A QUALITATIVE RESEARCH ON PATIENT CARE MANAGEMENT IN MALAYSIAN HOSPITALS; PATIENTS AND DOCTORS EXPERIENCES OF BEDSIDE CARE

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ABSTRACT

Over the past decade there has been an exponential increase of tertiary level specialized care to meet the needs of the population in Malaysia. The organisation structure of MOH which encompasses the three levels of the health care delivery system, which are Federal, State and District levels, demonstrates decentralization and efficiency. This system is changing towards wellness service that emphasizes a lifetime health plan in keeping the child and family well.

For centuries the traditional practice demonstrated by doctors has been a system of inquiry which consists of close-ended questions that fulfil the doctors' need in collecting information. This process has been part of the medical curriculum for years and had little concern of how patients felt and understood information. In a multicultural country like Malaysia, patients come from different background, race, religion and languages. Lack of information poses as a barrier in the quality of care provided. Patients may not fully comprehend their disease and may make the wrong decision. This research is significant because there are limited studies exploring patient care management in public hospitals in Malaysia

Therefore the purpose of the ethnographic research was to explore the experiences of patients and doctors on patient care management at public hospitals. Supportive issues and barriers that influence patient care management were identified. Qualitative approach using triangulation methods through in-depth interviews, observation, field notes and records of *vignettes* were carried out. A total of 44 participants from two tertiary public hospitals were interviewed in this research. The data was analysed by using thematic approach.

Research indicates factors associated with patient care management were the demonstration of quality of care provided, good clinical communication, leadership skills and the understanding of culture in the health care environment. The findings from the supportive issues showed that patients were generally satisfied with the overall care given by the doctors and the hospital team of which majority of them demonstrated good leadership and management skills. However some of the barriers reported by the patients were dissatisfaction in the autonomy of making decisions and not including family members in this process. Issues on patient's dignity and rights, culture and religion were also discovered in this research. In addition, lack of patient compliance and resources were reported as barriers in providing quality patient care. As a result situational factors have influenced the doctors' leadership styles and many of them inadvertently become transformational leaders.

To conclude, the key findings revealed the importance of medical education and leadership plan in the healthcare industry. The healthcare team, specifically the doctors should be trained as "clinical teachers" in the medical arena since they communicate and educate the patients and their families each time they provide patient care. Finally patient care management should incorporate appropriate teaching techniques using suitable resources and teaching plans in an effort to portray leadership dynamics in all situations in the wards. Efforts should also be taken by the government and the medical schools to incorporate medical education for future doctors in the medical training.

ABSTRAK

Dalam tempoh satu dekad yang lalu terdapat peningkatan tahap penghususan penjagaan pada peringkat tertiary untuk memenuhi keperluan penduduk masyarakat Malaysia. Struktur organisasi di MOH mempunyai tiga tahap dalam penyelengaraan penjagaaan kesihatan,iaitu dari segi wilayah, negeri and daerah yang menunjukkan penyelengaraan tersebut bebas dan berkemahiran. Sistem ini semakin berubah kepada perkhidmatan penyempurnaan yang menumpu kepada perancangan kesihatan seumur hidup untuk seisi keluarga.

Selama berkurun-kurun, latihan tradisi yang ditampilkan oleh para doktor telah menjadi suatu system persoalan terbuka yang memenuhi kehendak doktor untuk mengumpul maklumat. Proses in telah menjadi kurikulum perubatan selama bertahun-tahun tanpa menghiraukan perasaan para pesakit dan pemahaman mereka tentang maklumat tersebut. Dalam negara pelbagai budaya seperti Malaysia, terdapat ramai pesakit yang berlainan latarbelakang, kaum, agama dan bahasa. Kekurangan maklumat akan menghindarkan kualiti penjagaan yang diberikan. Para pesakit tidak akan berkesempatan memahami penyakit mereka dan akan membawa kepada keputusan yang salah. Oleh itu, penyelidikan ini amat penting kerana kajian-kajian seperti ini belum banyak dilakukan di Malaysia.

Oleh itu tujuan kajian ethnografik adalah untuk meneroka pengalaman para pesakit dan para doktor dalam penjagaan pengurusan di hospital-hospital kerajaan. Maklumat-maklumat sokongan dan halangan terhadap pengurusan penjagaan pesakit di hospital kerajaan telah dikenalpasti. Pendekatan kualitatif dengan menggunakan kaedah "triangulation" seperti wawancara mendalam, pemerhatian, mengambil nota di medan kajian dan "vignettes" mengenai kes-kes insitu telah dilakukan. Seramai 44 orang

daripada two hospital besar kerajaan telah mengambil bahagian di dalam wawancara tersebut. Maklumat dianalisis dengan menggunakan kaedah pendekatan "thematic".

