore found to be capable of judging the satisfaction level of patients from different cultures.

The difficulty in measuring quality of care was confirmed by some studies to be due to a lack of a standardised definition of what comprises quality and how best it can be measured (Mainz 2003; Groene et al. 2008). Mainz (2003) differentiated quality based purely on

structure (number of specialist doctors available, access to equipment and tests, access to specific units, etc.), process (protocols and procedures that were used in treatment and care), and outcome (mortality, health status, satisfaction and patient quality of life). From the consensus in the literature, it is now clear that when considering the patients' perspectives of their care, a range of influencing factors, including social-political, social-cultural, and socio-demographic, must be considered. Given the difficulty of defining and measuring quality of care, it stands to reason that it would also be difficult to measure patient satisfaction, the construct at the heart of this thesis.

Clinical effectiveness can not be accurately detailed through a verbatim application of the Donabedian model, and a number of additional indicators should be considered in order to more clearly detail and assess the specific structure, processes and outcomes assessed in each individual case; in order to better examine clinical effectiveness in practice. For example, in one study on quality of care in hospitals by Copnell et al. (2009), indicators were first classified based on aspects of care provision (structure, process, and outcome), then according to the dimensions of quality (safety, effectiveness, equity, patient-centeredness, efficiency, and timeliness), followed by the domain of application using the Donabedian's model, including hospital-wide surgical and non-surgical clinics. Copnell et al. (2009) found that while there were a large number of available indicators, there were instances where they were not applicable and inadequately measured the quality of care, and further studies were needed to determine which of the existing indicators are pertinent.

In addition to the Donabedian model, this thesis also identifies IOM's (2001) six dimensions of quality which includes safety, effectiveness, equity, patient-centeredness, efficiency, and timeliness as relevant components of process, structure and outcome. The information captured under these dimensions is all specific to aspects of care including quality found throughout the healthcare system and provides a more accurate measurement of patient perceptions of clinical effectiveness. Structure, therefore, encompasses the context and environment in which the care is provided, and can include the buildings, equipment and staff.



This thesis has adopted a specific definition of quality healthcare, which emphasises the importance of both the IOM's (2001) six dimensions of quality and the Donabedian (1980) model of structure, process and outcome to base its conclusions upon. The focus of this study is to assess patient satisfaction through understanding patient experience in oncology ward settings in KSA. For this purpose all six quality dimensions identified from the literature are assessed in relation to the KSA context.

## **2.4 Patient Satisfaction in the KSA**

This section discusses the KSA-based research on patient satisfaction, particularly patients' satisfaction with the quality of care provided to them. This study uses the frequently cited dimensions of quality; safety, effectiveness, equity, patient centeredness, efficiency, and timeliness in combination with process and structure to investigate how they impact a specific outcome which results in patient satisfaction. In order to further contextualise and justify the study, this section of the literature review describes research studies conducted in the KSA on patient's satisfaction with quality of care based on IOM's 6 dimensions of quality as explored in Section 2.3.

As evidenced in Table 2.1 few studies were found which focused on the quality of hospital-care in the KSA, and most research that deals specifically with the country was shown to be focused on the quality of primary care services (Mansour and Al-Osimy 1996; Al-Ahmadi and Roland 2005; Al-Doghaither and Saeed 2000; Al-Faris et al. 1996; Saeed and Mohammad 2002). Results from these studies demonstrated wide variations in quality of care in the primary care setting, and all recognised the need for further research.

One study of note assessed patient satisfaction in a tertiary care centre in the KSA (Alaloola and Albedaiwi 2008), and another focused on quality of cancer care, specifically, assessing

the quality of breast cancer care in a KSA health care institution (Akhtar and Nadrah 2005). Nevertheless the sample size and limited focus on patient-centred care perspectives do not impact upon the validity of the research gap identified in this thesis.

Notably, certain studies that used quantitative methods, based on patient satisfaction surveys or opinions of health care experts, appeared to have a number of flaws. Although the review included the studies assessed as robust, there were some weaknesses in study design or methodology, for example, small sample sizes, retrospective analysis, use of non-validated tools or poor transferability of results (Akhtar and Nadrah 2005; Alaloola and Al Bedaiwi 2008; Saeed and Mohamad 2002; Mahfouz et al. 2004). Also, there has not been any previous KSA empirical study that has focused specifically on patient satisfaction in oncology settings. It is also worth noting that there has not been any previous qualitative study that has explored the issue of patient satisfaction in KSA.

Despite a paucity of published literature and some flaws in the existing research in the KSA, there is a general, overall trend evident across the published literature. That is, there was evidence that patient satisfaction was adversely affected by (1) poor access to care and treatment availability, (2) poor service coordination between different units and professionals, (3) lack of communication within the multi-disciplinary team required for oncology care, (4) lack of patient communication and awareness, and (5) a general lack of adherence to standardised guidelines related to diagnosis, treatment and monitoring of cancer patients (Akhtar and Nadrah 2005; Al-Doghaither and Saeed 2000; Almuzini et al. 1998; Younge et al. 1997; Brown et al. 2009; Diab 2010; Shamieh et al. 2010).

To date, research on patient satisfaction in the KSA suggests that patient satisfaction generally varies according to various factors, in particular, the age of the patient (Al-Faris et al., 1996) and the healthcare providers' disclosure practices (Al Ahwal et al. 1998; Younge et al. 1997; Aljubran 2010; Al-Amri 2009).

	Author-date	Sample	Methods	Key findings	Comments
1	<b>Al Aloom &amp; Al Bedaiwi (2008)</b>  Patient satisfaction in a Riyadh tertiary care centre.	1983 inpatients, outpatients and ER patients	Cross sectional survey using self-developed patient satisfaction questionnaire	Patient satisfaction was noted in environmental aspect – for example, room temperature—and less found in inter personal skills of doctors, phlebotomies, as they failed to introduce themselves.	The focus of satisfaction domain was only in socio-demographic context.  Limited by absence of focus for specific service such as cancer.  Although it is valuable for originality, further research needed in cancer setting in the KSA
2	<b>Al-Doghaither &amp; Saeed (2000)</b>  Consumers' satisfaction with primary health services in the city of Jeddah, Saudi Arabia.	75 patients aged over 15 years, chosen systematically	Self- administered questionnaire pilot test	Satisfaction scores higher for patients that were assessed for consolidated services, while individual service component scored lower.	Although high scores for satisfaction were noticed, the service component needs to be monitored and assessed to provide satisfactory services
3	<b>Saeed &amp; Mohamad (2002)</b>  Correlation of patients' satisfaction with physicians' services in primary health care centers	540 patients in 8 PHC, selected randomly in Riyadh	Survey questionnaire, pilot-tested	Service items need to have correct measure.  Also young adults and adult patients need emphasis	Other domains like hospital services and nurses' skills would have an impact on satisfaction level of patients

4	<b>Al-Ahmadi &amp; Roland, M. (2005)</b>  Quality of primary health care in the KSA: A comprehensive review.	Systematic review of 31 papers.	Reviews of literature	There were variations in quality of primary health care services in the KSA  More effort needed in organisation of these services	Further research needed to address quality concerns from the patient's perspective to gain better insight into quality care
5	<b>Mahfouz et al. (2004)</b>  Primary health care services utilisation and satisfaction among the elderly in Asir region, Saudi Arabia	253 patients.	In 26 PHC in ASIR (6 urban and 20 rural centres), House-to-house survey by interview with expert health worker, Arabic speaker, to answer survey questions  Questionnaire addressed 5 aspects of services adopted from Mansour and Al-Osaimi study 1993 (continuity of care, humanity, accessibility, thoroughness and information).	Satisfied patients reported but 79% dissatisfaction found in 3 items: lack of audio-visual for patient education, lack of enough specialty clinics and prolonged waiting times in centres.	Emphasis on five aspects of lack reasoning  More attention needed in evaluating different socio-demographic characteristics in elderly patients - results will be significantly different from area to area so such a comparison would be desirable
6	<b>Akhtar &amp; Nadrah (2005)</b>  Assessment of the quality of breast cancer care: A single institutional study from Saudi Arabia	78 operable breast cancer patient	Retrospective analysis of breast cancer patient charts and histopathology reports from 1995-2000	Only 37% had triple assessment before surgical procedure  radiotherapy not used as per required standard  overall conclusion that quality below international standard	No socio-demographic data were retrieved for their sample, which was a limitation that could be addressed in future research

7	<b>Ibrahim et al. (2002)</b>  Appraisal of communication skills and patients' satisfaction in cross-language encounters in oncology practice.	255 patients	Questionnaire "Art of Medicine" used to assess patients' perceptions of clinicians' communication behaviours and patients' global satisfaction.	No difference - means that language doesn't affect interpersonal skills like communication and patient satisfaction. Patients were equally satisfied in both languages.	Interesting finding but the scale used was not described clearly.
8	<b>Alahwal et al. (1998)</b>  "Cancer patients' awareness of their disease and prognosis", <i>Annals of Saudi Medicine</i> , Vol. 18 No. 2, pp. 187-9.	136 (33 cancer patients, 63 doctors, and 40 laypeople)	Questionnaire of 4 questions developed for the purpose of this study  Distributed in western region of Saudi Arabia (major hospital providing cancer care)	All patients were in favour of being given full information regarding cancer; this would help them have a better understanding of how to deal with their illness. Doctors too favoured that the patients be disclosed to about their conditions.	Although patient views were taken, the methods would be more useful had qualitative interview been used as this provides expanded insights into communication issues with patients
9	<b>Younge et al. (1997)</b>  Communicating with cancer patients in Saudi Arabia	None	Literature review on communication aspects and factors influencing communication in the KSA	Communication influenced by many factors such as cultural and social and also health services that lack community care for chronic illness.	Number of studies reviewed was not mentioned which limits the generalization of the findings.

10	<b>Mansour and Al-Osimy (1996)</b>  A study of health centres in Saudi Arabia	Consumers	Assessment of centres' resources in terms of quality and availability and consumer satisfaction & a 4-point system Likert scale to measure satisfaction in 5 domains: continuity of care, accessibility, humaneness, information and thoroughness.	Discrepancy of findings between centres' resources evaluation and those from consumer satisfaction results	More studies needed to evaluate resources and satisfaction through valid measures.  Studies in hospital resources can provide further insight into patient satisfaction since they focus only on health centres.
11	<b>Almuzaini et al. (1998)</b>  The Attitude of Health Care Professionals toward the availability of Hospice Services for Cancer Patients and their Carers in Saudi Arabia	695 (398 health care professionals, 136 cancer patients and 161 informal carers)	Quantitative survey of participants on the quality of health care	The Ministry-owned or managed facilities score poorly on patient satisfaction with service organization.	Further research needed using a valid tool to determine which aspects of patient satisfaction are relevant or important to cancer patients while addressing the area of improvement in government facilities.
12	<b>Brown et al. (2009)</b>  Failure to attend appointments and loss to follow-up: a prospective study of patients with malignant lymphoma in Riyadh, Saudi Arabia	A 3-year prospective study of 199 patients with malignant lymphoma in Riyadh	Retrospective analysis of No Shows appointments (No Shows=340 )	34% were related to hospital-based communication errors.  17.6 % were related to errors in patient communication with hospital	Based on retrospective analysis which need further empirical research to understand the communication problems fully

13	<b>Jazieh, A.R. (2010)</b>  Human resources development, 'Initiative to Improve Cancer Care in the Arab World'	12 Experts in health care from across the Arab world and international experts	Interviews, situational analysis	There is lack of high-quality and well-trained health care professionals	The research is based on only situational analysis. So, further robust methodology required to evaluate the needs of human resources in cancer
14	<b>Saghir &amp; Azim (2010)</b>  Standards of Care and Guidelines for the Arab World with Limited Resources	12 experts in health care from across the Arab world	Panel discussions	Lack of standardisation in doctors' and nurses' skills leads to varying quality.	The research is based on panel discussion and does not use any objective methods or criteria.
15	<b>Diab, R. (2010)</b>  Access to Cancer Care Facilities, 'Initiative to Improve Cancer Care in the Arab World',	8 panel members made of experts in policy making, healthcare and scholars (a	Panel discussions  (Based on discussion of panel members about priority of objectives and available baseline information of accessibility to cancer care)	The panel found that quality of cancer care suffered from problems like long wait times for the patients, high costs, and lack of access to health care and inequality in access for people from rural and marginalised regions.	No mention of criteria for evaluating the health care facilities, such as introducing use of measures or indicators of quality.
16	<b>Shamieh et al. (2010)</b>  Access to palliative care	12 multi-disciplinary experts in palliative care	Panel discussion	Access to cancer care is poor compared to palliative care	Discussions purely based on the perceptions of the experts. Patient views are needed to allow comprehensive evaluation of the issue

17	<b>Al-Faris et al. (1996)</b>  Patients' satisfaction with accessibility and services offered in Riyadh health centers.	466 randomly selected patients from 6 randomly selected primary health care centres PHCC in Riyadh City	Patient satisfaction and attitude survey	The research found higher levels of satisfaction among older patients, housewives and non-Saudi patients.	The questionnaire was self-administered, which may add to bias.
18	<b>Al-Sirafy et al. (2009)</b> Hospitalisation pattern in a hospital-based palliative care program: An example from Saudi Arabia.	759 palliative patient admissions during a 4-year period (in the absence of sub-acute palliative care models)	Retrospective review of palliative admissions were studied for reason for hospitalisation, duration of stay and mortality rate	The research found that quality of life did not improve with palliative care in Saudi Arabia. The indicators of quality for palliative care included factors like duration of stay and mortality and quality of life.	While factors like mortality etc. were easy to understand and calculate, there was no elaboration on factors that may indicate quality of life improvement.
19	<b>Aljubran, A. (2010)</b>  The attitude toward disclosure of bad news to cancer patients in Saudi Arabia. Annual of Saudi Med, March April. 2010	None	Literature review	The reviewer highlights the changing trends in patients' need to understand and know their illness.	Cultural shift toward considering patient perspectives in Saudi culture is evident and warrants further exploration

**TABLE 2. 1: KSA STUDIES ON PATIENT SATISFACTION AND QUALITY OF CARE**



## **2.5 Perceptions of Patient Satisfaction in Existing KSA Research**

Throughout the literature patient care has been established as an indicator of person-centred care (PCC) but there is little literature available of evidence about PCC in KSA. In the KSA, other influences have also been identified, such as culture and language differences between KSA nationals and health care practitioners, and these have been found to affect the perceived quality of care patients receive. This is largely influenced by the fact that the nursing workforce in the KSA relies mainly on expatriates who are recruited from different countries such as India, the Philippines, South Africa, North America, the United Kingdom, Australia and Middle East countries (Luna 1998; Tumulty 2001; Aboulenien 2002). One study showed that the language and cultural differences of the expatriate nurses may cause Saudi patients to encounter barriers to communication during health care (Al-Dossary et al. 2008). Thus, the challenge for the KSA is to increase the proportion of Saudi nurses in the workforce in order to deliver culturally sensitive care, further facilitated by all nurses having a command of the Arabic language used by Saudi patients (Al-Dossary et al. 2008). This would enhance the experience of patients and allow them to construct their experiences in a positive way. Notably, however, an earlier study argued that language differences between patients and nurses do not impact on the satisfaction level of the patient (Ibrahim et al. 2002). These findings call for more research into KSA patient satisfaction, specifically in terms of language and cultural differences between patients and nursing staff.

Other factors highlighted as potentially affecting patients' perception of their experiences and the subsequent level of their satisfaction with care in the KSA are political-social, age, or educational issues. Patients who are better educated but having poor health have been found to be more dissatisfied than those who were less-educated and in better health (Alborie and Sheikh Damanhour 2013). Also, older patients tend to be more satisfied with the service quality than those in their twenties (Al-Faris et al. 1996; AlSakkak et al. 2008). This may be related to the previously mentioned transformation in the economic climate in the KSA. Older people may be more accustomed historically to living in austere conditions and therefore have lower expectations of the healthcare system and are appreciative of whatever care they receive (Bowling et al. 2013). Rahmqvist and Bara (2010)

likewise identified patient characteristics related to patient evaluations of their experiences in a health care setting, namely age, education and health status.

A systematic review of the available literature conducted by Williamson and Harrison (2010) confirms that culture plays a role in how patients experience health care. Failure to determine the cultural needs of individuals receiving care contributes to dissatisfaction with health care practices. Williamson and Harrison's (2010) study can be extrapolated to other countries where there are cultural differences between health care providers and health care receivers. In the KSA, there is a cultural belief related to the Islamic faith that patients who have terminal illness cope best with their illness at home surrounded by family members and friends (Younge et al. 1997). This may act as a barrier to proper health care provision due to communication issues that may arise in such a home-based treatment. For example, whilst doctors and nurses are welcomed into Saudi homes, there may also be a need for drivers, and possibly translators, to accompany them, especially when the patients are women, due to cultural prohibitions related to gender and social interaction (Dein and Stygall 1997; Al-Amri 2010). Moreover, since a large proportion of the nursing work force is expatriate, while the health care receivers are largely Saudi nationals, there is a potential for language and cultural differences, leading to misunderstanding and unsatisfactory encounters between patients and health professionals (Al-Dossary et al. 2008). In contrast, another study (Ibrahim et al. 2002) argued that the language differences between patients and doctors and nurses do not impact on patients' reflections upon their experiences. The study noted above by Ibrahim et al. (2002) found that the patients were satisfied with the doctors' skills and their interpersonal behaviour, even in cases where there were language differences between them. These contrasting findings suggest that more research is needed to determine the effect of and accurately identify communication barriers (between patients, doctors and nurses) on patient satisfaction. Indeed, a better overall understanding of the causes of the positive or negative views by patients on their experience is very much needed.

### **2.5.1 Disclosure Practices in KSA**

In the KSA, patients are often not given the privilege of being treated as independent individuals, but are approached as extensions of the family (Aljubran 2010). Al-Ahwal's (1998) study in the KSA evaluated the awareness of cancer patients of their diagnosis and prognosis from the perspective of a small population of doctors, patients and lay people. The study uncovered a low level of awareness about cancer patients' own prognosis, despite a desire that they be made fully aware of their own conditions and be treated as autonomous individuals. The doctors largely conceded that they preferred to tell the patients the truth regarding their diagnosis and prognosis but in practice this is not the method that they used. Indeed, it is increasingly being recognised that for KSA doctors to provide suitable treatments for their patients, disclosure and effective communication are important issues (Aljubran, 2010; Younge et al., 1997). There is evidence that information exchange between practitioners and patients tends to be very low, due largely to such poor patient participation in decision-making and/or a lack of patient interaction with doctors or nurses (Elzubier 2002; Al-Amri 2010). As a result, patients may not have full knowledge of their condition, despite the fact that they are the ones receiving the care and should be perceived as the key participants in the process.

The KSA health care system is gradually recognising the importance of sharing health care information with patients. There is a new trend in KSA health system towards encouraging oncology medical staff to keep patients well-informed about their health status. Conceivably, this may enhance patient satisfaction within the KSA (Mobeireek et al. 2008; Aljubran, 2010). As alluded to previously, it is important to recognise the way in which poorly informed patients could create bias in research findings and adversely affect the quality of surveys on patient satisfaction.

### **2.5.2 Gender Politics**

One social issue that hinders the quality of care in the KSA is the cultural background relating to women, who still require permission to seek health care from a male guardian, and cannot freely communicate their needs to health care professionals, especially regarding reproductive health. This can lead to restrictions of access to health care (Walker 2009). Intervention by the male relatives can mean that health

care professionals cannot properly investigate the illness of the women (McBride 2008). One of the drawbacks that are faced in allotting women healthcare services in KSA is that many women are unaware of their rights and knowledge of healthcare. For example, many women in KSA are not aware of their right to consent for their medical treatment. In addition, doctors may also not be aware of this legal right or deny women these rights out of fear of encountering issues with their male guardians (Walker 2014).

Gender inequality within the Saudi context causes an adverse impact on women's healthcare. The distribution of power and resources in the Saudi society places a higher preference on men than on women which causes issues in public health policy and practice leading to a decrease in patient satisfaction, mainly amongst female patients. According to Mobaraki and Soderfeldt (2007) the World Health Organisation has stated that gender inequality is not only a threat to economic development but also to population health especially for that of future generations. The traditional Arab family and society as a whole has a tremendous effect on women's health in a multitude of ways. Women in KSA are known to a high prevalence of obesity which is attributed to social restrictions that prevent women from participating in exercise activities in schools or in public although the Government does not forbid female practice of sport in segregated private places.

Other inequalities include the restriction of women from being admitted into a hospital without her male guardian. Also, a woman is not allowed to give her own consent for invasive medical procedures. For example, McBride (2008) and Elkum et al. (2007) both highlight serious issues relating to breast cancer in the KSA, namely, the cultural stigma associated with the disease, and a lack of empirical research on the protocols or techniques involved in its diagnosis and treatment. Breast cancer is the most common type of cancer among Saudi women, yet there is an exceptionally high proportion of young women not being diagnosed (Elkum et al. 2007; Ibrahim et al. 2008). This is largely due to the inherent barriers to screening associated with cultural issues, and leads to problems with obtaining accurate and early detection. This, in turn, has negative ramifications on prognosis (Elkum et al. 2007; Ibrahim et al. 2008) and, by extension, with quality of care, which can impact patient satisfaction, which is highly dependent upon meeting expectations. However, studies

such as Al-Sakkak et al. (2008), Ibrahim et al. (2008), and Mobaraki and Soderfeldt (2007) have shown that women regardless of the type of treatment allotted to them are more satisfied with their quality of care.

### **2.5.3 Respect for Religious Beliefs in KSA**

Almuzaini et al. (1998) noted that Islam has a great influence upon healthcare in Islamic nations such as the KSA. The provision of religious or spiritual care is often offered in the KSA as a relief mechanism to patients suffering from terminal illnesses (Dein and Stygall 1997). This may be either as an alternative to or alongside palliative medical care. Indeed, Boyles and Nordhaugen (1989) suggests that health care activities are at variance with the religious and cultural norms of the nation, when one considers that under the pervasive influence of Islam, there is widespread acceptance that one must die, and the suffering associated with death is regarded as an expression of one's faith in religion and God. This sentiment is said to help patients cope with cancer better than any other country of the world (Ezzat et al. 1995; Young et al. 1997; Al-Shahri 2002).

Many doctors and nurses are influenced by western models of care, which are largely secular and strive to provide the best service with a detachment from any religious reasoning of their patients. Clearly, given the issues previously discussed, it could be problematic if doctors lack empathy of such socio-cultural factors during their discussions, prognosis, and treatment of disease with Saudi patients. This could conceivably create distrust in the health care service, and may result in patients building their experiences in a negative manner.

### **2.5.4 Doctor-Patient Relationship in KSA**

The KSA faces a serious issue in the healthcare system with poor doctor-patient relationships which has a strong impact on patient experience particularly patient satisfaction (Elzubair 2002). Patient satisfaction depends a great deal on the doctor-patient relationship as asserted by Weber et al. (2014) who assessed that satisfied patients will follow the medical instructions given, return for follow-up care, and

maintain a longer-term professional relationship with their healthcare provider. However, it is also evident that poor doctor-patient relationships are as unsatisfying to doctors (Vermeire et al. 2001; Al-Sakkak et al. 2008; Stravropoulo 2010). Patient satisfaction has become a key issue in healthcare systems within Saudi Arabia and other Arabian Gulf health systems. In the setting of the KSA, practitioner-patient interactions are mostly characterised by the doctor having authority over the patient (Younge et al. 1997; Elzubier 2002). In the KSA, doctors' attitudes and behaviour have historically been influenced by their own culture (Aljubran 2010). In particular, patients are often viewed as fragile and extremely vulnerable, rather than as individuals with their own strengths and capacities to cope with their disease (Younge et al. 1997). Doctors can fail to maintain what in Western contexts would be considered issues of privacy about the patient's conditions, and disclose ailments to their relatives without the knowledge of the patient (Younge et al. 1997; Al-Amri 2010). At the heart of this is the relationship between disclosure and patient autonomy, which historically have been considered quite differently in the KSA. Instead, traditional cultural assumptions have dictated that physicians provide information about serious illnesses, such as cancer, to the family of patients first. The patient is then subsequently informed, but only if the family approve of doing so (Mobeireek et al. 1996; Al-Amri 2010). Thus, the next of kin has access to information regardless of the patient's own knowledge about his or her health situation (Al-Amri 2010). This not only affects the practitioner-patient relationship, but also means that the views of patients reported in previously published research need to be treated with some caution, since patients may lack key information about their own care. Therefore, findings from previously published literature on patient satisfaction within the KSA context may be affected by bias and lack of representation from among the patient populations that take an active role in medical decisions and their own care.

There is certainly broad agreement in the literature worldwide that patient autonomy is an important aspect of quality patient care (McCormack 1992; Gaston and Mitchell 2005). Nevertheless, this model of disclosure and patient autonomy has not historically been practiced in the KSA. A decade ago, research by Mobeireek et al. (1996) suggested that the KSA had a long way to go to get to a position where patients, as the actual recipients of fully informed care, are actively involved in decision-making about their care. More recently, Mobeireek et al. (2008)

demonstrated an increased recognition of patient autonomy amongst physicians. Weber et al. (2014) suggests that the key factor for these changes is linked to the increase of personal wealth in KSA which is the driving force behind the higher quality of care expected by patients including increased attention to doctor-patient component of to ensure patient satisfaction in providing quality care. Similarly, research conducted by Aljubran (2010) which refers to the rapidly changing KSA society has indicated that patients are expecting greater autonomy and are now increasingly demanding that they have full disclosure about their own diagnosis and prognosis. This is a major cultural shift, leading to a growing need for patients to be treated holistically and as individuals, and to take their perceptions of satisfaction with their care into account. For example, there is evidence that patients with breast cancer generally prefer to be fully informed regarding the status of their cancer, and to be involved to some degree in decision-making regarding their treatment (Elkum et al, 2007; Nichols et al. 2013; Sait et al. 2014). Several studies have proposed that the application of such patient-centred care would help eradicate the undesirable, yet common practice of preventing patients from accessing their medical information (Younge et al.1997; Al-Ahwal 1998; Elzubair 2002; Aljubran 2010). Patient autonomy and disclosure in KSA patients represent only two of the potentially influential aspects relating to patient satisfaction.

Patient satisfaction within the KSA will clearly be affected by how changes in the doctor-patient relationship are managed, especially with changing patient demographics. Cultural and communication difficulties may also contribute significantly as to how this relationship is understood, both by patients and by medical staff.

### **2.5.5 Patient-Centred Care in KSA**

As identified previously, there are few existing research studies that undertake the analysis of patient-centred care in KSA. Therefore, other non-KSA studies were used to contextualise the meaning and rationale of patient-centred care. Therefore, based on a thorough analysis of the literature, various dimensions of patient-centred care were considered which can be used to inform the KSA in implementing PCC based on international standards.

A systematic review conducted by Mead and Bower (2000) identified five conceptual dimensions of patient-centeredness: (1) bio-psychosocial, (2) patient-as-person, (3) sharing power and responsibility, (4) therapeutic alliance, and (5) doctor-as-person (Mead and Bower 2000, p.1087). They also identified other influential variables such as individual characteristics and consultation processes, suggesting that wider and more complex dimensions may be required before any firm conceptual basis of patient-centeredness can be established. A study of this nature has yet to be performed in the KSA. However, Al-Mutairi and Moussa (2014) have observed that medical staff in KSA are unwilling to understand patients' problems. Many are also not aware of the patients' bill of rights which includes the right of being fully informed of their diagnosis and treatment plan which is a key aspect in patient centred care (Al-Mutairi and Moussa 2014).

Patient-centeredness has been suggested to positively influence physical and psychological outcomes, however Michie et al. (2003) argue that the evidence is inconsistent. They reviewed the evidence about the effects on the outcome of chronic illness of two concepts in health care communication: one in which the health professional took the perspectives of the patients, and the other where the aim was to 'activate' the patient by ensuring they took an active role in their health care. Michie et al. (2003) discovered that in studies where the aim was to activate the patients, the results were more consistently associated with good physical health outcomes. Unfortunately, application of an 'activation of patient' approach may be limited within the KSA due to the cultural norms described previously, including issues of disclosure, lack of confidentiality of patients' health status, and poor patient autonomy (Younge et al. 1997; Walker 2009; Aljubran 2010). Better communication and a change in the policy on patient information provision and disclosure in the KSA is required to improve clinical effectiveness. This would concurrently enhance patients' understanding of their treatment and allow them to make informed decisions regarding their own treatment.

Holmstrom and Roing (2010) suggest that because patient-centred approaches seem to be understood in different ways by different groups within the health care



profession, a common language should be created to define the contextual and conceptual meanings of patient centeredness. They were able to differentiate between the terms patient-centred and patient empowerment, but concluded that while the concepts are complementary, patient empowerment has a wider aim, which may place more responsibility on health care professionals. On the other hand, patient-centeredness can be seen as the starting point from which patient empowerment can grow. Unfortunately, patients in the KSA generally have little provision for empowerment, given the entrenched cultural and patriarchal norms which are contrary to a patient-centred-care approach (Young et al 1997; Al-Amri 2010).

McCormack et al. (2011) researched an attempt made by an institution in the United States to promote the use of patient-centred care for oncology patients, and point out that no comprehensive measure of such care exists. They imply that research on patient satisfaction fails to focus on certain factors, for instance, the way in which patient satisfaction relates to evaluation of patients' expectations of care. There is no general model that can account for how patients construct the concept of satisfaction, and in an effort to address this issue, McCormack et al. (2011) conducted a comprehensive review of the existing literature and undertook interviews with selected patients. The research identified six core concepts which are prevalent to the notion of patient-centred care: (1) exchanging information, (2) fostering healing relationships through focus on affective care, (3) recognising and responding to emotions, (4) managing uncertainty, (5) making decisions, and (6) enabling patient self-management (McCormack et al. 2011).

Similarly, Mead and Bower (2000) emphasise the fact that delivery of high-quality health care is contingent upon the use of a patient-centred approach. However, the generalisability of their findings is questionable, warranting further research to test this notion in wider settings. It is notable from the findings in the extant literature that patient-centred care leading to enhanced patient satisfaction may be adversely influenced by specific socio-cultural contexts. For example, as mentioned previously, in the KSA, patient-centred care does not fit the socio-cultural norm in which doctors are seen as figures of great authority (Mobeeriek et al. 1996; Younge et al. 1997;

Elzubier 2002), and attempts to introduce this model may first necessitate a change in the cultural context in order to support patient satisfaction.

Some studies indicate that patient centeredness has a definite link to patient satisfaction. Studies by Griffin et al. (2004), Bredart et al. (2007), and Rao et al. (2007) which looked at the effectiveness of different approaches aimed at improving doctor-patient communication, demonstrated the evidence of a significant relationship between overall health outcomes and experience of care and patient satisfaction. Fielding (2009) argued that the perception of patient satisfaction and the adoption of a patient-centred approach were important since patients are the end-users of health care services. The importance of taking a patient-centred approach that recognizes the importance of patient satisfaction, is assuming an increasingly prominent role in health care systems worldwide, with the patients' perspectives being increasingly considered an essential criterion for judging the quality of care (IOM 2001; Mallinger et al. 2005; Wolf et al. 2008; Arraras et al. 2009).

Whilst there is evidence that patient satisfaction has a strong connection with the doctor-patient relationship, and with the level of positive communication within this relationship (Arrora 2003; Epstein et al. 2005), the connection with patient-centeredness remains ambiguous (Kupfer and Bond 2012; McCormack 2011), although there appears to be some interrelatedness between the two concepts (Jagosh et al. 2011; Kupfer and Bond 2012). Berwick (2009) argue that patient satisfaction and patient-centred care are not automatically related. The localisation of the concept of patient satisfaction, and hence, localisation of the concept of patient-centred care, means that patient satisfaction would be differently constructed in different locations. As a result, patient-centred care within the context of the KSA may demonstrate variations from the practice of other countries. For example, the construct of optimised, patient-centred communication may differ between cultures.

Kaba and Sooriakumaran (2007) demonstrate that many physicians do not feel an obligation to meet the demands of a patient-centred care approach. Indeed, the concept of personalised care, which assumes that patients are empowered and work together with physicians in determining their care provision and therapeutic options,

is rarely seen in the KSA (Elzubier 2002; Walker 2009; Aljubran 2010). Interestingly, it has been suggested that some evidence of high levels of satisfaction may distort the overall picture, as some physicians may over-order diagnostic tests and prescribe medications simply to satisfy the emotional needs of patients which is related to their expectations, even though they would not serve to improve patients' physical conditions (Kupfer and Bond 2012).

In summary, it can be noted that there is diversity when it comes to defining clearly the term of patient centred care. However, based on the review of literature it is evident that patient-centred care acts as a key factor in developing patient experience which later has a significant positive impact on patient satisfaction. As in other areas of health care, there would appear to be tension between what one group (health professionals) believe is best for patients, and that which patients themselves see as important. This is clearly evident in the context of Saudi Arabia. Many healthcare professionals in the country are not aware of the positive impacts that patient centred care brings. This lack of understanding of the patient centred model for care is due to the societal norms in which most doctors in the KSA believe that they know what is best for their patients and end up not formally including patients in their healthcare delivery process. This is of particular significance given how patient experiences can be positively influenced by the level of patient-centred care provided. At the moment, there is a relatively limited amount of literature on patient-centred care and how it impacts on patient-perceived satisfaction (Nichols et al. 2013).

#### **2.5.6 PCC and IOM's Six Dimensions of Care Quality in KSA**

It is important to note, however, that patient satisfaction in the KSA cannot be accurately assessed by utilising the Donabedian (1980) model alone. While this model providing an important framework for dividing contributory factors of quality of care within the categories of structure, process and outcome. This is important for the practical implementation of quality of care reforms for care organisations, however taken in isolation provides only a limited perspective on the complex relationship between quality of care and patient experience. To address this research gap in the KSA sample employed by this thesis, it is therefore also important to consider the

role of IOM's six dimensions of quality of care as a model that can reflect the nature of patient experience from a non-organisational perspective.

With this in mind, two existing studies are particularly relevant to help broaden our understanding of care quality in the KSA in practice. Table 2.2 summarise these two studies.

Author-date	Sample	Methods	Key findings	Comments
<b>AlMutairi and Moussa (2014)</b> <b>Quality of health care in Saudi Arabia :systematic review</b>	Literature Review study	Systematic review of 32 articles as per inclusion criteria ,based on 6 IOM quality dimensions	The health care system in KSA has shown considerable progress in recent decades, gaps in 6 IOM dimensions of quality are still apparent.	Only 6 of 32 studies found related to patient satisfaction. So further studies are needed.  The identified gaps in 6 IOM dimensions of quality indicated a low quality of care.
<b>Aljuaid et al.(2016)</b> <b>Quality of care in University hospitals in Saudi Arabia: Systematic review</b>	Literature review study	Systematic review of 8 relevant articles based on the inclusion criteria. Studies were reviewed based on 6 IOM quality dimensions	The research indicated that mean physician satisfaction scores of 4.2 (above the average of 2.1), indicate that quality of care may be greater in university hospitals	The review indicated the increase of patient centred care assessment in KSA. However, limited sample size of studies highlighted the need for accurate picture on quality of care and evidence the lack of data available for analysis.

**TABLE 2. 2 : STUDIES IN KSA INVESTIGATING QUALITY OF CARE BASED ON 6 IOM QUALITY DIMENSIONS**

The literature review developed by Al-Mutairi and Moussa (2014) is particularly relevant as it provides a systematic review of the quality of care in the KSA utilising a methodology based upon the IOM's six dimensions of care quality. Al-Mutairi and Moussa (2014) indicate that although the health care system in KSA has shown considerable progress in recent decades, barriers affecting the quality of care in KSA are still apparent. The research methodology extracted 48 relevant articles of which 32 met the researchers' rigorous selection criteria – assessing them for structural relevance and applicability to the IOM's six dimensions of care quality.

The review of 32 existing studies into healthcare quality in the KSA had a number of relevant findings for this research. For example, in relation to patient safety, a mere 30% of hospitals in KSA had a medication committee, while medical error litigations in KSA were found mostly involving surgeons and obstetricians, especially in the MoH hospitals ( Aljarallah and Alrowaiss 2013). Care effectiveness also evidenced a number of concerns within the literature review, with 20-27% of respondents noting they were deprived of medical information. Patient satisfaction rates from discharged information ranged from only 19.3% - 50%, and 56% of respondents disclosed errors and near misses from medical staff (Mahrous 2013). However, it must be noted that of the information released, only 6 of the 32 eligible studies had collated data relating to patient satisfaction.

This absence of patient-centered care is clear from both stakeholders, however, with 74.8% of 250 responding patients noting that they were not aware of the patients' bill of rights (Almoajel 2012). Furthermore empathy, being part of holistic care, is not shared across the board or not consistent between the nurses in morning shifts and night shift – evidencing a lack of equity between medical staff from the studies examined.

Al-Mutairi and Moussa's (2014) literature review into care quality in the KSA therefore has a number of implications for healthcare organisations; implications which could not be charted with a methodology based upon the Donabedian (1980) model in

isolation. For example, of the 32 studies reviewed, a number of key deficiencies were found in current care in relation to the IOMs six key dimensions, including: safety in dispensing medication, a rise in medical errors, providing treatment in a timely manner, avoiding long waiting lists, and the provision of discharge information for continuous care (Al-Mutairi and Moussa 2014). Al-Mutairi and Moussa (2014) conclude that these unaddressed issues mean that real-term quality of healthcare in the KSA may be degenerating. Furthermore, patient expectations are rising as medical technology is becoming more sophisticated, and population growth provides extra strain upon healthcare resources in the country.

Aljuaid et al. (2016) corroborate the research methodology utilized by Al-Mutairi and Moussa (2014), providing a systematic review of quality of care in University hospitals in the KSA. Although identifying 1430 possible studies, only 8 met the inclusion criteria for this research, however similar trends can be evidenced between this study and the previous research of Al-Mutairi and Moussa (2014). The research indicated that mean physician satisfaction scores of 4.2 (above the average of 2.1), indicate that quality of care may be greater in university hospitals (Aljuaid et al. 2016). Furthermore, 4 of the 8 qualified studies examined a patient-centered perspective, and revealed that 86% of patients were satisfied with the quality of nursing care.

The biggest difference between the two studies, therefore, is an increase in overall patient satisfaction in university hospitals; and an increase in patient-centered care assessment (50% of eligible studies in Aljuaid et al. 2016). This may reflect an increase in scholarly interest in this area of research, and again validates the research aims outlined by my study as part of a growing body of research. Indeed, Aljuaid et al. (2016) identify that the limited sample size may not provide an accurate picture of healthcare quality in the KSA, however it does highlight the relative lack of data available for analysis.

The importance of these two studies for this research cannot be underestimated, however. In providing a wide-ranging literature review of studies examining healthcare quality in the KSA, it is clear that the IOM's six dimensions provide a

robust analysis of organisational processes and patient-centered care. As evidenced in these two examples, patient-centered care is a relatively new concept to healthcare quality assessments in the KSA, and only by utilizing analysis based on both IOM quality dimensions and the Donabedian (1980) model, can an accurate picture which addresses gaps in each of the models when considered in isolation.

## **2.6 Identified Research Gap: Quality of Care Assessment in KSA**

This following section adopts the Donabedian model framework to discuss extant attitudes towards quality of care in the KSA in practice, and provides a number of insights into the developing research gap relating to patient satisfaction, quality of care assessment and clinical effectiveness measures in KSA context.

### **2.6.1. Structure**

The structure of care involves the manner in which a patient accesses and receives care. The way that care is provided and structured is important, particularly with respect to how patients conceptualise their satisfaction with their experiences in a health setting. A retrospective study by Al-Sirafy et al. (2009) indicated the need to improve access to palliative care services in the KSA, and revealed that patients could not identify evidence of improvement in their quality of life or health. Al-Muzaini et al. (1998) also found that improvements in structure and the manner of delivery are challenged by the lack of knowledge of evidence-based cancer care, and by drug shortages. It was concluded that there is a need for provision of an effective framework for palliative care services in the KSA health system.

The recent widespread recognition by Arab countries that the status of palliative care is poor and lacking in structures has given rise to the ICCAW initiative (Initiative to Improve Cancer Care in the Arab World). As part of this initiative, Shamieh et al. (2010) led a panel of experts tasked with recommending modifications to the Comprehensive Cancer Network (NCCN) Guidelines. These guidelines made various suggestions for improvements in the structures of palliative care provision. Shamieh

et al. (2010) also concluded that there was little research data from the KSA upon which to recommend changes.

In terms of access to services, Diab (2010) was tasked with finding out how to improve access to cancer care facilities, with the objective of identifying key issues, including concerns about excessive waiting times, prevention and screening, diagnosis and treatment, quality of life, and palliation. The findings were clear that there are problems with regard to the structure for the delivery of, and access to, care in the different Arab countries, including the KSA. The need for an initial assessment to develop a database of baseline information for cancer care facilities was identified.

