

Patients' Satisfaction With Surgical Out Patient Services At The Delta State University Teaching Hospital, Oghara, Delta State, Nigeria

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ABSTRACT

INTRODUCTION

Patient satisfaction refers to the extent of the patient's experience compared to his expectations. Over the years, patients are getting more aware of their rights with increasing expectations. With more efficient and well equipped private hospitals springing up and the recent upsurge of medical tourism, the need for regular assessment of client satisfaction with public health care provider services in order to make improvements where necessary has become imperative. This study aims to assess patient satisfaction with services provided at the Surgical Out-patient Department of the Delta University Teaching Hospital, Oghara, Delta State Nigeria.

PATIENTS AND METHOD

A cross sectional study of the satisfaction of patients with the services provided at the Surgical Out-patient department of the Delta State University Teaching Hospital, Oghara, Delta State, Nigeria using the short form Patient Satisfaction Questionnaire-18 (PSQ-18). Completed questionnaires from 103 randomly selected surgical out-patients were analysed using the SPSS, version 17.

RESULTS

One hundred and three patients who completed their questionnaires fully were used in the study. There were 40 males (38.8%) and 63 females (61.2%). Mean age of patients was 41 ± 15.6 with a

range of 16 – 85 years. The overall average satisfaction score was 3.4209 (68.42%). The highest subscale score was 3.8107 (76.21%) in the area of interpersonal relationship with the doctor while the lowest score of 2.8447 (56.89%) was given by respondents for satisfaction with the financial aspect of care. In terms of response to individual questions the least score was for question 9 on waiting time [2.6408 (52.82%)] while the highest score was for question 6 which borders on doctors' thoroughness (part of technical competence).

CONCLUSION

Most of the areas assessed for patients' satisfaction in this study will need one form of intervention or the other in order to further improve on the satisfaction level of our patients. Even areas with relatively high percentage satisfaction need steps to be taken to maintain that level of satisfaction. In particular the waiting time at the surgical out-patient department and the fees patients pay need to be addressed.

KEYWORDS: *Patient Satisfaction; PSQ-18; Surgical Services; Nigeria*

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INTRODUCTION

Satisfaction can be defined as the extent of an individual's experience compared with his or her expectations^{1,2}.

Patients' satisfaction has become a frequently researched outcome measure of quality of health care delivery³.

Only few clinicians would disagree with the idea that improving patients' satisfaction is a desirable end in itself⁴. Satisfied patients are more likely to comply with prescribed treatment and advice from doctors. They are also more likely to return for additional care when necessary and may be more willing to pay for services, thereby increasing revenue⁵.

Patients' satisfaction is a critical health care outcome indicator and should be given focus by hospital administrators⁶. Regular surveys of patients' satisfaction in order to assess care have thus been a regular phenomenon in many developed countries. However, this is not yet so in many other countries especially in the third world^{7,8}.

In Nigeria, recent years have witnessed the upsurge of what is now known as 'medical tourism' with large number of persons travelling out of the country to receive medical attention yearly, spending the country's hard earned foreign currencies. This has largely been due to claims of patients' dissatisfaction with medical services rendered in the country. Our public and private health institutions are thus deprived of patronage and are worse off for it.

The need for regular assessment of various aspects of our practice through patient satisfaction surveys outside the traditional practice of audit of morbidities, mortalities and other treatment out-comes in-house is thus, imperative. This will help the management of hospitals to make necessary changes that will once again bring back the confidence of our patients and help to sustain it.

The aim of this study is to assess the level of satisfaction of patients attending the surgical out-patient department of the Delta State University Teaching Hospital, Oghara and make recommendations for necessary changes

that will build up the satisfaction level of our patients.

PATIENTS AND METHODS

This was a cross-sectional study of randomly selected surgical out patients attending the surgical out-patient clinic of the Delta State University Teaching Hospital, Oghara, Delta State, Nigeria.

The study was done in October/November, 2011. Patients were randomly selected from those attending the surgical out-patient clinic on clinic days during the study. For patients to qualify to be included, he/she must have attended the clinic at least once in the past, is intelligent and old enough (at least 16 years) to respond appropriately to questions in the questionnaire and is not too ill to respond.

The Patients Satisfaction Questionnaire Short Form (PSQ-18) with only slight modification was used to collect data from patients after verbal informed consent was gotten from those who agreed to participate. Pre-instructed registrars and house officers in the surgical unit of the hospital administered the questionnaires on the patient. Educated/enlightened patients were allowed to answer the questions by filling the questionnaires themselves while illiterate and semi-literate patients had questions administered directly by the registrars and house officers.

One hundred and ten questionnaires were administered out of which 103 (93.6%) were properly filled and were included for analysis. The rest were not properly or adequately filled and as such were excluded.