Hasil kajian menunjukkan faktor-faktor yang berkaitan dengan pengurusan penjagaan pesakit adalah seperti kualiti penjagaan yang diberikan, komunikasi klinikal yang baik, kemahiran kepimpinan dan pemahaman tentang budaya di persekitaran penjagaan kesihatan. Hasil kajian daripada maklumat sokongan menunjukkan pada keseluruhannya para pesakit berpuashati dengan penjagaan yang diberikan oleh para doctor and pasukan perkhidmatan hospital. Kebanyakan daripada mereka menampilkan kemahiran kepemimpinan dan pengurusan. Walaubagaimanapun, terdapat sedikit halangan yang dilaporkan oleh para pesakit seperti ketidakpuasanhati di dalam kebebasan membuat keputusan dan tidak melibatkan ahli keluarga dalam membuat keputusan. Isu-isu seperti maruah, hak-hak asasi, budaya dan agama telah ditemui di dalam kajian ini. Selain daripada itu, kekurangan pematuhan oleh pesakit dan kekurangan sumber juga telah dilaporkan sebagai halangan di dalam perkhidmatan kualiti penjagaan pesakit. Natijahnya, faktor situasi telah mempengaruhi cara kepemimpinan para doktor dan kebanyakan daripada mereka menjadi pemimpin transformasi secara tidak langsung.

Secara kesimpulannya, penemuan penting dalam kajian ini menampilkan kepentingan pendidikan perubatan dan perancangan kepemimpinan di dalam industri perkhidmatan penjagaan kesihatan. Pasukan penjagaan kesihatan, khususnya para doktor perlulah dilatih sebagai "guru klinikal" di dalam medan kesihatan kerana mereka sentiasa berkomunikasi dan mendidik para pesakit serta keluarga mereka setiap kali mereka memberi perkhidmatan penjagaan pesakit. Akhir kata, pengurusan penjagaan pesakit mestilah menggabungkan teknik pendidikan yang sesuai, sumber yang

mencukupi dan perancangan pendidikan di dalam percubaan untuk menggambarkan kepemimpinan dinamik di dalam semua situasi di dalam wad pesakit. Kerajaan dan Institusi pendidikan perubatan mestilah berusaha untuk menggabungkan perancangan pendidikan dengan latihan perubatan dalam usaha menyediakan para doktor yang berkemahiran pada masa hadapan.

DEDICATION & ACKNOWLEDGEMENTS

Dedication

To my parents who never stopped believing in me. To my father who is looking down from heaven. To my husband, Mathew and my children Charisma and Joel who stood by me through trials and tribulations.

Acknowledgement

The past six years has been a journey of discovery for me. I have gone through my father's demise, my own surgery, my son's hospitalization and my children's major examinations. My novice research started early 2008. It came to a halt when my dad was hospitalized for pneumonia. We thought it was another trip to the hospital which he would return. Soon after, we realized that was his last trip. It took us one year to pull through as a family. The following year, Charisma obtained 5As in her UPSR exam in 2009. I was a proud mother of a 12 year old. After collecting her results and wishing all her friends the very best, I rushed off to UM to present my thesis proposal. Little did I expect from the crowd that was waiting for me at the postgraduate room who bombarded me with questions and criticism that blew me away. All my training as a Champion University Debater never prepared me for this. I succumbed to tears and disappointment. Despite that, the thesis defence in 2010 went on smoothly. Then another reality of life appeared in 2010, when I realized I had a growth in my neck which needed to be surgically removed. That was a short set back but I managed to recover and dwelled full fledge into the data collection. The year 2012, was a major year for all of us. Both my children were sitting for their major exams. Major sacrifices had to be made but we managed to pull through. Many times I felt like crawling under the table and wishing this insane reality would go away. How I wish, the world outside

my PhD realm would stay constant and the only change would be my thesis completion. However, reality stayed and so did determination. At the end of 2012, Charisma obtained 7As in her PMR and Joel, 5As in his UPSR. Finally in the year 2013, I completed my thesis.

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AMC	Australian Medical Council
CCM	Chronic Care Model
CPD	Continuous Professional Development
CRC	Clinical Research Centres
EPF	Employees Provident Fund
FOMCA	Federal of Malaysian Consumers Associations
GDP	Gross Domestic Product
GP	General Practitioners
HKL	Hospital Kuala Lumpur
HO	Houseman
HSA	Hospital Sultanah Aminah
IHM	Institute for Health Management
IHP	Institute for Health Promotion
IHSR	Institute for Health Systems Research
IMR	Institute for Medical Research
IPH	Institute for Public Health
MAAS-Global	Maastricht History-taking and Advice Scoring list
MBBS	Bachelor of Medicine/Bachelor of Surgery
MMA	Malaysian Medical Association
MMC	Malaysian Medical Council
MO	Medical Officer
MOH	Ministry of Health Malaysia
MQA	Malaysian Quality Assurance
MREC	Medical Research and Ethics Committee
NHFA	National Health Financing Authority
NHFS	National Health Financing Scheme
NHS	National Healthcare Service
NIH	National Institutes of Health
NINPVB	National Institute for Natural Products, Vaccines and Biological
NMRR	National Medical Research Register
O&G	Obstetrics and Gynaecology
PBL	Problem Based Learning
SOCSO	Social Security Organization
TCM	Traditional and Complementary Medicine
TQM	Total Quality Management
UNDP	United Nations Development Program
WHO	World Health Organization
NIHF	National Health Insurance Fund
SMEU	School of Medicine Education Unit
PCL	Patient Centered Learning
ICU	Intensive Care Unit
CCU	Critical Care Unit
HDU	High Density Unit