Lack of satisfaction from a patient's perspective has been reported in a number of other KSA studies that evaluated various dimensions of the quality of care. Mansour and Al-Osimy (1996) identified patients' dissatisfaction with the resources and care provided, whilst Al-Ahmadi and Rolands (2005) identified poor access to adequate chronic disease management programmes and inadequate health education, along with ineffective systems for referral and for prescribing. Research in breast cancer tertiary care health care institutions also indicated dissatisfaction with the quality of the general standards of cancer care and the significant underuse of radiotherapy: both were recognised as being below internationally accepted standards (Akhtar and Nadrah 2005).

A major study in the KSA, conducted by Alaloola and Albedaiwi (2008), highlighted that patients' perspectives of service delivery are a core service quality indicator. Their study focused on the level of patient satisfaction or dissatisfaction in a tertiary centre in Riyadh using a cross-sectional survey of 1,983 inpatients, outpatients, and emergency care patients. It was the first report of service quality and patient satisfaction of the KSA health care systems to appear in a peer-reviewed journal. One limitation of this otherwise invaluable study was that not every service was studied separately, so the patients' answers may not represent any one care setting. The researchers recommended that further studies on patient satisfaction in the KSA are needed.



### **2.6.2 Process**

Research suggests that the processes by which healthcare is delivered in the KSA are inconsistent in nature and quality, which may give rise to inconsistencies in patient satisfaction. A lack of consistency in the quality of the clinical care processes has been clearly identified in the KSA. Research in Riyadh (Saeed and Mohamed 2002) established that the patients were largely satisfied with the doctors and the nurses, but this research was undertaken in a context where experienced Muslim physicians and an Arabic-speaking health team were offering free services near patients' homes. This is problematic as this type of treatment is not particularly common across the KSA, and therefore the results are liable to sample bias.

A number of studies have also shown high levels of patient satisfaction in other specialties. The study by Mahfouz et al. (2004) showed that elderly patients were largely satisfied with the doctors and the health care givers' attitudes and behaviours, but they were generally dissatisfied with long waiting times, lack of speciality care, and lack of information provided to them. Al-Faris et al. (1996) studied primary health care centres (PHCC) in Riyadh and found that the satisfaction levels varied according to the factor investigated. Although patients were generally satisfied with the service provided and with the respectfulness of the staff, they were significantly dissatisfied with the interpersonal skills of some health care staff and with poorly explained procedures.

The KSA's Ministry of Health regulates both the governmental and private health sectors. The Ministry of Health has the capacity to set standards for national-level strategies for health reforms through change management and allocation of financial resources. Raising the health level of the population is informed by the Government's health research, which is included as a strategy within the National Health Program/Plan. In 2005, Al-Ahmadi and Roland acknowledged that there was a deficit in the literature on the effectiveness of quality primary care in the KSA, even though the Ministry of Health argued that high quality of care was a key to the national health strategy. The available evidence shows that clinical effectiveness in the KSA has historically been considered to be low.

A study of satisfaction among primary health care patients in the KSA by Mansour and Al-Osimy (1993) indicated low satisfaction with the quality of care of the referral system. More recently, research has shown that patients have developed poor perceptions of the effectiveness of primary health care in the KSA (Al-Ahmadi and Roland 2005). Ineffectiveness and inefficiency in primary care were reported in relation to disease management programmes, prescribing patterns, health education, referral patterns, and some aspects of interpersonal care, including those caused by language barriers. In addition, Al-Ahmadi and Roland (2005, p. 331) also identified other determinants of the ineffectiveness of primary care such as 'poor management and organisational factors', 'poor implementation of evidence-based practice', 'low professional development', 'lack of structured approach to use of referrals to secondary care', and 'use of healthcare professionals that were not sensitive to the culture of Saudi Arabian patients'.

A report by the Ministry of Health (MOH 2010) identified failures in health care in the KSA, which were largely people-related and not technology-related; they were also linked to complexities in the management of health information (Ministry of Health, MOH 2010). This led to a Ministry drive towards improvements in primary care practice in a number of regions. One important and positive change has been the adoption of an e-Health approach, as part of the wider KSA focus on e-Government, aimed at improving the efficiencies and effectiveness of health care. The KSA's use of e-Health has been identified as a strategic objective for the Ministry, which should not just improve health, but enhance how patients perceive the effectiveness of care and availability. The approach involves linking regional health directorates, hospitals, and hospital management centres. The KSA e-Health governance model claims to improve service design through alignment of health care with dimensions of quality of care, management of relationships (doctor-patient relationships, nurse-patient relationships), and by ensuring delivery of value to patients. However, despite this drive to provide high-quality health care services in the KSA, evidence of patients' perceptions of quality care in the KSA is lacking, and a gap in the knowledge remains. These findings highlight the need for research on patients' concepts of satisfaction as one of the key indicators of quality of care from the perspective of clinical effectiveness. Specifically, it would be pertinent to conduct research to

investigate how doctors' or nurses' skills could be developed to help improve perceived clinical effectiveness of care and other care processes.

### **2.6.3 Outcomes**

One potential problem identified in the KSA is accurate measurement of performance indicators. This is in line with the call by Bilimoria et al. (2009) in the US for a framework for policies and procedures to outline the best approach for such measures. In addition, there is a need for implementation of standardised, quality indicators in daily practice through effective strategies to reduce variability and enhance the level of improvement obtained (Vos et al. 2009). Indeed, Al-Moajel (2012) maintains that quality indicators are essential to improve the quality of health care services. Al-Moajel's (2012) study also recommends accreditation of hospital care services as a step towards aligning quality of care dimensions with set standards, as part of clinical governance. Despite the clear need for such measures, there is currently no literature on how accreditation and certification systems in the KSA have affected patient satisfaction or impacted on clinical effectiveness.

Additionally, in order to determine a practitioner's clinical effectiveness, the use of evidence-based practice is important. Evidence-based Clinical Practice Guidelines (CPGs) are important tools to help improve patient care and health outcomes. Al-Ansary and Alkhenizan (2004) conducted a review of CPGs and of the tools that have been employed in CPGs in Saudi Arabia for the last two decades. Their findings demonstrated the need for good quality, effective CPGs in the KSA to enable alignment with expected standards for quality of care. Ideally, to reduce work and costs, this could be accomplished through local adaptation of good-quality international guidelines. However, there is a dearth of information in the literature on the way CPGs could provide a basis for improving dimensions of care in the KSA. Recent studies have focused on quality measures/indicators which are known to improve care outcomes. Al-Moajel (2012) showed how improving the effectiveness of quality of care relies on the development of hospital performance indicators in the fields of accreditation/certification of health care structures and processes of care.

Furthermore, there is also a need to explore related aspects of cancer treatment within the KSA, including side effects (like osteoporosis) caused by current chemotherapy drug use (Al-Amri and Sadat 2009), and the need to focus on the significant number of patients failing to attend medical appointments (Brown et al. 2009). In the study by Brown et al. (2009) in Riyadh, which involved patients with malignant lymphoma, communication problems were responsible for 34.1% of missed appointments, while another 17.6% were found to be the result of patient communication errors. One area identified as problematic was the movement of patients with limited access to outpatient appointments and hospital facilities. Addressing such problems represents an essential role of a service organisation. These studies demonstrate the potential for considerable patient dissatisfaction with certain structural aspects of healthcare in the KSA and, hence, the need to further investigate patient perceptions of a range of specific key indicators of service organisation in the KSA. It should also be emphasised that much of the data presented from the KSA are not derived through primary research, but arise from retrospective analyses of data from patient files or records. The need for robust, reliable evidence from empirical research provided a rationale for my study to examine the quality of patient care in oncology wards in the KSA.

## **2.7 Working definitions of thesis**

Working definitions thesis is adopting for Quality of care, Patient satisfaction, Patient experience and Clinical effectiveness are outlined in Table 2.3:

<b>Key terms</b>	<b>Working definitions of thesis</b>
<i>Quality of care</i>	<p>The Institute of Medicine IOM (2001) defines quality as ‘<i>the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge</i>’ (IOM 2001, p.65). Service provision and access therefore form key components of effective quality, as defined within this thesis.</p> <p>Donabedian’s model (1980) and IOM’s (2001) dimensions of quality can effectively be combined to measure and assess ‘quality of care’ more efficiently (Figure1). Each of Donabedian’s categories of structure, process and outcome can be subdivided to include the six dimensions of quality to examine if the stages are executed effectively to derive inferences about the quality of care within the oncology ward settings of KSA as presented within this study.</p>
<i>Patient satisfaction</i>	<p>Patient satisfaction is defined as the evaluation of the conceptualisation of their individual experiences as well as the extent to which it has satisfied their needs and delivered the expected outcomes (Jekinson et al. 2002). This working definition is adopted throughout the thesis. Patient satisfaction is placed within a wider context of overall experience, and this is helpful for the forthcoming structure of the research methodology.</p>
<i>Patient experience</i>	<p>Patient experience is considered in terms of three key factors: (1) determinants of experience (i.e. organizational aspects); (2) components of experience (i.e. characteristics of interactions); and (3) outcomes of experience (i.e. overarching assessment and patient satisfaction) (Reimann and Strech 2010).</p>
<i>Clinical effectiveness</i>	<p>Clinical effectiveness is defined as ‘the right person doing the right thing (e.g. evidence-based practice), in the right way (i.e. skills and competence), at the right time (i.e. providing treatment and service when patient needs them), in the right place (i.e. location of treatment and service) with the right result (clinical effectiveness/health gain)’ (NHS QIS 2005). Clinical effectiveness represents a combination of characteristics of interactions (process component) and organizational aspect (structural determinant) which is consequently impacted by satisfaction, experience and previous expectation.</p>

**TABLE 2. 3 : WORKING DEFINITIONS OF THESIS**

## 2.8 Conclusion

The narrative synthesis approach to literature review has demonstrated the difficulty of defining and measuring quality of care and patient satisfaction. The review also demonstrated the gaps in current scholarship on patient satisfaction in the KSA. As such, a key element of this discussion has been the relationship between patient-centred care and patient satisfaction.

This review has evaluated the knowledge base of patient satisfaction, with particular focus on the oncology care setting in the KSA. It has identified key research gaps within the existing literature regarding a lack of patient-centred assessments of quality of care and clinical effectiveness. This review has therefore provided justification for this research, as evidenced in the following research question:

*RQ: What factors contribute to or hinder patient satisfaction with care in oncology ward settings in a Saudi Regional Cancer Centre in Riyadh?*

The identified gaps in knowledge highlighted in this review can be addressed by effectively interpreting the relationship between patient experience/satisfaction and quality of care, while maintaining a focus on oncology patient satisfaction in the KSA. The ultimate intention of my research is to contribute knowledge to a hitherto poorly researched area.

The literature review indicated the need for empirical research on patient satisfaction in the KSA, particularly patient satisfaction in oncology ward settings. As discussed, it is important to address these gaps by exploring, understanding, and interpreting the influential processes in oncology patient satisfaction in the KSA. Studies from outside the KSA offer insights into ways in which patient satisfaction varies in different care settings internationally. However, few studies to date have explored patient satisfaction in oncology ward settings in the KSA. This indicates that there is a need to consider how, in the cultural context of the KSA, various influencing factors might

determine satisfaction of care, and why and how a patient is satisfied or dissatisfied with the care provided in the KSA.

## **Chapter 3 - Methodology**

### **3.1 Introduction**

In this chapter, the methodology, the research question and study aims are considered in more detail before the rationale for the study design is presented. The chapter continues by providing a detailed description of how the study was conducted; this includes a description of the study setting, the procedures for recruiting and selecting patients, and the means of data collection and analysis for the two phases. The chapter concludes with an exploration of the ethical issues associated with this study and a description of how these were addressed.

### **3.2 Research Questions and Study Aims**

The primary research question driving this study was as follows:

RQ: What factors contribute to or hinder patient satisfaction with care in oncology ward settings at the Saudi Regional Cancer Centre in Riyadh (SRCC)?

This primary question was subsequently broken into three more specific sub-questions to be answered during Phase 1 of the research:

SRQ1: What are the socio-demographic characteristics of adult oncology inpatients at the SRCC in Riyadh?

SRQ2: Does the clinical effectiveness of health care (doctors' and nurses' skills, information provision, availability) influence adult oncology inpatients' satisfaction with care at the SRCC in Riyadh?

SRQ3: Does accessibility to health care (service organisation) influence adult oncology inpatients' satisfaction with care at the SRCC in Riyadh?

Informed by the responses in Phase 1, another series of specific questions was asked during Phase 2 of the research:

SRQ4: How do interpersonal aspects of care influence adult oncology inpatients' satisfaction with care at the SRCC in Riyadh?

SRQ5: How do socio-cultural communication factors influence adult oncology inpatients' satisfaction with care at the SRCC in Riyadh?

The primary aim of the study was to examine the extent to which clinical effectiveness impacts upon patient satisfaction and perceptions of quality of care among adult cancer patients in oncology wards at the Saudi Regional Cancer Centre in Riyadh (SRCC), in the Kingdom of Saudi Arabia.

The specific aims of the study were as follows:

1. To describe the characteristics of patients in adult oncology ward settings in SRCC.
2. To determine the likelihood that clinical effectiveness is associated with patient satisfaction in adult oncology ward settings in SRCC.
3. To determine how likely the accessibility to health care is associated with patient satisfaction in adult oncology ward settings in SRCC.
4. To explore the extent to which interpersonal aspect of care influence patient satisfaction in adult oncology ward settings in SRCC.
5. To provide recommendation for enhancing patient satisfaction in oncology ward settings in KSA.

### **3.3 Overview of Mixed Methods Research (MMR)**

Creswell and Plano-Clark (2011) have argued that combining qualitative and quantitative approaches provides a more complete understanding of the research problem than the use of only a single method. It is true that a quantitative method is able to identify the variables that are systematically or statistically correlated, but the method may provide limited insight into the reason why the variables are related in the first place. Furthermore, Creswell (2013) states that a qualitative explanation can



clarify ideas and substantiate the findings from the statistical analysis, and also provide guidance that helps in the interpretation of results.

Notably, it has been asserted that neither qualitative nor quantitative methods alone are adequate or robust enough to provide a complete analysis of the complex nature of research in areas such as health care (Sale et al. 2002). This is especially true in this investigation of patient satisfaction in oncology ward settings in the KSA since cultural, political and communication problems may all play a role, yet may be difficult to explain through using either a survey or interviews alone. This is at the heart of my decision to use a MMR design which has already been successfully used to understand patient satisfaction in other studies (Hyrkas and Paunonen 2000; Merkouris et al. 2004). As the purpose of this study is to explain the impact of various factors on a patients' satisfaction in oncology wards in KSA, the mixed-methods design is best suited for the research. Therefore, I chose the integration of the two methods to provide a more robust understanding of the research problem.

### **3.3.1 Key Issues in Mixed Methods Research**

According to Creswell and Tashakkori (2007 p.4) mixed methods research can be described as 'research in which the investigator collects and analyses data, integrates the findings and draws inferences using both qualitative and quantitative approaches or methods in a single study.' Some researchers claim that MMR results in clarity in understanding the complexities of the social phenomena that are under investigation (Wisdom et al. 2012).

There are several benefits in using a mixed methods approach to research, namely, (1) triangulation (using multiple data collection methods to corroborate findings and to validate these methods); (2) complementarity (elaborating, and clarifying the results of one method using another); (3) initiation (uncovering contradictions that lead to re-framing the research question); (4) development (using the findings from one method to inform the other); and (5) expansion (expanding the breadth of research by using different methods at different stages of research) (Greene et al. 1989).

The MMR method needs a research paradigm to provide a framework for the research to be able to adequately address the research questions. Creswell and Tashakkori (2007) maintain that a research paradigm represents a belief system or theoretical assumptions and propositions that provide guidelines on how to answer a research question. Four foundations of research paradigms exist (Tashakkori and Teddlie 1998), namely, (1) positivism (built on experimental testing); (2) post-positivism (viewpoint arising from the need for a research context and a recognition of the insufficiency of context-free experimental designs); (3) critical theory (viewpoint that ideas relate to specific ideologies, and biases ought to be articulated; and (4) constructivism (viewpoint that every individual researcher creates his/her independent reality, and therefore, multiple interpretations exist). According to Sale et al. (2002), one cannot be both a positivist and an interpretivist or constructivist (Sale et al. 2002, p.47). Similarly, Hammersley (1996 p.160) argues that: 'Quantitative and qualitative methods have been presented as opposing paradigms, to be used as and when appropriate, depending on the focus, purposes and circumstances of research'.

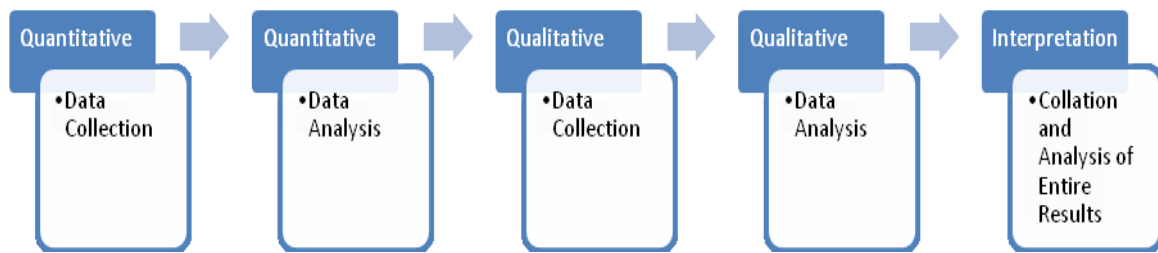
The primary question of this debate is whether, when using quantitative tools in a mixed methods design, one adopts a positivist interpretation, or whether the overall research design remains constructionist or interpretivist. The latter position implies that use of quantitative data collection tools means it is still important to develop conclusions using constructivist approaches. Keeping in mind the primary aim of this research it is evident that it is necessary to comprehend which major factors influence patient satisfaction which can be revealed through a quantitative measuring instrument, in this case a survey. However, to fully comprehend the factors further insight is needed in terms of understanding patient opinion on the healthcare delivered to them and ultimately how that impacted their satisfaction. This view echoes work by Feilzer (2010), who maintains that methodological choices should be based on the aim of the study, and that these can – in turn – be pragmatic research approach.

While Onwuegbuzie and Leech (2005) and Creswell (2013) stress the importance of pragmatism in MMR, some researchers maintain there is still lack of clarity in how pragmatism can shape and define the mixed methods approach (Tashakkori and

Teddlie 2003). Nevertheless, the general consensus in the literature is that some versions of pragmatism represent the most useful philosophy for supporting MMR. For example, Johnson et al. (2007) contend that pragmatism is a suitable philosophy for integrating different perspectives and mixing approaches through application of epistemological justification and logic. According to Johnson et al. (2007), by mixing approaches and methods, the outcome would more readily be able to address and provide tentative answers to one's research question(s). Similarly, Morgan (2007) provides a holistic view, describing how researchers can vary their approach depending on the research question and draw on pragmatic approaches as a philosophical and practical basis for conducting MMR. This approach enables a multiplicity of perspectives, which enables a deeper understanding of the research problem (Eaves and Walton 2013). Therefore, my study adapts pragmatism as philosophical framework underpinning this mixed methods research.

### **3.3.2 Sequential MMR Research Design**

This study adopts a sequential MMR design. The sequential model described by Creswell (2013) is known as the explanatory design. The explanatory design involves two-phases where qualitative data helps to explain and expand upon initial quantitative results (Creswell et al. 2003), and is especially useful when such data is needed to explain significant/non-significant results, or outlier results (Sale et al. 2002).

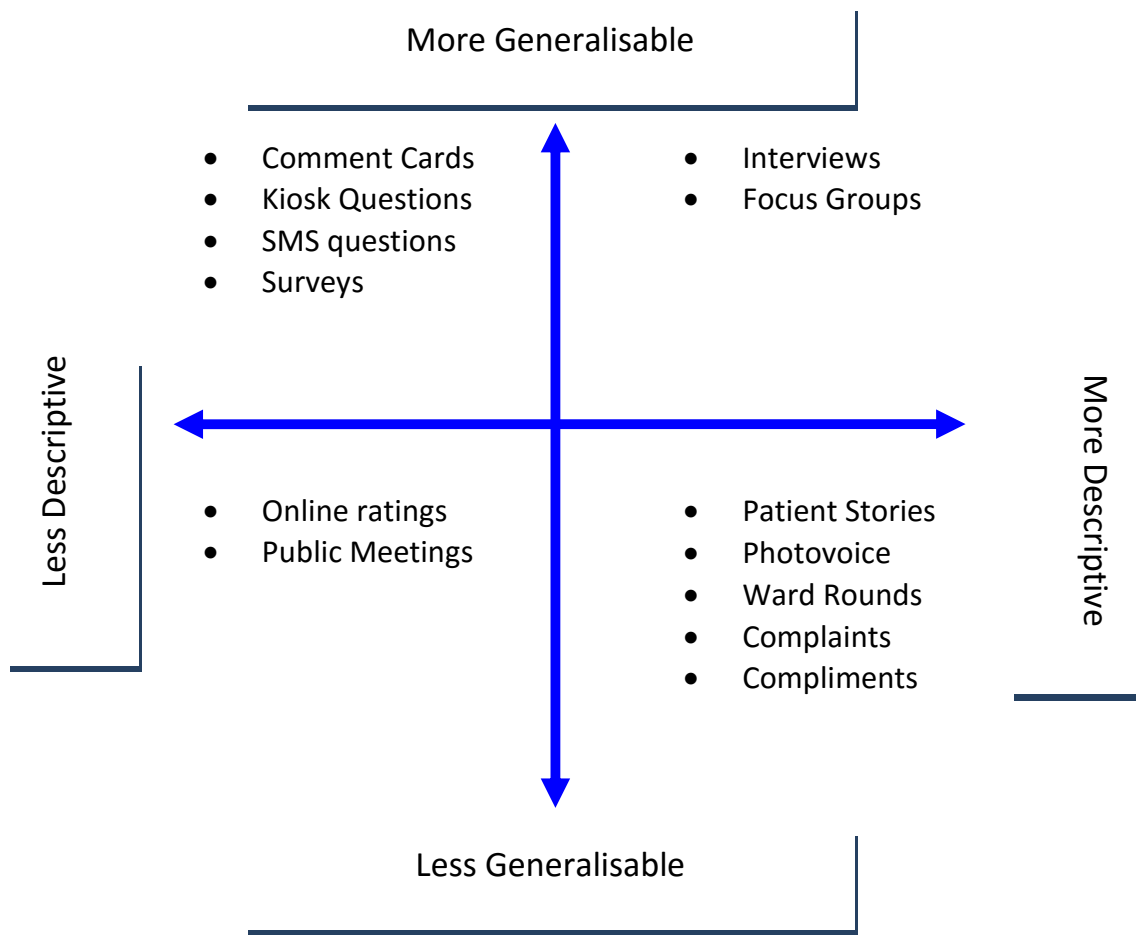


**FIGURE 6 - SEQUENTIAL MMR RESEARCH DESIGN (CRESWELL 2013)**

The explanatory design outlined (Figure 6) provides the requisite structure to approach the specific research questions in two distinct phases of quantitative and qualitative research. It also provides a model by which the resulting data sets can be analysed together to highlight evidenced trends and provide robust recommendations for future best practice.

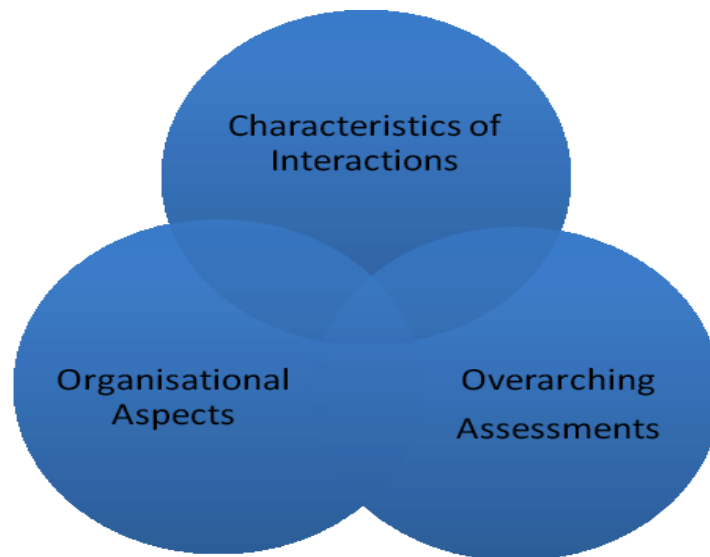
### **3.3.3 Mixed Methodological Research Strategy Development**

As noted by Figure 7, a number of potential methodological avenues are available when considering analysis of patient experience. These range from the generalisable to the descriptive, and are presented on a relational scale. This section analyses the potential options for sequential MMR strategy, and outlines a practical methodology based upon Creswell's (2013) model of sequential MMR research.



**FIGURE 7 - PATIENT EXPERIENCE RESEARCH STRATEGIES (HEALTH FOUNDATION, 2013 P.30)**

In this section, potential research strategies are analysed in relation to their applicability for this research, specifically in relation to assessing patient experience. This has been previously explored in Section 1.2.3, and the three central factors impacting upon patient experience namely (1) characteristics of the interaction between healthcare professionals and patient, for example doctor-patient relationship or communication (2) organisational aspects of the medical practice for example equipment, personnel, organisation and (3) overarching assessment for example patient satisfaction is placed within a wider context of overall experience. The three central factors impacting upon patient experience have been summarised in Figure 8:



**FIGURE 8 - CORE COMPONENTS OF PATIENT EXPERIENCE (REIMANN & STRECH 2010, P.240)**

The selected methodologies will therefore provide insights to all three of the central factors identified above. Patient satisfaction falls within the bracket of overarching assessments, whereas clinical effectiveness would represent a combination of characteristics of interactions and organisational aspects impacting upon the overall experience of the patient.

### **3.3.4 Applicability of Sequential Mixed Methods**

The following four key factors were examined as proposed by Creswell (2013) to determine if the MMR methodology was warranted for the study.

#### **3.3.4.1 Timing**

The collection of qualitative and quantitative data may be scheduled and timed so that the data are collected simultaneously or sequentially. According to Fowler (2013) the strength of a survey is identified with its ability to collect large amounts of

responses over a specific period of time and its ability to represent the target population. In this study, a reliable and validated instrument (Phase 1) was used and then followed with semi structured interviews to examine further the factors influencing patient satisfaction (Phase 2) of cancer patients in SRCC.

#### **3.3.4.2 Weighting**

Weighting refers to the priority and emphasis given to both the qualitative and the quantitative methods. Giving greater emphasis to the quantitative method was necessary to ensure that the maximum amount of data was collected and analysed prior to seeking explanation by using interviews in the qualitative phase. Additionally, the larger quantitative sample size took longer to collect, collate and analyse; in order for phase 2 of the research to be more effectively conducted.

#### **3.3.4.3 Mixing**

Mixing involves merging two forms of data into a structure that allows for reliable evidence to be drawn upon with relation to the research question and aims. Mixing involved analysing the complementary quantitative and qualitative data sets and then combining the findings from both. Mixing was conducted by analysing the quantitative data and then using the conclusions from that data to support the collection and analysis of qualitative data.

#### **3.3.4.4 Theorising**

Theorising requires consideration of whether mixed method research is suitable for the chosen research paradigm – the pragmatic paradigm in this instance. The MMR methodology was deemed suitable because it could generate a large amount of data from different perspectives which was needed to represent and understand how the patient constructed satisfaction with their care.

MMR methodology was deemed to be appropriate for this kind of research and is justified with respect to the ten criteria suggested by the Health Foundation 'when planning how to measure patients' experience' including satisfaction (Health Foundation, 2013, p. 28). My research meets the Health Foundation criteria as follows:

1. The term patient satisfaction was defined in ways that can be assessed by both quantitative and qualitative data.
2. The patient satisfaction being measured allowed for a good understanding of how patients construct their experience and it was possible to use data on their responses in this respect to answer the research question.
3. It was considered useful to combine both qualitative and quantitative data in order to maximise the data collected.
4. The MMR method was suitable as it enabled samples to be selected rather than all the general population, which was impractical in a study of this size. The MMR approach allowed me to draw from the samples the maximum amount of data possible.
5. The MMR method allowed for a significant amount of data to be collected within a tight time frame. This helped to address the particular challenge that I faced of a limited period permitted for field work
6. The MMR methods used were tested before they were implemented and they are all well established and proven data collection instruments as used in previous patient satisfaction studies (Hyrkas et al. 2000; Merkouris et al. 2004).
7. The data collected by MMR methods could be merged in such a way as to allow the information to be analysed robustly and reliably.
8. The MMR methodology was chosen because it could present information in a suitable way for the intended audience.



9. The MMR methodology allowed people to express their opinions freely and to feel comfortable providing information to the researcher.
10. As there is no single measurement of patient satisfaction, there needs to be several ways of measuring it. Therefore, by providing more than one perspective, the MMR provided the data needed to address the research question

(Health Foundation 2013, p. 27)

### **3.3.5 Quantitative Research Strategy Development**

Quantitative research is conducted based upon a survey analyses. However, a number of different methodological approaches have been conducted utilising questionnaires in the healthcare sector. This section analyses the types of surveys available, and eventually concludes that a hospital survey is required to meet the criteria of this research.

#### **3.3.5.1 Online Surveys**

Online surveys are one approach to data collection. As noted by Njio et al. (2008) these are becoming increasingly common. Principally among these the Patient Feedback Questionnaire (PFQ) designed by the Picker Institute provides an accessible and convenient means for healthcare organisations to gather large amounts of anonymous data without conducting separate research. As noted by the Health Foundation (2013) an analysis of all 146 acute general UK NHS hospital trusts was able to compare independent data from 9997 patient satisfaction ratings. These were subject to many biases, however, owing to the unsupervised nature of the response. The survey also did not collect information regarding the patient's previous expectations of care. While online surveys have many advantages, a lack of guidance and flexibility present key draw-backs in relation to my study. An analysis of potential advantages and disadvantages of online surveys is outlined in Table 3.1:

Potential Advantages	Potential Disadvantages
Potentially very large sample size	Bias prevalent from respondents
Encourages passionate responses	Certain types of respondents more likely to engage
Preserves anonymity	Engagement not necessary, therefore the sample may be selective and not random
A number of visual techniques can be used to ensure data is descriptive and valuable	May only cover limited appreciation of patient experience
Easy to correlate with other studies of patient experience	Lack of focus on interactions between patients and professionals
Focus on overarching assessments of total experience of care.	Rating scores are simplistic, and liable to individual value bias
	Greater levels of negative feedback expected.

**TABLE 3. 1: ADVANTAGES AND DISADVANTAGES OF ONLINE SURVEYS, ADAPTED FROM: (HEALTH FOUNDATION 2013, P.19)**

The single oncology centre sample required by this study negated a number of the benefits offered by online surveys. Additionally, the bias concerns and limited sample size also counted against utilising an online approach. The simplistic ratings also provided only a top-line assessment of patient satisfaction, rather than examining satisfaction as part of a wider discourse on overarching assessments of structure and process – as initially highlighted in the Donabedian model (1980). The lack of applicability of online surveys to a broader assessment of patient experience as highlighted by Reimann and Strech (2010) has resulted in my rejection of online surveys as an appropriate research tool.

### **3.3.5.2 Hospital Surveys**

This does not mean that the survey model should be abandoned, however, and a number of the advantages noted in Table 3.1 address key concerns regarding the potential integration of data with subsequent qualitative research, and a preservation of patient anonymity. As noted by the Health Foundation (2013) many of these hospital surveys were administered by mail, meaning that response times varied widely between samples. A number of key advantages and disadvantages of the hospital survey model are outlined in Table 3.2:

Potential Advantages	Potential Disadvantages
Can easily include Likert scales for assessment of satisfaction	Limited depth of research
Model can be adapted to fit locality of sample	Sensitive issues may not be covered
Provides a means for standardisation of results	Non-response and selection bias
Anonymity retained throughout the process	Patient-focus may not provide accurate judgement of clinical effectiveness and processes
Increased comfort from the patient when hospital staff are not directly involved	Context-specific limit wider applicability
Easy to implement and distribute	Can exclude respondents with poor literacy
Easy to analyse gathered data	
Relatively inexpensive to distribute and collate	
Ease of correlation for questions about experience/satisfaction	
Can include questions of clinical effectiveness through assessment of interactions	

**TABLE3. 2 ADVANTAGES AND DISADVANTAGES OF HOSPITAL SURVEYS, ADAPTED FROM: (HEALTH FOUNDATION 2013, P.25)**

An examination of the weaknesses of hospital surveys presents a clear example of the necessity of complementary qualitative analysis and further supports the strength of mixed methodological research. For example, a limited depth of research is addressed directly by the qualitative research slated for Phase 2. The context-specific nature of my research may limit the generalisability of research. That being said, this is the first of such studies to examine healthcare provision in the KSA, and as such will necessarily provide a signpost for future analyses into oncology ward settings.

The patient-focus does presents a wider consideration for the robust assessment of clinical effectiveness; taking into account the perceptions of patients only. This is important when considering the process aspect of Donabedian's (1980) model in examining quality of care. Additionally, it does not provide a holistic assessment of organisational processes. The strengths of the hospital survey, however, foreground this as the preferable research strategy for Phase 1 of the study, particularly in addressing SRQ1-3.

### **3.3.6 Qualitative Research Strategy Development**

Creswell's (2013) explanatory design requires a qualitative research element to be drawn from the findings of the quantitative research. As previously illustrated, hospital surveys were conducted to address the requirements of SRQ1-3. When considering the qualitative research approach required to assess SRQ4-5, a number of methodologies were considered. These are outlined in the next section, and a rationale provided for the eventual selection of semi-structured one-to-one and telephone interviews.

#### **3.3.6.1 Focus Groups**

The requirement to provide highly descriptive and generalisable results identifies interviews and focus groups as two key qualitative research strategies to consider for Phase 2 of this study. An exploration of the pros and cons of focus group analysis is offered in Table 3.3:

Potential Advantages	Potential Disadvantages
In-depth information	Difficult to translate data into numerical findings
Integration of patient stories within a group	Limited specificity of case-by-case analysis
Can utilise visual aids for research	Skills of the researcher paramount in chairing focus group sessions
Increases respondent engagement and investment in project	Time-consuming to organise
Group feedback can spark secondary ideas	Potentially limited sample owing to the severity of some respondents' illness
Greater exploration of unexpected responses possible	Social desirability bias from some respondents
	Consensus bias
	Difficult to replicate between groups depending on participants
	Facilitator bias

**TABLE3. 3 ADVANTAGES AND DISADVANTAGES OF FOCUS GROUPS, ADAPTED FROM: (HEALTH FOUNDATION, 2013, P.10)**

As noted by Schwarz et al. (2000) focus groups can be an 'excellent method for primary care practices to assess the complexities of patient satisfaction'. However, a number of situational problems exist when considering focus group analysis in this research context. For example, the sample of a single oncology unit means that the experiences of those within the focus group would be limited to the same location. This means that a broader appreciation of trends across a wider number of oncology wards could not be ascertained through the group and this particular advantage nullified. Participation in a focus group can also generate one-sided results, with some members of the focus group being more persuasive and vocal than other

members; whose personal opinions and perceptions of satisfaction and quality of care are equally valid. While offering a number of benefits towards detailed, descriptive examples of patient experience, therefore, focus groups present a number of problems in this case owing to the specificity of the sample size, and the limited extrapolation that this case can offer for other oncology wards.

### 3.3.6.2 Semi-Structured Interviews

Interviews present a different proposition, and the potential advantages of these are outlined here in Table 3.4:

Potential Advantages	Potential Disadvantages
In-depth information gathered	Difficult to relate to numerical findings
Private – meaning respondents are more likely to share sensitive information	Process of coding multiple responses difficult
Personal – information is specific to the individual respondent and isolated from group influence	Limited participation means increased potential for researcher bias
Convenient – less difficult to organise than focus group sessions	Potentially limited sample owing to the severity of some respondents' illness
Can use telephone calls – not required to be face-to-face	Potential requirement for medical staff intervention should patient be too ill to conduct interview
Greater exploration of unexpected responses possible	
Trend identification through coding can be equated to numerical findings	
Limited requirement for researcher leadership and group management	
Semi-structured allows for greater flexibility in exploring	

**TABLE 3. 4 : ADVANTAGES AND DISADVANTAGES OF INTERVIEWS, ADAPTED FROM: (HEALTH FOUNDATION 2013, P.6)**

As evidenced by Table 3.4 interviews present more positive than negative factors within the context of this research. As such, semi-structured interviews were used in this study for the following reasons: (1) to elicit the participants' perspectives on what areas were deemed deficient, satisfactory, or excellent regarding the care they had received, or to fill in the gaps that had been highlighted following analysis of the questionnaires; and (2) for complementarity. There are some researchers who argue that the credibility of research is often affected when it is based on semi-structured interviews (Creswell 1998; Patton 2002), for example, because the meaning or wording of questions may be interpreted differently by the respondents. However, other researchers (Barribal and While 1994; Opie 2004) lend their support to the use of semi-structured interviews. Careful consideration was taken throughout the research process to keep both perspectives in mind.

Semi-structured interview questions in a healthcare setting are not uncommon but for this particular type of study, however there were many factors and considerations to take into account during formulation of the questions, including the need to avoid leading questions arising from interviewer preconceptions which could introduce bias and adversely affect the credibility of the data (Balls 2008). Additionally, questions were developed keeping in mind that the comprehension level of participants can vary, so simple terms were used and medical jargon avoided. During interview testing, the questions were subject to pilot testing to ensure clarity and understanding for participants. This would ensure that the participant was able to comprehend what the question was asking of them, and provide an answer that accurately addressed the question.

### **3.3.7 Summary of the MMR Approach Taken**

The primary research question of my study focused on the factors that contribute to or hinder patient satisfaction with care in an oncology ward setting in a Saudi Regional Cancer Centre in Riyadh. Patient satisfaction has been identified as being a central element of overall patient experience; which is in turn affected by clinical effectiveness and quality of care. This methodology allowed for a richer



understanding of the relationship between patient satisfaction, patient experience, quality of care, and health care delivery for oncology patients in SRCC, KSA, and it has been developed from Reimann and Strech's (2010) model of patient experience outlined in Figure 7.

This methodology highlights the benefits of a sequential mixed methods design as the most appropriate for achieving the aim of the study and to answer the research questions. Accordingly, an explanatory approach was adopted, but with complementarity in mind, whereby the patient satisfaction survey was conducted first and, after analysis of the quantitative data, one-to-one interviews (both by phone and face-to-face) were carried out with oncology patients to provide an assessment of patient satisfaction and assess the relationship between the various factors identified and connected to patient satisfaction. The findings are expected to provide a significant contribution to the literature of patient satisfaction and patient experience to improve healthcare service delivery in KSA.

### **3.4 Phase 1: Quantitative Method**

The following section addresses the first phase of the MMR approach, charting the identification of a robust quantitative questionnaire design.

#### **3.4.1 Cross-Sectional Survey Design**

The first phase of the study comprised a quantitative, cross-sectional survey. Hennekens and Buring (1987) note a cross-sectional survey examines the relationship between disease, or other health state, and other variables of interest that exist in a defined population at a single point in time. Cross-sectional studies are descriptive in nature. For example, they are used to describe certain characteristics of a population, such as prevalence of illness, or they may be used to support inferences of causes and effects (Rothman and Greenland 1998).

The quantitative Phase 1 of data collection therefore addressed SRQ1-3 through a cross-sectional survey of an adult oncology inpatient group. It was administered to determine their levels of satisfaction with the care provided to them at the time of

their participation. A validated EORTC IN-PATSAT 32 questionnaire (the inpatient satisfaction quantitative questionnaire, as developed by Bredart et al. (2005), was distributed to adult oncology inpatients in a Saudi Regional Cancer Centre in Riyadh. This validated questionnaire was deemed a reliable data collection instrument as it has a track record of being used in similar research (Arrora et al. 2010; Obtel et al. 2012) and it has been designed to provide information on patients in oncology ward settings. Section 3.4.5 describes the questionnaire in detail.

The setting of this study was adult male and female oncology wards in one of the main KSA regional referral cancer centres in Riyadh (SRCC). The capacity of the oncology wards is 42 beds. This setting was appropriate, as the centres admitted adult male and female patients with varying types of cancer. Geographically, this area included a diverse population from which potential participants of various ages, and socio-demographic and cultural backgrounds could be sampled.

### **3.4.2 Sampling Strategy**

#### **3.4.2.1 Population**

The population of interest for this study was all adult male and female inpatients admitted to the SRCC in Riyadh. The research population was therefore controlled through location of patients, time of data collection, and was limited to a single oncology department.