The PSQ-18 contains 18 questions with 5 point likert scale type option answers that range through; 'strongly agree', 'agree', 'uncertain', 'disagree' to 'strongly disagree' which are scored 1 to 5 respectively. In order to reduce the bias of respondents towards positive answers as observed in some other questionnaires⁴, nine of the 18 questions (1,2,3,5,6,8,11,15 and 18) have been

structured such that respondents who 'strongly agree' and 'agree' (low scores) were satisfied with the service in question while dissatisfied respondents 'disagree' or 'strongly disagree' (high scores). The second set of nine questions (4,7,9,10,12,13,14,16 and 17) were structured such that respondents who 'strongly agree' or 'agree' (low scores) were dissatisfied with the service in question while those that 'disagree' or 'strongly disagree' (high scores) were satisfied with the service. The first set of questions were however, re-scored by the author after data collection from patients such that higher scores also means satisfaction (i.e, a score of 1 is converted to 5 and vice versa) as directed by the originators of PSQ-18. Scores were then averaged for seven sub-scales : 1.General satisfaction (Q.3&17); 2. Technical quality (Q.2,4,6& 14); 3. Interpersonal manner (Q.10 & 11); 4.Communication (Q. 1&13); 5. Financial aspect (Q.5&7); 6.Time spent with doctor (Q.12 & 15); 7. Accessibility and convenience (Q.8,9,16& 18).

In addition, data on socio-demographic characteristics of the respondents such as age, education, sex, marital status etc were also collected and analysed.

Data were fed into a spread sheet of the Statistical Package for Social Sciences (SPSS Inc. Chicago, Illinois. USA) version 17 and analysed. ETA statistics was used to determine association between satisfaction and two way variables like sex, previous admission, employment status etc and one way anova was used for association of age group and satisfaction. $P < 0.05$ is significant.

RESULTS

Data from 103 questionnaires were analysed. There were 40 male respondents (38.8%) and 63 female respondents (61.2%) giving a male to female ratio of 1:1.6. There was a weak association between overall average satisfaction and sex (ETA=0.146). Sixty five respondents (63.1%) were married while the remaining 38(36.9%) were single. The association between marital status and

average satisfaction was extremely weak or of no significance (ETA= 0.035). Ten point seven per cent of the patients (11 patients) had informal education while the rest 89.3% (92 patients) had formal education ranging from primary (14.6%), Secondary (33.0%) to tertiary (41.7%) levels. There was also only a medium association between education and average satisfaction (ETA=0.169).

The ages of the patients ranged from 16 to 85 years with a mean of 41+ 15.6 years. Table 1. shows the age distribution grouped in years. No significant relation was found between age and average overall satisfaction ($P = 0.616$). In terms of employment status, 42.7% (44) of respondents were gainfully employed at the time of interview. The remaining 57.3% (59) of them were unemployed at the time of interview.

Fifty respondents (48.5%) had previous history of hospital admission while the rest 53(51.5%) had not been admitted before. Also very weak or insignificant association was found between previous admission and average satisfaction (ETA=0.020).

In terms of responses to individual questions, the highest level of satisfaction was in the area of the health practitioners being careful to check all that is necessary (Q.6) while taking care of patients [score=4.1068 (82.14%)] and response to question 11[score=4.1650(83.30%)] which deals with doctor's friendliness and courtesy respectively. The lowest levels of satisfaction were in response to question 9 [score=2.6408 (52.82%)] which deals with waiting time and question 7 [score=2.6699 (53.40%)] which deals with ability of patients to finance or afford medical care respectively.

Average scores for the seven sub-scales are shown in table 2. The highest average score for satisfaction was in the area of interpersonal relationship with doctor [score= 3.81065 (76.21%)] while the lowest score was on financial aspect [score= 2.84465 (56.89%)] respectively.

The overall average satisfaction score was 3.4209 (68.42%).

Table 1: Showing Age Distribution

AGE GROUP IN YEARS	No. OF PARTICIPANTS	PERCENTAGE
16 – 25	16	15.5%
26 – 35	33	32.0%
36 – 45	15	14.6%
46 – 55	19	18.4%
56 – 65	14	13.6%
66 – 75	3	2.9%
76 – 85	3	2.9%

Table 2: Average scores for the 7 sub-scales

SUB-SCALE	AVERAGE SCORE	STANDARD DEVIATION (SD)	PERCENTAGE SATISFACTION
GENERAL SATISFACTION (1&17)	3.36895	1.121285	67.385
TECHNICAL QUALITY (2,4,6 & 14)	3.63593	1.055965	72.72%
INTERPERSONAL MANNER (10 & 11)	3.81065	1.134605	76.21%
COMMUNICATION (1 & 13)	4.08740	1.030010	75.15%
FINANCIAL ASPECT (5 & 7)	2.84465	1.24930	56.89%
TIME SPENT WITH DOCTOR (12 & 15)	3.27185	1.28115	65.44%
ACCESSIBILITY & CONVENIENCE (8,9,16 & 18)	3.2306	1.27400	64.61%

DISCUSSION

Measurement of patients' satisfaction stands poised to play an increasingly important role in the growing push towards accountability among health care providers⁹.