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CHAPTER 1 : INTRODUCTION

1.1   Background

This opening chapter provides a general overview on the history of the practice of medicine and the traditional role of a doctor. Particular emphasis is also provided on the health care delivery in Malaysia in comparison with some examples of other countries. This chapter also provides a brief pre-understanding and justification that inspired this research journey. A brief picture on the significance of this research and the research problems are also discussed. The final section of this chapter introduces the research questions, purposes, definitions and limitations. Incepts of publications are included in the footnote to explain the role of the researcher as an instrument in the qualitative research.

1.2   History of the practice of medicine

In many countries traditional medicine plays an important role especially in rural areas. Traditionally, in Africa the physical and medical interventions were performed by traditional healers. In Latin America the traditional healers are known as *curandero* while in India they are known as *ayurvedic* doctors. *Ayurvedic* medicine which is still practiced today focuses on drugs and diet. The ancient medication in China follows the principle imbalance of the *yin* and *yang*, and other types of treatments such as massage and acupuncture. In Europe and in America, chiropractic was popular in the nineteenth century and these doctors concentrated their effort as being family practitioners (Roemer, 1993). In Malaysia, before the colonial days different ethnic groups such as the Indians, Chinese and the Malays were also practicing traditional medicine and treatment. According to Ismail Merican and Rohaizat Yon (2002) these complementary medicine are well accepted by both rural and urban communities even today. One

common attribute about these traditional healers are that they are known to be trustworthy and sympathetic.

1.3   Background of the modern doctor

According to Roemer (1993), in ancient Egypt and Greece the majority of the doctors were priest. They would placate to their Gods and prescribe medicine. The Greek God of medicine known as Asclepius has a staff and the symbol of the snake which is a worldwide symbol of medical profession today. About 400 B.C the school of Hippocrates separated medicine from religion and magic. This school of thought emphasizes on observation and vigilant description in understanding the disease. The first formal medical school to train doctors was set up at Salerno, Italy in the ninth century. Its influence spread into many different countries such as Europe, Arab, Philippines, Britain, America and Canada. The medical schools that were set up were not only used for training doctors but also for other purposes such as research and consultation of national health systems (Roemer, 1993).

Over recent years the content, perspective and training in medical education has changed. Medical education has become more integrated with the inclusion of medical ethics, medical law, problem based learning, sociology and psychology. Even though medical education has become more expensive (Roemer, 1993), most countries place their national health systems as important and increase the number of doctors and healthcare delivery system (Ismail Merican & Rohaizat Yon, 2002; Phua & Chew, 2002).

1.4   Health care delivery in Malaysia[1]

Human capital and health improvement programmes are of central importance towards sustainable development and economic growth in any country (Chai, Whynes, & Sach, 2008).   In Malaysia, the health care system has changed from traditional remedies to meeting the emerging needs of the population (Thomas, Beh, & Rusli Nordin, 2011).   Since the Independence of Malaysia in 1957, there has been major reorganisation of health care services in the country (Ismail Merican & Rohaizat Yon, 2002).   The first reorganisation started at the public primary health care services and accelerated since the Alma Ata Declaration was made in 1978.   The Alma Ata Declaration indicated that primary health care is the engine of health care system which is the means in providing comprehensive, universal, equitable and affordable health care for all (Ismail Merican & Rohaizat Yon, 2002; Liow, 2008).   In Malaysia, the government under the Ministry of Health (MOH) is the main provider of health care services to the public.   MOH accounts for 53% of the Malaysian government's total health care funding allocation for the country (Ismail Merican & Rohaizat Yon, 2002). MOH health care delivery systems can be seen in Figure 1.1.