#### **3.4.2.2 Inclusion criteria**

All participants in the research were required to meet the following criteria:

- Confirmed diagnosis of cancer
- Aged 18 years or older
- Hospitalised for at least three days (to maximise number of patients)
- Mentally fit to answer the questionnaire
- Aware of their medical condition

Inpatients who did not meet each of these criteria were excluded from the study.

### **3.4.3 Recruitment Procedures**

Following ethical approval from the University of Stirling, School of Health Sciences' Ethics Committee, and from the Saudi Regional Cancer Centre (SRCC) Ethics Committee, I initiated contact with the clinical site in Riyadh. Senior managers, including the oncology nurse managers, head nurses in adult oncology wards, and the medical director were contacted to provide them with an explanation about the study's aims and methodologies, and to enlist their assistance.

Recruitment and consent took place on the ward by direct contact with oncology nurse managers, to secure cooperation and the help of the staff. One nurse educator in particular was assigned and made responsible for distributing the questionnaires and surveys on the researcher's behalf. Patients were given an information sheet and an invitation to participate (see Appendix 6 for the patient information sheet). They were given time to consider whether they wished to participate and to discuss this with their relatives. Those interested in participating were informed of opportunities to be selected for a follow-up interview for the qualitative phase of this study.

I communicated the criteria for inclusion and exclusion of potential participants to the nurse educator leading to her being aware of those criteria. Consequently, she was able to determine those eligible to participate and distributed the questionnaire to those who met the criteria.

An invitation letter, along with an information sheet, was distributed to eligible patients and those who wished to participate stated their intention to the nurse educator. Patients took one to two days to state their intention to participate. Patients who agreed to answer the questionnaire were asked by the nurse educator to sign the consent form (see Appendix 8 for the patient consent form). I entered patient information into a recruitment log to maintain the transparency of the research process. The recruitment log included a non-identifiable number for all participants

and the following: age, gender, date of admission and the date of data collection were coded. The log facilitated the anonymity and confidentiality of the received data, and also managed the time scale for the recruitment process (see Appendix 8 for the recruitment log). The recruitment continued until 100 patients who consented to participate were attained.

The questionnaire informed the participants of the procedures they needed to undertake if they were interested in participating in the interview phase. Specifically, a contact number was provided on the questionnaire so that potential participants, or someone acting on their behalf, could contact me for further information. Participants were also invited to provide their telephone number on the questionnaire so that I could contact them directly to discuss participation in interviews. Following collection of the questionnaires, I was passed the details of those who had indicated a willingness to be approached for interview, along with their contact details. This allowed me to recruit participants and arrange interviews for the qualitative phase of the study.

I am a native of KSA, and am therefore very sensitive to the cultural issues in the collection of data, particularly patients' cultural expectations. Privacy and respect for their opinions was considered essential and this was deemed necessary to ensure the cooperation of the sample population. I therefore assured the potential participants that their privacy would be respected and that all of their responses would be treated confidentially. In order to ensure that patients understood the research process and that their participation was kept confidential it was essential to explain to each of the participating patients the purpose of the study. This included highlighting to patients how their input and opinions can contribute to the study. Furthermore, patients were informed that all information regarding their illness, diagnosis, and other personal information would not be included in this study and confidentiality regarding their participation maintained.

During the initial data collection phase, there were certain limitations that became apparent. The relatively small sample raised issues over acquiring adequate data to analyse. Also, generalising the conclusions drawn from the data formed another

limitation to develop a general theory of patient satisfaction. That is, the question of how (and to what extent) the findings from this location were representative of the general levels of satisfaction of oncology patients in the KSA receiving such care. There was also the issue that this was the first study of its kind. This meant that there were no previous examples to base the research upon and no way to learn from others' experiences and indeed the limitations of such studies. A further limitation was caused by the restricted time available for conducting the research.

However, the findings are generalisable in the sense that the Saudi system is becoming more westernised and this means that the findings are more generalizable to oncology patients internationally. Research conducted elsewhere was a useful resource that helped to guide me the collection and analysis of data.

#### **3.4.4 Sampling Methods and Response Rate**

All eligible patients were invited to participate and included in the sample, upon provision of informed consent. A convenience sample (non-probability sampling) (Teddlie and Yu 2007) was used to select patients for the first, quantitative phase of the study. This sampling technique meant that only available people could be surveyed. The number of participants would depend on bed occupancy of the oncology ward settings, research timing, and resources. A limitation of one month (from the end of November 2012 till early January 2013) was placed on data collection for the first phase of research. This was necessary due to the need to adhere to a three-month timeframe, which had been set by my sponsors (Saudi Cultural Bureau office in London) for completion of the field work of the research.

During Phase 1 a total of 122 questionnaires were distributed to adult oncology patients in the SRCC in Riyadh, of which 100 completed questionnaires were received back. The response rate was therefore high at 82%, which was encouraging given the time-limited recruitment period.

### **3.4.5 Quantitative data collection**

#### **3.4.5.1 Instrumentation**

The European Organisation for Research and Treatment of Cancer (EORTC) Quality of Life Group has developed and cross-culturally validated the EORTC IN-PATSAT32 questionnaire to assess patients' perceptions of the quality of hospital-based cancer care (Bredart et al. 2005, Bredart et al. 2007; Arraras 2009). The development of the IN-PATSAT32 was based on existing patient satisfaction questionnaires, as well as interviews with oncology specialists and cancer patients (Bredart et al. 1998). The psychometric properties of this questionnaire have been tested and have been used in different countries (Bredart et al. 1999; Bredart et al. 2003; Arrora et al. 2010; Pishkuhi 2014) and translated into different languages using the EORCT translation guidelines (Cull et al. 2002).

The EORTC IN-PATSAT32 was constructed as comprising eleven multi-item and 3 single-item scales (Bredart et al. 2005). These include the doctors' technical skills (items 1–3), interpersonal skills (items 4–6), information provision (items 7–9), availability (items 10, 11) scales; the nurses' technical skills (items 12–14), interpersonal skills (item 15–17), information provision (items 18–20), availability (items 21, 22) scales; the other hospital staff's interpersonal skills and information provision scale (items 24–26); the exchange of information single-item scale (item 23); the waiting time scale (items 27, 28); the hospital access scale (items 29, 30); the comfort single-item scale (item 31); and the general satisfaction single-item scale (item 32) (See Appendix 9 for the IN-PATSAT32 Questionnaire).

Items are all rated on a five level Likert scale with the category labels 'poor', 'fair', 'good', 'very good' and 'excellent'. This response scale has been proven to have methodological advantages over other types of response scales (Ware and Hays 1988). Additionally, the socio-demographic data were collected for each patient including age, gender, marital status, educational level and place of residency. The choice of this survey instrument was justified because it is a well-validated measure of oncology patient satisfaction in the Western context and still applicable to Saudi

Arabia's healthcare system as this instrument has been used in Morocco (Obtel et al. 2012), another predominantly Islamic nations.

#### **3.4.5.2 Questionnaire Distribution**

For the first phase of this study, data was collected through use of the abovementioned EORCT IN-PATSAT32 questionnaire. It was forecast to take respondents roughly fifteen minutes to complete.

The distribution of the questionnaire was an important part in the data collection process, as selective distribution could bias the result (as evidenced in Chapter 2 which discussed previous positive reports of quality of care in the KSA). As described previously, the restricted timeline for the research meant that participants were recruited by convenience sampling where all eligible patients were invited to participate. Eligibility was based upon the fact that a person was being treated in an oncology ward setting and that they could understand the questions being asked. As described previously, eligibility was based on the specific inclusion criteria mentioned in Section 3.4.2.2. The nurse educator coordinating the administration of the questionnaire was careful not to coerce or pressurise patients to participate. This was done by making it clear that participation was not mandatory and that individuals would not be disadvantaged if they chose not to complete the questionnaire.

The questionnaires could be completed by the patient alone or with the help of their family or others, if necessary. Receiving such support was sometimes necessary for those who felt unwell or had poor literacy, such as older and/or poorly educated patients. Only a few participants did actually receive assistance during completion of their questionnaires, owing to the state of their condition. Either the nurse educator or a family member assisted them. Thus, research bias is acknowledged.

### **3.4.5.3 Cultural Considerations**

It must be acknowledged that the use of a translated questionnaire has the potential to present difficulties. Strauss and Corbin (2008) suggest there are four criteria to consider when using a translated questionnaire: (1) fit, (2) understanding, (3) generality, and (4) control. As IN-PATSAT32 is considered to meet these requirements, the existing Arabic Moroccan version of this questionnaire, first used by Obtel et al. (2012) when assessing Moroccan cancer patient satisfaction, was used. As it had been piloted in Arabic, it was regarded as a validated tool (Serhier et al. 2011) and suitable for use in this study. Slight adaptations in the Arabic were required due to differences between Moroccan and Saudi Arabia, and EORCT has translation guidelines for forward and backward translation (Cull et al. 2002). Any adaptations for language were undertaken cautiously with the assistance of an expert advisor, Dr. Obtel, who is an oncology doctor.

The questionnaire was reviewed by the Saudi ethics committee chair in the SRCC. Also, the questionnaire was tested to determine language suitability with Arabic speaking university students at the University of Stirling before data collection for the research was conducted. This process helped to identify any cultural barriers and ensure the language used in the questionnaire was fully understandable to Saudi patients.

### **3.4.6. Quantitative Data Analysis**

The IN-PATSAT32 data were scored according to the available validated scale module (Bredart et al. 2005) (See appendix 10 for the Scoring module). Scores for each of the fourteen subscales of the questionnaire were determined for each patient. All the scores for all items in a particular subscale are summed, and then divided by the number of items in that subscale. The scale scores are then linearly transformed to a 0-100 scale with a high score reflecting a higher level of satisfaction.



The data collected from the questionnaire (IN-PATSAT32) was then entered into a statistical package (SPSS, version 19), for processing and statistical analysis. The statistical analysis resulted in descriptive statistics of the questionnaire items, which are described and presented in Chapter four. Information presented includes the percentage of respondents (original Likert scale from the individual 32 questions) and the means and the standard deviation for the derived subscales. These sub-scales were also cross tabulated against overall satisfaction in order to determine which are the most influential for the patient.

### **3.5 Phase 2: Qualitative Method**

#### **3.5.1 Semi-Structured Interview Design**

Data was gathered through interviews with the participants selected from those who had answered the questionnaire used in Phase 1 and had agreed to be interviewed. It was also important to test the interview schedule in the initial interviews through a test interview conducted with university colleagues (Ritchie and Lewis 2003). Interviews are deemed suitable to explore attitudes and beliefs (Gordon 1975), and they can be structured, unstructured (open), or semi-structured (Mason 2006).

#### **3.5.2 Participant Recruitment**

Participants who responded to the questionnaire during Phase 1 were invited to participate in follow-up interviews. Participation was invited at the conclusion of the quantitative questionnaire by asking patients to indicate if they were interested in a follow-up interview. I contacted those who agreed to interview by telephone to arrange an appointment and obtain verbal consent (see Appendix 8 for the interview consent form). Patient information and contact details were entered into the interview recruitment log to manage the research recruitment process (see Appendix 9 for the interview recruitment log).

### **3.5.3 Sampling methods**

The sampling approach for Phase 2 was based on the results from Phase 1, but also relied on the agreement of the participants to be interviewed. Thus, selection of the sample for the interviews was based on convenience sampling. That is, the selection was based on those who were actually most readily accessible when conducting the study (Burns and Grove 2007).

Throughout the study, convenience sampling was used because of issues of access and time. These restraints meant that I could only identify a sample based upon those who could be approached in the oncology ward and those who were willing to participate. The convenience sampling method was also used since participation was based on the patients who had already completed Phase1. That is, only those who had previous access to the questionnaire were included in the sampling.

Following the completion of the questionnaire, 100 respondents were invited to participate in qualitative interviews. Of these, 38 expressed their interest, with 23 subsequently leaving contact details, and one person dropping out because of personal reasons, making a total of 22 participants for the interviews. This is a relatively small sample, but as discussed later in chapter five, it was sufficient to gather rich data so that it became common in the later interviews to be presented with views and experiences similar to those that had already been reported.

### **3.5.4 The development of the interview schedule**

The aim of Phase 2 of the mixed methods study was exploratory in nature, to help gain a deeper understanding of patient satisfaction in the KSA. The interview design was informed by several practical considerations, including a need to ensure each interview took no more than 30-45 minutes to avoid tiring the patients (Ritchie and Lewis 2003). An interview schedule was prepared to elicit the participants' perceptions of patient satisfaction. The interview schedule included a brief discussion on an outline of issues, a list of topics and subtopics relevant to the research, and the primary research question (Green and Thorogood 2009); the questions were adapted and refined based on the results of Phase 1.

It is important to recognise that researchers should use interview schedules with caution, as they can challenge the exploratory aim of qualitative research (Arthur and Nazroo, 2003). Accordingly, the interview schedule was derived from the quantitative phase by identifying a number of key issues. The areas of interest that were coherent with the research question were selected based on the IN-PATSAT 32 results. It was anticipated that the broad areas of interest would be evaluated and explored in the interviews, for example, clinical effectiveness and accessibility to health care.

These broad areas were then broken down into more specific and manageable concepts in order to facilitate further exploration. For example, the doctors' skills, nurses' skills, information exchange, service organisation/accessibility, and general satisfaction were identified as the specific areas of interest that were essential to be covered during the interviews. This led to a semi-structured interview schedule built around the results from Phase 1, but the actual interview used open-ended questions to allow scope for the patients to present their own views and provide answers in their own words (Bryman 2004). The interview questions in the schedule were checked and approved by my supervisors, ensuring the questions were not leading or focused towards generating responses that reflected my personal opinions.

Following approval, the English version of the interview schedule was then agreed by my supervisors and prepared for translation to Arabic. As mentioned previously, translation was an important step as there was a need to ensure that the questions and wording were consistent with cultural considerations. It was also important to test the interview schedule in the initial interviews (Ritchie and Lewis 2003). Therefore, in the pilot testing as indicated previously, it was possible to assess how well the interview schedule was working according to the types of data being generating and whether these data met the study aims. The prepared interview schedule can be found in Appendix 10.

### **3.5.5 Qualitative Data Collection**

20 of the 22 interviews were conducted by telephone rather than face-to-face. The use of telephonic interviews came about from various reasons. First, many of the oncology patients were discharged after the survey was completed. Also, the difficulties of Riyadh travel and transport meant face-to-face interviews with these participants would have meant travelling a great distance. Second, there was a need to adhere to a specific timeframe in completing field work for this study. Two face-to-face interviews were conducted within the oncology ward.

#### **3.5.5.1 Telephone interviews**

Telephone interviews were administered to oncology patients who could not be reached for face-to-face interviews due to distance, or because of the patient's own preference for a telephone interview. It is noteworthy that problems with recruiting participants for face-to-face interviews (even for practice interviews) are common (Mann and Stewart 2000). Telephone interviews have been previously used successfully for qualitative semi structured interviews (Bowman et al. 1994; Barriball et al. 1996). One advantage of telephone interviewing is that it extends access to participants (Mann and Stewart 2000).

Telephone interviews are considered to be a credible and robust method, although the researcher is unable to see non-verbal and social cues such as body-language (Novick 2008). This lack of visual cues is considered a minimal loss in the context of the participants in my study as they were all familiar with the issues raised (Opdenakker 2006). Indeed, there are other social cues available in telephone interviews such as voice and intonation (Opdenakker 2006). In addition, the patients seemed more relaxed, reflective and able to freely discuss sensitive topics during telephone interviews. This was surprising as previous literature (Sturges and Hanrahan 2004; Irvine et al. 2013) suggests that respondents may feel more removed from the process, without having the researcher in the room; and therefore may be less open with sharing sensitive information and insights. Fortunately, for this study, this potential limitation was not observed. For example, participants were very comfortable in discussing their doctor's attitude towards them and openly spoke of

lack of compassion exerted by doctors to their patients. The telephone interview especially suited the cultural context. Therefore, the arguable limitations of telephone interviewing were not relevant in this instance. A total of 20 telephone interviews were conducted.

#### **3.5.5.2 Face-to-Face Interviews**

Face-to-face interviews were conducted with two patients in the oncology ward settings of the SRCC in Riyadh. The limited sample size for face-to-face interviews did not impact upon the benefits of utilising the tool within my research. The interview process is described in more detail in the following section.

#### **3.5.6 Interview Process**

In a sequential mixed method study, it is important to maintain a short time interval between the first and second phase and this was managed by the use of telephone interviews. This increases the likelihood of aligning the quantitative findings with the interview schedule (Harris and Brown, 2010). A short interval between the phases was therefore chosen in order to maximise patients' recollections of the underlying reasons behind their responses in the quantitative questionnaire (Cronholm and Hjalmarsson 2011).

Follow-up hospital appointments for these patients were six to eight weeks post-discharge, and this meant they were interviewed between discharge from hospital and their next appointment. There was also a possibility that patients' conditions might deteriorate over time, which could have made participation at a later date highly unlikely. Accordingly, in order to extend access to discharged patients and maximise recruitment for the qualitative phase without compromising the quality of the information, telephone interviews were performed with these patients at a mutually convenient time.

Although it was originally planned to record interviews, this was not possible since the ethical committee of the SCCR in Riyadh insisted on a separate patient agreement if audio was to be used. Since interviews were not recorded, this placed substantial emphasis on effective note taking to accurately capture all participants' responses. Good notes must preserve interview information by providing an accurate account of the verbal responses and dialogue. A potential disadvantage to note taking over recording interviews is the possible inability to capture all relevant details (Muswazi and Nhamo 2013).

Additionally the writing process can mean long gaps or pauses in the interview plus the interviewer may find it rather challenging to combine concurrent note taking with guiding the conversation (Beebe 2001). Similarly, Muswazi and Nhamo (2013) describe how note taking disrupts the effectiveness of communication between the interviewer and the respondent. Conversely an advantage of note taking is that it can facilitate data analysis since the interviewer may already have already classified the information into appropriate response categories (Burnett et al., 1998).

To guard against potential problems I undertook practice interviews, with Arabic speaking colleagues at the University of Stirling and note taking before conducting real ones. The first interview was conducted on the 6<sup>th</sup> of March 2013 and the last one on the 24<sup>th</sup> April 2013.

Each interview started with introducing myself to the participant as a research student and healthcare professional not associated with their care. Before starting an interview, a brief review of the aims of the study was performed as a reminder to the participant. This served to further highlight to the patients the importance of their participation in order to generate valuable research data, hence help improve the quality of health care in the future. The fact that the study information would be made anonymous and kept strictly confidential was also emphasised at the outset. I tried to make the participant as comfortable as possible by consciously attempting to establish an informal atmosphere and a rapport with the participant. I also reminded the participants of the voluntary nature of taking part in the study and that they could

withdraw at any time. I also encouraged them to ask for clarification if they did not fully understand any of the questions. I emphasised that they should not feel embarrassed to refuse to answer any question should they feel uneasy.

A number of areas of concern became evident during the interview process, which initially appeared to affect the openness of the participants' responses. Anonymity was one of these, since participants were concerned that any negative perspective they voiced might filter back to the health care professionals caring for them, thus affecting any future care that they might receive in the hospital. All participants were therefore assured of anonymity many times. I also sometimes sensed nervousness and hesitation and a tendency towards formality in the way the participants responded to my questions. This was understandable given Saudi culture and the fact that Saudis tend to be reserved and respectful, granting considerable authority to health care workers and holding them in high regard. Moreover, in the KSA, strong family ties and the hierarchical structure within the family unit means women might feel inhibited about criticising people in authority. Indeed, some Saudi women must seek permission from a male guardian before openly communicating their needs and wishes to health care professionals (Walker 2009). It was therefore not surprising that some people initially felt uneasy about describing negative health care experiences or raising concerns and voicing dissatisfaction over their doctors.

I became increasingly sensitive to these potential barriers, and soon learned how to adapt my interview techniques to encourage informality and transparency. In particular, this meant respecting the patients' own cultural choices, ensuring an informal ethos, and treating them as individuals, in order to minimise stress. Thus, in order to encourage participants to continue talking and elaborate on particular issues of interest, I used verbal prompts such as, 'tell me more about', 'please explain', and 'why do you think that?' I also followed recommendations made by Fontana and Frey (1994) and ensured I was courteous, friendly and pleasant. As the interviews proceeded, participants appeared to become increasingly relaxed and tended to open up more.

During the beginning of some interviews, patients made many positive comments which might have been interpreted as their having considerable satisfaction with their hospital care. However, as the interviews progressed, participants started voicing concerns over their care, making several negative comments and pointing to areas where they thought improvement could be made. This honesty is consistent with an emotional shift as the interview-interviewee relationship evolves and a rapport develops (King and Horrocks 2010). Nevertheless, the extent to which the participants' culture adversely affected the transparency of the answers they provided remains unknown. There was awareness that culture was a potential factor that needed to be addressed in the discussion. The context of the findings needs to be accounted for when discussing them. It was important to make clear that the participants were from the KSA and what they expressed was based on how its culture influenced their responses. Any findings derived from these responses are therefore in themselves a reflection of these cultural influences.

Because of my training in communication as a nurse and my professional skills, this led to an awareness of these constraints and limitations and was important when analysing and interpreting the data. I had an understanding of the difficulties and challenges involved for a patient and how this could have influenced their views. My experience as a nurse in KSA was also helpful as it had provided me with an insight into the cultural assumptions of my patients. My training in communication allowed me to interact with people and to an extent allowed me to overcome any cultural barriers. This and an awareness of the influence of culture allowed for a fuller and more complete discussion of the findings. To a certain extent it was a bit difficult to separate roles as a researcher and nurse particularly in terms of developing rapport that maintains the limit of a researcher. Rapport building as a nurse is more focused on building relationships with patients to ensure quality of care and comfort throughout the delivery of healthcare services. However, as a researcher it is essential to only indulge in communication building to the extent that it provides appropriate information to the participant. Also, as a researcher it is essential to abstain from bias by favouring specific participants over another. As a researcher it was essential that I refrained from emotional attachments. Therefore, a middle ground was struck which assured participants that I valued their input without becoming emotionally attached to them.



### **3.5.7 Qualitative Data Preparation**

Generally, interviews create a large amount of data in audio or textual format (Pope et al. 2000). Whilst translating the annotated interviews from Arabic to English, problems were encountered. Literal (word-for-word) translation can often be inappropriate and lose the actual meaning behind the original narrative (Rubin and Rubin, 1995). The bias inherent in translation in qualitative research has been extensively discussed in previous publications (Brislin et al. 1973; Rubin and Rubin 1995; Temple 1997).

A noted primary methodological dilemma is whether to use literal translation, or 'free' translation, that changes the wording in order to improve the readability and understanding of direct participant quotes or not. Two risks of free translation are the potential loss of information about the participant, and the possibility of misinterpreting the meaning of their words (Rubin and Rubin 1995). In an attempt to reduce these risks, I used literal translations as far as possible, but with minor modifications to improve grammar and enhance understanding of their meaning in English. It should be noted the extracts drawn from patients' interview narratives and presented in chapter 5 should not be regarded as verbatim translations. All extracts represented by translated notes taken during interviews were imported to NVIVO 10 software, which is an electronic package for qualitative data designed to manage data and assist data organisation (Bazeley and Jackson 2013).

### **3.5.8 Qualitative Data Analysis**

In qualitative research, there are diverse approaches for analysing qualitative data. However, it is argued that qualitative data analysis should be aligned with the research aims and theoretical framework that underpins the research (Pope and Mays 1995). Thematic analysis is defined as a search for themes that emerge as being important to the description of the phenomenon (Daly et al. 1997). Thematic analysis helps to describe and organise the content of interviews through coding and categorisation of data into themes and sub-themes (Creswell 1998). By taking a hybrid, MMA-based approach it is possible to facilitate both inductive and deductive

development of coding, which means a combination of the data-driven inductive approach (Boyatzis 1998) and the deductive a priori code template, as described in the next section (Crabtree and Miller 1999). Accordingly, it fits the research questions by allowing the phenomenon of patient satisfaction to be fundamental to the deductive thematic analysis, whilst also allowing for themes to emerge from the data by inductive coding. Additionally, it is aligned with the mixed methods framework, as connecting theory and data by moving back and forth between theories and data (both quantitative and qualitative) is an essential part of creating a theoretical understanding (Morgan 2007).

#### **3.6.8.1 Thematic analysis using coding**

Six major stages are identified by Fereday and Muir-Cochrane (2006) in the use of a process thematic analysis: (1) development of the coding manual; (2) testing for coding reliability; (3) identifying the preliminary themes which have emerged from the data; (4) applying templates of codes and additional coding; (5) connecting the codes and identifying themes; and (6) corroborating the identified themes by the process of confirming the findings. The coding process was carried out based on these stages as described next.

##### *Stage 1: Developing the coding manual*

A coding manual is important because it helps a researcher to clearly recognise the textual data from the transcribed interviews (Crabtree and Miller 1999). In addition, it enables the researcher to divide the textual data into segments, to label each identified segment, and to further assess the developed interview segments for evidence of reoccurring themes (Miles and Huberman 1994; Janesick 2003).

I developed the coding manual based on the research questions and the results from Phase 1 then compared it to the qualitative data received in phase 2. The codes were identified as those factors that were influential in determining a patient's level of satisfaction with their care based upon the Donabedian (1980) quality of care model. The coding was based on the findings and the themes that emerged and were somewhat different from the initial expectations. This is a common feature of research and it is an expected part of the research process.

The themes that emerged were (1) clinical effectiveness, (2) structure of care (accessibility to health care), and (3) outcomes of care (patient satisfaction). Within the domain of the three main codes, five sub-codes were identified: (1) doctor skills as a process of care, (2) nurse skills as process, (3) information exchange as process, (4) service organisation as structure of care, and (5) general patient satisfaction as an outcome of care.

However, it is argued that a credible code must capture the qualitative richness of the phenomena (Boyatzis 1998). Therefore, codes were identified by label, definition of what the theme concerns, and a description of when the themes occurred. Table 3.5 provides an example of the coding manual that was developed.

<b>Code 1</b>	<b>Definition</b>	<b>Description</b>
<b>Label: Process of Care</b>	Clinical effectiveness	doctors'/nurses' interpersonal skills technical skills information provision availability information exchange
<b>Code 2</b>	<b>Definition</b>	<b>Description</b>
<b>Label: Structure of Care</b>	Accessibility to health care service organisation	hospital environment access to department medical personnel attitudes lab services admission services
<b>Code 3</b>	<b>Definition</b>	<b>Description</b>
<b>Label: Outcome of Care</b>	Patient satisfaction	general patient satisfaction during hospital stay

**TABLE 3. 5 : A-PRIORI CODING DEVELOPED FROM TEMPLATES RELATED TO PATIENT SATISFACTION**

In applying a NVIVO computer-assisted method in qualitative data analysis, I coded the interview data based on initial key topics in the coding manual. NVIVO was used to import data from the MS-Word processing package into it (Morrison and Moir 1998; Richards 1999). Further use of NVIVO makes it possible to determine coding stripes from the margins of the document, an aspect that made it possible to determine which code had been used at which point.

However, computer-based data analysis and coding were implemented with full knowledge of the limitations of computer-assisted coding methods (Bourdon 2002). For example, there are concerns that use of computer-assisted methods may result in 'guiding' the researcher only in a particular direction. This disadvantage occurs due to the capacity of computer-assisted methods to create a sense of detachment from the actual data (Bazeley and Jackson 2013). Despite these limitations and critiques, computer-assisted methods promote accuracy and transparency in the data organisation processes.

Within the NVIVO software, the creation of codes is achieved through use of free nodes present in the navigation view window or by using the 'create and analyse' tab that is located in the ribbon of commands (Richards 2009). For example, interview data related to clinical effectiveness generated 32 free nodes. If a new code was identified, I re-read the annotated extracts from interviews to ensure the new codes were appropriate to textual data. Thus, I repeatedly reviewed and refined the coding manual before I generated the final coding framework.

### *Stage 2: Testing codes reliability*

In order to achieve coding reliability, it is recommended that two or more researchers individually code an interview transcript, rather than relying on single researcher (Stewart et al. 2007). Therefore, I checked the coding framework with my supervisors and compared it with the interview data. Overall, agreement of coding was high, and the few minor issues were discussed and resolved before proceeding to the actual analysis.

### *Stage 3: Summarising data and identifying initial themes*

Summarising the data was achieved through repeatedly reading and re-reading the raw data and outlining key points in relation to the questions I asked during interviews. Table 3.6 demonstrates the process of summarising data.

Research Question	Summary of Responses
Doctor communication aspects	listening, psychological support, kindness, information about illness progress, understanding and responsiveness were important aspects of communication to participants

**TABLE3. 6 : EXAMPLE OF THE PROCESS OF SUMMARISING DATA**

### *Stage 4: Applying template of codes and additional coding*

The template of codes was applied to facilitate the template analytic technique, as suggested by (Crabtree and Miller 1999). The coding manual was used to ensure systemic application and to identify the important sections in the text. All the codes from the coding manual were entered into the NVIVO software as free nodes. From this basic structure, the free nodes were organised and categorised according to four groups of data: (1) clinical effectiveness of doctors (2) clinical effectiveness of nurses (3) accessibility to health care and (4) patient satisfaction as outcome of care. Table 3.7 demonstrates the method of coding the three data sets by applying codes from the coding manual.

<b>Name of theory-driven code</b>	<b>Care Assessment Based Model: (Donabedian 1982)</b>
<b>Explanation of Code</b>	process of care (clinical effectiveness of doctors and nurses), structure of care (accessibility), outcomes of care (patient satisfaction)
<b>Clinical Effectiveness (Doctors' Skills )</b>	psychological support, availability, and information regarding illness prognosis
<b>Clinical Effectiveness (Nurses' Skills )</b>	caring, technical skills, patient centred care
<b>Accessibility of Health Care (Service Organisation)</b>	friendly hospital environment preferred, waiting times for admission needs to be considered
<b>Outcome of care (general satisfaction)</b>	Generally, patients were satisfied with care while simultaneously having concerns regarding provided care

**TABLE3. 7 : DEDUCTIVE CODING**

Data analysis was not only guided by the coding manual, but also involved inductive coding from annotated extracts that identified new themes (Boyatzis 1998). For example, the concept of power dynamics of doctors that affect patient satisfaction emerged from data during the coding of the clinical effectiveness (doctor skills). An example of this is provided in Table 3.8.

<b>Name of data driven code</b>	<b>Power dynamic in doctor communication</b>
<b>Explanation of code</b>	the perception of doctors as ultimate figures of authority over health in the KSA
<b>Perception of doctors</b>	Perceived as too busy or rushed, unapproachable and as failing to consider psychological status of patient

**TABLE3. 8: EXAMPLE OF INDUCTIVE CODING**

### *Stage 5: Connecting the codes and identifying themes*

The process of connecting codes is critical for discovering themes which identify a pattern in the data to describe the observations and then interpret features of the phenomena (Boyatzis 1998; Crabtree and Miller 1999). By connecting similar free nodes, themes were identified and similarities and differences between sets of data were found at this stage, which indicated areas of relevance to the research questions. Additionally, themes started to cluster within the differences identified between the views of participants regarding varying situations. For example, Table 3.9 shows the process of connecting the codes and identifying themes.

Clinical Effectiveness (Doctors/Nurses)	Factors related to doctor skills:	Factor related to nurses skills
	Psychological support by doctors	Time devoted by nurses
	Information provision about illness	Nurses' language barriers
		Psychological support provided by nurses
Accessibility	Impact of settings (single versus shared room) on patient satisfaction	
	Delay in admission services affects patient satisfaction	
General Satisfaction	Patients are generally satisfied with provided care	
Contextual Factors	Power dynamic in doctor-patient communication	
	Multicultural environment (effects of nurses)	
	Role of religion in affecting patient satisfaction	
	Role of family in affecting patient satisfaction	

**TABLE 3. 9 : THE PROCESS OF CONNECTING THE CODES AND IDENTIFYING THEMES**

### *Stage 6: Corroborating and legitimating coded themes*

In this final stage, it was important to confirm the findings by ensuring that the themes identified were representative of the original data (Crabtree and Miller 1999; Fereday and Muir-Cochrane 2006). Before the analysis moved to the interpretative stage, in which the themes were connected to the explanatory framework, the clustered themes that were identified from the previous stage were reviewed in order to check if they captured key aspects of the phenomena. Also, re-reading the text from original extracts helped to illuminate agreements and disagreements in views between segments of data. Further, the analysis tools in NVIVO, such as queries, text searches, and models, were used to develop the analytical process. Thus, the patterns of meaning, similarities, and differences could be explored and set out. Lastly, core themes that captured the phenomena of patient satisfaction in an oncology ward setting in the KSA were identified. The qualitative findings, including all identified core themes that related to the aspects of patient satisfaction as phenomena, are presented in chapter 5.

## **3.6 Ethical considerations**

### **3.6.1 Informed consent**

It was essential that patients understood that participation in the study was voluntary, and that declining to participate did not mean that they would be disadvantaged in any way regarding their health care provision (Parahoo 2006). All willing patients were asked by the nurse educator to sign a consent form (see Appendix 7), and were provided with an explanation of the study and a participant information sheet (see Appendix 6), to enable them to make an informed choice about participation. Informed consent was also required from those patients willing to participate in the follow-up interview. I contacted participants by phone to appraise them of the possibility of the interview and to discuss with them participation issues.



### **3.6.2 Anonymity and Confidentiality**

The identity of participants was protected in the study through complete data anonymity and confidentiality (Polit and Hungler 2001). Patients and their associated results were assigned study identification numbers, and participants' answers, records, notes of interviews, and completed questionnaires were kept confidential in a locked cabinet during the study. Data was only shared with my PhD supervisors, and participants were not identifiable at any stage.

### **3.6.3 Data protection**

To ensure adherence to legal requirements (Data Protection Act 1998) and ethical guidelines, I ensured data protection by keeping all data in a secured cabinet. Following completion of my study, these will be stored in the Archive Section of the University of Stirling for ten years.

### **3.6.4 Cultural and Linguistic Barriers**

Sand et al. (2007) noted that it is important that the researcher be fully aware of the barriers that can affect their research, and, where possible, take preventative actions. One important potential barrier in this research was the form of Arabic used in the KSA. All correspondence, including the patient consent form, information sheet, and letter of approval from the University of Stirling, were translated into Arabic, reviewed by the authorities at the SRCC in Riyadh, and the translation was officially verified. This process of approval took some weeks to complete, and was longer than anticipated and had a bearing on the timings of the study.

An important cultural barrier to consider was that some women who are diagnosed with cancer in the KSA may be influenced by the involvement of a male guardian, as discussed previously. To obtain consent from such women (Rashad et al. 2004; Walker 2009) required having to fully explain the study to the male guardian, which could have adversely affected the woman's decision to participate. The implications of these socio-cultural issues conflicted ethically with, and would be contrary to, the UK guidelines on good clinical research practice (GCRP) (Medical Research Council, 1998). A further problem in this regard was the inconvenience of having to ensure the availability of a suitable male guardian. However, I didn't face this issue during interviews.

### **3.6.5 Potential Distress**

McIlfatrick et al. (2006) point out that non-maleficence, justice, and respect for human dignity are the guiding principles for interacting with the vulnerable, and that a researcher's well-developed sense of reflectivity should go some way to mitigate problems arising. For this reason, consideration was given to the health status of patients throughout the study. For example, those who participated in Phase 1 of the study were first judged to be well enough by gatekeepers such as the nurse educator before being asked to proceed with the interview in Phase 2. I was fortunate in being able to liaise with oncology staff and the attending physician, and this helped to inform my decisions regarding patient vulnerability. I was also vigilant to detect any sign of patient distress becoming apparent during the study participation. Had this happened, I would have immediately considered withdrawing patients to protect them from any exacerbation of their already poor health. In practice, during the conduct of the study, there were no instances of patient distress, and no evidence of any adverse impact of the research on any participant, hence there was no need to consider any withdrawal.

### **3.6.6 Researcher Skills and Resources**

Appropriate skills for implementing both quantitative and qualitative data collection and analysis were required in the study, thus I attended a wide range of university courses during my PhD studies. Further training in the use of SPSS software was also undertaken. For the qualitative phase of the study, I attended the University of Stirling NVIVO training program. Other skills which I developed during the research years included managing electronic databases and, English being my second language, I tried to improve my academic writing. Workshops in these areas were attended during the course of my study.

As a native Saudi, I had good understanding of potential socio-cultural barriers which might arise during interviews. I was also able to communicate with the patients in their mother tongue which was convenient and practical. These positive aspects of my skills helped me build a rapport with the patients, and also helped enhance their trust in me and their willingness to share their views. Potential negative aspects were related to my inexperience in conducting formal interviews, although certainly my

experience as a nurse had helped develop skills for interviewing patients which was transferable to the more formal research setting. To overcome any potential difficulties and to address my novice interviewer status, I practised my interview technique through workshops and through guidance and encouragement from my supervisors, from whom I learned techniques for ensuring there was consistent focus on relevant areas of enquiry. Developing an interview schedule also kept me focused.

As I was an oncology nurse prior to beginning my PhD, I was more comfortable in the oncology setting than someone who had no experience in such an environment. This allowed me to interact and communicate with patients very successfully when seeking interviews. Furthermore, it allowed me to create an informal and relaxed atmosphere for the interviews.

However, interacting with cancer patients as a former nurse is different from studying them. In the interviews, it could be argued that I was interacting with them as much in my familiar role as a nurse as I was acting as a detached researcher. This could have led to potential bias in the data collected, although in many respects the model of the fully objective and detached researcher is not sustainable in the context of informal and semi-structured qualitative interviews. I had to work hard to establish a rapport with the participants, despite my previous experience.

### **3.7 Chapter Summary**

This chapter has provided an overview of the research design and a theoretical rationale for its use. The study employed a mixed methods approach in the form of an explanatory sequential design to complement the quantitative and qualitative nature of the research aims.

The research was divided into two phases: Phase 1 made use of a quantitative method, which involved conducting a cross-sectional survey of the satisfaction levels of adult oncology inpatients in the SRCC at Riyadh. Phase 2 focused on the qualitative aspects of the study, including the semi-structured interviews that were carried out with adult oncology inpatients who had answered the initial questionnaire.

The chapter also identified patient recruitment issues and data collection methods, including the sampling technique and data analysis used for each phase. It also highlighted the ethical issues behind this study. The findings for both phases of this mixed methods study are presented in the following two chapters.

## Chapter 4 Quantitative Results

### 4.1 Introduction

The quantitative research questionnaire was designed to address SRQ1-3 reproduced here for reference:

SRQ1: What are the socio-demographic characteristics of adult oncology inpatients at the SRCC in Riyadh?

SRQ2: Does the clinical effectiveness of health care (doctors' and nurses' skills, information provision, availability) influence adult oncology inpatients' satisfaction with care at the SRCC in Riyadh?

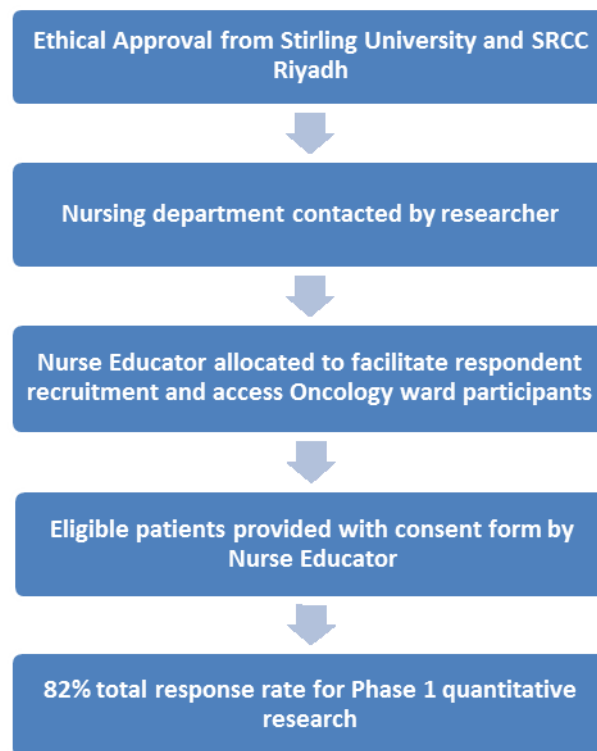
SRQ3: Does accessibility to health care (service organisation) influence adult oncology inpatients' satisfaction with care at the SRCC in Riyadh?

This chapter presents the results of the analysis of survey data collected using a structured questionnaire (EORCT, IN-PATSAT32) to assess the satisfaction of cancer patients in an oncology ward settings. The variables measured together with patient overall satisfaction included: socio-demographic characteristics, clinical effectiveness of doctors and nurses (skills of doctors and nurses, availability and access to information by patients), and accessibility to health care (services and care organisation) by patients.