The efficiency of services provided to patients in hospitals play an important role in determining the satisfaction of patients^{5,10}.

In this study, about 39% of patients were males while the remaining 61% were females, giving

a male : female ratio of 1:1.6. This is similar to findings in some previous studies^{11,12}. where the female sex predominated but contrasts findings in other studies^{1,6,7,9}. Where there were male predominance. There was a weak or insignificant association between sex and average satisfaction in this study (ETA=0.146). However, Benerand Ghuloum¹³ reported that males were more satisfied with Psychiatric treatment than females in their study. In contrast, Aldaqalet al⁶ reported that females were more satisfied with services provided at the surgical out-patient department and Umar et al¹⁴ similarly reported more female satisfaction in their study on patients waiting time.

About 89% of patients in this study had one level of formal education or the other (ranging from primary to tertiary) while the rest had informal education. This is similar but a bit higher than findings by Iliyasuet al¹¹ in Kaduna who reported that 83.6% of their respondents had formal education. Ofili and Ofovwe⁵ in Benin reported a lower percentage of 72% educated respondents. Umar et al¹⁴ found in their study that educated patients spend less time in the consulting room with doctors thus reducing the overall patient waiting time and improving patients' satisfaction. The association between education and patients' satisfaction in this study was also largely insignificant (ETA= 0.169).

The mean age of respondents in this study was 41±15.6 years with a range of 16 – 85 years. Most of the respondents (65%) fell within the groups of 26-55 years. Lower means were recorded in some other studies. Iliyasu et al¹¹ got a lower mean of 31.9±12 years (range: 16-61 years), Ofili and Ofovwe⁵; 36.3±19.7 and Megbalayin et al⁷; 37.2±15.6 (range: 17-92 years) all in Nigeria. In contrast slightly higher mean ages of 43.9 years and 45.9±2 years have been reported Aldaqalet al⁶ and Jawaid et al¹ from Saudi Arabia and Iran respectively. Patients/respondents selection methods and the fact that patients were from different backgrounds presenting with

different illnesses may be responsible for these variations.

The overall average percentage patients' satisfaction in this study was about 68.42%. This is fairly similar to satisfaction rates of 63.2%, 66.1% and 66.8% reported by Soleinmanpour et al⁹, Damghi et al⁸ and Iloh et al¹² respectively in their studies. However, relatively higher mean percentage satisfaction rates of; 83% and 89.6% were gotten by Ilyyasu et al and Aldaqal et al respectively. These differences might be real and reflect actual facilities on ground and patients' experiences and expectations with services provided by the health care facilities where these studies were carried out. It may however, also be influenced by other confounding factors like: questionnaire and research design, patients' expectations including socio-demographic factors like age, sex, educational status and others^{4,6,13,14}.

Nevertheless, the fact that over 30% of the patients accessing our surgical out-patients services are generally not satisfied with the services provided is a serious cause for concern. The hospital management and all those involved in rendering services to patients at the surgical out-patient including; the doctors nurses, orderlies, records officers etc, must make concerted efforts to improve on our services. The aim must be to attain close to 100% patient satisfaction. Specific areas that may need attention will include; trying to shorten patients' waiting time, making our services more affordable and improving on doctor/patient relationship and interaction process as will be more obvious from further discussions below.

Waiting time is one of the most important sources of patients' dissatisfaction with medical services especially in public health institutions. It is also the most frequently investigated element in studies on patients' satisfaction^{1,3-9,12,13,15,16}. The waiting time could be real (actual) or perceived. The actual waiting time in minutes or hours could be recorded as the time from when the patient

enters the hospital to the time he sees the doctor, time spent at the pharmacy before drugs are gotten, time spent at pay points etc. The perceived waiting time on the other hand depends largely on patients' previous experiences and expectations and is quite subjective as no actual measurement is done and reliance is on the patients' opinion. Perceived waiting time is said to be a better predictor of patients' satisfaction than actual waiting time⁸. Engaging patients in activities such as watching of health related television programmes, waiting in group, receiving of health related lectures, reading of health related literature and similar activities are said to make perceived waiting time more endurable and appear shorter to patients even when the actual waiting time is long^{8,9}. Soleinmanpour et al⁹ reported that patients who waited for longer periods in the hospital were less satisfied compared with those who waited for a shorter period. Waiting time (perceived) was assessed by patients as the item with the lowest score in this study [score=2.6408 (52.82% satisfaction)]. This means more than 47% of patients were not satisfied with the waiting time at our surgical out-patient department. This percentage satisfaction is quite low compared with that observed by Ilyyasuet al¹¹ who reported that 70% of their patients were satisfied with the waiting time in their study with only 30% dissatisfied. Reasons usually adduced for prolonged waiting time according to Ofili and Ofofwe⁵ include: large number of patients with few doctors, delay in locating case files, loss of case files, delay at pay points and other bureaucratic bottle necks. It is necessary for the hospital management and authorities in charge to work on these areas to reduce the waiting time and thus improve patients' satisfaction.