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[1] Part of this have been published in Thomas, S., Beh, L. S., & Rusli Nordin. (2011). Health care delivery in Malaysia: Changes, challenges and champions. *Journal of Public Health in Africa*, *2*, 93-97.
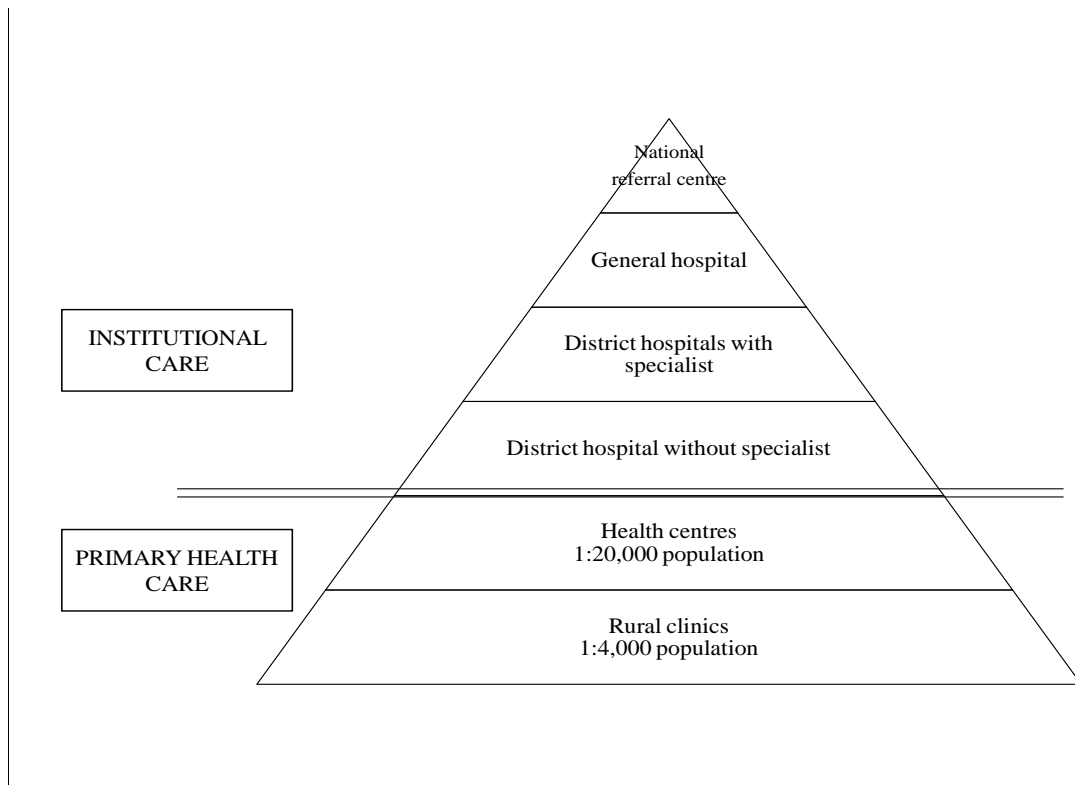
Figure 1.1: Ministry of Health: Health care delivery system
Note. From "Public Health Care Provisions: Access and Equity," by Muhamad Hanafiah Juni, 1996, *Social Science & Medicine*, *43*, p. 760. Copyright 1996 by the Elsevier Science Ltd.

The primary health care in Malaysia is supported by secondary and tertiary medical care (Rohaizat Yon & Abu Bakar Suleiman, 2000). The main objective is to provide a greater network of physical facilities, equity, accessibility and utilization of health care resources. At the same time, National Referral Centres were established to provide specialized care to enhance the basic care provided in health clinics. The organisation structure of MOH has three levels which are Federal, State and District levels which are decentralized to ensure efficiency. Each hierarchical level determines the level of authority, information flow, accountability and supervision. This system also encompasses all aspects of care such as preventive, promotive, curative and rehabilitative (Muhamad Hanafiah Juni, 1996).