Individual questions within the questionnaire are summarised together with its 14 derived sub-scales. These sub-scales are also cross tabulated against overall satisfaction in order to determine which are the most influential for the patient.

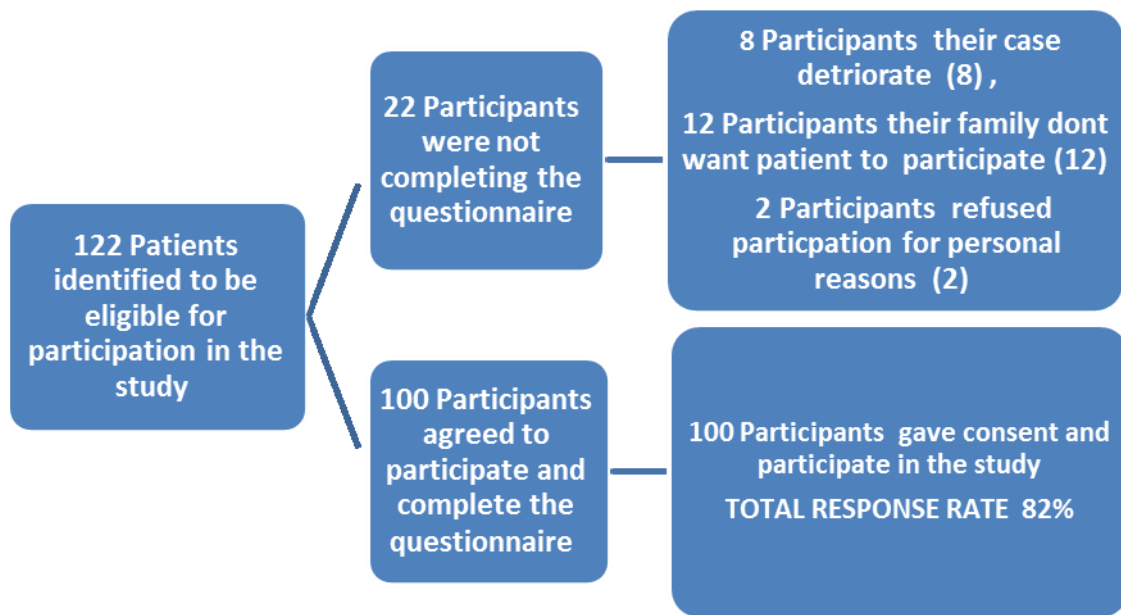
#### 4.1.1 Missing Data and Response Rate

The quantitative data collection process is outlined below in Figure 9:



**FIGURE 9 - FLOW CHART OF QUANTITATIVE DATA COLLECTION PROCESS**

Figure 10 indicates the response rate for the questionnaire among inpatients at the SRCC in Riyadh. As demonstrated, of the 122 patients who were eligible for the study, 100 agreed to participate – and of those who agreed a 100% response rate can be evidenced. The total response rate from among all eligible inpatients at the SRCC is 82%. The reasons for non-response are noted in Figure10.



**FIGURE 10 - BREAKDOWN OF PATIENT PARTICIPATION**

## **4.2 Socio-Demographic Distribution of Adult Oncology Patients (SRQ1)**

This section illustrates the distribution of respondents in regards to their gender, age, educational level, marital status, and residency location. The sample consisted of cancer patients from Oncology ward settings in Riyadh ( $N=100$ ). These data are summarised in Table 4.1 and show that the majority of respondents were female (58%). Patients spanned all age ranges from 18-25 years to over 75 years, but the majority fell within the younger age groups, being less than 45 years (52%). The largest percentage of patients were married (65%), with only 21% single. Most of the respondents had high levels of education (high school or university) (54%) and resided outside of Riyadh (56%).

		Respondents (%) [N=100]
Gender	Male	42
	Female	58
Age Group	18 - 25 years	17
	26 - 35 years	17
	36 - 45 years	18
	46 - 55 years	25
	56 – 65 years	12
	66 -75 years	8
	>75 years	3
Marital Status	Single	21
	Married	65
	Divorced	4
	Widowed	10
Education Level	Illiterate	10
	Primary	19
	Intermediate	17
	High school	26
	University or above	28
Residence	Riyadh	44
	Outside Riyadh	56

**TABLE4. 1 DISTRIBUTION OF RESPONDENTS' GENDER, AGE, EDUCATION, MARITAL STATUS & HOME (N=100)**

### **4.3 Quantitative Metrics of Clinical Effectiveness (SRQ2)**

Initially, these quantitative results will address SRQ2's requirement to explore the impact of 'clinical effectiveness' upon patient satisfaction in the SRCC. The following set of questions was used to capture doctors and nurses effectiveness. The questions under each of these headings were grouped into the following four categories (Table 4.2):



Clinical Effectiveness of Doctors	Clinical Effectiveness of Nurses
Technical Skills (Q1-3)	Technical Skills (Q12-14)
Interpersonal Skills (Q4-6)	Interpersonal Skills (Q15-17)
Information Provision (Q7-9)	Information Provision (Q18-20)
Availability (Q10-11)	Availability (Q21-22)

**TABLE4. 2: DIFFERENTIAL MEASUREMENT OF THE EFFECTIVENESS OF DOCTORS AND NURSES**

The respondents' views on the clinical effectiveness of doctors and nurses are discussed in this section. Overall, these results indicate broad patient satisfaction with the technical and interpersonal skills, information provision, and availability of the doctors and nurses during their hospital stay in Oncology wards in Riyadh.

As shown in Table 4.3, respondents were most satisfied (scored excellent) with the doctor's knowledge of illness (65%) and their treatment and medical follow-up (65%). Fewer respondents scored excellent with the availability of doctors. Only 47% of them scored excellent for visitation time and 43% for the frequency of doctor's visits. For these latter two questions, four patients rated each of these aspects as poor and four as only fair.

Almost all of the respondents were satisfied with the nurse's physical examination, scoring it as very good or excellent (94%). However, other technical skills (attention to comfort and care handling) only ranged from 84 to 81%, respectively. The majority of patients were satisfied (scoring very good or excellent) with the nurse's human quality (88%), but fewer were satisfied with their other interpersonal skills (74-80%). In terms of information provision, more respondents expressed satisfaction (very good or excellent) with the nurse's information about treatment (82%). Overall, respondents were least satisfied with the availability of nurses with only 74% of respondents scored very good/excellent for buzzer promptness and time devoted to patient (See Table 4.3).

	Poor	Fair	Good	Very. Good	Excellent
<b>Doctor's Clinical Effectiveness</b>					
Doctor's Technical Skills					
Knowledge and experience	2	1	10	22	65
Treatment and medical follow-up	0	2	9	24	65
Attention to physical problems	2	1	16	34	47
Doctor's Interpersonal Skills					
Willingness to listen	3	4	9	32	52
Interest in you personally	2	2	11	30	55
Comfort and support given	1	2	8	29	60
Doctor's Information Provision					
Information about illness	0	4	11	31	54
Information about medical test	2	3	11	35	49
Information about treatment	1	4	10	27	58
Doctor's Availability					
Frequency of visits/consultations	4	2	15	36	43
Time devoted in visits/consultations	4	4	15	30	47
<b>Nurse's Clinical Effectiveness</b>					
Nurse's Technical Skills					
Carrying out physical examination	0	0	6	22	72
Handling of care	2	3	11	27	57
Attention to physical comfort	1	6	12	25	56
Nurse's Interpersonal Skills					
Interest showed in you personally	0	6	20	29	45
Comfort and support given	2	4	14	33	47
Human quality	2	0	10	29	59
Nurse's Information Provision					
Information about medical tests	3	5	17	32	43
Information about care	2	5	15	37	41
Information about treatment	1	5	12	34	48
Nurse's Availability					
Buzzer promptness	3	3	20	33	41
Devoted time	3	4	19	33	41

**TABLE4. 3: RESPONDENTS' VIEW OF CLINICAL EFFECTIVENESS (N=100 PATIENTS)**

#### 4.4 Impact of Service Organisation on Patient Satisfaction (SRQ3)

Respondents were asked to rate other hospital services and care provided by the organisation as a whole. The main categories of other services and care organisation analysed were: Exchange of information between caregivers, other personal interpersonal skills and information provision, waiting time, accessibility and comfort (physical environment of hospital).

	Poor	Fair	Good	V. Good	Excellent
<b>Other Service and Care</b>					
Exchange of information	1	3	13	36	47
Kindness and helpfulness of technical staff	0	4	12	29	55
Information provided on admission to hospital	3	1	15	32	49
Information provided on discharge hospital	1	3	10	34	52
Waiting time for results of medical test	7	7	18	39	29
Speed of implementing medical tests/treatment	6	7	17	32	38
Ease of access	11	8	20	27	34
Ease of finding different departments	5	4	26	31	34
Hospital Environment	2	2	11	26	59

**TABLE 4.4: RESPONDENTS' VIEW OF SERVICE AND CARE ORGANISATION (N=100 PATIENTS)**

As shown in Table 4.4, the respondents were more satisfied (scoring very good/excellent) with discharge information provision (86%) and hospital environment (85%). Respondents were less satisfied with the waiting time for medical test (68%), speed of treatment (70%), and department access (65%). Only 62% of them were satisfied with parking accessibility to the Oncology ward (parking or means of transport), with 11% scoring this aspect as poor and 8% as only fair.

## 4.5 Patient Satisfaction

In order to capture patients' overall satisfaction, patients were asked to rate the general level of healthcare received during their stay in the Oncology ward as excellent, very good, good, fair or poor. Most patients reported that they received excellent healthcare (52%). This was followed by very good (34%) and good (12%). Only one patient recorded their healthcare as fair and another as poor (Table 4.5).

		Respondents (%) [N=100]
Overall Satisfaction	Excellent	52
	Very Good	34
	Good	12
	Fair	1
	Poor	1

**TABLE4. 5 : DISTRIBUTION OF RESPONDENTS OVERALL SATISFACTION**

To further analyse patients' overall satisfaction, cross-tabulations using each socio-demographic characteristic were also performed (Table 4.6). The results showed that more male respondents (55%) recorded excellent care, compared to females (50%). Patients in the older age groups were also more satisfied with their care than those in the younger groups. The lowest satisfaction was seen in the 18-25 years, with 71% recording very good or excellent compared to 84% in the 46-55 years group and 100% in the 56-65 years group and above. More married patients (88%) recorded scores of very good or excellent compare to single patients (76%) and more respondents who were resident in Riyadh (55%) recorded excellent care, compared to those living outside (50%). In terms of level of education, lower levels of satisfaction (scores of excellence) were seen for respondents with primary (42%), high school (38%) or university (46%) education when compared to those who were illiterate (80%) or with an intermediate level (76%).

		Overall Satisfaction = N (%)				
		Poor [N=1]	Fair [N=11]	Good [N=12]	Very Good [N=34]	Excellent [N=52]
<b>Gender</b>	Male [N=42]	0	0	6 (14%)	13 (31%)	23 ((55%)
	Female [N=58]	1 (2%)	1 (2%)	6 (10%)	21 (36%)	29 (50%)
<b>Age</b>	18-25 [N=17]	0	1 (6%)	4 (24%)	3 (18%)	9 (53%)
	26-35 [N=17]	0	0	2 (12%)	7 (41%)	8 (47%)
	36-45 [N=18]	0	0	3 (17%)	8 (44%)	7 (39%)
	46-55 [N=25]	1 (4%)	0	3 (12%)	7 (28%)	14 (56%)
	56-65 [N=12]	0	0	0	4 (33%)	8 (67%)
	66-75 [N=8]	0	0	0	3 (38%)	5 (63%)
	>75 [N=3]	0	0	0	2 (67%)	1 (33%)
<b>Marital Status</b>	Single [N=21]	0	1 (5%)	4 (19%)	5 (24%)	11 (52%)
	Married [N=65]	0	0	8 (12%)	24 (37%)	33 (51%)
	Divorced [N=4]	0	0	0	2 (50%)	2 (50%)
	Widowed [N=10]	1 (10%)	0	0	3 (30%)	6 (60%)
<b>Education</b>	Illiterate [N=10]	0	0	0	2 (20%)	8 (80%)
	Primary [N=9]	1 (5%)	0	3 (16%)	7 (37%)	8 (42%)
	Intermediate [N=17]	0	0	0	4 (24%)	13 (76%)
	High School [N=6]	0	0	5 (19%)	11 (42%)	10 (38%)
<b>Residence</b>	University [N=28]	0	1 (4%)	4 (14%)	10 (36%)	13 (46%)
	Riyadh [N=44]	1 (2%)	0	4 (9%)	15 (34%)	24 (55%)
	Outside Riyadh [N=56]	0	1 (1%)	8 (14%)	19 *34%)	28 (50%)

**TABLE4. 6: CROSS-TABULATION OF GENDER, AGE, MARITAL STATUS, EDUCATION AND HOME VERSUS PATIENT SATISFACTION**

## **4.6 Extent of Sub-Scale Impact upon Satisfaction**

### **4.6.1 Descriptive Summaries**

Scores for each of the fourteen sub-scales of the questionnaire (outlined in Table 4.3, Table 4.4) were determined for each patient. The mean score for each subscale was then determined (Table 4.7).

Results showed that the highest mean sub-scales scores were obtained for technical skills (88.1 doctors and 88.6 nurses), doctor's interpersonal skills (87.0) and comfort based on assessment of the hospital environment (87.6). Sub-scales with the lowest scores were accessibility of hospital (75.0), waiting times (76.5) and availability of staff (82.4 for doctors and 81.1 for nurses).

	Mean	Std.D (SD)	Median	Range
Doctor's technical skills	88,13	14.605	93.33	<b>26.7 – 100</b>
Doctor's interpersonal skills	87.00	15.319	93.33	<b>33.3 – 100</b>
Doctor's information provision	86.53	15.512	93.33	<b>33.3 – 100</b>
Doctor's availability	82.40	18.374	90.00	<b>20.0 – 100</b>
Nurse's technical skills	88.60	14.159	93.33	<b>33.3 – 100</b>
Nurse's interpersonal skills	85.00	16.531	86.67	<b>26.7 – 100</b>
Nurse's information provision	82.67	17.702	86.67	<b>20.0 – 100</b>
Nurse's availability	81.10	18.472	80.00	<b>20.0 – 100</b>
Exchange of information between caregivers	85.00	17.379	80.00	<b>20.0 – 100</b>
Other personal interpersonal skills and information provision	86.07	15.573	86.67	<b>26.7 – 100</b>
Waiting time	76.50	21.195	80.00	<b>20.0 – 100</b>
Accessibility	75.00	22.496	80.00	<b>20.0 – 100</b>
Comfort (physical environment of hospital)	87.60	18.153	100.00	<b>20.0 – 100</b>
Overall Satisfaction	87.00	16.175	100.00	<b>20.0 – 100</b>

**TABLE4. 7: DESCRIPTIVE STATISTICS OF EORTC IN-PATSAT32 SUB-SCALES**

When these data were further stratified by overall satisfaction with care received in hospital, patients who rates their overall care as poor/fair or good (N=14), had the lowest scores for all the fourteen subscales of the questionnaire, indicating that these all factors are influential in the determination of general satisfaction for the patient (Table 4.8).

	Overall Satisfaction			
	Mean [N=100]	Poor, Fair, Good [N=14]	Very Good [N=34]	Excellent [N=52]
Doctor's technical skills	88.13	71.90	84.90	94.62
Doctor's interpersonal skills	87.00	70.00	82.75	94.36
Doctor's information provision	86.53	68.10	81.96	94.49
Doctor's availability	82.40	62.14	75.29	92.50
Nurse's technical skills	88.60	70.00	86.27	95.13
Nurse's interpersonal skills	85.00	63.81	81.18	93.21
Nurse's information provision	82.67	61.43	78.43	91.15
Nurse's availability	81.10	59.29	77.65	89.23
Exchange of information between caregivers	85.00	70.00	79.41	92.69
Other personal interpersonal skills and information provision	86.07	70.48	82.35	92.69
Waiting time	76.50	53.57	71.18	86.15
Accessibility	75.00	49.29	70.29	85.00
Comfort (physical environment of hospital)	87.60	67.14	81.76	96.92

**TABLE4. 8 : DESCRIPTIVE STATISTICS OF EORTC IN-PATSAT32 SUB-SCALES, STRATIFIED BY OVERALL SATISFACTION**

## 4.7 Summary of Key Results

Data quality was important in assuring the reliability and validity of the results. The data was collected from a sample of participants that were all patients in oncology wards. To establish the measurement of various satisfaction items, the Arabic pilot version of the validated EORTC IN-PATSAT32 survey was administered to the



participants. No data losses were recorded as all 100 participants responded to every question.

Generally, most respondents' satisfaction level with the services received was very high, with 86% reporting very good or excellent care during their stay in hospital. These results support previous findings mentioned in the literature review that high scores are usually reported in patient satisfaction surveys.

The study showed that more male respondents (55%) recorded excellent care, compared to females (50%). Patients in the older age groups were also more satisfied with their care than those in the younger group and more married patients (88%) recorded scores of very good or excellent compare to single patients (76%) and more respondents who were resident in Riyadh (55%) recorded excellent care, compared to those living outside (50%). In terms of level of education, lower levels of satisfaction (scores of excellent) were seen for respondents with primary (42%), high school (38%) or university (46%) education when compared to those who were illiterate (80%) or with an intermediate level (76%).

Scores for each of the fourteen sub-scales of the questionnaire were also examined and results showed that the highest mean sub-scales scores were obtained for technical skills (88.1 doctors and 88.6 nurses), doctor's interpersonal skills (87.0) and comfort based on assessment of the hospital environment (87.6). Sub-scales with the lowest scores were accessibility of hospital (75.0), waiting times (76.5) and availability of staff (82.4 for doctors and 81.1 for nurses).

When these data were further stratified by overall satisfaction with care received in hospital, patients who rates their overall care as poor/fair or good (N=14), had the lowest scores for all the fourteen subscales of the questionnaire, indicating that these clinical effectiveness of doctors and nurses and service organisation factors are influential in the determination of general satisfaction for the patient. These identified factors may assist future research on patient satisfaction in a KSA oncology ward settings.

## **Chapter 5 - Qualitative Findings**

### **5.1 Introduction**

This chapter explores the qualitative research conducted under Phase 2 of the research detailed in the methodology of Chapter 3. It is focussed principally on addressing two key sub-research questions, noted here:

SRQ4: How do interpersonal aspects of care influence adult oncology inpatients' satisfaction with care at the SRCC in Riyadh?

SRQ5: How do socio-cultural communication factors influence adult oncology inpatients' satisfaction with care at the SRCC in Riyadh?

Notably, however, a number of responses relating to service organisation came out of the interview process. These relate mainly to SRQ3 (as explored previously in Chapter 4), and are thus discussed here, following analysis of SRQ4 and SRQ5.

A number of central factors impacting upon patient satisfaction have been identified in the research. This chapter presents each of these thematically, with relevant examples from the translated, and non-verbatim, interview extracts. These interview extracts were selected based on the coding process and also to represent the wide range of participants' views. Commentary is provided to link these findings with the literature, where appropriate, and also to highlight any similarities and differences between participants' responses.

### **5.2 Socio-Demographic Contextualisation of Research Sample**

Initially, it is important to examine the sample within the wider context of cancer patients in the KSA, and the structure of the sample as distinct from Phase 1 of the research. The socio-demographic details of the participants in Phase 2 of the research are presented in Table 5.1. This outlines key socio-demographic indicators including participant age, gender, education level, marital status and place of residence.

There are evident limitations with this sample regarding the extrapolation of the research findings. Most predominant among these is the limited gender diversification evidenced from the sample of 22 participants. Based on Table 5.1, of the 22 participants only three were male. This is evidently not representative of the wider sample collected through quantitative research in Chapter 4. Although the gender balance was also uneven in the quantitative sample (58% female), the qualitative participants demonstrate a great gender imbalance. This does limit the potential extrapolation of qualitative research to demonstrate differences from the male sample.

Age	Gender	Education	Marital status	Residency
36-45Y	Female	High school	Married	Riyadh
46-55Y	Female	Primary	Married	Riyadh
36-45Y	Female	High school	Married	Riyadh
26-35Y	Female	University	Married	Outside Riyadh
36-45Y	Female	High School	Divorced	Riyadh
36-45Y	Male	Intermediate	Married	Outside Riyadh
18-25Y	Female	Intermediate	Single	Outside Riyadh
26-35Y	Female	High School	Married	Outside Riyadh
36-45Y	Female	Illiterate	Married	Outside Riyadh
36-45Y	Female	High School	Married	Outside Riyadh
66-75Y	Male	Primary	Married	Riyadh
46-55Y	Female	Primary	Widowed	Riyadh
46-55Y	Female	University	Married	Riyadh
56-65Y	Female	Intermediate	Widowed	Riyadh
46-55Y	Male	Intermediate	Married	Riyadh
46-55Y	Female	Intermediate	Married	Outside Riyadh
46-55Y	Female	University	Married	Outside Riyadh
36-45Y	Female	University	Married	Outside Riyadh
26-35Y	Female	High school	Single	Outside Riyadh
Above 76Y	Female	Primary	Married	Outside Riyadh
18-25Y	Female	High school	Single	Outside Riyadh
36-45Y	Female	University	Married	Outside Riyadh

**TABLE5. 1: SOCIO-DEMOGRAPHIC CHARACTERISTICS OF QUALITATIVE SAMPLE**

The study garnered three male respondents (36-45, 46-55 & 66-75 years old), the remaining 19 participants were females of varied age, marital status, and education level. The median age of females within the sample was 36-45 years old. This high proportion of younger people (<45 years) was due to the largely self-selecting aspect

of this part of the research, since the choice of interviews was based on those who volunteered. This may have made the sample unrepresentative of the general target population, since the average median age of the diagnosis of cancer for a man is 58 years of age and 51 for women, in 2010 ( Saudi Cancer Registry 2010). The age of the sample is therefore not reflective of wider oncology patient trends in the KSA. The sample remains robust within the research question outlined, however, as the methodology was designed to assess perceptions of patient satisfaction in a limited sample of one oncology centre. The rationale limiting the study to this context was explored in Chapter 3, and developed from the principles of factors influencing patient experience (Reimann and Strech 2010) as outlined in Chapter 1. The subjective nature of participant expectations and experience, which necessarily differ between wards with unique levels of clinical effectiveness, therefore validate the single-centre locus of this research.

The male sample is also limited in relation to education as a contextualising factor. Here the three participants had only received relatively low levels of education (intermediate and primary). The female sample, by contrast, presented more diversified results. A majority of the participants (7) had attained a high school level education, while the remaining were dispersed with three primary, three intermediate, and five university level education amongst the participating females. This reflects a broad span of education levels similarly reflected in the quantitative analysis (Table 4.1) and is relatively proportionate with the results evidenced in Phase 1.

Marital status is similarly reflective of the proportions of results evidenced in Phase 1 of the study. Of the female participants 13 were married, 3 were single, 2 were widowed and one was divorced. All of the male respondents were married, and this is to be expected with 65% of the total quantitative sample presenting this status.

One final observation regarding the contextualisation of the sample in relation to the quantitative study of Phase 1 can be made regarding residential location. Two of the male respondents lived in Riyadh while one male respondent lived outside of Riyadh. A majority of the female participants, however, resided outside of Riyadh (11). This is a slightly higher proportion than presented in Phase 1's results.

The qualitative sample does present some limitations. This is particularly relevant regarding the lack of gender diversification among the sample. The research questions, however, do not require an analysis of gender to differentiate patient satisfaction. While it is recognised that this is a key component of socio-demographic factors impacting upon patient expectation, from which trends regarding divergence in patient experience could be extrapolated, the nature of the research is limited to one single oncology centre (SRCC). The sample provides an accurate representation of those consenting to partake in the study. As evidenced in Chapter 3, the sample required self-selection, and as such the quality of the data attained is high and reliable. The strengths and limitations of the research are integrated throughout this section, and reflected in the overall results.

### 5.3 Key Themes from Qualitative Research

The four primary themes identified from interview data are shown in Table 5.2 and are discussed in the sub-sections. The following sections will address these core themes by their relevant SRQ. As Table 5.2 demonstrates, the findings from Phase 2 of the research have particular relevance to SRQ3, initially examined during Phase 1, especially with regards service organisation. The results from Phase 2, taken cumulatively, also have implications for the impact of perceived clinical effectiveness upon patient satisfaction. This element is expounded in greater detail in Chapter 6.

Relevant SRQ	Themes	Subthemes
SRQ4 – Interpersonal	Doctor-Patient Relationship	Non-Disclosure, Listening skills, Information provision, Motivation, Care and Compassion
	Nurse-Patient Relationship	Clinical effectiveness: the role of nurses within the service organisation, Technical competence, Interpersonal skills, Care and Compassion, Availability
SRQ5 – Socio-Cultural Factors	Contextual factors of Cancer in the KSA	Perception of cancer Power dynamic of KSA doctor Religious influence Family influence Impact of multi-cultural environment on nurses
SRQ3 –Service Organisation	Service Organisation	Overarching assessment of general service organisation Accessibility Waiting times for services

**TABLE5. 2 : KEY THEMES FROM QUALITATIVE RESEARCH**

## **5.4 Impact of Interpersonal Aspects of Care on Patient Satisfaction (SRQ4)**

Initially, it is important to outline the manifold factors impacting upon interpersonal relationships between medical staff and patient, as established by SRQ2. This analysis takes the form of identifying individual relationships, between the participant and doctors and nurses separately, in order to offer a clearer distinction between staff roles. This differentiation is important when assessing clinical effectiveness as noted by SRQ2, and service organisation outlined in SRQ3.

### **5.4.1 The Doctor-Patient Relationship**

The analysis of participants' descriptions of their interactions with their doctors provides insights into the aspects of the doctor-patient relationship that are especially meaningful to the patient and influence their understanding of their experiences and the satisfaction with the care they receive. This section addresses four central factors which impact interpersonal communication as outlined SRQ4. These four central factors can be evidenced from the collated and codified qualitative information and are outlined here:

1. *Listening*: listening to and addressing the patients' questions and concerns
2. *Information provision*: providing adequate information about the patients' conditions and treatments
3. *Motivation*: being encouraging and motivating to the patients
4. *Care and compassion*: being caring and compassionate, with attention to the patients' psychological as well as medical needs.

These factors are outlined and considered next. These are then analysed foregrounding the influence of the local policy of non-disclosure, to demonstrate the practical impact of this policy upon the Doctor-Patient relationship.



#### **5.4.2 Non-Disclosure**

The doctor-patient relationship in KSA is different to the western model. The family often needs to be consulted concerning the doctor's disclosure of information to a patient. Doctors are often required to inform a patient's family of their treatment and health. This means that the doctor-patient relationship is more complex and that a doctor needs to consider the family in their relationship with their patient. Additionally, non-disclosure in the KSA setting is influenced by cultural norms, religious beliefs, and attitudes of the doctors. For example, female patients need to have a male guardian who makes the ultimate decisions regarding their healthcare; this will include deciding between treatment options. Therefore, patient information is disclosed to the male guardian of the patient, which is ultimately against the philosophical and legal context of non-disclosure.

Many patients in the KSA are comfortable with this, because of cultural considerations. However, this particular take on non-disclosure has a significant impact on patient satisfaction and restrains the KSA healthcare delivery from becoming patient-centred. It is possible that since females do not have a participatory role in the delivery of their healthcare they will be less satisfied when compared to male patients. However, although male patients are involved in their healthcare and treatment options, they may not be as satisfied as ultimately the decision for treatment and discussion of patient health status is discussed by the patient's family. The issue of non-disclosure increases patient dissatisfaction owing to their experience with having their health information disclosed to people other than themselves. The additional requirement that treatment decisions are made by family members increases patient discontent with the process further.

It is important to note initially that non-disclosure was not universally accepted by the sample as negatively impacting upon the Doctor-Patient relationship. Fourteen of the twenty-two research participants in the study were positive about their experiences of the doctor-patient relationship. They expressed appreciation and gratitude for their doctors' personal qualities and interpersonal skills, which had clearly contributed to satisfaction with their hospital stay, despite the local non-disclosure requirements that were practiced with all participants. Those reporting positive experiences described

their doctors in terms such as comforting, trustworthy, helpful, kind, co-operative and patient. Participant 2, for example, noted:

*They are so patient and obliging, and dealing with them is easy and comfort(able). (Participant 2)*

Eight participants, however, were critical of some aspect of the doctor-patient relationship. They commented that, although the doctors' medical expertise was of a very high standard, they were lacking in interpersonal skills, including communication skills, kindness, empathy, and compassion. These eight participants were not involved in the decision making stage of their treatment. Crucial care options and information were not disclosed appropriately to patients but was left to the families. In this case, families (as opposed to patients) were consulted by the doctor in regards to the patient treatment options and updates, as required by the local policy of non-disclosure.

In these instances, non-disclosure causes patients to feel that doctors are not communicating with them properly when it comes to disclosing information that aids the patient in decision making in regards to their health. Participant 3, for example, notes:

*They told me about chemotherapy and sent me to the health educator to explain the cycles and side effects, which was good. But the doctors here didn't give the whole treatment plan or future plan to clarify things for me more. (Participant 3)*

Because many families restrict information disclosure this prohibits doctors from disclosing information to some patients, especially females. Doctors often need to consult patients' families on providing information or what should be revealed. This can lead to many patients to not being fully informed of their treatment. In fact, many patients are not aware of this family request and the restrictions that it places upon doctors' level of communication with their patient, especially with regard to the disclosure of treatment plans. This may cause some patients, especially females, to believe that their doctors are poor communicators, while in fact they are only conforming to the families' wishes.

There was no indication that doctors were avoiding contact with these patients. However, in some cases the doctors' communications with their patients were not satisfying experiences. Females and males are treated differently under the non-disclosure arrangements. However, the male participants expressed their opinion that doctors have 'poor communication' and this suggests that some patients perceive their communications with doctors as being unsatisfactory owing to additional factors of poor clinical effectiveness and issues of service organisation. The policy of non-disclosure therefore has a central role to play in examining interpersonal discourse between doctors and patients. The following analysis will address each of the four identified factors central to effective communication, and address the impact of non-disclosure in relation to each.

#### **5.4.3 Listening Skills**

Participants reported that they often had questions and concerns about their illness or treatment, which, if not answered, caused great anxiety and stress. It was important to them to have adequate opportunities to ask their doctor questions or discuss their concerns, and to feel comfortable in doing so. The fourteen participants who mostly expressed satisfaction with the doctor-patient relationship all indicated that their doctors were frequently available to them, encouraged them to ask questions, and provided all the information needed to address their concerns, as the following extracts demonstrate:

*They made me comfortable enough to share my concerns with them and patiently listened to me. They answered each of my queries and cleared my doubts. (Participant 15)*

*They have been very kind and patient. They listen to my concerns and give complete attention to what I say ... They answer all my questions no matter how foolish my questions might sound. (Participant 9)*

The majority of the participants experienced perceived high levels of personal attention from their doctors, providing evidence of listening skills, and indicating that the doctors are addressing the concerns and psychological needs of their patients. This was the case with both males and females and suggested that doctors display

good communication skills despite the limitations imposed upon them by the non-disclosing cultural attitude. Communication involves issues like 'listening' which would not be greatly influenced by any non-disclosure requirements.

In contrast, eight participants reported negative experiences of communicating with their doctors, which they perceived as mainly owing to the doctors' busy routines and limited time for patient conversations. These participants commented that the doctors seemed unwilling to listen to their questions and concerns, or to provide the information being sought. The following extracts demonstrate this, and also highlight the power dynamics implicit in these doctor-patient relationships:

*I ... didn't have the courage to stop them or ask them more as they look busy and just talk quickly during rounds. (Participant 5)*

This participant's concerns and emphasis on his/her own lack of courage convey a state of being afraid to engage doctors in conversation, which may or may not be related to the doctors' actual listening capacity. However, the subsequent observations made by other participants indicate that this listening capacity may be limited, in some cases:

*My talk with them is usually very brief and one sided in which all I had to say was 'yes' or 'no'; they tell and I listen. (Participant 6)*

*The doctors asked me general questions but were never interested in my specific concerns. (Participant 21)*

These comments suggest a power dynamic that is downwards directed from doctor to patient, where the doctor is the one in control of the knowledge that the patients need in order to allay their anxiety. The fact that this anxiety is not adequately listened to, and the knowledge is not shared, highlights an unequal balance of power and control in the patient-doctor relationship here. In particular, the repeated reference to 'fear' and 'courage' demonstrate the distress some participants felt at not being adequately listened to. These findings indicate that at least some of the oncology doctors were of the impression that the participants' concerns are not of interest. Previous research by Jagosh et al. (2011) argues that physician listening

has three very important functions: (1) clinical data gathering, (2) healing and therapeutic value, and (3) building the doctor-patient relationship.

It is unclear from these findings as to whether or not the doctors were actually listening to the concerns of their patients. The results do indicate that some participants felt that they were not being heard. As Ansmann et al. (2013) found, a busy hospital work environment and heavy workload may hinder physicians' ability to adequately support patients and they may feel constrained in communicating with patients because of any non-disclosure arrangements. It must be noted, however, that non-disclosure arrangements are not the sole cause for patient dissatisfaction with the extent to which doctors listen to their patients, and greater interpersonal considerations should be made here when considering the impact this has upon overall patient experience. While non-disclosure limits the extent of information doctors can share with patients, it does not preclude those doctors from listening to patient concerns. As such, these results indicate the impact perceived lack of listening can have upon clinical effectiveness and service organisation. Over-worked doctors, for example, have less time to share with each individual patient's concerns.

#### **5.4.4 Information Provision**

Another consideration raised from the qualitative research results pertains to the sharing of information between doctors and patients. Given the local requirement for non-disclosure this is to be expected, however the relationship between information provision and non-disclosure is more complex in practice than required by the policy in theory.

It should be noted, for example, that most participants reported positive experiences of receiving comprehensive information from their doctors, and noted the calming and reassuring effects that these had on them. The following extracts illustrate this:

*The doctors listened to my queries and clarified my doubts in detail. They took every step to inform me well at the start of treatment and also provided me with relevant information. (Participant 16)*

*I even had some misconceptions about radiology but they clarified the concepts and now I'm not scared of my treatment. (Participant 11)*

These statements would indicate that despite any non-disclosure arrangements in many cases doctors are, in fact, listening to patients and offering them information on their treatment. They are able to clarify a patient's treatments in a general way and in doing so keep patients somewhat informed.

These participants' statements provide a contrast to some of the more negative perceptions of doctors' listening skills described in the previous section. Of particular note here is the frequent referral of participants to their lack of clarity regarding their illness and treatments. However, these findings suggest that some doctors' do attempt to alleviate patients' anxiety regarding the course of their disease and treatment (even if the prognosis itself may not be positive) through adequate information provision.

It did appear that information provision was problematic for some participants; some reported having to wait too long to receive the information they needed. This is to be expected owing the localised requirement of non-disclosure. This was at least partly due to the doctors' busy schedules, and partly due to the hospital protocol arising from policies of the KSA health service, which prevents the nursing staff from providing certain information to patients. As one participant noted:

*I am waiting longer to get information about results from doctors, while nurses can't give me this information until the doctors do their round. This process makes me feel more worried and anxious about my stay. (Participant 5)*

Even though some data showed a positive trend toward taking patient satisfaction into account, participant responses such as these indicate that organisational factors such as hospital policies or procedures can sometimes adversely affect the experience of patients and have a negative impact on patient well-being (Aljubran 2010). The following comments highlight this:

*It's worrisome and irritating to wait so long. Especially for cancer patients, it's even more irritating to wait. I don't like it when hospital management forget about the psychological state of their patients. (Participant 13)*

*I had even requested my oncology team twice to come quickly for the referral visit. They didn't pay any attention and I'm still here waiting for my psychologist session. I feel so dissatisfied and depressed. (Participant 10)*

The stark contrast between these perceptions and those of the participants who were satisfied with the quality and timing of the information they had received conveys high variability in the level of information provision among different doctors. What is also apparent from these extracts is that long waiting times to receive information can substantially increase patients' stress levels. Addressing this issue is important since studies have shown that psychological distress has an impact on cancer mortality (Hamer et al. 2008). Information provision can therefore be directly linked to patient perceptions of satisfactory care quality. Additionally, a lack of information, and convoluted process of information sharing, present barriers to clinical effectiveness and service organisation from the perspective of patient satisfaction.

#### **5.4.5 Motivation**

The interviews provide insights into the overall impact of a trusting and motivational relationship between the doctor and patient on patient satisfaction and well-being, and particularly on the patients' abilities to cope with and fight their illness. Participants' comments tend to support the findings of previous studies that have highlighted the association between a trusting doctor-patient relationship and patients coping with their illness, which may result in improved patient outcomes (Epstein and Street 2007; Arora 2008).

*In the beginning of all this I was scared to death and every step of my treatment used to frighten me ... But when I talked about this with my doctors, they listened and gave such kind advice and motivation that finally I started to feel calm. (Participant 4)*

*The doctors were very friendly and took time to build up my confidence. This provided me with the strength to fight (the) suffering caused by the disease and treatment. I felt comfortable in their presence and that brought a lot of positive energy to me to receive the treatment with great hope and confidence. (Participant 16)*

The data from the interviews further supports the evidence that the nature, as well as the level of communication between doctor and patient, has a significant influence on

patient satisfaction and how it is perceived (Mobiereek et al. 1996; Ezubair 2002). It is clear from participants' statements that doctors potentially play an essential role in raising and maintaining patient morale, by being encouraging and positive about their recovery:

*They advise me to keep myself hopeful. They tell me that I can get healthy again and I'll be able to live a normal life. I'm so determined to get rid of my breast cancer and I'm thankful to my doctors that they have been helping me so much. (Participant 9)*

*They were supportive in the success of the treatment. They were encouraging and kind. They sounded like they truly wanted me to get well. (Participant 3)*

The key elements here are the nurturing of hope, encouragement, and the perception of genuine well-wishing on the doctors' part. The doctors' positive attitudes and the nature of patients' communication with them may reflect, at least in part, the culture of the KSA, in which physicians are traditionally held in high regard and as figures of authority (Mobeireek et al.1996; Younge et al. 1997; Aljubran 2010). Being in the position of authority means that compared to other members of the health care team, doctors have a greater impact, either positive or negative, on the health and wellbeing of patients.

Some of the participants expressed being motivated and encouraged by their doctors which is evident from the excerpts below, attesting that communication and relationship with doctors is a significant factor in enhancing patients' psychological well-being;

*I myself didn't want to stay as I felt depressed, but their motivating words helped me and I started being hopeful. Now, I can proudly say that if my doctors hadn't stayed positive and supportive, I wouldn't have been able to come out of my illness ever. (Participant 19)*

*They have inspired me with their attitude and kindness. They are encouraging, it becomes easier to hope for successful treatment ... Their supportive words became my strength and here I'm ready to go home with a healthy body and healthy mind. (Participant 13)*

These examples also reflect on the connection between a healthy body and a positive mind, as 'hope' was a key word emerging in positive descriptions of doctors



who were seen as motivating. When doctors are encouraging and motivating, this can be perceived as having a positive impact on the progression of the patient's recovery. As previous research has indicated, doctors' communication in an oncology setting can affect the level of patient satisfaction and may also influence the patient's wellbeing and quality of life (Ong et al. 2000; Wildes et al. 2011).

Previous research argues that a patient's attitude may be positively correlated with doctor behaviours that are perceived as encouraging and motivating, often resulting in positive medical outcomes such as improved adherence to treatment and self-care (Street et al. 2009). By being motivating and encouraging to the patient, doctors' communication may have a significant impact on the patient's state of mind, such as lowering anxiety, and thus, may indirectly influence the overall outcome of the illness episode (Ommen et al. 2010). While it has been argued that an awareness of psychological distress is an essential aspect of patient care, oncology doctors are often unwilling to note the distress in patients, and to ask questions regarding patients' psychological health (Cull et al. 1995; Fallowfield et al. 2001).

Some participants, however, reported that communication with their doctors had been negative, in the sense that their experiences with doctors were not constructed as encouraging or motivating. This is demonstrated by two participants, who explicitly stated how this had disheartened them and weakened their resolve to recover from their illness:

*As medical attendants their behaviour has never been motivating or heartening. (Participant 10)*

*They have a very casual attitude which I don't appreciate much. They don't fill the patient with motivation and determination to fight against their illness. (Participant 6)*

The practice of non-disclosure could, especially for females, lead to them to build their experiences in a negative way and this in turn could impact upon their health outcomes. The implication of the non-disclosure as a cultural attitude could therefore mean that females are more likely to suffer a negative health outcome than males in KSA oncology settings.