In Nigeria, most persons still have to pay for health care services directly from their pockets. The national health insurance scheme introduced by the federal government some years back is still quite limited in coverage as most of the state governments and private entities and individuals have not yet

bought into it. Finance is therefore, still a major limiting factor to many persons seeking medical attention. The average score for the financial subscale in this study was 2.8446 (56.89%). This percentage satisfaction with the cost of medical care is low when compared with that recorded by Iliyasuet al¹¹ in Kano, Northern Nigeria who reported that 73% of the respondents in their study were satisfied with the charges they pay for medical attention. In Qatar, where medical services are free for their nationals, Bener and Ghuloum¹³ reported that patients' satisfaction was largely not influenced by the cost of treatment. Our centre is a state government owned public health institution. However, the cost of treatment at present in this centre is relatively higher than that paid in other government owned health institutions in Delta state. This is probably why a large proportion of the respondents in this study, expressed dissatisfaction in the area of finance and payment for medical services in our centre. As a result, there is need for the Delta State government and the management of the hospital to critically look into this aspect of our services to the public with a view to possibly review some of the charges downwards to a more acceptable level in order to improve patients' satisfaction and confidence in the system.

The mean score for physicians' personal manner of interaction with patients in this study was 3.8107 (76.21%). Ilohet al¹² from Umuahia in Nigeria reported that 88.8% of their respondents were satisfied with their interaction with Physicians while Soleinmanpour et al⁹ in an Iranian study reported that 82.5% of their patients were satisfied with their encounter with their doctors. The average percentage satisfaction for interpersonal interaction with doctors in this study is a bit lower than other centres mentioned above even though this subscale was given the highest score by respondents in this study. While other confounding factors like questionnaire design and administration, patient selection and other factors might have contributed to this relatively lower rating, there might be actual need for the doctors to

build up more patients' confidence in the process of interacting with them. Areas such as; involving patients in decision making, proper explanation of reasons for tests, diagnosis and its implications including treatment and prognosis may need to be explored by the doctors in order improve on patients' satisfaction. There might also be general need for short courses on doctor/patients' relations to be organised for the doctors in addition to regular training and retraining to improve on professional skills.

Access to health care and the convenience of accessing such care is another area where patients may be dissatisfied with the medical care they receive. Iliyasu et al¹¹ in Kano, northern Nigeria reported that 84% of the respondents in their study were satisfied with the ease with which they access medical care in their centre while Iloh et al¹² reported 88.8% satisfaction among National Health Insurance Scheme (NHIS) patients in Umuahia, eastern Nigeria. In contrast, only about 64% (score=3.2308) satisfaction was expressed by respondents in the area of accessibility and convenience in this study. This relatively low rating may not be unconnected with the fact that our centre is located in a suburban area some distance from the major cities in Delta state where most of our patients have to travel from in order to receive medical care from us.

The importance of free, unhindered and well understood communication between the patients and health care providers cannot be over emphasized in the health industry. No matter the effort and expertise put in by the health care practitioner and other care givers, without appropriate communication with the patients and relations the patient may likely still not be satisfied with the system. For instance, a patient who is sent to do a very expensive investigation like Magnetic Resonance Image (MRI) of the spine while investigating him for low back pain, may feel the health practitioner is probably just wasting his hard earned money if the need and relevance of the investigation is not well communicated to him. In this study the

communication subscale was scored 3.7573 (75.15%). This is fairly close to but lower than the 79.9% and 82.5% satisfaction with patient-physician communication reported by Iloh et al¹² and Soleinmanpour et al⁹ respectively. There might be need to train and retrain doctors and other health care professionals on communication skills order to improve on their performance in this regard.

In conclusion, if the current state of medical tourism where a huge proportion of the nation's hard currencies is spent on Nigerians seeking medical care abroad is to be abated, there is need for us to make conscious efforts to satisfy our patients more through regular conduct of patients' satisfaction surveys and improvement on our services based on the outcome of such surveys. Findings from this study have been quite revealing. Although many of our patients were generally satisfied with our services, a significant percentage were also dissatisfied. There is thus need for general improvement on our services especially in the area of reducing the waiting time to an acceptable level (this having been a major problem of public health institutions over the years) and making our services more affordable and accessible to our patients.

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