Over the past decade there has been an explosion of tertiary level specialized care to meet the needs of the population (Amar, 2004). Tertiary care focuses on *curative model* which is doctor and illness focus. This is expensive, fragmented and institutionally focused and inappropriate for majority of health consumers. Amar (2004) commented that health care is changing towards *wellness* services as opposed to *illness* services. This service includes a lifetime health plan that focuses at keeping the child and family well. It aims at prevention issues such as visits to health professionals regularly from conception through childhood and adolescence to adulthood. Amar (2004) argues that this gives greater prominence on preventive issues and takes on healthier lifestyles by choices with risk prevention. The healthcare providers also need not function as a controller but acts as a facilitator or partners with health consumers. Figure 1.2 illustrates this.
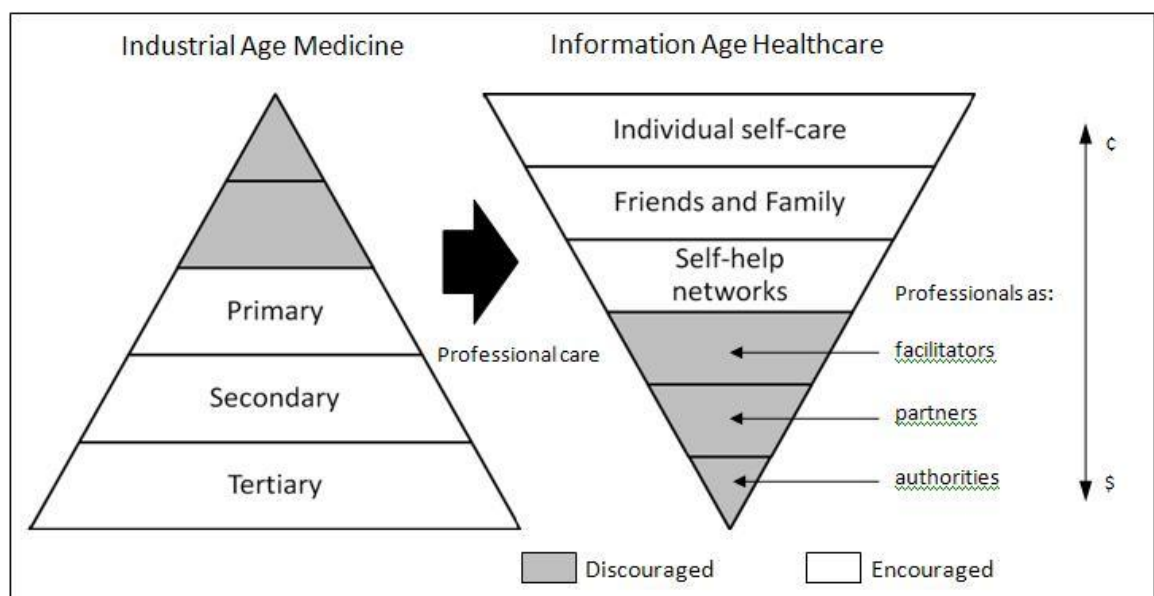
Figure 1.2: Transformation from industrial age medicine to information age healthcare
Note. From "Current Challenges in Health and Health Care," by Amar, 2004, *Asia-Pacific Journal of Public Health*, *16*, p. 88. Copyright 2004 by the Asia-Pacific Academic Consortium for Public Health.

Apart from the size of the hospitals there are differences in terms of the services provided. Small district hospitals provide general medical and nursing care and their

manpower consist of medical officers and other personnel. Larger district hospitals and regional hospitals provide a wide range of specialist services that includes high technology such as open heart surgery. The public has easy access through walk-in or referral system. However nominal fee is levied for patients who walk-in and waived for those who are referred and those who cannot afford to pay (Muhamad Hanfiah Juni, 1996).

MOH seeks to ensure the public is informed of health issues and has access to safe water, safe food and quality medicine. The Malaysian health care system focuses on Primary Health Care (PHC) that places social equity as important and allocates public funds for the poorest 20% of the population (Liow, 2008). According to Muhamad Hanafiah Juni (1996), the government's good socio-economic development planning has given Malaysia an advantage through excellent health care delivery system and good health status for the nation.

In 1956, there were only 42 primary health care facilities in the country (Liow, 2008). After independence, the health sector became an integral part of the national and development process and MOH was responsible to deliver health care to communities throughout the country (Nik Rosnah, 2004). In 2001 the health care facilities has grown to 204 mobile teams, 843 health clinics, 1,924 rural clinics, 115 hospitals and 6 medical institutions throughout Malaysia (refer to Table 1.1). In 2001, these hospitals supply an overall of 29,123 acute beds for secondary and tertiary care while the medical institutions provide 5,551 chronic beds, which were mainly for psychiatric care (Ismail Merican & Rohaizat Yon, 2002).

Table 1.1: Health facilities by the Ministry of Health Malaysia in 1984, 2001 and 2008

MOH's Facilities	1984	2001	2008[a]
Health Clinics	361	843	802
Rural/Community Clinics	1, 039	1, 924	1, 927
Mobile teams	35	204	193
Hospitals	89 (21,159 beds)	115 (29, 123 beds)	130 (33 004 beds)
Medical Institutions	8 (10, 235 beds)	6 (5, 551 beds)	6 (5 000 beds)

Note. Adapted from "Health Care Reform and Changes: The Malaysian Experience," by Ismail Merican & Rohaizat Yon, 2002, *Asia-Pacific Journal of Public Health*, *14*, p. 18. Copyright 2002 by the Asia-Pacific Academic Consortium for Public Health. Adapted with permission.
[a]Extracted from *Health Facts 2008*, by Ministry of Health Malaysia, 2009.

According to the Minister of Health, Dato' Liow Tiong Lai, our primary health care facilities increased further to 2,874 in 2005, comprising 809 health clinics, 1,919 community clinics and 146 mobile clinics (Liow, 2008). Health facilities have increased further in 2008 to 130 hospitals with 33,004 beds, 1, 927 community clinics and 6 Special Medical Institutions with 5 000 beds (MOH, 2008; 2009).