Exploring further the connection of trust with patients feeling motivated and encouraged by their doctors, it was found that where there was insufficient trust in the doctor's genuine interest in the patient's well-being, feelings of hope and encouragement suffered to the detriment of the patient's emotional state. For example:

*Doctors' change in behaviour or attitude can make the patient feel 'unwanted'. Depression and hopelessness take over his mind and his hopes to get healthy fade away. Fear, frustration and sadness fill his mind. (Participant 3)*

These findings support evidence from other studies regarding the lack of a trusting doctor-patient relationship, which can negatively influence patients' levels of satisfaction (Stewart 1995; Parker et al. 2003). It is evident from my findings that, if doctors fail to communicate in appropriate ways with patients, the lack of trust and subsequent lack of motivating and encouraging behaviour may adversely impact on the psychological wellbeing of the patient, and potentially on the clinical outcome.

The results of my study are similar to those of Fogarty et al. (1999) and Ommen et al. (2010), but additionally provide a deeper, more meaningful contribution to the hitherto poorly researched field of patient satisfaction from the perspective of the KSA context. They would also indicate that greater disclosure of health information is important to enhance the doctor-patient relationship and this in turn – based on the evidence that good communications improve patients' well-being (Aljubran, 2010) – would lead to better health outcomes for those being treated in an oncology setting.

The interview data therefore shows a strong link between hope and trust, reiterating the notion of a positive power dynamic between doctors and patients, where the doctors are respected figures of authority who are seen as crucial to reassuring and encouraging the patient with whom they have built up a good relationship. Other research similarly indicates that having a trusting relationship with one's doctor can have a positive impact on the patient's mind, generating a more hopeful attitude towards the condition and thus aiding the overall mental state and self-care, which ultimately improves the patient's quality of life (Clever et al. 2008). Trust could

become an issue as a result of the non-disclosure by doctors of issues related to the patient's treatment. However, there are multiple factors involved in patients' construction of satisfaction, such as listening and if a doctor concentrates on these then any arrangements between the family and doctor about non-disclosure would not impact too negatively upon patients trust.

#### **5.4.6 Care and Compassion**

The analysis revealed that a further communication aspect that can have a significant influence on patient satisfaction is when doctors show compassion and care. The compassionate behaviour of physicians is defined by Carmel and Glick as 'strong devotion to the welfare of the patient on two crucial dimensions of patient care: technical and socio-emotional' (1996, p. 1253). Doctors perceived as caring and compassionate with patients may provide an element of emotional healing, which could be viewed as a determinant of patient satisfaction (Fogarty et al. 1999; Bertakis et al. 1999).

Many of the participants frequently reported experiences associated with compassion and caring exhibited by their doctors, using terms such as tender, understanding, patient, concerned, and reassuring, and indicating a broader definition of care and compassion. For example:

*Doctors have been so tender and (re)assuring. (Participant 13)*

*The doctors were concerned about me and wanted me recover soon.  
(Participant 15)*

Many also directly alluded to the concepts of compassion, or lack of compassion, when discussing the care they had received from doctors. The absence or presence of compassion clearly had an impact on patients' overall level of satisfaction with their care. These findings evoke the understanding that an important dimension of patient satisfaction is the ability of the doctor to relate to and engage with the patient as an individual or, as highlighted in the 2001 IOM definition of the patient centred

approach, to be concerned with the 'needs, and values [of the patient], and ensure that patient values guide all clinical decisions' (IOM 2001, p. 40).

The perceived lack of compassion may have been attributable to doctors' avoiding close engagement with some patients due to the practice of disclosure of certain health information to families rather than patients. Another possible explanation is that expatriate doctors for whom Arabic is a second language experience difficulty verbally expressing care and compassion to Saudi patients. These expatriate doctors may feel in particular constrained about communicating with patients in the context of the requirements regarding the non-disclosure of information to patients.

The findings indicated that some participants had experienced compassion and care from their doctors according to these terms, which in turn helped them to feel more comfortable in discussing their concerns with the doctor; this also made them feel the doctor was truly interested in their recovery. The following extracts illustrate this:

*The doctors were understanding about my need for a sitter<sup>1</sup> and sent me a social worker to facilitate that during my stay. (Participant 20)*

*The doctors were compassionate enough to give me a few minutes (out of) their busy routine and listen to my concerns. (Participant 10)*

These extracts convey that compassion and care was shown towards these patients by showing that the doctors understood and responded well to their personal circumstances, paying attention to their concerns and preferences.

In contrast, other participants commented that the doctors showed inadequate compassion in their communication with them and appeared uninterested in their personal well-being. Thus, these patients felt discouraged from asking questions, and this constraint reportedly made it more difficult for them to cope with their illness:

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<sup>1</sup> Sitters are commonly relatives of the patients who, at the patients' request accompany them during their hospitalisation, offering moral and practical support. Typically, patients are required to ask for their doctor's permission to have a sitter stay with them overnight.

*They don't have time to talk to patients and everything is so routine to them that they don't have compassion towards the patient. They just ask routine questions and provide general reassurance. I am suffering so much of it without any psychological support from doctors. (Participant 19)*

*The doctors are not compassionate at all. They just asked a few questions about our illness but never appeared concerned with our psychological state. (Participant 21)*

Two main findings emerge in relation to compassion and the doctor-patient relationship. First, there is a link made between compassion and coping (psychologically), with the implication being that an absence of compassion impacts negatively on the ability to cope. Second, the appearance of a lack of concern on the doctors' part is recurrent within the participants' narrative. 'Concern' is here distinguished from basic communication, the implication being that it is more than just asking questions, rather it requires a 'patient-centred' attitude that achieves a balance between meeting the patient's clinical and psychological needs.

Expatriate doctors for whom Arabic is a second language may be hindered in expressing care and compassion by the language barrier between themselves and Saudi patients. The language barrier may mean that they appear detached from their patients and not appear as empathic, especially as they may also lack cultural sensitivity. The findings of my research agree with previous research that indicates the positive impact of doctors' compassion on decreasing the level of anxiety in cancer patients, which in turn increases the level of patient satisfaction and results in improved medical outcomes (Fogarty et al. 1999).

Patients' satisfaction related to the important role that the doctor plays in all aspects of their recovery, and highlighted the need for excellent interpersonal skills in order for them to fulfil this role effectively:

*To me, doctors aren't diagnosticians only but also the ray of hope. Their behaviour, words and facial expressions are important to me, and the means by which I judge the chances of getting well. (Participant 3)*

*By interpersonal skills I mean the communication skills and compassion. They need to have more kindness and empathy. Here doctors are good — I don't say they are bad — but in the situation of these skills and characteristics there is a lot lacking. (Participant 18)*

A comment from one of the participants summed up the importance of the interpersonal aspects of the doctor-patient role, which appears at times to be disregarded by the medical profession, but which are often the standards by which doctors are judged by patients:

*The patients classify doctors on an additional criterion that is 'behaviour'. The doctor who's good at his job but isn't so supportive or caring is designated as a bad doctor, while the doctors are selected by hospitals on the basis of their abilities and experience. (Participant 3)*

These findings suggest that it is not only doctors' medical expertise that is valued but, also their interpersonal communication skills and the level of trust, compassion and 'felt' concern that they bring to their relationships with patients. It also suggests a disagreement between what patients value in a doctor and those attributes and values considered by doctors as important to the organisation. Non-disclosure and language barriers may all interfere with doctor's expression of care and may make them appear as remote figures, who show 'detached concern', rather than empathy. This may be a factor in patients constructing their experiences when interacting with doctors in a negative way.

#### **5.4.7 Summary**

Based on the analysis of the findings, doctors functioning within the KSA healthcare delivery environment are hindered in their interpersonal communications with patients by the policy of non-disclosure. The results indicate that there have been attempts by doctors to communicate more directly with the patients and it must therefore be noted that the policy is not necessarily adhered to in every case. The results further indicate that this differs on a doctor-by-doctor basis. Indeed, the divergent nature of many of these qualitative results indicates the extent to which individual doctors can be the cause of positive or negative patient experience.

Table 5.3 (next) summarises participants' responses to the four central factors of interpersonal communication in the doctor-patient relationship, and evidences the impact of the policy of non-disclosure on those factors. While the divided results

indicate the extent to which individual experience can differ within a single oncology ward, a number of organisational aspects of clinical efficiency are also indicated in these results. These are addressed further in Section 5.7.

Central Factors of Interpersonal Communication	Impact on Communication (SRQ4)	Impact of Non-Disclosure
Listening	<p>Lack of organisational listening demonstrates poor clinical effectiveness –limited time for doctors to communicate with patients.</p> <p>One-way conversations evidence lack of care and compassion and one-sided power dynamic.</p>	<p>Limits the extent to which doctors can address patients' concerns.</p> <p>Reduces the role of the doctor to professional diagnosis and results distributor. Limits interpersonal connection with patient.</p>
Information Provision	<p>Only doctors can deliver test results. Waiting times frequently high for information sharing.</p> <p>Differences observed on a doctor-by-doctor basis.</p> <p>Non-disclosure not universally adhered to.</p>	<p>Limits the extent to which the doctor can interact with patient directly.</p> <p>Limits the extent to which ancillary hospital staff can share information with patient. Reduces the ease of information sharing.</p> <p>Promotes different treatment of male and female patients, with dissatisfaction from both sides: males more unhappy with care due to information provided, and females less happy being deprived information.</p>
Motivation	<p>Doctors play a central role in offering hope for patients.</p> <p>Connection works both ways, however, and lack of attention and casual attitude can cause de-motivation</p>	<p>Findings indicate this varies from doctor to doctor.</p> <p>Limited connection between doctor and patient to results. Human contact minimised.</p>
Care and Compassion	<p>Experience of sample is divided between positive and negative experiences of care.</p> <p>Lack of time to talk and listen to patients a key concern for effective communication.</p> <p>Important to encourage motivation- in turn key to patient satisfaction and experience.</p>	<p>Minimisation of non-diagnosis based contact means limited care and compassion encouraged.</p> <p>Differs on a case-by-case and doctor-by-doctor basis.</p>

**TABLE 5. 3 : NON-DISCLOSURE AND INTERPERSONAL COMMUNICATION**



## 5.5 The Nurse-Patient Relationship

Findings in this theme can broadly be divided into three core elements, which interplay to varying degrees, and elucidate unique insights into the nurse-patient relationship:

1. Clinical Effectiveness: *the role of nurses within service organisation*
2. Technical Competence: *professional skills, administering medication and treatment*
3. Interpersonal Skills: *caring attitude, compassion, availability.*

This section examines each of these key factors impacting upon perceptions of interpersonal care, and examines the relationship between both factors to present findings for both the centrality of communication to patient satisfaction, and the impact of technical competence upon clinical efficiency.

### 5.5.1 Clinical Effectiveness: The Role of Nurses within the Service Organisation

The majority of participants recognised the importance of the nurses' roles and were appreciative of their help and attitudes. Those reporting positive experiences when describing their relationship with nurses used words such as 'kindness', 'supportiveness', 'accuracy', 'responsiveness', 'trustworthiness', and 'understanding', as the following extracts show:

*They are always willing to help us. It's so inspiring that despite their busy routine they like to wear a kind and reassuring smile on their faces. (Participant 13)*

*The nursing staff was very dedicated. They provided a great deal of help and support. They attended to each patient with a smile and performed their work diligently. They made my stay comfortable. (Participant 16)*

These comments convey the impact of the nurses' positive interpersonal attitudes (being kind and reassuring), as well as their professional qualities and competencies (performing their work diligently), on patient satisfaction.

In contrast, a few participants reported that nurses did not have supportive attitudes, and were sometimes too busy for positive communication. The most noteworthy aspects of dissatisfaction related to issues such as inadequate attention to individual patients' needs and a lack of psychological support:

*Generally, nurses are good but need to recognise the psychological status of the patient by allowing more time to spend with cancer patients when asking questions. (Participant 5)*

*The nursing staff is good but there's a lot of need for further development. They are not able to adapt to patients of different mind-sets, having a generalised attitude which isn't sufficient at all. And that's the reason I'm not really satisfied. (Participant 7)*

The findings also indicate that, in order to deliver improvements regarding the nurse-patient relationship, there is a need to address organisational constraints. Patient perceptions of the role of nurses within the organisation clearly draw comparisons to perceptions of clinical effectiveness. These include the low number of trained nurses at the hospital, which places a strain on their capacity and/or capability. It seems that there is a need to increase the number of nurses and enhance their efficiency so that they can devote more time to effective communication with their patients, as illustrated by the responses of two participants:

*They are good but they are very busy and there is a real staff shortage. (Participant 1)*

*The number of nurses is a drawback, as they are limited. Therefore, sometimes I don't want to bother them to get assistance for the bathroom, so I asked them to teach me how to disconnect the IV plug, and then it was easier for me to help myself. But of course, when I need them they are around and respond well to my calls. (Participant 18)*

The last excerpt highlights the awareness that, while nurses' capacity may be limited, this is not owing to any technical incompetency or lack of care, but is rather an issue of resources. The positive opinions towards the end of the extract indicate that, despite constraints, nurses do make themselves available to help patients with urgent needs. Patient satisfaction is therefore directly impacted by the clinical effectiveness demonstrated in nurses' workloads, for example.

Overall, therefore, it was apparent that a nurse not having sufficient time to interact and communicate with patients was a determinant of patient satisfaction with the nurse/patient relationship. These findings concur with those of Shattell (2004) and Rachiadia (2009), who indicate that patients want nurses who are approachable, available, empathic and willing to talk with them, as well as nurses who are not rushed because of their workload and responsibilities.

### **5.5.2 Technical Competence**

Having confidence in professionals' technical competence represents one of the most important underlying indicators of patient satisfaction or dissatisfaction with nursing care (Dowling 2008; Wagner and Bear 2009; Zhao et al. 2009). The findings of this research indicate that patients generally have positive attitudes towards nurses' technical skills. Most of the participants highlighted the proficiency of nurses' professional and technical competence, also asserting that such competence helped to build trust between them and the nurses. A recurrent notion that was also seen to be important in the doctor-patient relationship, was "trust" built on patients' perception of nurses' expertise:

*Nurses are with us all day round. Their technical expertise in preparing accurate drugs, administering them properly at the right pace and constantly watching for any alarming symptoms, are vital for any patient. (Participant 16)*

*Their time management and team work impressed me a lot. They were overburdened yet they managed to deliver the correct drug at the correct time to all the patients. They were well organised and very professional in their job. (Participant 17)*

*The nurses were very professional and have good experience. They took enough care to be accurate with indicated treatment. Whenever they had a doubt they consulted the doctor to be accurate. I am impressed with their competence. (Participant 15)*

These comments reveal a high level of satisfaction with the attendant nurses, which in turn had a positive influence on patients' constructions of their interactions with nurses.

In contrast, some participants had less positive experiences, in particular voicing uncertainty or concerns over the technical expertise of some nurses. There was often an apparent lack of understanding regarding the nature of the chemotherapy treatment being administered and anxiety over the accuracy of its administration. Such concerns could stem from the fact that the ultimate objective of these patients was to cure their cancer and survive the illness, which depends directly upon the technical skills of the nurses supporting them. The following are examples of these experiences; that is, of problems arising from a deficit in nurses' skills or knowledge:

*In my first visit a nurse had almost given me the very strong tablets intended for a neighbouring patient. But fortunately she realised her mistake in time and I threw up the medicine. Since then I keep a keen eye on my medication. (Participant 6)*

*Medication administration seems the most important technical skill to me. Nurses should consider the medications they control for patients. They work so closely with patients that they are for the most part the ones who capture drug slips made either by the pharmacist or prescribing doctor. Drug handling is important as well. (Participant 6)*

Technical competence evidently varies from nurse-to-nurse within the ward, and therefore (as with interpersonal factors evidenced in the doctor-patient relationship) no universal conclusion can be evidenced from the research. The findings do present a number of constructive suggestions regarding what could be done to improve the relationship between patient and nurse. On one hand this implies that more could be done to make their experiences more satisfying in an oncology setting. It could, however, also indicate the engagement of participants in the research, and further strengthens the argument in favour of the value of patient experience in relation to clinical efficiency – indicating that patients are proactively and critically engaged in the process of care.

The findings present a number of examples of possible improvements in the patient-nurse include better time management, better explanation of medication administration and, in particular, enhanced skills at inserting intravenous lines. It was also emphasised that nurses should be better trained to ensure the optimal skills in intravenous therapy, as one participant states:

*Hate anaesthesia, it makes me feel very uncomfortable. And it feels even worse if the nurses have to try 2 or 3 times to insert the medication. I wish that nurses could learn to do it and get well trained at it so they would be able to do it with one attempt. (Participant 13)*

Researchers argue that patients often view optimum nursing care as a combination of practical skills and professional knowledge, which are agreed as fundamental to all nursing practice (Halldorsdottir and Hamrin 1997; Calman 2006; Duff 2013). From a nursing perspective, competence has been defined by ICN (2005, p.6) as ‘the effective application of a combination of knowledge, skill and judgment demonstrated by an individual in daily practice or job performance’. Specifically, in terms of nursing definitions, competence reflects the following: knowledge, understanding, and judgment; a range of skills, including cognitive, technical, or psychomotor and interpersonal; and a range of interpersonal attributes and attitudes (ICN 2005). This definition describes a fundamental requirement which influences the quality of care of the participants. My findings suggest that there is a need to address nursing competencies, especially in relation to medication administration and the insertion of intravenous lines for chemotherapy.

### **5.5.3 Interpersonal Skills**

Participants highlighted several aspects of nurses’ interpersonal skills as significant:

1. Being caring, supportive and compassionate;
2. Paying attention to the patients’ psychological as well as medical needs;
3. Responding appropriately and taking time to listen and understand the patients’ needs;
4. Ensuring they are available whenever patients need them, even when overloaded with work.

By embracing all of these, the nurse-patient relationship was seen to have the potential to evolve into a trusting relationship. The next section Care and compassion examines the impact of these interpersonal elements of communication upon patient satisfaction.

#### 5.5.4 Care and Compassion

Participants generally felt that nurses should be able to understand patients' needs. Some vital interpersonal skills that were highlighted related to the level of nurses' supportiveness, care and compassion. A connection was apparent between the levels of care and compassion shown by nurses and the motivation of patients to get better, which, in turn, related to patients' level of satisfaction with their care:

*They spent time talking with me. I found it so lovely and caring and sensitive to my needs, I really appreciate them and their way of dealing and sharing with patients. (Participant 8)*

*They were caring towards me... Their kindness and sympathetic attitude were always encouraging and helped me to cope during my stay, thank God... They always asked me if I had any complaints or if I needed pain medication. Even if I rang them they were quick to respond and provide me with comfort and help during either their day or night shift. (Participant 20)*

These examples indicate awareness from the patients as to the flexibility of nurses, in addition to an appreciation of the workload. The centrality of this work in oncology ward settings is evidenced within the sample, as participant 8 notes:

*I see this as very important to cancer patients, to be surrounded by good nurses who are willing to accept and talk and dedicate their time to us. (Participant 8)*

In contrast, however, some participants reported negative aspects of their interpersonal relationship with the nurses, including inadequate attention to the individual patient's needs and a perceived lack of understanding and failure to supply support. Some participants noted, for example, that nurses did not always have enough time to give patients adequate attention. This was complicated by the fact that some of the nurses were non-Saudi nationals, for whom Arabic was a second language:

*Generally, the nurses are good but need to recognise the patient's psychological state by allowing more time to spend with cancer patients when asking questions. They should also ask for a translator if the patient can't understand some points in conversations, such as helping with room transfer from a shared to a single room. (Participant 5)*

This again raises the issue of resources of time and cost for interpretation through translation, specifically, the challenge of expatriate nurses, who potentially do not

have adequate capacity to develop trust and good communication with patients. This may also be due to a lack of proper language training, specifically Arabic. Previous research indicates that, without a shared culture and language, it is difficult for expatriate nurses to deliver effective nursing care to Saudis (Al-Shahri 2002; Al-Dossary et al. 2008). The language barrier may lead nurses to appear as detached and remote to the patients. This is contrary to the patients' expectations of how a nurse should behave and act (Rchaidia et al. 2009). Such barriers will lead to patients construing their experiences with some nurses, as being unsatisfactory.

It is also possible to evidence the impact of the local non-disclosure policy in this case. This may influence nurses' attitudes to communicating with patients. For example, they may interpret the non-disclosure requirements of some families as meaning that they must avoid their communications with all patients or they may seek to minimise communication to avoid patients, especially female patients from asking questions, which the nurses are prohibited from answering. This will mean that patients view their interactions with nurses as being unsatisfactory.

The findings discussed in this section have shown the importance of nurses being perceived as compassionate and caring by patients, features that have been highlighted in cross-cultural studies. For example, a review by Rchaidia et al. (2009), who investigated cancer patients' perceptions of the 'good nurse', indicates that the personal characteristics of being caring, showing compassion and relating to the patient as a person are fundamental traits, which pertain to both western and eastern cultures.

The findings of this research would suggest (as in the case of the doctors) that cultural attitudes and the language barrier may interfere with nurses' ability to express empathy and care that is expected of them by patients. If nurses are perceived as not acting compassionately and expressing care then they are not acting in ways that a patient can construe as appropriate or satisfying.

### 5.5.5 Availability

The findings demonstrate that several participants had a positive attitude towards nurses' availability and their time management during care provision:

*Their time management is commendable. They attended each patient with great competence. They performed their duties... dedicated enough time to each patient. (Participant 15)*

However, other participants noted that nurses were sometimes too busy to give patients the attention they needed:

*They just need more time to spend with patients as they have a staff shortage and the nurse couldn't spend time with me when I asked or called in the afternoon... Then they do attend... but they just need to be faster... one nurse who was caring for me had two beds in the room to look after so I always felt too shy to ask her for help with walking or the bathroom as I could see she was busy and couldn't help me. (Participant 5)*

The emphasis was on nurses being present and devoting the appropriate amount of attention predominantly to patients' physical needs, but also to psychological needs, since the right attitude can make patients feel more comfortable. Some participants highlighted this lack of psychological support, rather than technical assistance, as being the key feature that defined their relationship with nurses:

*Nurses need to be specifically trained to deal with cancer patients. They should be aware of our psychological state and their attitude should provide confidence to patients as we sometimes have many questions or are worried about the next appointment or discharge. They should welcome questions and comfort us with patience and kindness. (Participant 21)*

According to Rchaidia et al. (2009), this state of 'being present' both physically and mentally in terms of their openness to patients' psychological needs, is an important indicator of a good nurse, based on the perceptions of cancer patients. This extract gives the impression that the nurses did not fulfil their role appropriately and failed to offer psychological support, which is important for a patient-centred approach to nursing. Moreover this participant felt that nurses should focus more on communication and relationship building.



### **5.5.6 Summary**

The analysis of the nurse-patient relationship highlights a number of important factors in determining successful interpersonal communication. It also evidences the impact of the patient-nurse relationship upon patient perceptions of clinical effectiveness. A summary of the findings can be found in Table 5.4:

	<b>Impact of Nurses on Service Organisation (SRQ2)</b>	<b>Impact of Nurse-Patient Relationship on Interpersonal Communication (SRQ4)</b>
<b>Clinical Effectiveness</b>	<p>Staff shortage identified.</p> <p>Consequently, high workload evidenced for nurses – leading to limited contact between nurse and patient.</p>	<p>Kindness, supportiveness, accuracy and responsiveness all evidenced as positive elements of nurse-patient relationship. Not universally true, however, and changed on a nurse-by-nurse basis within the organisation</p> <p>Generalised attitude focusing on cases rather than individuals</p>
<b>Technical Competence</b>	<p>High proficiency evidenced by most nurses mentioned in the study.</p> <p>Positive time management evidenced for some nurses on the ward – in spite of large workload.</p> <p>Concerns over technical skills and training of nurses evidenced in research.</p>	<p>Understanding the personal needs and concerns of the patient when administering medicine, for example.</p> <p>Examples of medicine being administered to wrong patient. Limited understanding of care from patient.</p>
<b>Interpersonal Skills</b>	<p>Positive examples of listening to patients concerns.</p> <p>Examples of being able to respond to patient needs.</p> <p>Available when patient needs.</p> <p>Occasional examples of nurses being too busy to respond to patient needs.</p>	<p>Caring and compassionate.</p> <p>Attention to detail.</p> <p>Psychological as well as medical needs – especially with the specific concerns of cancer patients.</p>

**TABLE 5. 4: IMPACT OF NURSE-PATIENT RELATIONSHIP ON PATIENT SATISFACTION**

## 5.6 Impact of Social-Cultural Communication Factors on Patient Satisfaction (SRQ5)

This section examines the research aims outlined in SRQ5. It presents qualitative analysis of participants' perceptions of cancer, and identifies context-specific influences upon patient notions of experience, satisfaction and quality of care. The subthemes of the contextual factors that found are:

1. Patient perceptions of cancer;
2. Culturally endorsed power dynamics regarding the doctor-patient relationship;
3. The influence of religion;
4. The role of family;
5. The effects of a multi-cultural hospital environment.

### 5.6.1 Patient Perceptions of Cancer

Patients within the KSA view certain illnesses, such as cancer, as being of greater medical priority than other forms of disease or illness. Therefore, oncology patients believe they are deserving of greater attention from medical staff and require better treatment conditions. The following quotes illustrate this:

*Oncology patients must have priority in appointments for labs or x-ray. (Participant 8)*

*Organisations should learn to treat cancer patients differently to other patients. They should understand that time is of utmost importance in our treatment. Any delay on their part could have a devastating impact. They could help us a lot by improving the pace of functioning. (Participant 1)*

These extracts convey some participants' perceptions that oncology patients should be given priority in accordance with their special requirements. The second extract, in particular, emphasises the urgency with which the need for treatment is perceived, with words such as 'priority', 'delay', and 'pace' in both extracts denoting the importance of timeliness.

Illness, particularly cancer, is perceived in various ways depending on national or regional cultural factors. In the context of this study, participants' perceptions that cancer should have priority status in terms of treatment may be drawn from the cultural beliefs of the KSA that cancer is likely to be an imminent death sentence. For example, one participant commented:

*I never knew about cancer and its treatment. In my mind it was just one fatal disease and I knew nothing else about it. But when I came here and the tests confirmed that I had cancer, I started believing that I would be dead in few days. (Participant 12)*

Similarly, cancer has been found to carry a social stigma worldwide (Goffman 1963; Albrecht et al. 1982; Chapple et al. 2004; Rosman 2004). However, Joffe (2002) has argued that fear of cancer has decreased markedly as medical knowledge and success rates have increased. Nevertheless, my findings indicate that cancer within the KSA is perceived in ways that go beyond stigma alone; that is, as a fatal disease which can evoke a strong fear of death.

Another factor that has been found in other studies to impact on oncology patients' satisfaction is the treatment environment (Gotlieb 2000; Ulrich et al. 2004; Rowlands and Noble 2008). Evidence emerged that patients' main concern was not being able to have privacy. The following participants emphasised the importance of having a single room, as being in a shared arrangement adversely affected them physically and psychologically:

*I feel so shy when I have nausea in a shared room as I can't tolerate the smells of food during lunch time. That's why I am so irritated at sharing a room with someone. But if I am in a single room, I feel comfortable and free to request from the nurse that no food should be supplied to my room due to my severe nausea. (Participant 3)*

*Having a single room is important for me because I feel comfortable when I can sleep and rest with no noise, and can have a quiet place to rest and read the Quran. I prefer to be alone and not to socialise with people during my stay as staying with people increases my worries and fear as other patient have different treatment and stages, which is not always encouraging to me. (Participant 5)*

For example, high-quality environments with high levels of support seem to be associated with higher levels of patient satisfaction, especially for the cancer patients

(Bredart et al. 1998). The findings of my research also demonstrate the importance of a treatment environment that is sensitive to oncology patients' needs, particularly the need to be able to express the physical symptoms of their illness without fear of shame or embarrassment. Being unable to do so has a negative psychological effect and may even make patients feel uncared for and despondent over whether they will get better, as the extracts illustrate. A central desire was for a private space if they were very ill. These findings indicate that patient preferences are deemed to be an important element in providing patient-centred care, thus influencing the level of cancer patient satisfaction.

As these findings have shown, patients' perceptions of cancer specifically in the KSA context, and their experience of the treatment environment both contribute to their perception of the treatment they should be receiving, and the quality of actual care they feel they are receiving. The following sections elaborate on the other key contextual factors affecting this perception.

### **5.6.2 Doctor-Patient Power Dynamics**

As previously noted, the doctor-patient relationship in the KSA context is typically mediated by the perception of doctors being powerful figures of authority, whose word should be trusted, rather than encouraging dialogue or discussion between doctor and patient for purposes of shared decision-making. Patients' perceptions of doctors in the KSA, and the power imbalance that occurs, can be seen as closely related to the conventional role of physicians in KSA culture. Whether or not they are native to the KSA, doctors are considered to be highly respected figures of authority (Elzubier 2002). As one respondent commented:

*The relationship with doctors is important to every patient. We actually give them, after God, the authority over our body and illness, so having a good trusting relationship with my doctors keeps me calm and satisfied. (Participant 9)*

Doctors are positioned as the ultimate human authority on health, who, by implication, have the necessary knowledge and skills to administer whatever treatment is best for the patient, and therefore should not be questioned. This view, in turn, lends itself to a top-down power relationship between some patients and their doctors, as the following extracts illustrate:

*The doctors were not interested in patients' mental condition. They took care of treatment and that's it. We could not feel comfortable enough to express our concerns to them. This has adversely affected the whole situation by making us feel unmotivated. (Participant 19)*

*In the beginning, I had endless fears and doubts but I wasn't able to talk about it with my doctors. I had once tried to tell them about it but they shooed me away and since then I never gathered enough courage to communicate openly with them. (Participant 7)*

Both of these extracts imply a sense of being intimidated or 'not comfortable' with doctors. In particular, the fact that the second participant's anxiety is not adequately listened to and the necessary knowledge is not shared highlights an unequal balance of power and control in the patient-doctor relationship. Participant seven's emphasis on (lack of) 'courage' suggests a state of feeling intimidated by those who have the power to allay the fears and doubts associated with the illness. The participant's feelings may stem from the fact that families wish to restrict information, a cultural attitude.

These feelings impact upon patient satisfaction, as patients can feel anxious because they have little or no information on their treatment keeping them in the dark and questioning the treatment options chosen for them. The anxious feeling and the feeling of being shut out of making decisions about their own body leads to their dissatisfaction of the healthcare provided to them. Patients such as participant seven desire to overcome the family restrictions that are placed on them terms of their treatment and giving them the sole right to decide about their healthcare.

In contrast, several patients mentioned feeling very well-informed by doctors, to the extent of feeling they knew whether their illness would be cured or not. Given the

strong cultural context at work, this effect can be seen as part of the high regard in which doctors are held in the KSA. As one respondent stated:

*The doctors in oncology were so respectful and helpful, they tell me everything about my condition and options for treatment such as surgery, chemo and radiation, also they were honest about prognosis and this was so important for me to know (whether my disease is) curable or not. (Participant 8)*

This finding also reflects a cultural shift in doctors' information provision to patients in the KSA as evident from the experience of the participants, indicating that they are increasingly providing patients with full details about their condition, such as the prognosis. As noted previously in this chapter, there is a gulf between theory and practice of non-disclosure practices. This is further evidenced above, and demonstrates the extent to which patient satisfaction can be further determined on a doctor-by-doctor basis within the same oncology ward.

As discussed in Chapter 2, studies conducted in the KSA and internationally (Al-Ahwal 1998; Tanaka et al. 1999; Al-Amri 2010) provide evidence that patients prefer to have full disclosure of information about their illnesses. In contrast, surveys of physicians in the KSA (Bedikian et al. 1985; Mobeireek et al. 1996) have revealed their preference for discussing patients' condition and treatment with patients' close relatives rather than with the patients themselves.

More recently there has been growing public awareness of medical issues, as well as ethical pressures, in the KSA that are reportedly driving a change in doctors' attitudes and behaviour, with full disclosure of diagnosis to the patient rather than their relatives becoming more common (Sokol 2006; Mobeireek et al. 2008; Al-Amri 2010; Aljubran 2010). These findings support that some doctors in the KSA today do provide full disclosure of information to oncology patients which implies that it is moving towards becoming a norm, however, if the family has expressly stated that a patient is not to be informed of about their health or treatment doctors do not do so.

Considering these cultural factors, it becomes evident that the perceived power imbalance between doctors and patients can affect patient satisfaction with care either positively or negatively, depending largely on the interpersonal dimension, that is, the capacity and the way in which doctors deliver relevant information. Some of the participants indicated the ideal power balance they would like to have with doctors, including a preference for an open and trusting relationship in which they could feel comfortable discussing any of their concerns in a sensitive manner. The following extracts illustrate these expectations:

*A patient should trust and be able to depend on his doctor. This relationship develops with understanding and interaction. Doctors shouldn't be the medicine/treatment prescribers but also a counsellor. (Participant 21)*

*The personal skills of the doctors here need much improvement as they should consider the psychological state of the cancer patient. I want them to deal with me in a kind way and consider that their attitude will affect the patient, like if they didn't listen or just try to be in hurry during visits. (Participant 7)*

This apparent change of attitude where patients wish to build relationships of trust with their doctors and openly verbalise their concerns is surprising in a KSA context. This preference for patient empowerment and advocacy is arguably at variance with cultural norms in the KSA. These patients' attitudes, and their emphasis on doctors' 'kindness', represent a shift towards the need for a more western and patient-centred approach involving active patient participation in care.

### **5.6.3 Influence of Religion**

A major point to consider was that the religion of Islam is the main aspect shaping the culture of the KSA. Many of the participants indicated that their faith affected their perceptions not only of their disease, but also of the care they received. These findings add to other studies conducted in KSA which have drawn the importance of faith in receiving healthcare, particularly the study conducted by Halligan (2006) who argues that Islam is a contributing influence on patient satisfaction. He highlights the way in which the influence of Islam can be felt in every aspect of patient care.

All of the participants in Halligan's study, who were expatriate nurses, recounted that everything people do is centred on religion, and it is the main way of life.



Consequently, Halligan (2006) correlates patients' attitudes towards their illness with their religion, which is identified as 'central to the provision of caring' (Halligan 2006 p1565). The findings of my research relate to the discussion produced by Halligan (2006) as they brings to surface the impact of religion on patient's assessment of healthcare delivery while Halligan (2006) focused on experiences of nurses.

Participants indicated that their belief in God was more powerful than medicine. In addition, some of the participants stated that it is their faith and connection with God through prayer that helps to keep their spirits up, as one person stated:

*I believe that my disease has been gifted from God as a test to see how I will be patient and deal with this fact; therefore, I accept my destiny of cancer and I will be working hard to deal with recovery by praying first to God to help me and then also to help my doctors to cure my disease in the near future, Inshallah. (Participant 8)*

Religion can therefore directly impact the patient's morale, over and above any care received from doctors or nurses. These finding are in line with other research which conveys the positive influence of religion on coping with cancer; specifically, some have argued that cancer patients in Islamic countries have better coping mechanisms than those in other countries (Ezzat et al. 1995; Young et al. 1997; Silbermann and Hassan 2011).

The emphasis on the spiritual dimension of coping in illness was also evident through the fact that SRCCs have visiting religious scholars, who are on hand to lend patients moral support and spiritual guidance through their situation, and some of the participants commented on this aspect of their care:

*The weekly official visit of a religious scholar was very helpful and motivating for me and other patients. I felt so great during religious scholar visits and really need the hospital to consider his visits to be daily for patients, as this reassured me and helped me a lot in my spiritual condition during the treatment. When I felt lost I wished to see someone who could connect my heart with God so I could find some peace. (Participant 7)*

*Religious lectures on Islamic affairs are needed to bring positive changes for us as cancer patients. (Participant 12)*

These extracts demonstrate the importance placed on spiritual health by these oncology patients, and highlights how a visit by a religious counsellor or a lecturer on religious themes can fulfil the spiritual needs of the patients. This fulfilment is also shown to improve their mood and confidence about their situation, as conveyed through language such as attaining 'peace' and 'positive changes'.

However, other participants presented contrasting views by emphasising their belief that the doctors and nurses were the only ones who could help them:

*I believe that they are the only ones who could clear my mind about my situation. (Participant 10)*

This extract echoes the other dominant cultural context that is relevant here, that is, the conventional perception of physicians in the KSA, who are seen as highly respected figures of authority (Elzubier 2002).

#### **5.6.4 Influence of Family**

The principal idea of family is fundamental to the provision of care within the KSA. This is further supported by Halligan (2006) and Younge et al. (1997), who argue that the importance of family has a direct impact on the perceived level of care by the patient. This is especially the case with the family's ability to influence doctors' disclosure of information to a patient. These researchers describe family involvement as pivotal to the experience of the care being delivered and as a significant factor affecting the emotional, social, and psychological well-being of the patient.

Participants viewed family members as the principal decision-makers who often dictate the care that patients receive, including the extent of the care to be given. For example, participants recounted how families help to direct their treatment and also offer vital moral support:

*Thank God my family are with me; this helps me bear the after effects of the treatment. (Participant 21)*

However, while the patient's family has significant influence on the care to be provided, patients still look to the medical staff, such as their doctor, for ultimate guidance and explanation of treatment prior to making any decisions. In the following extracts, participants underline the doctors' involvement in the process of informing family members as well as the patient him/herself:

*But my mother wasn't able to understand and she was very afraid. The doctors calmed her down and assured her that they wouldn't be doing anything wrong to me. (Participant 13)*

*They explained all about the treatment to my husband. (Participant 22)*

These extracts underline the critical role of the family, in that they are physically present at key diagnostic stages; the implication here is that they are then expected to be involved in subsequent decision-making about treatment. This is in line with other findings that, in developed countries, patients often demand more resources, i.e. medical staff attention, to be available to their family (Given et al. 2001). However, these extracts also emphasise the continuing importance of medical staff not only for informing and reassuring the patient, but also for reassuring all members of the family. Thus, while the family can be a determining factor in terms of care, patients are also aware that professionally trained medical staff are essential in providing clarification and ultimately informing treatment decisions (Given et al. 2001; Ezubair 2002).

It is important to note that although fundamentally important, the influence of family is still biased towards females. As noted before, female patients in KSA need the presence of male guardians which can be their father, husband, or son depending on their marital status. The treatment decisions of female patients fall on the father or brother if she is unmarried, on the husband if married, or on the son if widowed or divorced with children. This contrasts to the role that women have when the patient is male. The treatment decision making, disclosure of information, and advice given by a doctor or nurse in the case of male patient is restricted to the male members of the family. In the case of a male patient, the wife is not the sole decision maker for her husband, the male family members of the patient are the ones who are handed the responsibility of decision making and being the main point of contact for information.

This is due to the societal hierarchy framed from cultural beliefs within KSA which is male-centric and male dominated.

#### **5.6.5 Influence of Multi-Cultural Healthcare Environment**

The health care environment and its own cultural context play a vital role in patient satisfaction (Rafii et al., 2008). A major cultural factor in terms of the KSA hospital environment, and prevalent in the specific SRCC examined in this study, is the presence of largely expatriate nursing and medical staff from all over the world (in particular South Africa, India and the Philippines) who are unlikely to speak Arabic (Luna 1998; Al-Dossary et al. 2008). In particular, the expatriate nursing staffs were found to affect patient satisfaction in that their difficulties with the Arabic language created some tension in communicating with patients. Many participants noted that they could only express their emotions and needs clearly in Arabic languages, which these nurses were not always able to understand fully. As several participants commented:

*Their language is a bit of problem; it would be easier to communicate with them if they were capable of speaking Arabic. (Participant 10)*

*Communication skills are the most important, for example, being able to talk freely and ask about treatment, but in my opinion the nurses need to understand more of the Arabic language to be able to deal with patients easily. (Participant 5)*

Inadequate communication arising from language barriers can be seen as a determinant of these patients' satisfaction level, frequently causing a loss of rapport with nurses. Accordingly, Arabic-speaking nurses were deemed more likely to provide the optimum psychological support and to be able to meet patients' medical needs than non-Arabic speakers. Evidence of language barriers in communication between the patient and their nurses has been reported by a number of studies in the KSA owing to these nurses frequently being non-KSA nationals (Al-Shahri 2002; Attalah et al. 2013). As previously mentioned, there is currently a drive towards employing greater numbers of Saudi Arabian nurses or Arabic national nurses as part of the Saudisation process (Al-Malki et al. 2011).

Because of the multi-national mix of personnel, including many non-Saudi doctors, English was the default language being spoken among professionals in the presence of the patient, and this could create a feeling of anxiety in the patients. The following extract illustrates this:

*For example, the doctor saw me and requested some tests or radiology; then I asked the nurse, but she said there was no instruction written by doctors, so I felt lost between doctors and nurses because doctors speak English with them in front of me, which is difficult for me to understand – is he requesting something or just talking? That's why I felt worried and asked a lot if doctors were requesting tests or x-rays. (Participant 5)*

In this patient's case, the language barrier negatively affected the way patients constructed their experiences. The use of English rather than Arabic by the medical staff led the patient to feel excluded from discussions about his/her own health, and created a sense of dissatisfaction with the care they were receiving. The issue of the language barrier overlapped with the requirement of non-disclosure to the patient, thus compounding the potential problems with establishing a personal relationship between expatriate nurses and Saudi patients.