Statistics in the year 2001 shows that the returns collected by MOH from providing medical, health and dental care services amounted to 2.2% of the total operating budget (Chai et al, 2008; Ismail Merican & Rohaizat Yon, 2002; Muhamad Hanafiah Juni, 1996). This is not comparable to the rising expenditure in MOH facilities. The report from the Health Department of Selangor in 2006 shows that the total expenditure has increased to RM 881.3 million compared to RM628.83 million in 2005 and RM577.77 million in 2004. The increase is due to new hospitals and comprehensive health services that are provided by the government (Department of Health Selangor, 2007). With the increase of hospitals, community clinics and other facilities such as 2 special institutions, 6 National Institutes of Health, 7 non-MOH government hospitals, 1, 707 MOH dental clinics, 493 MOH mobile dental clinics and 95 MOH maternal and child health clinics (refer to Table 1.2), the number of health

clinics and mobile clinics have reduced in 2008. Special Medical Institutions among others are National Heart Institute, Institute Paediatrics and Institute of Respiratory Medicine (MOH, 2008). Furthermore, there are also two Special Institutions in Malaysia which are National Blood Centre and Public Health Laboratory. The idea of National Institutes of Health (NIH) was formed in 1980s and approved in the 7th Malaysia Plan to strengthen health research in the MOH. Currently NIH consists of seven institute and they are Institute for Medical Research (IMR), Institute for Public Health (IPH), Network for Clinical Research Centres (CRC), Institute for Health Management (IHM), Institute for Health Systems Research (IHSR), Institute for Health Promotion (IHP) and National Institute for Natural Products, Vaccines and Biological (NINPVB).

Table 1.2: Health facilities by the Ministry of Health

Health Facilities		
	NO.	BEDS (OFFICIAL)
Hospitals (MOH)	130	33,004
Special Medical Institutions (MOH)	6	5,000
Special Institutions (MOH)[a]	2	-
National Institutes of Health (MOH)	6	-
Non-MOH Government Hospitals	7	3,245
Private Hospitals	209	11,689
Private Maternity Homes	22	174
Private Nursing Homes	12	274
Private Hospice	3	28
MoH Dental Clinics	1,707	2,910[c]
MOH Mobile Dental Clinics[b]	493	1,149[c]
MOH Health Clinics	802	
MOH Community Clinics (Klinik Desa)	1,927	
MOH Maternal & Child Health Clinics	95	
MOH Mobile Health Clinics	193	
Private Medical Clinics	6,371	
Private Dental Clinics	1,435	

Note. From *Health Facts 2008*, by Ministry of Health Malaysia, 2009.
[a]National Blood Centre & Public Health Laboratory. [b]Includes Mobile & Pre School Dental Team. [c]Dental Chairs.

Studies have shown that the Malaysian health standard is almost at par with those of the developed countries (Nik Rosnah, 2004; Noor Hazilah Abd Manaf, 2005; Phua & Chew, 2002). The Malaysian health system has been described as egalitarian and focuses on primary health care and the accessibility is assured in geographical and financial terms (Balasubramaniam, 1996, Meerman, 1979, as cited in Nik Rosnah, 2004). The Second National Health and Morbidity Survey in 1996 reported that 88.5% of the population stays within 5 km of a health facility and 81% lived within 3 km (Liow, 2008). Findings also show that basic health care and facilities are accessible to about 70% of the population in Sabah and Sarawak and more than 95% of the population in Peninsular Malaysia (MOH, 1993). These estimates do not include other types of outreach services such as flying doctors, mobile health teams, dental clinics, travelling dispensaries and riverine services (Ismail Merican & Rohaizat Yon, 2002; Muhamad Hanafiah Juni; 1996).

However, there are other government agencies that complement the role of MOH to preserve the health of the people. For instance the Ministry of Human Resources that enforces safety and health regulations of employees, Ministry of Education that is responsible for the operation of the teaching hospitals and training of the health personnel of the country, Ministry of Defence that provides health services for its population within the territory, Ministry of Rural Development that is responsible for the health of the aborigines and Ministry of Housing and Local Government is responsible for some of the licensing and enforcement under its purview (Rohaizat Yon & Abu Bakar Suleiman, 2000).

Ismail Merican and Rohaizat Yon (2002) reported that the data from World Health Report in 1999 indicated that the health indicators of Malaysians were much

better compared to some of the ASEAN countries. For example the Infant Mortality Rate (IMR) in Malaysia is 11 per 1,000 live births while in Indonesia is 48 per 1,000 live births and Thailand is 29 per 1,000 live births. This figure is still high compared to IMR of Singapore (5/1000 live births), United Kingdom (7/1000 live births) and America (7/1000 live births).

Despite Malaysia's effort in socio-economic development plans, there still exist issues in equity and accessibility especially for the indigenous groups, rural population and the hard-core poor (Liow, 2008). According to Chai et al. (2008) equity is defined as an assessment of fairness. Malaysia's effort in equity is assessed through quality in health services, sufficiency in manpower, equity in price and tariff and accessibility of health care in terms of geographical location (Economic Planning Unit, 2001). At a macro level, equity is much more difficult to reach in Asian countries. Ever since the Asian economic crisis in 1998, the poverty level in several countries in Asia has increased 50% which added difficulty for the poor and middle class in accessing health care. Nevertheless, efforts are taken by the government to strengthen the rural health services in Malaysia through the improvement of existing facilities and introducing new health services that range from outpatient curative care to preventive and promotive services (Muhamad Hanafiah Juni, 1996). These rural health units consist of one health centre, four rural health units and mobile clinics. The rural health unit follows a two-tier system that provide subsidized or free health services to 15, 000 to 20, 000 rural population (Ismail Merican & Rohaizat Yon, 2002; Muhamad Hanafiah Juni, 1996). The population at the rural area enjoy comprehensive health services that is delivered free of charge (Muhamad Hanafiah Juni, 1996).

With reference to equity through sufficient manpower, it is noted that there is a remarkable difference in doctor patient ratio in the country. Muhamad Hanafiah Juni (1996) who made a comparison between states and the capital city described the ratio for Kuala Lumpur as 500 patients per doctor compared to 4000 patients per doctor in Terengganu and East Malaysia. Table 1.3 shows the overall ratio for the country has reduced over the years. As in 2009, the ratio of doctors to patients in Malaysia is 1:927 and in 2012 the ratio is 1:800 ("Ministry Emphasises Quality of Medical Training", 2012) compared to 1:1,105 in 2008 (MOH, 2009, 2010). Nonetheless this deficit is expected to reduce in the coming years to a ratio of 1:600 by 2015 ("Ministry Emphasises Quality of Medical Training", 2012) with the existence of more medical and health sciences related schools in Malaysia.

Table 1.3: Doctor-population ratio in Malaysia

Year	Ratio
1975	1: 4650
1980	1:3000
1990	1: 2533
1993	1: 2301
2004	1:2718
2008[a]	1: 1105
2009[b]	1:927
2012[c]	1:800

Note. Adapted from "Public Health Care Provisions: Access and Equity," by Muhamad Hanafiah Juni, 1996, *Social Science & Medicine*, *43*, p. 764. Copyright 1996 by the Elsevier Science Ltd.
[a]Data is extracted from *Health Facts 2008*, Ministry of Health Malaysia, 2009; [b]Data is extracted from *Health Facts 2009*, Ministry of Health Malaysia, 2010; [c]Data is extracted from "Ministry emphasises quality of medical training", 2012, *New Straits Times*, p. 3.

On the other hand, Table 1.4 shows there is a remarkable deficit in the number of other professional manpower such as pharmacist, dentist, opticians, optometrists that are needed in Malaysia.

Table 1.4: Human resources in MOH

	PUBLIC	PRIVATE	TOTAL	PROFESSION: POPULATION
Doctors[a&b]	15,096	10,006	25,102	1 : 1,105
Dentists[a&c]	1,922	1,718	3,640	1 : 7,618
Pharmacists[a&d]	3,070	3,327	6,397	1 : 4,335
Opticians[e]	-	2,514	2,514	1 : 11,030
Optometrists[e]	159	532	691	1 : 40,128
Asst. Medical Officers[a&f]	8,310	768	9,078	1 : 3,054
Asst. Pharmacy Officers[a]	2,778*	n.a	2,778*	1 : 9,982
Asst. Environmental Health Officers[a]	2,566*	n.a	2,566*	1 : 10,806
Medical Lab. Technologists[a]	4,039*	n.a	4,039*	1 : 6,865
Occupational Therapists[a]	426*	n.a	426*	1 : 65,091
Physiotherapists[a]	593*	n.a	593*	1 : 46,760
Radiographers[1]	1,518*	n.a	1,518*	1 : 18,267
Nurses[a&g]	38,575	15,633	54,208	1 : 512
Dental Nurses[a&h]	2,287	-	2,287	1 : 12,124
Community Nurses[a&g]	18,143	500	18,643	1 : 1,487
Dental Technicians[a&h]	772	704	1,476	1 : 18,786
Dental Surgery Assistants[a&h]	2,970	n.a	2,970	1 : 9,336
Traditional & Complementary Medicine Practitioners[i]	n.a	n.a	8,739**	1 : 3,713

Note. n.a. = not available; * MOH only; ** refers to voluntary registration by local practitioners & application for professional visa by foreign practitioners. From *Health Facts 2008*, by Ministry of Health Malaysia, 2009.
[a]Human Resource Division, MOH. [b]Malaysian Medical Council. [c]Malaysian Dental Council. [d]Pharmacy Board Malaysia. [e]Malaysia Optical Council. [f]Medical Assistant Board. [g]Malaysia Nursing Board. [h]Oral Health Division, MOH. [i]Traditional & Complementary Medicine Division, MOH.

According to the Health Minister, Datul Seri Liow Tiong Lai, Malaysia has more than 30 000 doctors and MOH is working closely with the Higher Education Ministry in maintaining the quality of the medical graduates and the current doctors. MOH is also working on plans to ensure that each university that is offering the medical course has their own training centre ("Ministry Emphasises Quality of Medical Training", 2012). Besides that, the Malaysian government is also tabling a medical bill to enhance the regulation of the medical profession in the country by strengthening the MMC. The amendment introduces the set-up of the Medical Qualifying Committee that monitors the accreditation of qualifications of international and local institutions that offers medical training (Carvalho, Yuen, & Wong, 2012).