Personal relationships can only be established when communications are possible. The fact that a nurse and patient only have limited communications mean that a nurse can appear as not engaging with a patient or may appear as being inattentive. The ability of a nurse to establish a relationship is further impacted by the fact that they often have to ensure that they don't disclose information to a patient at the request of the family which is considered a norm of non-disclosure in the KSA healthcare setting. This may make nurses unwilling to spend time and interact with a patient. The language barrier and non-disclosure means that often the nurse-patient relationship is not a satisfying one for both parties.

### **5.6.6 Summary**

This section has highlighted the importance of nurses and other medical staff in oncology wards tailoring their care to patients' needs and providing a more patient-centred approach, as this can significantly affect patient satisfaction levels. It also

evidences the impact of a number of socio-cultural factors upon patients' expectations of care. This is outlined in Table 5.5.

Additionally, this section indicates that the requirements for a more positive experience are determined by a confluence of social and cultural factors, in addition to technical and organisational elements of each particular case. These necessarily differ on a patient-to-patient basis, and in turn impact upon the quality of care required. In relation to a broader discourse of patient satisfaction, therefore, this section has corroborated a number of trends highlighted above – particularly the impact of non-disclosure upon communication – and demonstrated the subjective expectations and requirements of each individual patient in determining quality of care.

	SRQ5	Impact for Patient Satisfaction
<b>Patient Perceptions of Cancer</b>	Patients expect a higher level of care.	Greater expectations for a higher quality of care.
	Patients expect first use of medical resources.	Increased expectations on availability of staff- owing to the cultural status of the disease.
	Similar expectations regarding amount of doctors' time they are eligible to.	
	Expect better facilities – single rooms.	
<b>Doctor-Patient Power Dynamics</b>	Patients uncomfortable with doctors owing to implied cultural status.	Lack of information can result in increased anxiety. Symptomatic of culture of non-disclosure.
	Symptomatic to top-down power relations.	Not universal, however, as some patients believed themselves to be well informed.
	Communication and approachability differs on a doctor-by-doctor basis within the same oncology ward.	Non-disclosure not practiced universally.
<b>Religion</b>	Attitudes towards health and treatment determined by religion.	Visiting scholars engage with patients to improve morale.
	Islam a contributing factor for patient satisfaction – beyond satisfaction with medical staff	Not universally positive, however, some participants felt religious influence hindered care.
<b>Family</b>	Family influence doctor's treatment plan & are principal decision makers.	Family occupy some of the burden of patient attention from medical staff.
	Bias towards male patients. Information frequently withheld from female patients.	Male-bias can encourage greater dissatisfaction of female patients.
	Doctor provides ultimate guidance.	
<b>Hospital Environment</b>	Language barrier important between staff-patient communication	Language barrier perceived as inhibiting quality of care.
	.	Resentment from some patients having to communicate in English

**TABLE 5. 5 : IMPACT OF SOCIO-CULTURAL FACTORS UPON PATIENT SATISFACTION**

## 5.7 Service Organisation Impact on Patient Satisfaction (SRQ2)

This section presents the findings that highlight the organisational factors influencing patients' satisfaction or dissatisfaction. Based on the participants' responses, three main factors were identified as important aspects of the service organisation which influenced their overall satisfaction levels:

1. Accessibility to healthcare (i.e. having full access to the hospital and permission to use all the necessary facilities);
2. Waiting times (i.e. that they should be reasonable and that the staff should be supportive of patients while they were awaiting treatment).
3. Overarching Assessments of General Service Organisation

These three key factors are examined in this section, and their relative influence of service organisation upon patient satisfaction subsequently summarised in Table 5.6.

### 5.7.1 Accessibility of Healthcare

Participants in this study reported broadly positive experiences regarding access:

*It was good and I didn't face any problems with it as it was well arranged. There were always supportive services, for example from the social worker or from the cancer support society. (Participant 20)*

*The admission process was good, well ordered. I didn't have problem in waiting for admission or referral; it was perfect during my stay. (Participant 8)*

In contrast to these positive experiences, however, a limited number of participants reported problems with accessing the hospital and its facilities:

*I remember the trouble I had to bear at my first CT scan. Firstly, it was crowded all the time and the personnel didn't bother to do things quickly. I had to wait for two hours to get it done. According to them, it was a busy day, but I think if it's better organised or there is a separate clinic for oncology it would benefit us more and improve our experiences. Also, referrals and labs have been working at a poor pace. My referral to an orthopaedist took three months; I was already on pain medication but still looking to see a specialist as soon as possible to get a clearer idea about the knee pain. (Participant 18)*



This was not an isolated incident. Indeed, patterns of ineffective communication between staff are also evidenced by Participant 19:

*Sometimes I got correct information but most of the time it was very confusing. There is lack of coordination between departments and nobody is in a position to provide all the information. The people here were also unconcerned with the trouble of the patient. (Participant 19)*

These negative experiences relate mainly to the slow pace at which care was given, and the lack of coordination in information giving or confusion regarding the information actually provided. Timeliness was closely linked with efficient access to services, and impacted adversely on patients' satisfaction if it was not present. In addition, patients' criticism of crowded circumstances also denotes the importance of the hospital environment when accessing it, which the following section explores in further detail.

### **5.7.2 Waiting Times**

Waiting times are one of the indicators that have been found to influence patients' perceptions of the health care service and lead them to construct their experiences with it as satisfactory. Waiting times for services were mainly positively assessed by the participants, as these extracts show:

*I had a very good experience with the service of the organisation during my stay. There was well organised admission in a timely manner, and that was excellent. (Participant 16)*

*I feel so comfortable and like the earlier arrangement, such as getting my blood test earlier before going to the admissions office, which means that I can process my admission after the oncology staff confirmation, so that is very well arranged and organised and then I will just be waiting for doctors to be seen directly and treatment to be started. (Participant 8)*

In contrast to these positive experiences, some reported that usually admission took longer and they had to spend time waiting in the emergency room for oncology doctors to decide and agree about admission. If patients book ahead for the admission process, it becomes easier and means that they can reach the doctor easily without a further waiting period. The following extracts demonstrate several patients' dissatisfaction with admission and referral times:

*I have been referred to two different doctors – a psychologist and neurologist – and neither of them have any available appointments; it has been almost a month now. It has been really hard for me to wait for so long. (Participant 11)*

*My admission had been delayed for 8 days. Isn't this unfair and troubling? And the reason behind it is the unavailability of beds in oncology wards. I couldn't be admitted to any other wards in hospital to receive my scheduled treatment. (Participant 6)*

By using language such as 'unfair', 'really hard', and 'troubling', these participants display a feeling of neglect that is experienced by patients being left to wait for long periods of time for medical attention and referrals, in some cases to the extent that they need to seek private care. This feeling of neglect can also be seen as connected to patients' views that cancer is a priority disorder. Similarly, other professionals have argued that inadequate access to KSA cancer services such as the long waiting times negatively affects the level of patient satisfaction with the care provided (Al-Muziani 1998; Al-Sirafy 2009).

In light of this, another important element to assess is the perceived level of supportiveness of the health care personnel during these waiting times. Participants mainly reported positive experiences, emphasising the staff's supportiveness, helpfulness and willingness to help:

*Whomever I interacted with, they were well informed, nice and patient. They always provided us with the correct information about the services. (Participant 17)*

*They are cooperative and helpful in guiding me if I need help such as fixing an appointment or changing the time of an appointment; they have been very cooperative with this. (Participant 8)*

However, others noted less positive impressions of their communication with the medical staff during the time they were waiting to receive medical help:

*They are good but CT staffs need to be more kind and patient, especially with oncology patients. Lab services are usually crowded and need more organisations to make sure they have enough space to accommodate all the patients and not have them always waiting in corridors for a lab call as it's not helpful for patients to be in crowds with their pain. (Participant 3)*

*Another thing is the lack of psychological understanding among medical staff. They don't try to understand the patient's individual psyche. (Participant 6)*

These criticisms indicate that medical staff needs to act kinder and provide more supportive care, especially towards oncology patients, and that they sometimes demonstrate an inadequate psychological understanding of their patients' needs.

As the following extracts also show, reference to crowded space and a lack of proper organisation indicates that participants felt that having adequate coordination within the health care system was important, yet was perceived as currently problematic and impacting on waiting times. This is illustrated by one who stated:

*There is lack of coordination between departments and nobody is in a position to provide all the information. For example, my next readmission date was not provided until after discharge as the clerk was unavailable that day, so we had to follow this up with them after discharge and my son had to go back to get it confirmed. (Participant 21)*

Another connected the problem of long waiting times with the shortage of nurses and the approachability of available staff noting that:

*Here the situation is dependent upon the individual personnel; some of them are willing to help and some aren't. No, I can't reach out to all personnel if I need, they don't seem easy going. (Participant 10)*

The issues of capacity and problems with staff shortages have been highlighted by some researchers attempting to elucidate the impact of the staffing levels of nurses and the mix of nursing personnel in hospitals on patient satisfaction. For example, one study argues that hospital administrators, accrediting agencies, insurers, and regulators should take action to ensure that adequate nursing staffs are available to protect patients and to improve the quality of care (Needleman and Buerhaus 2002). I found that good accessibility to health care – in terms of waiting times and availability of oncology ward staff (doctors, nurses) – is an important factor influencing patient satisfaction in the KSA.

### 5.7.3 Overarching Assessment of General Service Organisation

Overall, there was a mix of views among the research participants regarding their experiences of the service organisation, with many indicating that, while they were generally happy, there was some dissatisfaction with the operational structure of the facility.

The majority of participants who reported positive feedback on the general service organisation talked about both the medical services and overall service organisation:

*The referral system is good here. Labs and other testing services are very good and prompt. I don't have any problem with them. (Participant 9)*

*My overall experience with the service organisation during my stay is good. (Participant 4)*

In particular, some of the participants emphasised the high level of effectiveness of cancer support services with regard to the non-medical support they received, including that provided by the social workers:

*I wish them all the best as this main referral hospital deals with a large number of patients and still manages to have great services available to us, such as a social worker and Saudi cancer society officer, who always support me. (Participant 16)*

*I have the ability to connect freely to the Internet during my stay, as well as social worker services that let me feel happy and rest assured. Also the way they approach me is friendly and helps me feel supported and satisfied during my hospital stay. (Participant 8)*

However, some of the participants reported negative experiences of the organisation of medical services. The following extract illustrates this factor:

*I had to wait for a long time to obtain the approval of referrals. My treatment was delayed because of a delay at the lab. Sometimes it was really troublesome to get things done with them. (Participant 19)*

The previous extract highlights one of the most problematic issues, as several participants reported long waiting times for referrals, admission and for labs. The waiting time for psychiatric services was also seen as problematic:

*Other services like referral took a long time, it took a long time to get appointments and it was very uncomfortable to be seen by psychiatric services after 1 month. Generally, I don't like this waiting time because I feel more worried and less assured, which sometimes makes me feel unstable and anxious during my stay. (Participant 3)*

These findings demonstrate that, while there are positive findings regarding the healthcare services, there may be a need to improve certain aspects of service provision for oncology patients, particularly with regard to waiting times and doctor availability. The following interview excerpts emphasise this point:

*It's worrisome and irritating to wait so long. Especially for cancer patients, it's even more irritating to wait. I don't like it when hospital management forget about the psychological state of their patients. (Participant 13)*

*What is needed is making more doctors available to oncology patients. (Participant 3)*

The opinions arising from these excerpts and discussed throughout this section show that there are several organisational policy factors that may be at odds with patients' preferences for the treatment setting or logistics of care such as referrals that are not seen as fast enough and a shortage of medical staff on oncology wards.

#### **5.7.4 Summary**

Service organisation can play a crucial role in patient satisfaction. Factors principally pertaining to poor communication and slow processes are negatively received by patients who expect a fast pace of care owing to the nature of, and cultural expectations relating to; their illness. These factors are detailed in Table 5.6, in relation to SRQ3's focus on service organisation:

	SRQ2 – Service Organisation	Impact on Patient Satisfaction
<b>Accessibility of Healthcare</b>	<p>Many respondents reacted positively to existing processes.</p> <p>Negative responses focussed on overcrowding, slow processes and long waiting times.</p> <p>Poor communication between hospital staff also evidenced.</p>	<p>Slow pace of care impacts upon patient satisfaction.</p> <p>Timeliness exacerbated by the nature of illness and patient expectations for rapid care.</p> <p>Criticism of overcrowding highlights importance of hospital environment to satisfaction.</p>
<b>Waiting Times</b>	<p>Admission particularly problematic for participants.</p> <p>Referrals indicate further lack of communication between doctors and departments – result of non-disclosure.</p> <p>Negatively impacts upon communication between patient and medical staff.</p> <p>Capacity issues and staff shortage evidenced.</p>	<p>Poor communication between departments impacts on patient care.</p> <p>Long waiting times for treatment and referral negatively impact satisfaction.</p>
<b>Overarching Assessment of General Service Organisation</b>	<p>Participants divided in perceptions of service organisation and performance.</p> <p>Nature of the illness results in patients less willing to wait for treatment.</p>	<p>Waiting lists and referrals impact upon perceptions of satisfaction</p> <p>Lack of doctors also a concern and poor communication with limited number of doctors available.</p> <p>Concerns regarding pace of treatment.</p>

**TABLE5. 6 : IMPACT OF SERVICE ORGANISATION ON PATIENT SATISFACTION**

## 5.8 Summary of Qualitative Findings

This chapter has evidenced the impact of interpersonal, socio-cultural and service organisation-based factors upon patient satisfaction. With regard to SRQ4, a strong emphasis was placed by participants on the psychological as well as physical elements of care. Many patients noted that doctors should understand and respond to their psychological state. Nurses' interpersonal skills were deemed important as they impact on the quality of their experience. Largely, nurses were seen as supportive and understanding. However, some patients perceived the nurses as lacking in compassion and responsiveness, although this was also linked with nursing shortages and the observed lack of time that nurses had to interact with patients. In addition, it is attributable to the non-disclosure policies that means that nurses are not able to communicate certain health information to patients.

A number of contextual factors unique to the socio-cultural landscape of the KSA were also evidenced. For example, it is evident that cultural perceptions of the doctor as a figure of authority and power in relation to one's health often engendered a top-down power dynamic, where patients felt constrained about asking questions or interacting with doctors. However, other patients recognised the need for a more balanced dynamic of trust and rapport. In addition, there was evidence to suggest that doctors are increasingly sharing information with patients themselves rather than with their families, as has historically been the norm in KSA. This departure from longstanding non-disclosure policies appears to promote patient satisfaction.

Furthermore, the multicultural care environment, comprising mainly expatriate nurses, had an impact on patient satisfaction levels. The language barrier with nurses who did not speak Arabic presented challenges to some patients and lowered their satisfaction with nursing care. In addition, the default English-speaking between doctors and nurses engendered a feeling of exclusion and anxiety among some patients.

The findings were mixed relating to patients' perceptions of the SRCC's operational efficiency and its impact on their satisfaction with care. While some participants

praised the SRCC for its efficiency, environment and admission processes, many voiced strong views in their criticism of two main organisational factors: accessibility to health care and waiting times. These two factors were closely linked. Many patients noted having had to wait for long periods of time to be admitted to hospital, whether for a referral, or to gain access to a laboratory test or results. This, in turn, compromised their access to the treatment they needed and greatly lowered their levels of satisfaction with the services offered.

The norm of non-disclosure was considered a common factor that influenced patient satisfaction as seen through the analysis of the all the four themes and their subsequent subthemes. Non-disclosure is complex issue in KSA. In the Western context, the patient is the key individual who is responsible for the decision making in terms of treatment, interaction with doctors and nurses, and acquires crucial information about their health which they deem sensitive. This Western form of disclosure links very closely to doctor-patient confidentiality. However, in the KSA setting non-disclosure is the total opposite as shown in the findings. Non-disclosure in the KSA setting means that information regarding the health of the patient is disclosed to the family of the patient, and the family decides which information is disseminated to the patient.

The qualitative findings add to the plethora of knowledge of interpersonal aspects that focuses on healthcare professionals exclusively. However, the findings of this research expand the knowledge of how interpersonal aspects of care coupled with service organisation influence the level of patient satisfaction. From my findings it can be concluded that patient satisfaction is closely linked to specific contextual factors that are related to the themes which have been discussed in this chapter.



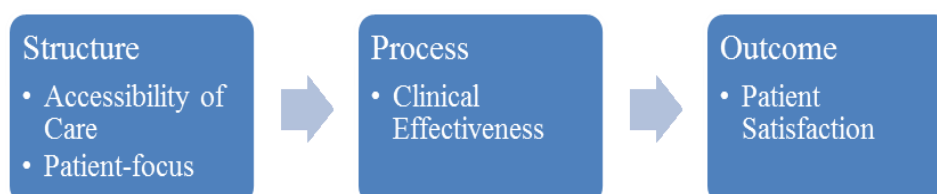
## Chapter 6 - Discussion and Conclusion

### 6.1 Introduction

In this chapter, the quantitative results from Phase 1 and qualitative findings from Phase 2 are presented together and discussed in relation to the primary research question:

RQ: What factors contribute to or hinder patient satisfaction with care in oncology ward settings at the Saudi Regional Cancer Centre in Riyadh (SRCC)?

This discussion focuses on this research question by addressing each of the sub-research questions examined in Chapters 4 and 5. The rationale for this research was developed from two principal models for assessing patient satisfaction: Donabedian (1980) and Reimann and Strech's (2010) model of patient experience (of which satisfaction formed a contingent part of 'overarching assessments'). These two models are summarised here in Figures 11 and 12, and adapted to reflect the core findings of my research.



**FIGURE 11-COLLATED RESEARCH RESULTS, ADAPTED FROM DONABEDIAN (1980)**

The research findings from the four themes that emerged from categories of 'process of care' (clinical effectiveness), 'structure of care' (accessibility to health care), and 'outcomes of care' (patient satisfaction), based on Donabedian's (1980) model are

discussed in Section 6.2. These themes are: interpersonal relations, accessibility of care, cultural expectations and organisational structure.

The second key model utilised to examine patient experience as a whole is adapted from Reimann and Strech (2010). The key findings from this model are highlighted in Figure 12:

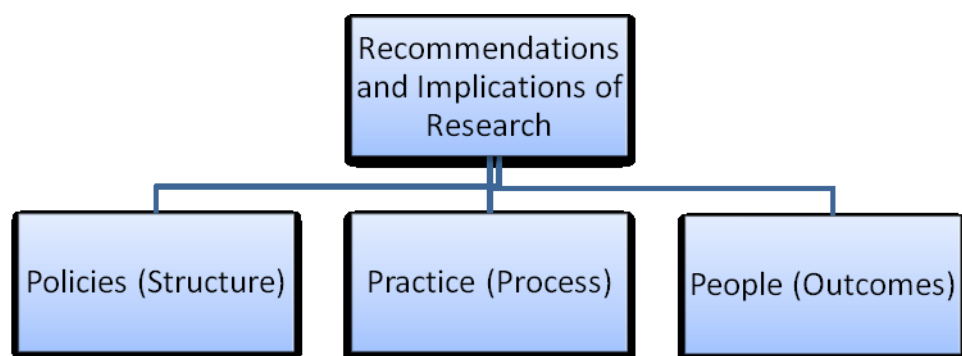


**FIGURE 12 - COLLATED RESEARCH RESULTS, ADAPTED FROM: REIMANN & STRECH (2010, P.240)**

The key contribution of this thesis to extant literature is also outlined in this section. I also argue that this study has global significance as it is the first such study of patient satisfaction in oncology ward settings in the KSA. The patient-centred focus of research is unique among studies of healthcare in the KSA, and no other assessment of patient satisfaction has been conducted in this context. It also evidences important cultural values impacting upon patient expectations of care, which subsequently impact satisfaction if they are not met. Finally, a recommendation for the development of clinical effectiveness in the wider healthcare

system of the KSA through the proposed removal of non-disclosure is made. In evidencing the damaging impact non-disclosure has upon intra-department and staff-patient communication, this research stresses the importance of open communication with the patient as key to increasing patient satisfaction.

The thesis concludes with a discussion of the contribution and implications of this research in regards to patient centred care and quality of care in the following areas: (1) patients, (2) for practice, and (3) policies. This process is outlined in Figure 13:



**FIGURE 13 - RECOMMENDATIONS AND IMPLICATIONS OF RESEARCH**

## 6.2 Overview of KSA Results

It is clear from this research that there are a number of key determinants that influence the degree of patient satisfaction in oncology ward settings in the KSA. The literature review highlighted that the major issues identified by patients as barriers to achieving quality in primary care include:

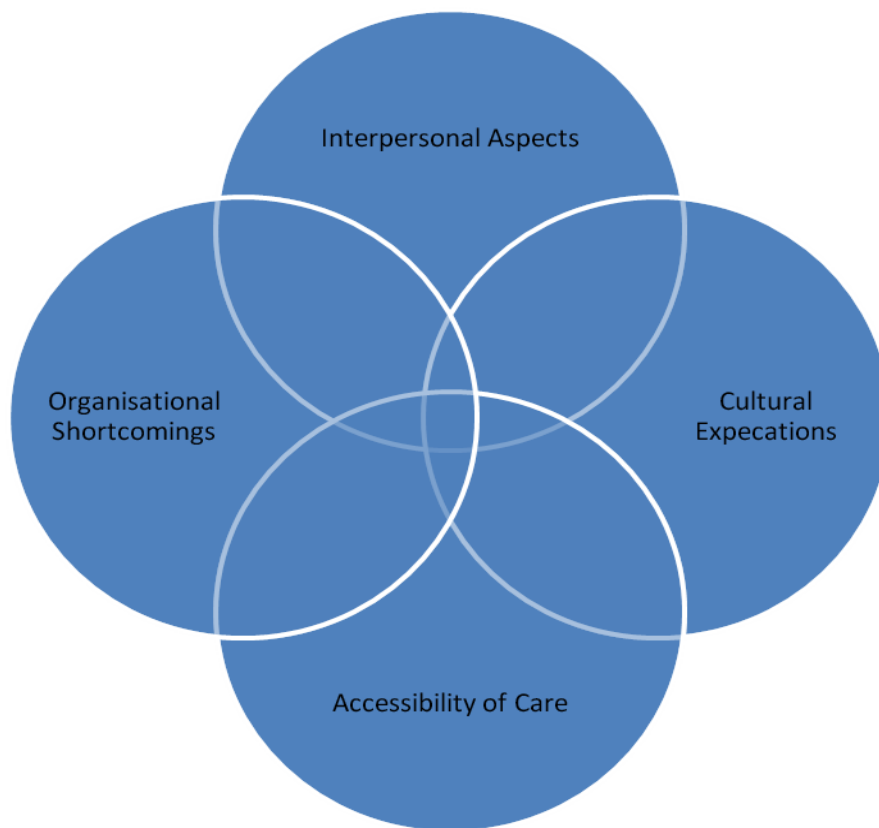
1. Poor interpersonal skills of health care providers,
2. Lack of continuity of care and accessibility,
3. Hospital overcrowding,
4. Transportation limitations,
5. Lack of efficiency in appointment systems,
6. Inadequate drug supply and laboratory services,
7. Long waiting times,
8. Short consultation times

(Adapted from: Al-Faris et al. 1996; Saeed and Mohammad 2002; Al-Ahmadi and Roland 2005)

One notable issue is that the KSA suffers from a lack of health care professionals with the necessary language skills to interact meaningfully with Saudi nationals. The quantitative results of this study provided evidence that patients' satisfaction levels are significantly influenced by the clinical effectiveness of doctors and nurses, accessibility and socio-demographic factors.

The qualitative data facilitated further exploration of these determinants and gave rise to a number of additional emergent themes related to these areas of care. For example, doctor-patient relationships, nurse shortages, and language barriers are particular areas where changes could be made to improve care, thereby enhancing patient satisfaction. These findings contribute by providing important new insights

into the interpersonal aspects of care in the light of the underlying social and cultural contextual factors regarding patient satisfaction in the KSA. These themes are demonstrated in Figure 14, and explored in depth in the discussion below:



**FIGURE 14- KEY DETERMINANTS OF PATIENT SATISFACTION IN THE KSA STUDY**

## **6.3 Interpersonal Aspects of Care in the KSA**

### **6.3.1 The Doctor-Patient Relationship**

The analysis of the quantitative Phase 1 found that, in particular, the following factors were important to patients' satisfaction: hospital accessibility, waiting time, availability of doctor and nurses. In addition, the results have shown that respondents with primary education tended to have the lowest levels of satisfaction for doctor's interpersonal skills, information provision, exchange of information between caregivers and comfort (physical environment of hospital). In order to better understand this aspect of patient satisfaction, during the qualitative Phase 2, participants were questioned on their satisfaction with these aspects of care.

One of the key themes arising from this stage of the research was the doctor-patient relationship. In recent years, the nature of the doctor-patient relationship has been extensively reviewed in the literature, and it is recognised as being one of the most important factors influencing patient satisfaction (Little et al. 2001; Mallinger et al. 2005), as well as being associated with other positive patient outcomes such as greater adherence to treatment and improved self-care (Ware et al. 1983; Cecil and Killeen 1997; Street et al. 2009). The impact that interpersonal aspects of care can have upon patient satisfaction is therefore further elucidated by the findings of study. Notably, when questioned about doctor-patient relationships it was evident that participants placed considerable emphasis on the interpersonal aspects of care. Many participants believed doctors should understand and respond appropriately to patients' emotional and psychological well-being as well as to physical needs.

The doctor-patient relationship common in the KSA is that the doctor is the authoritative figure who knows best and fails to fully take into consideration the opinions of the patient in regards to their healthcare plan. It is from this norm that many participants believed that doctors need to improve their behaviour towards patients in particular with improved communication. This concept of the need for support for oncology patients is not new (Merckaert et al. 2010; Nichols et al. 2013). However, in the cultural context of the KSA, the family and the Islamic faith are pivotal to patients' experience of care, and generally provide them with the necessary emotional and psychological support during their illness (Al-Shahri 2002). Al-Shahri's (2002) analysis of the family and Islamic faith's influence on oncology patients is reflected in my findings. From analysis it was evident that the societal structure of KSA further influences the doctor-patient relationship. A patient's family is known to influence the delivery of health care to the patient which at time undermines the patient's experience of care. Throughout the research, non-disclosure of information to patients was a pivotal issue that greatly impacted the doctor-patient and nurse-patient relationship resulting in negative outcomes of patient satisfaction. Healthcare staff turn to the family of the patient when it comes to making decisions about the patient's health. The family makes the ultimate decision of what information is shared with the patient with regards to their health and relying heavily on the family takes away from the whole foundational theme of patient-centred care. KSA doctors will be

unable to deliver healthcare using the patient-centred care model if they do not recede from using the norm of non-disclosure and an authoritative style of interacting with patients.

During the interviews, many of the participants voiced their underlying fears and anxieties regarding their condition. These findings, where patients look to doctors for psychological and emotional support, may be related to an apparent shift in patients' perceptions of their expectations of health care in the KSA. Through their responses, the participants seemed to be questioning the commonly accepted paternalistic medical model of care, where doctors are figures of authority and encourage an imbalance of power and authoritarian type relationship with their patients. The findings illustrate a desire for a more patient-centred approach to care and for patients' personal needs to be taken into account, particularly within the cultural and religious context of the KSA.

Research based on the concept of patient-centred approach to care had not been previously conducted in the KSA. An emphasis on good communication is in keeping with the findings of researchers such as Stewart (1995) and Street et al. (2009), who have argued that physicians' communication behaviour is a fundamental determinant of patient satisfaction. Similarly, my findings indicate that doctors' interpersonal communication skills represented important factors that influence patients' satisfaction levels. The four key elements to arise were: (1) doctors' listening skills, (2) information provision, (3) the extent to which patients felt motivated and encouraged, and (4) the extent of compassion doctors showed towards patients. Arguably, if doctors consistently practised such patient-centred care, there would be increased levels of patient satisfaction. A strong link was found between doctors having a motivating and encouraging attitude and building greater trust with patients. Participants who noted that doctors had a casual or uncaring attitude expressed less satisfaction. In other words, a strong emphasis was placed on psychological as well as physical needs; with many patients highlighting that a doctor should understand and respond compassionately and empathically to their psychological state. This is a first step in establishing patient centred-care, as more patients wish to be involved in their own health care. Once patients become more informed about the significance of the part that they play in shaping the healthcare they receive, doctors will be more

prone to act according to a healthcare system that is patient centred. Based on these research findings, patients are more interested in discussing their healthcare plan with their doctor and demand more involvement with them. If all patients are familiar with the notion of patient centred care, they will expect their doctors to act accordingly leading to improved patient satisfaction.

Reducing patients' psychological distress would undoubtedly serve to improve their outcomes since studies have shown that psychological distress has an adverse impact on cancer mortality (Hamer et al. 2008). Previous research which studied patient satisfaction through the opinions of healthcare professionals only, also suggests that the patient-centred approach is required to meet oncology patients' needs and improve the quality of care provided in the KSA (Nichols et al. 2013). This is also confirmed by the findings of my study which bring a new perspective to patient satisfaction in that a number of patients emphasised their desire for a patient-centred approach in which their needs were prioritized by the health care professionals.

Findings showed that despite the need for a patient-centred approach from doctors, the degree to which this was achieved by doctors was variable, with some doctors appearing to lack the ability for dealing with their patients as individuals, and with consideration. This lack of a patient-centred approach clearly had a negative impact on the level of patient satisfaction. One particular issue was the policy of non-disclosure of information to patients and this in itself is a significant factor in doctors failing to appear sympathetic and understanding. The findings of the study brought to light that a few doctors in the KSA setting are attempting to change the norm policy of non-disclosure. But a majority persist in using the current norm of non-disclosure which restricts information to patients about their health and treatment. Non-disclosure also places the responsibility of decision-making of the patient's health on the family. This takes away from the patient's power of decision-making which leads patients to become dissatisfied with healthcare delivery.

The implication from these findings is that implementing a patient-centred approach in the KSA health care system through policy reform and other initiatives could



enhance the quality of care and hence improve patients' perception of; and overall satisfaction with, their experiences of their health care as discussed in section 6.4.

In cancer settings especially, suboptimal communication between doctor and patient can increase patient anxiety and distress levels, thereby adversely affecting patient satisfaction with the doctor-patient relationship (Fogarty et al. 1999; Thorne et al. 2013). It is common for doctors themselves to be unaware of these problems. Researchers argue that there is often a large gap between patients and doctors in their perceptions of the quality of communication between them (Kenny et al. 2010). While the majority of the participants indicated that communication was of a good standard, the analysis of the perceptions of participants who were dissatisfied with the doctor-patient relationship indicates that some doctors were not adequately aware of, or concerned about, the patients' concerns and anxieties, or sufficiently willing to address them.

### **6.3.2 The Nurse-Patient Relationship**

The quantitative results provided evidence that nurses' interpersonal skills and nurses' information provision were important to patient satisfaction. A deeper understanding of this aspect of patient satisfaction was obtained during the qualitative phase by questioning participants on their satisfaction with different aspects of nursing care. One of the main themes arising was the nurse-patient relationship.

The quality of nursing care has been identified as a key determinant of patient satisfaction in hospitals in different contexts by a number of researchers (Wagner and Bear, 2009; Findik et al. 2010). Indeed, it has similarly been postulated by Johansson et al. (2002) that patient satisfaction can be affected by the nature of the nurse-patient relationship, which is often viewed as being interactive and participatory in order to meet patients' needs. In a related manner, research by Ervine (2006) indicates that the nurse-patient relationship is important if patients are to be satisfied with the kind of medical intervention they receive. The stronger the relationship, the more motivated the nurse will be to help the patient, and the patients

to cooperate with their nurse. For example, nurses must understand the patient's needs whilst the patient should follow the nurse's requests such as compliance with medication administration. This kind of mutually respectful and compliant relationship would help optimise the treatment process, promote positive outcomes, and hence, increase the level of patient satisfaction.

This research significantly contributes to international literature by bringing forth evidence that patients in oncology ward settings in the KSA expect prompt and attentive care from their medical providers. The patients require a good interpersonal relationship with their nurse as part of their care. Nurses are not merely dispensers of medicine but rather are there to support the patient. In the qualitative phase of this study, the interviews were used to probe deeper to investigate what the participants considered to be important with respect to nursing care. Two areas of concern were identified: (1) technical competence and (2) interpersonal skills. Technical competence related to nurses' professional skills at administering medication and other treatments; overall patients had positive attitudes towards such skills. Moreover, the perceptions of nurses' expertise conveyed an element of trust. However, some concerns were mentioned such as inadequate knowledge regarding the nature and dose of chemotherapy treatment being administered; this may partly explain why some patients conceived of their care as less than satisfactory.

In terms of interpersonal skills, participants felt strongly that they wanted to develop a supportive and trusting relationship with nurses, and that to do so, nurses needed to show care, compassion, and support to patients by listening to their needs. As previously mentioned, doctors were considered to be facilitators of a patient's progress towards recovery by providing them with motivation and encouragement. A similar picture emerged with nurses. A number of psychological patient needs were also evidenced in the study, showing that a lack patient-centred care that produces low levels of patient satisfaction.

The findings indicate that patients in the KSA are seeking a holistic approach to their care. These are also traits that Rchaidia et al. (2009) highlight in their cross-cultural studies, which investigated cancer patients' perceptions of the 'good nurse'. This

phenomenon appears to be universal, as it is evident across both western and eastern cultures. Rchaidia et al. (2009) described the need for nurses to 'be present' both physically and mentally to adequately support their patients. My findings add that despite the particular culture of the KSA, it begins to conform to the international pattern whereby nurses are expected to provide strong interpersonal care along with technical competence. Analysis of the interview data shows that some nurses could not be attentive enough for individual patients due to their high workloads and overall shortage of staff. Other research also indicates that nursing workloads can influence the quality of health care provided (Aiken et al. 2001; Haberfelde et al. 2005; Lankshear et al. 2005) and can therefore affect the level of patient satisfaction with nursing care. It has also been argued that nurses' workloads today are directly linked with patient outcomes (Shuldham 2009; Duffield et al. 2011), which my findings support. Moreover, the perceived shortage of nurses, which is a prevalent observation among participants is linked to patient satisfaction (Al-Zayyer 2003; Al-Dossary, 2008). Other researchers have indicated that the shortage of nurses affects patient satisfaction, and suggest that hospitals should consider strategies to better manage such deficiencies (Al-Dogaither 2000; Atallah et al. 2013). Additionally, these studies and mine suggest that hospitals should recognise that problems arising from deficiencies in nursing capacity may be further compounded when nurses are non-Arabic speakers.

The results suggest that increasing workloads can act as a barrier to achieving such patient-centred care. Other researchers have also shown how high nursing workloads can adversely influence the quality of health care (Lankshear et al. 2005). The findings of the my research agrees with this contention in the KSA context since 'availability', or the lack of time available for patient care due to nurses' busy work schedules created dissatisfaction for a number of participants. The feeling was that lack of time negatively impacted on nurses' communication with patients, creating a sense of being undervalued in the patients. It is clear that a shortage of nurses negatively affects patient satisfaction.

A perceived shortage of nurses in health care systems is universally evident within the literature, but is especially the case in the KSA where the employment of non-Saudi nurses is a common practice to fill the gap in the workforce (Al-Dossary et al.

2008). Even with the KSA Government's Saudisation programme and the fact that expatriate nurses still dominate the KSA health care system points to a need for better policies to encourage Saudis to train as health care professionals. Indeed, this contention is supported by Al-Dogaither (2000) and Atallah et al. (2013), who emphasise that KSA hospitals need to consider implementing strategies to better manage this problem, especially since the expatriate nurse force may not have the appropriate cultural and language skill set to attain high quality care. This was also an issue that emerged in my study: many of the patients were concerned that the nurses from different cultures may not fully understand their particular needs and this could be a factor influencing their level of satisfaction with the quality of care that they receive in oncology ward settings.

Additionally, nurses were believed to be acting in ways that were construed as supportive and understanding, and patients were generally satisfied with the nursing care they received; the exceptions being with some issues of interpersonal care, which were often due not to poor nursing but rather to cultural and language problems. Despite the workload of nurses, the patients were found to be more concerned with the different cultural background of many of their nurses. Cultural differences have often hindered the understanding between nurses and patients and can lead to poor communication (Luna 1998; Tumulty 2001; Aboulenien 2002). This has implications for a patient-centred approach in KSA, possibly indicating inadequate training of the expatriate nurses being recruited; with many possibly lacking specialist knowledge in oncology. Conceivably the recruitment of nurses lacking specialist knowledge of oncology could also result in inadequate or unsatisfactory patient care. This could in turn represent a significant factor in reducing patients' conceptions of their level of satisfaction with the quality of care provided (Al-Dossary 2008; Griffith et al. 2013).

The research also found that patients' concerns over nurses of different cultures could lead to problems in interpersonal relationships. In particular, differences in language were an issue that impeded the desired interpersonal relationship between patient and nurses. This is a factor in patients' quality of care and this indicates that more locally recruited nurses could improve patient satisfaction in oncology wards. Also, it would be pertinent to recommend expatriate nurses to attend workshops and

training programs that improve their language and cultural skills. This would encourage patient perceptions of greater levels of care. Furthermore, highly skilled expatriate nurses can be used to provide training to locally recruited nurses which may allow doubling the nurse work force in KSA and also give locally recruited nurses direct exposure to international standard of care by training with expatriate nurses or buddying-up with them in the hospital setting.

Language issues between patients and their carers is a factor in explaining why patients with a language barrier from health care professionals have generally lower levels of patient satisfaction in the findings. This could result in them having fewer opportunities to communicate with health professionals. As English is the most common language employed by expatriate health professionals, this may mean that the less educated patients (who generally do not speak English) will therefore have unsatisfactory interpersonal relationships with many of their nurses and this impacts negatively on their perceptions of satisfaction. In contrast, the better educated patients, often with an education in a second language, can communicate with expatriate nurses. This may result in them having a better interpersonal relationship with the health care professionals in the oncology ward settings and therefore having a better level of satisfaction. Therefore, effective language training in Arabic is necessary for expatriate nurses before they are placed in a hospital setting.

### **6.3.3 Cultural Expectations of Care in the KSA**

While health care systems vary across cultures, several studies have highlighted the significance of contextual factors in health care delivery for patients' constructions of their experiences as satisfactory. In particular, the nature of the health care delivery has a direct impact on patients' perceptions of their treatment and the quality of the care they receive (Tzeng et al. 2002; Scott et al., 2003; Siorouni et al 2012; Al-Harbi et al. 2012; Jacobs et al. 2013).

The findings have illustrated a relationship between the quality and nature of the patients' relationships with medical staff and their overall perceptions of the care being provided, which, in turn, impacts on their levels of satisfaction. However, other

qualitative issues also emerged as important to these areas, which may be seen as specific to KSA. One issue in particular worth noting is the culturally endorsed power dynamics in terms of the doctor-patient relationship. The findings evidence that cultural perceptions of the doctor as a figure of authority in relation to one's health often engenders an imbalanced power dynamic, in which patients feel constrained and reluctant to ask questions or interact with their doctors. This negatively impacts on the level of patient satisfaction. The findings indicate the need for a more balanced dynamic of trust and a greater rapport.

Saudi culture has traditionally been hierarchic but when it comes to patients' reflections on their satisfaction with their care they want doctors to respect their needs and respond to their requests. Patients expect a more personal approach from their doctors. There is evidence to suggest that there is an increasing tendency for some doctors to share information with the patients themselves, rather than with their families. This particular finding contributes greatly to the body of evidence relating to patient perception of healthcare in the various Middle Eastern countries.

Historically, studies have largely portrayed patients in the KSA as being fragile and vulnerable, with little capacity to cope with their illness (Younge et al. 1997). It is for such reasons that doctors frequently confide in patients' relatives regarding life-threatening conditions, rather than speaking with the patients themselves (Younge et al. 1997). There is a wealth of past evidence indicating a lack of effective communication between physicians and patients with serious illness (Mobeireek et al. 1996; Elzubier 2002). The findings have brought to light an attempt to engender a cultural shift, in which patients in the KSA are given full disclosure of their diagnosis and prognosis. However, based on my findings this shift is only evident among a few doctors. Regardless of how small the number is; this shows that some doctors are attempting to change the current non-disclosure policy to one which is patient-centred.

The study found that culture is a factor in patient satisfaction. Health professionals' failure to recognize the cultural needs of a patient are a factor in their level of satisfaction. A multi-cultural environment was a significant theme that emerged from

the qualitative analysis of the findings which had a significant impact on nurses and ultimately on patient satisfaction. Although culture per se was not a significantly dominant theme that emerged in the results of the quantitative phase of the study, it did highlight the impact of the multi-cultural hospital environment on patient satisfaction, in particular concerns about language and difficulties in communicating.

This research showed that there is a need for health professionals to be more culturally aware when it came to providing patient care in oncology settings in KSA. This may be specific to the Islamic context of the KSA, and it is not unexpected, given the fact that the health care environment has its own cultural context, which can affect patient satisfaction (Rafii et al. 2008).

The qualitative phase served to enrich current knowledge in this area, indicating that expatriate nursing staff experienced some challenges in communicating with patients due largely to the language barrier. Many patients noted that they could only express their emotions and needs in Arabic, which certain nurses were unable to understand. Indeed, barriers in communication were widely seen to adversely affect provision of information to patients.

The findings raise the issue of cultural considerations in patients' satisfaction with their care. There is an anxiety among some patients that the multicultural context of a KSA oncology setting could detract from the quality of care they receive. In order to enhance patients' satisfaction further, there is a need for nurses to employ greater sensitivity to the particular characteristics and background of individual patients and tailor their communication accordingly. In other words, the findings convey the need for a tailored, individualised approach towards patients rather than assuming a standardised approach, which the expat nurses were seen as routinely delivering. Staffs in oncology settings need to be aware of the cultural considerations when they are providing care in oncology wards in the KSA. Failure to do so will result in failure to deliver true patient-centred care. These cultural considerations do not only encompass an Islamic dimension but should also include all cultures and beliefs that are present within the patient population within KSA oncology wards.

A further cultural issue that emerged was the stigma associated with cancer. The potential impact this has on prognosis, due to stigma acting as a barrier to screening, is especially concerning (Younge et al.1997; Elkum et al. 2007; Al-Amri 2010). A further theme was how, within the KSA, cancer diagnosis extends beyond stigma and is perceived by some as a death sentence, instilling great fear and a sense of doom. This further highlights how health care workers in the KSA must develop good interpersonal and communication skills, to support cancer patients. The improvements in medical knowledge and prognosis, and hence, survival rates, should help alleviate such fears. However, in the KSA context, there is a cultural barrier to overcome before these issues can be properly addressed.

#### **6.3.4 Summary**

To summarise, patients perceived the interpersonal skills of both doctors and nurses as being significant contributors to satisfaction with their care. Additionally, patients felt these health care professionals should ensure that they relate well to their patients and provide the best patient-centred care possible, so as to minimise distress and anxiety. This should in turn optimise patient outcomes. It was also evident that expatriate nurses could potentially exert a negative impact on patient satisfaction, largely arising from the language barrier although the idea of patient-centred care is a statutory requirement for registered doctors and nurses in the UK (NMC 2010), this is a relatively new perspective of care in Middle Eastern countries. My study has revealed evidence to suggest that, at least in the oncology ward settings investigated, patient-centred care is assuming an increasingly prominent role in the KSA, though there are still areas of concern over cultural issues among patients.

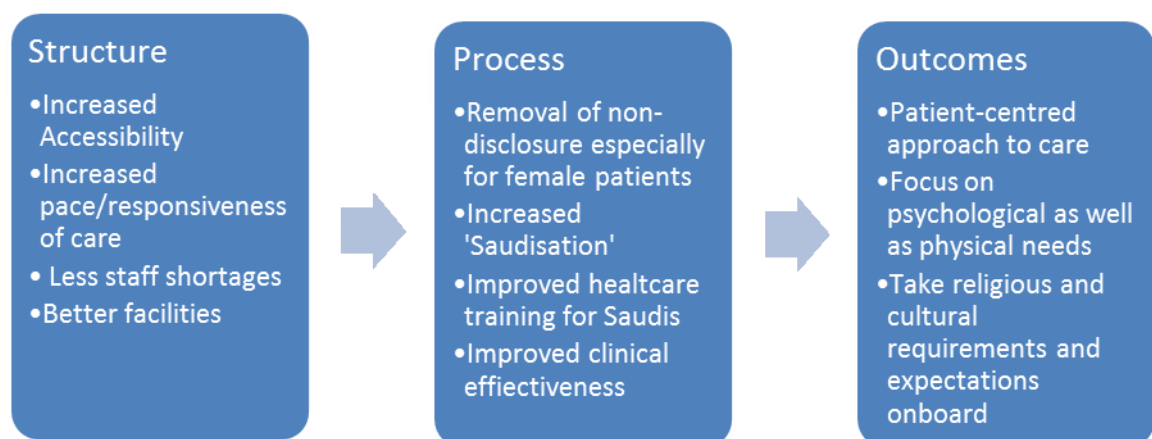
KSA authorities should be willing to address such issues in the care of oncology patients through policy reform, in particular by developing strategies that will help healthcare professionals deliver patient-centred care practices. Such strategies may include developing programmes that bring awareness to patients about their rights and importance in healthcare delivery. Also, KSA authorities should also conduct special workshops and introduce training for doctors to help them in coming out of



the authoritative stance of delivery of healthcare to one which is more patient centred. Furthermore, language and culture training should be given to expatriate nurses to help them in providing improved care to KSA patients and locally trained nurses should also be recruited.

## 6.4 Implications for Improved Patient Satisfaction in the KSA

As noted in 6.1, this thesis has a number of implications for practice, patients and policy. These are extrapolated and outlined in Section 6.4. These recommendations are based upon the Donabedian (1980) model, and have been categorised into structural, processional, and personal implications for improved outcomes. These are illustrated in Figure 15:



**FIGURE 15 - IMPLICATION OF RESEARCH IN ONCOLOGY WARD SETTINGS IN THE KSA, ADAPTED FROM DONABEDIAN (1980)**

### 6.4.1 Organisational Structure in Oncology Ward Settings in the KSA

The results of the quantitative survey indicated that certain aspects of services and care organisation adversely affect levels of patient satisfaction. Accessibility, such as ease of movement of patients from one facility to another, and availability of services, such as screening and testing, were important considerations in this regard. Additionally, attitudes of health care personnel (showing kindness and being helpful), provision of information, and waiting times were other key issues. Considerable

variation in responses was especially evident regarding satisfaction with waiting times for performing medical tests/treatment. In order to better understand this aspect of patient care, and in keeping with the mixed method design, the qualitative phase included questions on organisational efficiency and how it affected participants.

Although it is encouraging that when questioned about the health care system the majority of participants gave positive responses, there were also some negative responses concerning the accessibility to health care facilities. Discussions with participants regarding organisational issues exposed a number of failings; poor accessibility in relation to waiting times was particularly concerning to many participants, especially given the perceived 'life-limiting' nature of cancer. The slow pace at which care and information was given also served to heighten patients' anxieties. The lack of availability of single rooms was a further area of concern, as several participants felt sharing a room with several others was detrimental to their spiritual and physical well-being. If they are in a crowded room, the patients tend to feel undervalued and even neglected and this could lead to them having a poor sense of satisfaction with their care.

It is widely accepted that quality of care relates closely to the organisation of health care delivery, including structure and process (Donabedian 1980; Campbell et al. 2000; Donabedian 2005; Fenny et al 2014). It is therefore not surprising that the organisational deficits identified here would adversely influence the cancer patients' perceptions of the care being provided, hence, resulting in lower levels of satisfaction (Stizia and Wood 1997). Pascoe's (1983) early conception of patient satisfaction identified it as a combination of the personal health care experience and evaluations of health care services in general.

This was clearly the case where the lack of single rooms, overcrowding, staff shortages, and lack of organisational efficiency in the oncology ward where the study was conducted impacted on patient satisfaction. This would indicate that authorities should seek to create an environment in an oncology setting that makes a patient feel comfortable and this will have a positive impact on their sense of wellbeing. This

would also increase patients' confidence that they are in a setting which can cater for their needs and fulfil their goal of restoring them to health and wellbeing. This confidence will allow them to reflect positively upon their treatment and raise their satisfaction levels. In particular, there needs to be enough staff to enable them to spend time on the needs of patients. The presence of more staff on the ward would help to reassure patients, who are often distressed and anxious. Furthermore, the extra staff would be able to provide more time in caring for patients and allowing them the opportunity to treat them as individuals.

#### **6.4.2 Process in Oncology Ward Settings in the KSA**

Policy and medical reforms are of paramount importance in the KSA, with evidence-informed policy development being a vital part of improving patient care (Snilstveit et al. 2012). There is a clear need for local policy makers, and more widely, for the Saudi Ministry of Health to confront the failings of the KSA health care system highlighted by this research. Policy-making authorities need to recognise that there are currently a number of unacceptable standards; they must embrace the challenges of improving patient satisfaction in oncology settings by taking appropriate steps. The findings of this thesis provide valuable evidence to guide policy reforms, so that new health care service policies can focus on improving the key aspects of patient care that patients are most dissatisfied with.

To enable patients to feel that they are receiving a good level of care there needs to be a policy to promote communication between staff and patients. Although there is a start in terms of a shift in the policy of non-disclosure to patients, this can still remain a problem for a number of patients, particularly female patients. As mentioned in the findings, female rights in KSA are quite restricted. They need a '*wali*' or guardian, who needs to be a male. The male guardian changes throughout the stages of their life transitioning from being single to becoming married and then having children, and therefore the impact on the patient may change depending on the nature of the guardian and the patient's age. Female patients' health care in terms of their interaction with medical staff, patient medical information, treatment options, and decision making is solely the responsibility of the male guardian due to the status of females in KSA.

There is also a need to ensure there is sufficient recruitment of Saudi medical and nursing staff, in line with the KSA's existing policy of Saudisation. And finally, there are changes in the organisation of health care in this context that also need to be addressed.

#### **6.4.2.1 Adopting Increased Disclosure**

A further implication arising from the research relates to policies regarding disclosure of diagnosis and prognosis and provision of patient information. In the past, patient nondisclosure regarding life-threatening or terminal illness was universally common (Field and Copp 1999). In contrast, nowadays, requests for disclosure increasingly represent a departure from the norms of clinical practice in the KSA towards those of Western societies (Field and Copp1999).

My findings suggest that the authoritarian approach by doctors still is influential among some, who may not see disclosure as relevant or important for a patient. There is a pressing need for health care providers and policy makers in the KSA to embrace the idea that doctors should be required to tell patients the truth, and that disclosing diagnoses to patients is their moral and professional duty. Failure to fully disclose information on a patient's condition to them could lead to an irretrievable breakdown in relations between doctor and patient.

Achieving this would require the formulation of guidelines outlining a systematic process to follow for breaking bad news. To this end, doctors could be advised to follow an approach involving effective communication and negotiation skills, for example by adopting the model developed by Hallenbeck and Arnold (2007), which has already been found to be highly applicable to the KSA setting. Aljubran (2010) suggests that this approach should be formally developed and taught in medical schools, as well as being part of postgraduate training in order to promote doctor-patient communications. This is essential if doctors are to develop the good interpersonal relationships with patients which are necessary for a patient-centred approach.

Based on my analysis, non-disclosure of health information to patients was a major cause of patient's being dissatisfied towards the healthcare they received. Doctors and nurses in the KSA setting need to be trained in terms of helping them understand that patients are the focal point in the delivery of healthcare. In order to provide adequate healthcare and appropriate treatments doctors and nurses need to involve patients more than their families. This means providing patients with diagnostic and prognosis information, setting up treatment plans, and communicating with patients throughout the healthcare delivery process. The Ministry of Health in KSA can enforce this by providing patients with the legal knowledge of their rights.

#### **6.4.2.2 Encouraging Healthcare Training**

All of the previous failings that have been highlighted, namely, patient nondisclosure, poor patient information provision, and physician-centred care, have doctor-patient communication at the heart of the problem. However, a breakdown in some aspects of nurse-patient communications was also a feature identified as problematic as the research indicated language problems of expatriate nursing staff.

The findings support the Saudi government's Saudisation programme to encourage more Saudis to train as health care professionals to progressively replace non-Saudis in the KSA health care system (Al-Dossary et al. 2008). It is evident from the findings that this approach is vital, not just to address the shortage of health care workers but, equally important, to tackle the general lack of cultural awareness and the poor language skill set of non-Saudi or expatriate nurses.

Unfortunately, the Saudisation process is progressing very slowly in the health care sector, and is hampered by the fact that nursing in the KSA is not viewed highly as a profession for women (Miller-Rosser 2006). This rests primarily on the fact that women are expected to meet the demands and needs of their family first and foremost (Maben et al. 2010). It would seem that not enough is being done to

address this issue and there is a need for education and social policies that allow women to train and work as nurses and also to meet the needs of their families.

In order to expedite the Saudisation process, robust local and national policies are needed to implement strategies in hospitals to encourage women and educators to develop a more positive view of nursing as a career. So, supporting this cultural change could enhance perceptions and the value of nursing, and thus to facilitate the education and career development of a number of Saudi women. Since the overall pace of the Saudisation process is quite slow, it is recommended that the Ministry of Health and other KSA authorities recruit healthcare workers internationally that have an intermediate understanding of the Arabic language. The KSA authorities can also provide language training for international healthcare workers to learn the language in order to provide improved care to patients. This has been evidenced to increase patient satisfaction by improving communication between staff and patients, and reducing patient anxiety.

A greater number of linguistically and culturally competent doctors and nurses are therefore required in the KSA, especially those who are familiar with implementing patient-centred care and supporting patient autonomy. This will enhance patient satisfaction, as those from the same culture will not only be able to communicate with patients in Arabic, they will also be more likely to develop good interpersonal relationships and allay patients' anxieties over cultural and religious differences with expatriate staff members. This could also raise the level of patient satisfaction in oncology ward settings.

#### **6.4.2.3 Improved Service Organisation and Clinical Effectiveness**

The failings identified in organisational efficiency in service provision also serve to inform health care providers and policy makers. The need for improved service organisation, through the design and implementation of more effective and efficient systems and processes to better meet patients' operational expectations is clear.

Moreover, the exchange of information, information on discharge, and cleanliness were further significant areas of service organisation that were indicated as needing improvement. These quantitative results could mean that effectiveness affects satisfaction more than kindness. The qualitative findings underscored the need for addressing the issue of waiting time, as it was found that accessibility to health care and waiting times were closely linked and greatly lowered their levels of satisfaction with the services offered.

In summary, it appears that more effort is needed by the Government towards encouraging a change of attitude in healthcare professionals and the public of KSA to facilitate patient-centred care and patient autonomy. This research found that patients wanted more consultation with doctors and a conscious effort by health care providers to develop interpersonal relations with patients to enhance the patients' ability to communicate their needs and desires, especially with regard to information on their condition.

If these issues are addressed, then patients' autonomy would be increased in oncology ward settings in KSA. This is particularly important given the ethical principles and Islamic values which underpin the legal and moral aspects of society and public opinion in the KSA. It is also important that hospital management teams formulate local policies and guidance aimed at supporting aspects of care valued by the patients. This would facilitate a more balanced, trust-based relationship between health care professionals and patients, and ultimately improve patients' levels of satisfaction.

#### **6.4.3 Patient-Centred Outcomes in Oncology Ward Settings in the KSA**

One of the most prominent findings of this research is the fact that many oncology patients in the KSA appear to be rejecting the paternalistic medical model of care commonly practiced in the region, preferring instead a more holistic, patient-centred approach, which takes account of their psychological as well as their physical needs. This would suggest a need for health care professionals and policy makers to recognise that the imbalanced, authoritarian type of relationship that doctors have

previously had with their patients is unproductive and potentially detrimental to patient outcomes. Instead, policy makers should consider the introduction of initiatives and methods to educate health care professionals in patient-centred, rather than physician-centred care.

Patient-centred care enables patients to feel part of the treatment process and as part of the decision-making process. Communication is crucial for any patient-centred approach. Nurses and doctors need to be able to give patients information and establish a rapport with them as part of the process of providing patient centred care.

I recommend that the authorities could help the many expatriate nurses and doctors by providing them with more workshops and training in communicating with Saudi patients by teaching these expatriates the Arabic language and culture. Furthermore, training in the process of patient centred care is required. If the medical staff try to engage with patients routinely this could lead them to construct their experiences in oncology ward settings in a positive way.

## **6.5 Contributions of Research to Existing Literature on Patient Satisfaction in KSA Oncology Ward settings**

The thesis makes a contribution to understanding patient satisfaction in oncology ward settings in the KSA and the factors that influence patient satisfaction. This is a significant contribution as patient satisfaction has not been researched in KSA from a patient-centred perspective. As such, this research makes an international contribution to academic literature. In particular, it provides insight into patient satisfaction in a non-Western context, where cultural values of health care, and particularly patient satisfaction, are measured in relation to the local Saudi cultural context. Health care in the KSA is becoming increasingly westernised; alongside this there is the parallel process of the Saudisation programme currently being implemented in the KSA health service. Therefore, this exploration of patient satisfaction and experience in KSA provides a great deal of valuable knowledge



which will serve to help enhance future delivery of health care in a rapidly developing context.

My findings have in particular, provided valuable new insights into the meanings and descriptions of factors which underpin and influence patient satisfaction in the oncology ward settings in the KSA. These factors include interpersonal relationships, disclosure and cultural issues. The study has significantly contributed to the body of knowledge available in this field, generating evidence that is of significant potential to policy makers and hospital management teams wanting to improve the care of the population studied by improving healthcare delivery by health care professionals. It is also conceivable that the results may be cautiously generalised to other patients receiving care in hospital settings in other Middle Eastern health system (and other developing world contexts) and who are suffering from life-threatening or terminal illnesses.

The study has also offered a framework for analysis of the theory of patient satisfaction, based on its particular context of findings from the KSA and in doing so makes a contribution to the theory of patient satisfaction in general.

For all these reasons, my study makes an important contribution to patient satisfaction studies, not only in the KSA, but internationally and throughout the Middle East because of the KSA's increasing Westernisation and influence in the region. It focuses on all the factors that are influential in the construction of patients' concept of satisfaction. The findings can help to fill the knowledge gap in the KSA surrounding patient satisfaction, including the possible impact of doctors' and nurses' perceived clinical effectiveness and the perceived accessibility of services. It also makes a contribution to the wider international debates about patient satisfaction, since it explores the issue within a particular, non-Western cultural context.

A primary contribution of the study lies in its sequential explanatory mixed methods design which allowed for the research question to be answered effectively. A mixed methods approach is widely recognised as offering a greater likelihood of answering

research questions, particularly when there is a limited amount of existing research on the topic under investigation, as was the case here (Johnson and Onwuegbuzie, 2004; Health Foundation 2013). It facilitated acquisition of a rich data set to allow assessment of the level of patient satisfaction in relation to processes of care, structure of care, and the outcomes of care in a KSA setting.

Phase 1 was able to extract the numerical value of the important factors that influence patient satisfaction based on the patient questionnaire, while Phase 2 gave insight into patients' opinions on the specific factors which influence their experience with the healthcare delivered and overall their satisfaction with the healthcare provisions. This process demonstrates the complementarity of the MMR, and so enhances the validity of the results. Another reason why the qualitative component of this study was necessary was that there has not yet been a qualitative study on patient satisfaction in the KSA. So this aspect of the research represents a contribution to the field of study in the KSA.

Another methodological decision, the choice to use a patient satisfaction questionnaire in the quantitative phase, was made because it has been well-validated in both Western English-language settings and Arabic (Morocco) language setting (Bredart et al. 2005; Obtel et al. 2012). Further, the instrument developed as a methodological tool for this research has been developed specifically for oncology settings. The applicability of this model to other hospital-ward settings presents a further contribution of this research to existing literature.

The mixed method approach has allowed for a variety of perspectives to be examined with regard to patient satisfaction in KSA oncology wards. This approach has also helped deepen the understanding of the factors influencing patient satisfaction with quality of care provided in the study setting. By utilising the findings of this research to guide further research and/or inform policy makers during their design and implementation of reforms, there could be improved patient satisfaction.

An additional benefit of combining data in MMR in the manner adopted here provides complementarity, or explanatory power. The former has been described as when the results of one research method are used to elaborate or clarify the results of another, thus achieving a fuller understanding of the phenomenon (Sale et al. 2002; Creswell 2003; Bowling 2007). The latter is defined as involving two phases where qualitative data helps to explain and expand upon initial quantitative results (Creswell et al. 2003). Complementarity has therefore served to enhance the credibility of the findings. To facilitate a sequential explanatory mixed methods design the semi structured interviews in the qualitative Phase 2 synthesised general explanation of the factors that influenced oncology inpatients' satisfaction with the quality of their care.

The fact that analysis of the first quantitative phase began as soon as data was collected proved advantageous. This allowed me to start to code the data early and develop a coding manual hence paving the way for the qualitative phase and ensuring that the interview questions were appropriately focused with regard to the research question.

The Donabedian (1980) model and the Patient experience model (Reimann and Strech 2010) were used to assess what factors contribute to patient satisfaction in oncology ward settings in the KSA. These models were chosen because they illustrated an analysis of a wider patient experience including satisfaction. Moreover, they were highly flexible and do not seek to impose a definition of what quality of care is. Applying these models facilitated gaining a deeper understanding of cultural issues of patient satisfaction.

## **6.6 Limitations of Research**

The main aim of the study was achieved; however, upon reflection various limitations can be identified. Certain limitations arose because this was a single centre study constrained by official policy which restricted sampling, recruitment, and the timeframe for conducting the research in oncology ward settings. The limited time available for the fieldwork and restriction of the research to only one hospital arose

from KSA regulations and governance. These in turn resulted in the sample size being restricted due to factors such as patient diagnosis, ward-size, frequency of patients to number of beds, etc. Indeed, during the initial data collection phase, the relatively small sample raised concerns over confidence of the data analysed being large enough to reveal significant patterns, themes and relationships. Despite these concerns, sufficient data were collected to perform reliable statistical analysis.

Additionally, recruitment from a single centre limited the generalisability of the data. That is, it raised a question of how (and to what extent) the findings from this location were representative of the general levels of satisfaction of oncology patients in the KSA receiving such care. There was also the issue that this was the first study of its kind. This meant that there were no previous studies upon which to base a sample size calculation and no way to learn from others' experiences or the limitations of such studies. However, research conducted on patient satisfaction in other setting did prove to be a useful resource that helped to guide me through study planning, and the collection and analysis of data.

For future studies, these constraints could be overcome by addressing the policy of sampling and recruitment beforehand and aiming to conduct a larger, multicentre study. In this way, researchers would be able to devise a logistically sound research plan, which would adhere to official policies whilst also ensuring the sample of the study is of adequate size to enhance reliability of the data. In addition, a multicentre study would facilitate the capture of more diverse opinions from a wider population, which means the results would be more generalisable to other oncology ward settings and be more representative of the wider healthcare sector in the KSA as a whole. Nevertheless, the findings may still be transferable to other settings that have similar characteristics and populations.

The nurse educator was completely aware of the need to avoid study bias whether selection bias or investigator bias. However, although during study conduct all attempts were made to minimise such bias, there was inevitably some potential for unintentional bias. For example, the manner in which the data was collected could be unintentionally biased. In this study the sample obtained was through convenience

sampling; that is the sample was composed of individuals that were available for the survey. Efron (2012) asserts that such forms of sampling can be biased as they include people whom the researcher chooses based on established criteria that they create themselves. Such a technique may occasionally result in over-sampling people who have strong opinions and under-sampling individuals who do not care much about the topic of the survey. Conceivably, the decision to participate may reflect some inherent bias within the characterisation or traits of consenting patients. Thus perhaps those individuals willing to participate may have been individuals who were largely satisfied with the system. Alternatively older patients, because of their cultural expectations, may have felt compelled to participate in the study, even though it was made clear to them that participation was voluntary. Accordingly, the use of this specific sampling method could conceivably have resulted in a degree of self-selection bias.

A further potential limitation was regarding whether patients answered the questionnaires truthfully, particularly as the nurse educator was sometimes involved in helping them complete the questionnaires. However, there were very few instances of patients needing nurses' help and therefore the vast majority of responses were independent of any input from the nurse educator. Nevertheless, there was an issue of a patient receiving help from family members when completing their questionnaire and this could have led to inaccuracies in the data, for example if a relative made suggestions regarding responses or if they failed to accurately record the patients' actual response.

A further potential limitation were concerning participants' (or the family's) literacy skills to fully comprehend and answer the questions and the fact that translation of the interviews from Arabic to English was not verbatim which meant that there was a possibility that there was a risk of losing the meaning of particular responses. To avoid this loss of meaning, every effort was made during translation to taking into consideration the context of the answers. Thus during translation simple, commonly used English words were used to try to accurately reconstruct the meanings of the respondents, thus ensuring that the participants' views during the interviews were appropriately captured. Finally, during the qualitative phase, there was a gender

imbalance in the sample recruited, due to a lack of gender diversification among the sample. This represents a further limitation of the data.

## **6.7 Recommendations for Future Research**

The research strategy employed in this study could be further developed in order to better understand patient satisfaction in oncology ward settings and in other inpatient settings in the KSA. Indeed, the complex multidimensional nature of patient satisfaction illustrated from the results presented here would suggest the need for further studies to explore the reason for and the extent of patient satisfaction or dissatisfaction in this setting. Accordingly, the results of the study and its limitations have informed a series of recommendations with regards to possible future research, as outlines below.

In order to build on the findings presented here, further research regarding patient satisfaction in the KSA should be multi-centred and recruit larger numbers of participants from a more diverse population. In doing so, it would be prudent to draw up quantitative questionnaire and qualitative interview methods specific for use in the KSA which would allow for even greater collection of relevant data about patients' satisfaction with their care and their levels of satisfaction. Research into the possibility of developing standardised tools to be used by researchers in order to uniformly collect data on patient satisfaction with quality of care in various inpatient settings in the KSA should be encouraged.

Collating a robust, rich data set about patient satisfaction should involve the collection of data using a mixed methods approach, as illustrated in this study, but without time and resource restrictions. Through the MMR approach, the researcher is able to use qualitative and quantitative data, which complement each other and produce results that can provide an in-depth insight into patient satisfaction. Mixed method research would allow for a deeper understanding of patient satisfaction with care nationally and over time, and enable health service providers to adjust their care in order to provide greater patient satisfaction. During such studies, it would be beneficial to examine and measure the specific impact of patient-centred care as a

domain in patient satisfaction, plus incorporate a quality-of-life measure, which can be linked to levels of satisfaction. The quality-of-life measure should take into account the specific cultural needs of Saudi patients, and not just take account of their sense of physical and mental well-being. Any further research on quality-of-life measures should be adapted to reflect the specific contexts of Saudi cultural and religious values, and how these impact on medical staff, patients, and the running of hospitals.

It is evident from this study that patient satisfaction is subjective and based on a number of socio-cultural and demographic expectations of care, which may be impacted by the nature and severity of the disease, for example the poorer the patient's prognosis the higher a patient's expectations of rapid and high-quality care. This is an area which could be investigated in a larger, multicentre study through stratification of disease severity against constructs of patient satisfaction.

In addition, further research could investigate culture in greater depth, for example by developing a greater understanding of how to enhance culturally competent communication between patients and health care professionals from different backgrounds; also by exploring the extent to which culture positively or negatively influences patient care and satisfaction in the context of the power dynamic in doctor-patient relationships in the KSA. A deeper understanding of the cultural factors that impact upon patients' relationships with their nurses and doctors could inform policy makers and potentially improve patient outcomes.

Another important research topic, which could be pursued is the impact of the Saudisation process on patient satisfaction, and the factors behind the limited success of the Saudisation programme. There needs to be more research on how Saudisation can enhance levels of patient satisfaction, with particular attention to nurse-patient and doctor-patient communication, and the cultural sensitivity of health care staff. Further, it would be important to determine whether the shift to Saudisation in KSA oncology ward settings could ensure greater patient satisfaction at the cultural level and lead to an improvement in communication between patients and health care professionals, and result in improved patient satisfaction with their care.

Saudisation should not only be seen as an economic necessity, but also as a necessary strategy to improve the quality of care in oncology ward settings.

Effective, therapeutic relationships between patients and their nurses or doctors are critical for successful health outcomes for patients. My research has shown that there were occasionally problems in these relationships due to cultural differences between the Saudi patients and the mainly expatriate medical/nursing staff. Future research should aim to provide a greater understanding of how cultural barriers can be overcome to ensure effective relationships between nurse, doctor and patient. There also needs to be research on how to provide models for explaining the relationships between expatriate health professionals and Saudi patients, and models to exemplify how expatriate doctors and nurses can interact in ways that could improve communication with patients, as this has been shown to be critical to a therapeutic, person focused relationship. There would also be a need to consider how such models could be implemented within hospital oncology ward settings, in the KSA and beyond.

## **6.8 Conclusions**

This study was centred on the research question:

RQ: What factors contribute to or hinder patient satisfaction with care in oncology wards setting in the SRCC?

Table 6.1 evidences how factors relating to patient satisfaction are categorised by each model, and corroborated to offer a synopsis of the central findings in relation to each RQ and SRQs.



Relational Model		Donabedian (1980)	Reimann & Strech (2010)	Findings
<b>RQ1</b>	Factors that hinder patient satisfaction	Structure, Process & Outcomes	Overarching Assessments	Interpersonal, Cultural Expectations, Organisational Limitations all impact upon overall satisfaction.
<b>SRQ1</b>	Socio-Demographic Characteristics	Outcome	Interactions	Socio demographic characteristics impact upon patient satisfaction
<b>SRQ2</b>	Clinical Effectiveness	Process	Organisational/ Interaction	Determined by contact between staff and patients, and effective communication and treatment.
<b>SRQ3</b>	Accessibility	Structure	Organisational	Limited waiting times. Primary access to treatment. Responsive staff.
<b>SRQ4</b>	Interpersonal	Structure	Interactions/ Organisational	Non-disclosure negatively impacts upon patient satisfaction and hinders communication between staff and ultimately treatment.
<b>SRQ5</b>	Socio-Cultural Communication	Process	Interactions	Expectation of immediacy of care. Doctor –patient power dynamics, Family and Religious factors impacting upon patient satisfaction

**TABLE 6. 1 INTEGRATED RESEARCH QUESTIONS AND PATIENT SATISFACTION FRAMEWORKS**

This study also aimed to provide recommendations to improve patient satisfaction in SRCC setting in the KSA. It is clear from the findings that levels of patient satisfaction were based both upon patients' physical treatment and upon expectations as to the standard of care they hoped to receive. Not only was patients' satisfaction with the quality of their care shaped by the nature, speed and efficiency of their treatment and the environment in which it takes place, but it was also influenced by the sense that

their psychological needs were being addressed as well as their physical health needs. Patients sought a caring and sensitive approach from their nurses and doctors and their satisfaction depended on strong interpersonal and individualised care. Patients also sought a patient-centred approach from both nurses and doctors.

Of particular importance is the fact that patients wished to be informed of their prognosis and treatments. This is contrary to the generally accepted traditional practice in the KSA, where physicians provide information about serious illnesses and treatments to family members first and seek approval before informing the patient.

Doctors, nurses and health care organisations are seen by patients as providing not only physical care but also psychological support. This suggests the need for development of the doctor/nurse-patient relationship and for healthcare providers in oncology ward settings to deliver a patient-centred approach. It is evident that the four emergent themes were related to the patients' needs to feel secure and have confidence in their nurses, doctors and health care setting. Therefore patients' views must be taken into account if improvements in patient satisfaction and high quality care are to be attained. This examination of how to improve interpersonal relationships could then inform policy makers and ultimately lead to not only improved perceptions of the quality of their care, but could also conceivably lead to real improvements in patient outcomes.

My study has added valuable knowledge to the previously under examined field of patient satisfaction with care in oncology ward settings in the KSA. It has highlighted factors that influence patients' satisfaction with the quality of their care. In particular, it has provided evidence of a need for healthcare professionals in the oncology KSA health system to develop strong, interpersonal relations with their patients and practice a patient-centred approach. The new theories and fresh evidence provided by this research will be of substantial significance to policy makers and hospital management teams in the KSA wanting to improve patient satisfaction in oncology ward settings.

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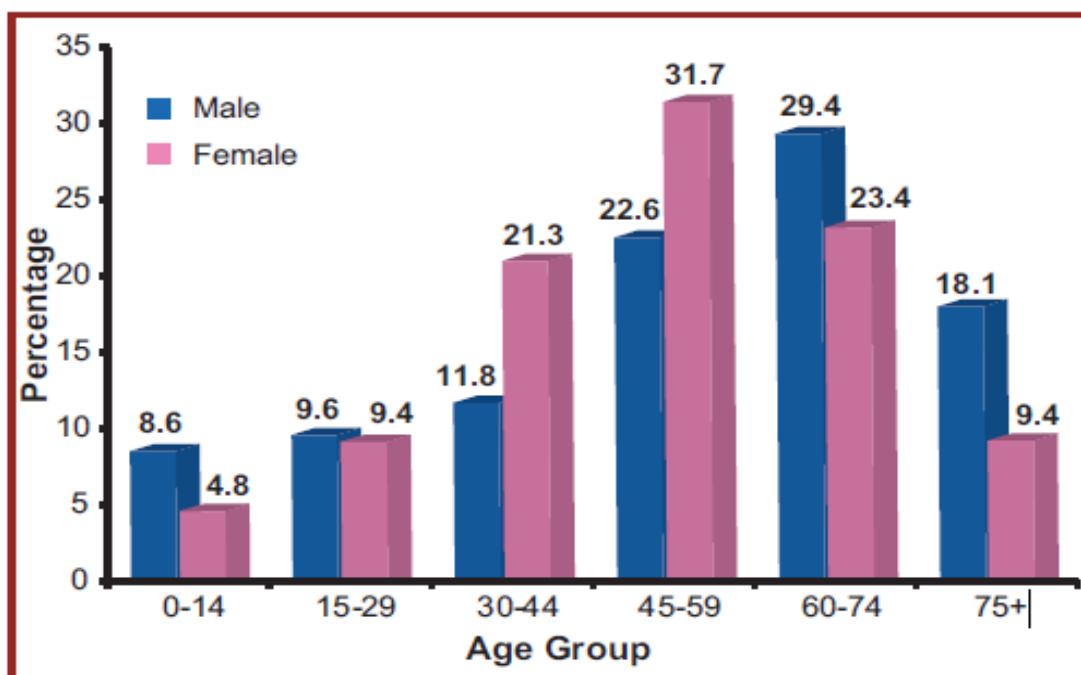
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## **APPENDICES**



**Appendix1: Percentage Distribution of Cancer Incidence among Saudis by Sex according to Age Group, 2010 (Saudi Cancer Registry 2010)**

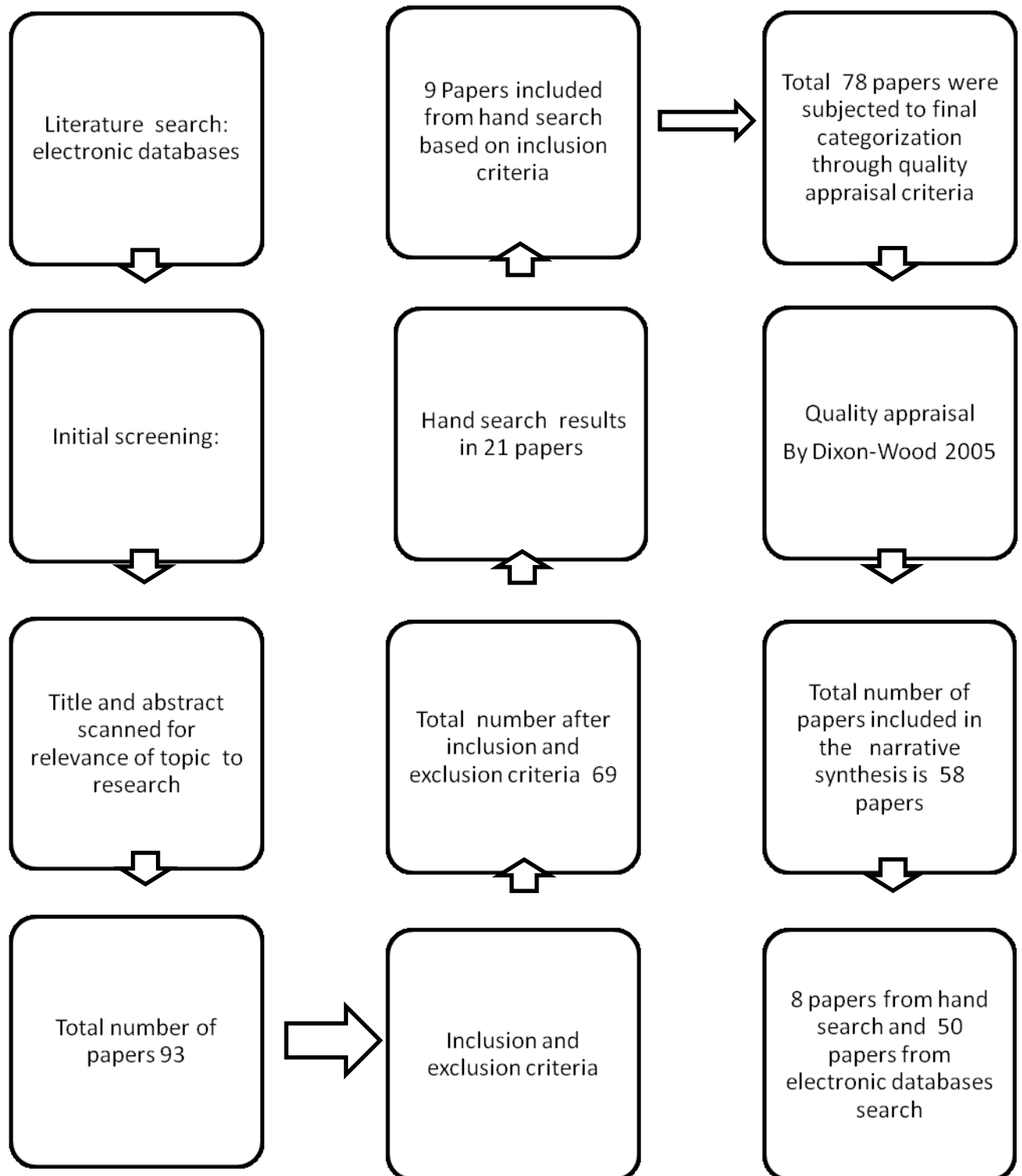


## Appendix 2: Search and screening process

DATABASES SEARCH DATE: 07-01-2014

Databases	Search terms	Results
<b>Science direct</b> <b>Limiters:</b> <ul style="list-style-type: none"> <li>Published Date: 1980 - 2014</li> <li>English Language</li> </ul>	patient satisfaction, quality of care patient satisfaction, Saudi Saudi patient satisfaction, quality of care Saudi Cancer, patient satisfaction, quality care	4969 papers returned 100 papers returned 38 papers returned 467 papers returned
<b>Boolean operator AND , OR</b>	quality health care, Saudi communication , Saudi, quality of care	177 papers returned 219 papers returned
<b>CINAHL</b> <b>Limiters FOR CINAHL :</b> <ul style="list-style-type: none"> <li>Published Date: 1980 - 2014</li> <li>English Language</li> <li>Peer Reviewed</li> <li>Language: English</li> <li>Inpatients</li> </ul>	patient satisfaction ,quality of health care patient satisfaction , Saudi quality of health care, Saudi doctor communication skills , Saudi	38 papers returned 1 paper returned 29 papers returned 53 papers returned
<b>Boolean operator: AND,OR</b>		
<b>Web of Science (including Medline)</b> <b>Limiters:</b> <ul style="list-style-type: none"> <li>Published Date: 1980 - 2014</li> <li>English Language</li> </ul>	patient satisfaction ,Saudi communication, Saudi cancer care patient satisfaction, Saudi hospital quality care cancer patient satisfaction, Saudi	163 papers returned 14 papers returned 36 papers returned 5 paper returned
<b>Boolean operator: AND,OR</b>		
<b>Google Scholar</b> <b>Limiters:</b> <ul style="list-style-type: none"> <li>Published date: 1980-2014</li> <li>English language</li> </ul>	patient satisfaction, Saudi, quality care, patient centered care, oncology ,hospitals, doctor patient communication	2500 papers returned
<b>Boolean operator: AND,OR</b>		

## Appendix 2 (continued) - Screening process



### Appendix 3: Inclusion and exclusion criteria of literature search strategy

Inclusion criteria	Exclusion criteria
1. Research papers that were found in peer reviewed journals or referenced government/non-government publications were included.	1. Papers that were limited to the outcomes of cancer treatment drugs or symptoms management were excluded.
2. Studies based on KSA that had investigated quality of hospital care for patients in general and cancer care patients in particular were included and only adult cancer patient's studies were included for the focus of this review.	2. Studies investigating quality of hospital care for non-adult patients with or without cancer were excluded.
3. Those studies that had used review, qualitative, quantitative or mixed approaches were included.	3. Studies not supported by peer reviewed journals were excluded.
4. Studies conducted between 1980 and 2014 were included.	
5. Research that examined patient satisfaction using either of the factors of measurements, patient centred care, doctor-patient relationship, structure of healthcare delivery system, disclosure practices, and gender inequality were considered and included in the literature review. Other literature included examined the impact of patient satisfaction as a basis for theoretical arguments for the study even if the study was not based on KSA.	

## **Appendix 4: Criteria for quality appraisal of chosen studies in literature review**

Quality appraisal criteria by Dixon-Woods et al. (2005)

1. Are the aims and objectives of the research clearly stated?
2. Is the research design clearly specified and appropriate for the aims and objectives of the research?
3. Do the researchers provide a clear account of the process by which their findings were produced?
4. Do the researchers display enough data to support their interpretation and conclusions?
5. Is the method of analysis appropriate and adequately explicated?

One point was given for each of the above, and studies that conformed to 3 out of 5 were selected for review.

## Appendix 5: Table of included studies

	Author-date	Sample	Methods	Key findings	Comments
1	Alaloola & AlBedawi (2008) Patient satisfaction in a Riyadh tertiary care centre. <i>International Journal of Health Care Quality Assurance</i> . vol. 21, no7, 2008	1983 inpatients, outpatients and ER patients	Cross sectional survey Using self-developed patient satisfaction questionnaire	Patient satisfaction was noted in environmental aspect - room temp—etc. and less found in inter personal skills of doctors, phlebotomies, as they failed to introduce themselves.	<ul style="list-style-type: none"> <li>• Lack of clarity in describing the tool they used –like question areas.</li> <li>• The focus of satisfaction domain was only in socio-demographic context.</li> <li>• No focus for specific service such as cancer, or medical, which is a limitation</li> <li>• Although it is valuable for originality, further research needed in cancer setting in the KSA</li> </ul>
2	Al-Doghaither & Saeed A. A. (2000) Consumers' satisfaction with primary health services in the city of Jeddah, Saudi Arabia.	75 patients aged over 15 years, chosen systematically	Self- administered questionnaire pilot test	Satisfaction scores were higher in those taking consideration of all services, while individual components of the service were scored less.	<ul style="list-style-type: none"> <li>• Although high scores for satisfaction were noticed, service component needs to be monitored too and assessed to provide satisfactory services</li> </ul>
3	Saeed & Mohamad (2002)  Satisfaction and correlates of patients' satisfaction with physicians' services in primary health care centers	n=540 patients in 8 PHC, selected randomly in Riyadh	Survey questionnaire, pilot-tested	Service items need to have correct measure Also young and adult patients need more attention	<ul style="list-style-type: none"> <li>• No clear description of recruitment and methods - Other domain like hospital services, nurses' skills would have impact on satisfaction</li> </ul>

	By <i>Saudi Medical Journal</i>				level of patients
4	Al-Ahmadi & Roland, M. (2005)  Quality of primary health care in Saudi Arabia: A comprehensive review.	Systematic review of 31 papers met the inclusion	Reviews of literature	There were variations in quality of primary health care services in the KSA More effort needed in management and organisation of these services	<ul style="list-style-type: none"> <li>• Further research needed to address quality concerns from the patient's perspective to have better insight into quality care</li> </ul>
5	Mahfouz et al. (2004)  Primary health care services utilisation and satisfaction among the elderly in Asir region, Saudi Arabia	253 patients	In 26 PHC in ASIR (6 urban and 20 rural centres), House-to-house survey by interview with expert health worker, Arabic speaker, to answer survey questions Questionnaire address 5 aspects of services adopted from Mansour and Al-Osaimi study 1993 (continuity of care, humanity, accessibility,	Satisfied patients reported but 79% dissatisfaction found in 3 items: lack of audio-visual for patient education, lack of enough speciality clinic and prolonged waiting time in centres.	<ul style="list-style-type: none"> <li>• More information needed regarding tools used</li> <li>• Emphasis on 5 aspects lack reasoning</li> <li>• More concerns needed in evaluating different socio-demographic characteristics in elderly patients - results will be significantly different from area to area so such a comparison would be desirable</li> </ul>

			thoroughness and information).		
6	Akhtar & Nadrah (2005) Assessment of the quality of breast cancer care: A single institutional study from Saudi Arabia	78 operable breast cancer patient	Retrospective analysis of breast cancer patient charts and histopathology reports from 1995-2000	Only 37% had triple assessment before surgical procedure radiotherapy not used as per required standard overall conclusion that quality below international standard	<ul style="list-style-type: none"> <li>No socio-demographic data were retrieved for their sample, which was a limitation that could be addressed in future research</li> <li>Lack of patient perspectives, which is very important to determine quality</li> </ul>
7	Ibrahim et al. (2002)  Appraisal of communication skills and patients' satisfaction in cross-language encounters in oncology practice.	255 patients	Questionnaire "Art of Medicine" used to assess patients' perceptions of clinicians' communication behaviours and patients' global satisfaction.	No difference - means that language doesn't affect interpersonal skills like communication and patient satisfaction. Patients were equally satisfied in both languages.	<ul style="list-style-type: none"> <li>Interesting finding but the scale used was not described clearly.</li> <li>Further research needed to evidence that cross language communication is not barrier to patient satisfaction within the multi-dimensional needs of cancer patient and cultural differences</li> </ul>
8	Alahwal et al. (1998) "Cancer patients' awareness of their disease and prognosis",	136 (33 cancer patients, 63 doctors, and 40 laypeople)	Questionnaire of 4 questions developed for the purpose of this study Distributed in	All patients were in favour of being given full information regarding cancer; this would help them have a better understanding of how to deal with their illness. Doctors	<ul style="list-style-type: none"> <li>Although patient views were taken, the methods would be more useful had qualitative interview been used as this provides expanded insights into communication issues</li> </ul>



			western region of Saudi Arabia (major hospital providing cancer care)	too favoured that the patients be disclosed about their conditions.	with patients
9	Younge et al. (1997) Communicating with cancer patients in Saudi Arabia	None	By literature review on communication aspects and factors influencing communication in the KSA	Communication influenced by many factors such as cultural and social and also health services that lack community care for chronic illness.	<ul style="list-style-type: none"> <li>Although valuable information was obtained, there was no clear methodology mentioned, also number of studies reviewed was not mentioned and this generalisation potentially limits the findings.</li> </ul>
10	Mansour and Al-Osimy (1996) A study of health centres in Saudi Arabia	300 Consumers	Via assessment sheet of centres' resources in terms of quality and availability and consumer satisfaction & a 4-point system likert scale to measure satisfaction in 5 domains: continuity of care, accessibility, humaneness, information and thoroughness.	Discrepancy of data has been found between centres' resources evaluation and those from consumer satisfaction results	<ul style="list-style-type: none"> <li>More studies needed to evaluate resources and satisfaction through valid measures.</li> <li>Studies in hospital resources can provide further insight into patient satisfaction since they focus only on health centres.</li> </ul>

11 Sweden	Rahmqvist and Bara (2010)  Patient characteristics and quality dimensions related to patient satisfaction.	7425 patients in all medical centres in Sweden	Questionnaire concerned with the perceived quality of health care	Older patients with good health status were satisfied 90% Interestingly, educated patients with poor health status were dissatisfied in comparison to less-educated patient and better health status	<ul style="list-style-type: none"> <li>Further similar research needed in the context of Saudi Arabia to study the relationship between patient characteristics and quality dimensions</li> </ul>
12	Williamson, M.J. & Harrison, L. (2010)  Providing culturally appropriate care: A literature review	None	Literature review through multiple databases search	Cultural factors found to impact on health Focus was on cognitive aspect of culture, values & beliefs, thus there was a failure to identify specific mechanism that culture has as a negative health mechanism	<ul style="list-style-type: none"> <li>Studies of cultural consideration from a Saudi patient's perspective is needed especially since the majority of health care providers are expatriates and have different backgrounds that may affect understanding of Saudi patient needs</li> </ul>
13	Walston et al. (2008)  The changing face in health care in Saudi Arabia	None	Review of literature	The complexity of changing health care system in the KSA is a continuous challenge and private health care need to be reformed in order to augment the needs of health care	<ul style="list-style-type: none"> <li>No criteria was mentioned for the chosen studies in their review &amp; whilst challenges were discussed, their only focus was on maintaining cost of health care and less about quality of care</li> </ul>

14	Almuzaini et al. (1998) The Attitude of Health Care Professionals toward the availability of Hospice Services for Cancer Patients and their Carers in Saudi Arabia	695 (398 health care professionals, 136 cancer patients and 161 informal carers)	Quantitative survey of participants on the quality of health care	There is lack of consistency in the quality of health care in KSA. The Ministry-owned or managed facilities score poorly on patient satisfaction with service organisation. The university and the military facilities do slightly better than the government-managed facilities on patient satisfaction.	<ul style="list-style-type: none"> <li>• Further research needed using a valid tool to determine which aspects of patient satisfaction are relevant or important to cancer patients while addressing the area of improvement in government facilities.</li> </ul>
15	Elkum et al. (2007)  Being 40 or younger is an independent risk factor for relapse inoperable breast cancer patients: The Saudi Arabia experience	867 breast cancer patient data at King Faisal Specialist Hospital and Research Centre (KFSH&RC) from 1986 to 2002 were reviewed	The researchers used hospital patients' records for collecting data. They employed statistical techniques to establish the correlation between age and breast cancer prognosis.	The research established that women under 40 were more prone to having a terminal prognosis and complexities. It also found that the treatment protocols in KSA were the same as in the USA, and hence the quality of care was good.	<ul style="list-style-type: none"> <li>• The research demonstrates a relationship between age and incidence of cancer in Saudi Arabia but there was no focus on quality of cancer care from patient's perspective.</li> </ul>
16	Amri and Sadat (2009) Cancer chemotherapy-induced osteoporosis: How common is it among Saudi Arabian cancer survivors	71 patients who received chemotherapy in Saudi Arabia were examined for osteoporosis through bone scan.	71 patients	The main findings indicated that there was a high level of risk for osteoporosis for patients treated with chemotherapy. There was lack of standard BMD (Bone Mineral Density) testing that could lead to early detection.	<ul style="list-style-type: none"> <li>• The research established that there were gross differences in screening patients for BMD in the KSA and in Western nations, which indicates the need for skilled</li> </ul>

				There was also a scarcity of drugs that can help prevent the condition	knowledgeable staff and improved resources including new drugs.
17	Brown et al. (2009) Failure to attend appointments and loss to follow-up: a prospective study of patients with malignant lymphoma in Riyadh, Saudi Arabia	A 3-year prospective study of 199 patients with malignant lymphoma in Riyadh	Retrospective analysis of No Shows appointments (No Shows=340 )	34% were related to hospital-based communication errors. 17.6 % were related to errors in patient communication with hospital	<ul style="list-style-type: none"> <li>The research indicated some gaps in communication in Saudi cancer context thus evidenced the need for future studies to address communication system improvement in cancer care</li> <li>Based on retrospective analysis which need further empirical research to understand communication problems</li> </ul>
18	Jazieh, A.R. (2010) Human resources development , ‘Initiative to Improve Cancer Care in the Arab World’	12 Experts in health care from across the Arab world and international experts	Interviews, situational analysis	There is lack of high-quality and well-trained health care professionals	<ul style="list-style-type: none"> <li>The research based on only situational analysis. So, further robust methodology required to evaluate the needs of human resources in cancer</li> </ul>
19	Saghir & Azim (2010) Standards of Care and Guidelines for the Arab World with Limited	12 experts in health care from across the Arab world	Panel discussions	Lack of standardisation in doctors’ and nurses’ skills leads to varying quality.	<ul style="list-style-type: none"> <li>The research is based on panel discussion and does not use any objective</li> </ul>

	Resources				methods or criteria.
20	Diab, R. (2010) Access to Cancer Care Facilities, 'Initiative to Improve Cancer Care in the Arab World',	8 panel members made of experts in policy making, healthcare and scholars (a	Panel discussions (Based on discussion of panel members about priority of objectives and available baseline information of accessibility to cancer care)	The panel found that quality of cancer care suffered from problems like long wait times for the patients, high costs, lack of access to health care and inequality in access for people from rural and marginalised regions.	<ul style="list-style-type: none"> <li>No mention of criteria for evaluating the health care facilities, such as introducing use of measures or indicators of quality.</li> </ul>
21	Shamieh et al. (2010)Access to palliative care	12 multi-disciplinary experts in palliative care	Panel discussion	Access to cancer care is poor compared to palliative care	<ul style="list-style-type: none"> <li>Discussions purely based on the perceptive of the experts. Patient views are needed to allow comprehensive evaluation of the issue</li> </ul>
22	Copnell, B. et al. (2009) Measuring the quality of hospital care: an inventory of indicators.	None	Literature review	The literature review revealed that the quality indicators for measuring health care quality were varied and non-standardised. The researchers found over 300 indicators of quality used in the available literature.	<ul style="list-style-type: none"> <li>This research is important as it reviewed available research globally on quality indicators and showed that it is difficult to measure quality with the lack of agreement on specific quality indicators</li> </ul>
23	Walker (2009) The right to health in Saudi Arabia	None	Review of available international and	Social issues like low position of women in society, lack of social and	<ul style="list-style-type: none"> <li>The paper is not based on any empirical research or</li> </ul>

			regional human development reports, independent researches and newspaper articles	political freedom impact on the access of quality care.	systematic review and holds the opinion of the reviewer alone.
24	Dein & Stygall (1997) Does being religious help or hinder coping with chronic illness? A critical literature review.	None	Literature review	The researchers found a correlation between spiritual beliefs, religious practices and psychological prognosis, and made recommendations for integrating religious empathy in health care	<ul style="list-style-type: none"> <li>The research does not provide a clear explanation of the search the strategy and includes a very limited number of studies in in the review</li> </ul>
25	Al-Faris, E.A., Khoja, T., Falouda, M. and Saeed, A.A.W., (1996). Patients' satisfaction with accessibility and services offered in Riyadh health centres.	466 randomly selected patients from 6 randomly selected primary health care centres PHCC in Riyadh City	Patient satisfaction and attitude survey	The research found high level of satisfaction among older patients, housewives and non-Saudi patients.	<ul style="list-style-type: none"> <li>The questionnaire was self-administered, which may add to bias.</li> </ul>
26	Al-Sirafy , S.A., Hassan, A.A. and Al-Shahri, M.Z. (2009) Hospitalisation pattern in a hospital-based palliative care program: An example from Saudi Arabia. American	759 palliative patient admissions during a 4-year period (in the absence of sub- acute palliative care models)	Retrospective review of palliative admissions were studied for reason for hospitalisation, duration of stay and mortality rate	The research found that quality of life did not improve with palliative care in Saudi Arabia. The indicators of quality for palliative care included factors like duration of stay and mortality and quality of life.	<ul style="list-style-type: none"> <li>While factors like mortality etc. were easy to understand and calculate, there was no elaboration on factors that may indicate the quality of life improvement.</li> </ul>
27	Groene, et al. (2008) An international review of projects on hospital	None	Literature review, expert interviews, performance	The research found that there was a substantial lack of standardisation in terms of	<ul style="list-style-type: none"> <li>This global research included a very large</li> </ul>

	performance assessment.		assessment tool for quality improvement in hospitals (PATH).	quality indicators. The research could identify only 11 hospital performance measurement projects that contained standardised methodology and showed robust design.	number of projects that were used for assessing quality of hospitals.
28	Mainz J. (2003) Defining and classifying clinical indicators for quality improvement.	None	Literature review	Review of available literature on quality indicators for health care highlighted that quality is divided into structural, process-related and outcome related.	<ul style="list-style-type: none"> <li>• Further research needed to consider other factors that may hinder or contribute to patient satisfaction such as socio-cultural factors.</li> </ul>
29 Japan	Tanaka, A, et al. (1999) Thoughts and feelings of in-patients with advanced terminal cancer: Implications for terminal care improvement	Eight terminally ill patients with cancer	Semi –structured Interviews	The research found that the patients wanted solutions for pain control, need the family support, and want to live their life in an ordinary manner as much as possible. The desire to do their best with what they have led them have a positive attitude and improved their illness management better.	<ul style="list-style-type: none"> <li>• The research was conducted on a very small group of patients, and all the patients were over 80 years of age. Thus the scope of this research is limited.</li> <li>• It's been undertaken in the context of Japan that has different socio-cultural factors, but the insights were valuable to be</li> </ul>

					applied in context other than the KSA
30	McBride, D. (2008). Blood Test for Breast Cancer Introduced in the Middle East.	None	Article based on independent research by the author who is a nurse at the Kaiser Permanente Oakland Medical Centre and a faculty member at Samuel Merritt College in Oakland, CA	The article discusses the introduction of blood tests in the Middle East to improve breast cancer detection	<ul style="list-style-type: none"> <li>The article is not based on primary research but employs newspaper and other sources to present its case. It raises the complex issues of breast cancer and women in the Middle East</li> </ul>
31	Aljubran, A. (2010) The attitude toward disclosure of bad news to cancer patients in Saudi Arabia.	None	Literature review	The researchers highlight the changing trends in patients' need to understand and know their illness.	<ul style="list-style-type: none"> <li>The research was not based on direct data collection from the patients, but based its findings on reports, books and some research undertaken on the subject. A more comprehensive and valid research would include direct survey or interview of the patients themselves.</li> </ul>
32	Bredart et al. (2007) Determinants of patient satisfaction in oncology settings from European and	647 cancer patients from hospitals in EU and Asia	EORTC IN-PATSAT32 Questionnaire; quality of life of	Quality indicators found included number of nurses and doctors per bed, size of the hospital, setting of the	<ul style="list-style-type: none"> <li>The research used a comprehensive questionnaire in the form</li> </ul>



	Asian countries: Preliminary results based on the EORTC IN-PATSAT32 questionnaire.		the patients and socio-demographic data; institutional data.	ward; geo-cultural origin, patient awareness; global health status, and education level	of EORTC IN-PATSAT 32 that has been tested for validity and reliability. The findings are therefore valid.
33	Linder Pelz Towards a theory of Patient satisfaction.	None	Review of literature	Defining and conceptualising what is patient satisfaction	<ul style="list-style-type: none"> <li>Provides five social psychological variables that effect patient satisfaction.</li> </ul>
34	Pascoe.(1983) Patient satisfaction in primary health care; a literature review.	None	Review of literature	An interpretive and reflexive review on literature on access to health care	<ul style="list-style-type: none"> <li>Patient satisfaction can be measured in order to enhance primary care</li> </ul>
35	Keith. R. (1998) Patient satisfaction and rehabilitation service.	None	Discussion about patient satisfaction in rehabilitation services.	High level of satisfaction with rehabilitation services	<ul style="list-style-type: none"> <li>Measures of patient satisfaction involve progress and a return to independent living</li> </ul>
36	Ware et al (1983) Defining and measuring patient satisfaction with medical care.	55 Likert type survey measuring patients satisfaction analysed	Describe the patient satisfaction questionnaire and test validity and reliability	Measured variables of customer care	<ul style="list-style-type: none"> <li>Study reliability was confirmed with cross reference with literature and shows the potential for using Likert studies to assess patient s satisfaction.</li> </ul>

37	Kupfer and Bond.(2012) Patient Satisfaction and Patient-Centered Care Necessary but Not Equal	None	View point	States that patient satisfaction is not the same as patient centred care. Suggest patient satisfaction is not always guaranteed by patient centred care	<ul style="list-style-type: none"> <li>• Raises some questions about patient centred care.</li> </ul>
38	William's (1994) Patient satisfaction, a valid concept?	None	Review of literature	Presents satisfaction as complex concept as the extent to be measured depend on the extent to be defined	<ul style="list-style-type: none"> <li>• Many satisfaction surveys used to confirm the existing status quo in health service providers.</li> </ul>
39	Turris,(2005) Unpacking a patient's concept of satisfaction- a feminist perspective.	None	Review of literature	A feminist critique of patient satisfaction	<ul style="list-style-type: none"> <li>• Helps in understanding female patients special needs</li> </ul>
40	Kaba and Soronkabium, (2007) The evolution of the doctor patient relationship.	None	Literature review	The need for ever great progress toward a patient centred approach	<ul style="list-style-type: none"> <li>• The importance of doctor patient relationship within patient centred model to improve satisfaction</li> </ul>
41	Rao et al.(2006) Toward patient centred care in India- a scale to measure patients' perception of quality.	1869 Outpatients and 611 Inpatients were sampled from 4 different health care facilities in India	Cross sectional survey	Measures of Perceived quality included: medicine availability, medical information, staff behaviour, doctor behaviour, and hospital infrastructure.	<ul style="list-style-type: none"> <li>• These dimensions provide direct measurement of "structure" and "process" of care</li> </ul>
42	McCormack et al. (2011), Measuring patient-centred	None	Literature review	Identified Six core concepts related to Patient clinician	<ul style="list-style-type: none"> <li>• The Six core concepts</li> </ul>

	communication in cancer care: A literature review and the development of a systematic approach			communication as critical element of patient centred care	identified could enhance patient clinician communication in oncology setting thus support patient centred care which will enhance patient satisfaction
43	Jagosh et al. (2011), The importance of physician listening from the patients' perspective: Enhancing diagnosis, healing, and the doctor-patient relationship,	58 Patients from McGill university health centre in Canada	Qualitative interpretive study	Three main themes identified on why doctor listening is important to patient: 1) essential components of clinical data gathering, 2) listening as healing and therapeutic agent, 3) fostering the doctor patient relationship	<ul style="list-style-type: none"> <li>Importance of doctor listening as critical part of communication in doctor patient relationship. Findings support the need for patient centred approach to strength the doctor patient relationship</li> </ul>
44	Jackson et al. (2001), Predictors of patient satisfaction,	Patient survey of their satisfaction. A sample of 500 adult with physical symptoms attended general medicine clinic in USA	Cohort study	Satisfaction influenced by person characteristic and by time frame as who immediately reported after clinic visit 52% of them satisfied while those at 2 weeks after visit 59 % of them satisfied and at 3 months after visit 65 % of satisfied	<ul style="list-style-type: none"> <li>Evidence for Importance of age and time frame in conducting patient satisfaction survey</li> </ul>
45	Ong et al. (1995) Doctor-Patient Communication: A review of the literature.	None	Literature review	Synthesis of the existing literature on patient doctor communication. It is central	<ul style="list-style-type: none"> <li>Importance of communication in patient</li> </ul>

				for a good relationship and health outcome	doctor relationship
46	Holmström and Roing (2010). The relation between patient-centeredness and patient empowerment: A discussion on concepts.	NONE	Concept analysis approach compared to literature review	Patient centeredness and empowerment are complementary to each other. Patient empowerment can also be achieved by patient centeredness	<ul style="list-style-type: none"> <li>• Patient empowerment is yet to be developed in other cultural setting such as KSA</li> </ul>
47	Roter (2000). The enduring and evolving nature of the patient-physician relationship	NONE	Review of literature	Exploring relationship centred medical paradigm on the nature of doctor patient relationship. Thus, suggested a framework Linking therapeutics relationship to communication in doctor patient relationship	<ul style="list-style-type: none"> <li>• Effectiveness of therapeutic relationship in enhancing doctor patient relationship in patient satisfaction</li> </ul>
48	McWilliam et al (2000), Breast cancer patients' experiences of patient–doctor communication: a working relationship,	11 Women with breast cancer interviewed	Qualitative phenomenological study	Identify the importance of patient centred, working relationship. Effective communication as affective, behavioural and instrumental were linked linked to positive experiences of women with breast cancer	<ul style="list-style-type: none"> <li>• Importance of the effective communication to women with cancer to enhance patient satisfaction with doctor patient relationship</li> </ul>
49	<b>AlMutairi and Moussa (2014)</b> Quality of health care in Saudi Arabia :systematic review	Literature Review study	Systematic review of 32 articles as per inclusion criteria ,based on 6 IOM quality dimensions	The health care system in KSA has shown considerable progress in recent decades, gaps in 6 IOM dimensions of quality are still apparent.	<ul style="list-style-type: none"> <li>• Only 6 of 32 studies found related to patient satisfaction. So further studies are needed.</li> <li>• The identified gaps in 6 IOM dimensions of quality</li> </ul>

					indicated a low quality of care.
50	<b>Aljuaid et al.(2016)</b> Quality of care in University hospitals in Saudi Arabia: Systematic review	Literature review study	Systematic review of 8 relevant articles based on the inclusion criteria. Studies were reviewed based on 6 IOM quality dimensions	The research indicated that mean physician satisfaction scores of 4.2 (above the average of 2.1), indicate that quality of care may be greater in university hospitals	<ul style="list-style-type: none"> <li>The review indicated the increase of patient centred care assessment in KSA. However, limited sample size of studies highlighted the need for accurate picture on quality of care and evidence the lack of data available for analysis.</li> </ul>
51	Kenny et al. (2010), Interpersonal perception in the context of doctor–patient relationships: A dyadic analysis of doctor–patient communication,	91 doctors and 1749 patients in Canada	Cross sectional study Doctors and patient independently completed questions on doctor communication skills after consultation visit	Doctors and patients had different views and perspective on communication held during consultation	<ul style="list-style-type: none"> <li>The results emphasised that communication need to be aligned with patient centred care approach as proposed by Institute of Medicine</li> </ul>
52	Michie et al. (2003), Patient-centeredness in chronic illness: what is it and does it matter?	None	Review of literature They review 2 types of communication in chronic illness patient – patient activation and taking patient perspective and if	Activation of patient results in , good physical health outcomes more than takin only patient perspective . Therefore different types of patient centred communication results in different health outcomes	<ul style="list-style-type: none"> <li>Activation of patient is yet to be developed in KSA.</li> <li>Information disclosure need to be emphasised in policy for better patient understanding of their treatment thus they make</li> </ul>

			it affects health outcomes		informed decision about their treatment.
53	Donabedian, (1980). <i>Explorations in quality assessment and monitoring. Vol. 1. The definition of quality and approaches to its assessment.</i>	None	Review	A proposed model to determine patient satisfaction with quality of care. Three domains which are structure, process and outcome can be used to define quality	<ul style="list-style-type: none"> <li>The Care assessment model by Donabedian(1980) is greater tool for comprehensive understanding of what constitute quality assessment</li> </ul>
54	Khamis, & Njau (2014).Patients' level of satisfaction on quality of health care at Mwananyamala hospital in Dar es Salaam, Tanzania.	a SEQUAL Questionnaire was used to collect data from 420 patients in outpatient clinic in Tanzania	Cross sectional survey study	The use of Donabedian model to assess the level of patient satisfaction on quality of care proves useful Poor satisfactions among patient generally because of a lack of communication	<ul style="list-style-type: none"> <li>Evidence supporting the use of Donabedian model in assessing patient satisfaction but in outpatient setting</li> <li>The importance of communication in patient satisfaction levels</li> </ul>
55	DuFrene R., (2000), An evaluation of a patient satisfaction survey: validity and reliability,	None	Comparative analysis	Testing the validity of external patient satisfaction surveys. They were often unreliable because issues of poor design	<ul style="list-style-type: none"> <li>Survey need to be well design with adequate sample to be reliable and valid</li> </ul>
56	Street et al. (2009). How does communication heal? Pathways linking clinician-patient communication to	None	Literature review	Identified Seven pathways of communication to improve health	<ul style="list-style-type: none"> <li>The results imply the need for taking patient centred approach in communication to improve health as</li> </ul>

	health outcomes.				proposed by Institute of Medicine definition of patient centeredness
57	Mead, and Bower, (2000). Patient-centeredness: A conceptual framework and review of the empirical literature.	None	Literature review	Five conceptual dimension identified in order to support patient centred model in doctor patient relationships	<ul style="list-style-type: none"> <li>The findings cannot be generalized as patient centred care depend mainly on sociocultural aspects of setting and applicability of the 5 dimensions identified need to be tested in other cultural setting like KSA</li> </ul>
58	Reimann and Strech 2010 The representation of patient experience and satisfaction in physician rating sites	None	Systematic review of research instruments for measuring patient experience and satisfaction. Followed by Qualitative content analysis of the measurement instruments	13 components of patient experience and satisfaction has been identified	<ul style="list-style-type: none"> <li>Identified components of patient experience can be used to assess patient satisfaction and experience in further studies.</li> </ul>

## Appendix 6: Participant information sheet (patients)



UNIVERSITY OF  
STIRLING

SCHOOL OF  
NURSING, MIDWIFERY  
AND HEALTH

**Study Title:** Patient Satisfaction in Oncology Ward Settings in Saudi Arabia: A Mixed Methods Study

**Project Investigator:** Manal Banaser **Contact Number:** (number given)

Dear Participants

I would like to invite you to participate in a research study. Before you agree to participate, it is important for you to understand the reason for the study and what it will involve in order to make an effective contribution to the study field. Please read below information about the study. Feel free to ask about any of the information and if you need even more information you can contact me any time at the above given contact number.

The study is a post graduate research student project which is supervised by Dr. Kathleen Stoddart and Dr. Nicola Cunningham at Department of Nursing, Midwifery and Health at University of Stirling in the United Kingdom. This project is funded by King Fahd Medical City Scholarships department in Riyadh.

**Project Aim:** The project is aimed to help assess the satisfaction of adult hospitalised oncology patients with the received care. The research study will be conducted in two phases. First, a questionnaire of patient satisfaction with care will be distributed to adult hospitalised cancer patients in a Saudi Regional Cancer Centre in Riyadh. Second, 6 participants of those who completed the questionnaire will be invited voluntarily to attend an individual interview with the research investigator in order to expand our knowledge of optimising



satisfaction with care or making recommendations for areas of improvement in quality of care.

**Advantages of taking part in the study:**

Your expectations and opinions for the received care in an oncology setting are an important aspect in ensuring quality of care. Your satisfaction scores will help health care providers to identify area for improvement, as well as to maintain the quality of care in the future. By giving reasons for either satisfaction or dissatisfaction with care within the interviews, health care providers can have more understanding of your experiences with hospital care and eventually will make an effort to contribute to deliver effective, high-quality cancer services in Saudi Arabia.

In the first phase you will have to complete the questionnaire by rating the aspects of care that were given in the hospital and then return it back to the investigator. In the second phase, you will be invited to attend an interview with the researcher. You will be asked about the reasons for your satisfaction with care, or the reasons if you are not satisfied. It will use open-ended questions and it might be recorded if you agree to maintain the accuracy of the results. Participation in both phases of this project is voluntary. You may withdraw at any time with no consequences. Please note, if you are interested in joining an interview for the second phase of the study, you can contact me as early as possible.

**Confidentiality**

Confidentiality will be maintained by providing identification numbers rather than participant names for either questionnaire and interview records or notes. This will enhance the confidentiality of provided information. All records, notes of interviews, and answered questionnaires will be kept by the researcher in a secure place during the study period. Once the data have been analysed and the study completed, the information will be destroyed. Two supervisors will monitor the study and the findings will be written up as a Ph.D. thesis. You will not be identified at any stage of the written report or the thesis. All information will be kept anonymously, known only to the researcher and her supervisors. This project has been cleared by the University of Stirling Ethics Committee, as well as approved by the Ethics Committee of the Saudi Regional Cancer Centre in Riyadh.

Thank you for taking time to read this information sheet and thinking about participation in the study.

**Researcher Name:** Manal Banaser **Contact Number:** (number provided)

**Principal Supervisor:** Dr. Kathleen Stoddart

## **Appendix 7: Patient consent form**

Study Phase:

Participant identification number:

**Study Title: Patient Satisfaction in Oncology Ward Settings in Saudi Arabia: A Mixed Methods Study**

Researcher Name: Manal Banaser

I have read and understand the study information sheet and this consent form. I have had an opportunity to ask questions about my participation.

I understand that I am under no obligation to take part in the study.

I understand that I have the right to withdraw from the study at any stage without giving any reason.

I agree to participate in the study.

**Name of Participant:**

**Signature of Participant:**

**Signature of Researcher:**

**Date:**

**Contact details of the researcher**

**Name: Manal Banaser**

**Address: (address given)**

**Telephone Number: (number given)**

**Email: (address given)**

Reference: University of Stirling Research Ethics Committee. Informed consent. Available from: <http://www.goodresearchpractice.stir.ac.uk/documents/Chapter6.pdf>

## Appendix 8: Recruitment log for patients

Study Title: Patient Satisfaction in oncology ward settings in Saudi Arabia: A mixed methods study

Name of Researcher: Manal Banaser

Patient ID	Age	Gender	Date of admission	Yes/No to study	Reason for admission	Date recruited	Date of data collection

## Appendix 9: EORCT Inpatient satisfaction questionnaire EORTC IN-PATSAT32

We are interested in some things about you and your experience of the care received during your hospital stay. Please answer all the questions yourself by circling the number that best applies to you. There are no 'right' or 'wrong' answers. The information that you provide will remain strictly confidential.

**During your hospital stay, how would you rate doctors, in terms of:**

**Poor , Fair, Good, Very good, Excellent**

Questionnaire Item	Poor	Fair	Good	Very good	Excellent
1 Their knowledge and experience of your	1	2	3	4	5
2 The treatment and medical follow-up they	1	2	3	4	5
3 The attention they paid to your physical	1	2	3	4	5
4 Their willingness to listen to all of your	1	2	3	4	5
5 The interest they showed in you personally?	1	2	3	4	5
6 The comfort and support they gave you?	1	2	3	4	5
7 The information they gave you about your	1	2	3	4	5
8 The information they gave you about your	1	2	3	4	5
9 The information they gave you about your	1	2	3	4	5
10 The frequency of their visits/consultations?	1	2	3	4	5
11 The time they devoted to you during	1	2	3	4	5

**During your hospital stay, how would you rate nurses, in terms of:**

**Poor, Fair, Good, Very good, Excellent**

Questionnaire Item	Poor	Fair	Good	Very good	Excellent
12 The way they carried out your physical examination (took your temperature, felt your pulse,...)?	1	2	3	4	5
13 The way they handled your care (gave your medicines, performed injections,...)?	1	2	3	4	5
14 The attention they paid to your physical comfort?	1	2	3	4	5

15 The interest they showed in you personally?	1	2	3	4	5
16 The comfort and support they gave you?	1	2	3	4	5

**During your hospital stay, how would you rate nurses, in terms of: Poor, Fair, Good , Very Good, Excellent**

Questionnaire Item	Poor	Fair	Good	Very good	Excellent
17 Their human qualities (politeness, respect, Sensitivity, kindness, patience,...)?	1	2	3	4	5
18 The information they gave you about your medical tests?	1	2	3	4	5
19 The information they gave you about your care?	1	2	3	4	5
20 The information they gave you about your treatment?	1	2	3	4	5
21 Their promptness in answering your buzzer calls?	1	2	3	4	5
22 The time they devoted to you?	1	2	3	4	5

**During your hospital stay, how would you rate services and care organisation, in terms of: Poor, Fair, Good, Very good, Excellent**

Questionnaire Item	Poor	Fair	Good	Very	Excellent
23 The exchange of information between	1	2	3	4	5
24 The kindness and helpfulness of the technical, reception, laboratory personnel?	1	2	3	4	5
25 The information provided on your admission to the hospital?	1	2	3	4	5
26 The information provided on your discharge from the hospital?	1	2	3	4	5

27 The waiting time for obtaining results of medical tests?	1	2	3	4	5
28 The speed of implementing medical tests and/or treatments?	1	2	3	4	5
29 The ease of access (parking, means of transport...)?	1	2	3	4	5
30 The ease of finding one's way to the different departments?	1	2	3	4	5
31 The environment of the building (cleanliness, calmness....)?	1	2	3	4	5

**In general**

Questionnaire Item	Poor	Fair	Good	Very good	Excellent
32 How would you rate the care received during your hospital stay?	1	2	3	4	5

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## **DEMOGRAPHIC QUESTIONNAIRE ( Quantitative Phase 1 )**

### **1. Age**

- 1. From 18-25Years old ☐
- 2. From 26-35 Years old ☐
- 3. From 36-45 Years old ☐
- 4. From 46-55 Years old ☐
- 5. From 56-65 Years old ☐
- 6. From 66-75 Years old ☐
- 7. Above 76 Years old ☐

### **2. Gender**

- 1. Male ☐
- 2. Female ☐

### **3. Marital status**

- 1. Single ☐
- 2. Married ☐
- 3. Divorced ☐
- 4. Widowed ☐

### **4. Education level**

- 1. Primary ☐
- 2. Intermediate ☐
- 3. High ☐
- 4. University degree – above ☐
- 5. Illiterate ☐

### **5. Place of Residence**

- 1. Riyadh ☐
- 2. Outside Riyadh ☐



## **Appendix 10: Scoring manual for In-patient satisfaction questionnaire**

### **Scoring Procedure for the EORTC IN-PATSAT32**

[Reference: Brédart et al, EJC, 41 (2005) 2120-2131]

The international field-testing study of the EORTC cancer in-patient satisfaction with care measure (EORTCIN-PATSAT32) has confirmed the hypothetical structure of the questionnaire. This questionnaire should thus be scored as follows:

#### **1) Content of the questionnaire**

##### ***Multi-item scales***

##### **• Doctors**

Interpersonal skills (items 4-6)

Technical skills (items 1-3)

Information provision (items 7-9)

Availability (items 10, 11)

##### **• Nurses**

Interpersonal skills (items 15-17)

Technical skills (items 12-14)

Information provision (items 18-20)

Availability (items 21, 22)

• **Other hospital personnel kindness and helpfulness, and information giving (24-26)**

• **Waiting time (performing medical tests/treatment, receiving medical tests results) (items 27, 28)**

• **Access (items 29, 30)**

##### ***Single item scale***

• **Exchange of information (item 23)**

• **Comfort/cleanliness (item 31)**

• **General satisfaction (item 32)**

#### **2) Format of the questionnaire**

Period of reference: Refer to interactions with health care providers and services in the oncology hospital during hospital stay.

How would you rate? Poor (1)/Fair (2)/Good (3)/Very Good (4)/Excellent (5)

Number of items: 32

#### **3) Scoring procedure**

All multi-item or single item scales are all constructed in a similar manner: (1) the raw scores for the individual items within a scale are first summed, and then, for the multi-item scales, divided by the number of items in the scale; and (2) these scale scores are then linearly transformed such that all scales range from 0 to 100, with a higher scale score representing a higher level of satisfaction with care.

##### **Scoring details**

In the 32-item questionnaire each response is given a numerical equivalent (poor=1, excellent=5). Scores for each of the fourteen subscale of the questionnaire will first be determined for each patient. All the scores for all items in a particular subscale are summed, then divided by the number of items in that subscale. For example, for doctors' technical skills, the patients' responses on items 1, 2 and 3 are added together, then divided by 3. The scale scores are then linearly transformed to a 0-100 scale with a high score reflecting a higher level of satisfaction. So, for example, the items relating to satisfaction with doctors' technical skills are questions 1, 2 and 3. If a participant answered with a rating of 3, 4, and 4 for those questions, the scores would be summed (=11), then divided by 3 (=3.67). To linearly transform the data to a scale ranging from 0-100, that score will be divided by 5 (highest possible score) and multiplied by 100 (in this case  $3.67/5 = .7333 * 100 = 73.33$ ).

## Appendix 11: Interview schedule

**Study title:** Patient satisfaction in oncology ward settings in Saudi Arabia: A mixed methods study

**Study Phase 2** Qualitative Data collection (Semi-structured interviews)

Researcher Name: **Manal Banaser**      Contact Number: (number given)

Participant study ID:	Date:	Location of Interview:
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### 1. Doctor's skills

- How do you describe the doctors' communication regarding illness?
- Could you say more about your relationship with doctors during your hospital stay?  
Why is it important to you?
- Regarding the treatment, did doctors explain how to take treatment?
- Could you say more about that? Were the doctors giving details about your illness?
- Did the doctors listen to your concerns?
- Did you feel you had been given the opportunity to explain your concerns about illness, health state?
- Were the doctors supportive in treating the illness with success?
- Do you want to say more about doctors' skills during your hospital stay?

### 2. Nurses' skills

- What was the nurses' attitude when dealing with you?
- Could you say more about that?
- Was the nurse accurate about indicated treatment?
- What do you think was important to you in technical skills of nurses?
- What do you think was important to you in interpersonal skills of nurses?
- Do you want to say more about nurses' skills during your hospital stay?

### **3. Exchange of Information**

- Can you characterize in your opinion the exchange of information? The way you have seen it in the hospital?
- What you think the way it should be?
- Do you want to say more about exchange of information?

### **4. Service organisation (Access and waiting times)**

- Tell me about your experience with service organisation during your stay? Lab, admission, referral.
- How do you feel about that?
- How could service organisation help you better?
- How would you describe medical personnel during waiting time?
- Were they interested in assuring you during waiting time?
- In trying to access hospital and its facilities were you able to get help?
- Were you given direction or able to ask information? Do you have possibility to talk to all personnel if you need to?
- How you would describe the hospital and its environment.

### **5. General satisfaction**

- In general, were you satisfied with health care during your hospital stay?
- Do you want to say more?
- How could we help you better to be more satisfied during your hospital stay?