Furthermore under the 10th Malaysian plan, the government is preparing a better quality of life for all the citizens by 2015 through quality healthcare which is affordable and accessible through the increase of doctors and nurses along with the 1Malaysia clinics (Myplan, 2012). According to Maimunah Hamid (2010), the proposed model for the restructured national healthcare system is 1Care. This model provides choice of quality health care ensuring universal coverage which has several benefits such as reduce brain-drain, personalized care, client satisfaction, care nearer to home, access for vulnerable group and responsive health care system. However this model requires a more comprehensive study and longer term planning (Maimunah Hamid, 2010).

The Malaysian health care system is primarily divided into private and public sectors. One of the pending concerns of the government is that there are high concentrations of private practices in the urban areas due to the demand by the affluent community (Muhamad Hanafiah Juni, 1996). Generally, the services provided by private hospitals are curative and selective in nature, but they are much more comprehensive when there are issues of equity. Access to private health services is limited to the richer society that can afford out-of-pocket payments of higher fees (Chai et al, 2008). As cited by Noor Hazilah Abd Manaf (2005) in an article from Lim (2002), there is also a big difference in the salary remuneration received by doctors serving in public hospitals compared to those who serve in private hospitals in Malaysia. This is one of the reasons of migration of doctors to the private practice. Noor Hazilah Abd Manaf (2005) cited Lim (2002) about 300 doctors and specialist leave the public sector annually to join the private sector. This situation affects the supply of doctors in the public hospitals. In her research about quality care in Malaysian public hospitals Noor Hazilah Abd Manaf (2005) explains the shortage of

doctors in public hospitals is one of the reasons why the doctors in public hospitals describe their workload as heavy and consequently are hard pressed to take up roles in quality management of the hospitals.

In 1993 there are 3, 055 general practitioner clinics and 190 private hospitals and nursing homes in Malaysia (Muhamad Hanafiah Juni, 1996). In 2000, 46.2% of all doctors in the private sector were accountable for only 20.3% of hospital beds while the rest of the 53.8% of doctors in the public sector looked after 79.7% of the beds (Ismail Merican & Rohaizat Yon, 2002). It was also reported that 58.8% of the specialist were recruited in the private sector whilst only about 41.2% remain in the public sector (Ismail Merican & Rohaizat Yon, 2002). The findings through interviews with key personnel from MOH conducted by Nik Rosnah (2004) states that the charges from private hospitals on services component range from 15 – 28% of the hospital bills and medication. However, 15% of this bill is not made known to patients and yet the professional service fees take up almost 50% of the total bill. The differences in the public and private sectors in terms of specific services provided may have a significant effect on the equity of services and the question on efficiency and effectiveness (Twaddle, 1996). This leads to an imbalance of the distribution of manpower in public and private sectors in Malaysia (Economic Planning Unit, 2001).

Health care financing is a key concern all over the world today. Among others, some of the sources of funding health care are through taxation, social and private health insurance and out-of-pocket payments (Chai et al., 2008). In Britain, the National Healthcare Service (NHS) provides healthcare to the majority of the population (British residents) since 1948. The funding comes directly from the taxes and it is the cheapest and the fairest way in funding the healthcare system in Britain

compared to other countries. This is because it covers from antenatal care, surgeries to palliative care. The budget has increased 10 times more from whence it started (£437mil) to £100bil in 2009, which equate to £1980 for every man, woman and child in Britain (Sidhu, 2010).

In Australia, Medicare was set up in 1984 to provide affordable and accessible high-quality healthcare which is financed through income tax and income-related Medicare levy. The public receives free treatment in public hospitals and free or subsidised treatment at clinics for specified treatments. However, in United States, even though there was high resistance from some groups of people, the healthcare reform was finally approved. The new medical bill (US$940) now covers a total of 32 million Americans who are without any insurance coverage. The aim of the new healthcare reform is to ensure healthcare is affordable, health insurers are more accountable and health system more sustainable. Most importantly it terminates discrimination by the insurance industry against those who have pre-existing conditions in their health (Sidhu, 2010).

In Malaysia, the government finances the public health services through the Consolidated Revenue Fund under the Ministry of Finance while the sources from the private sector are essentially from the consumers (Kananatu, 2002). The system of financing is inclined towards the public sector whereby only a nominal fee of RM1 for each outpatient visit is charged (Kananatu, 2002) in accordance to the Fees (Medical) Order 1976 (Chai et al., 2008). Government employees and their family members benefit from these services even after their retirement while the Social Security Organization (SOSCO) and Employees Provident Fund (EPF) do not finance employees in the private sector during their retirement (Kananatu, 2002). Comparatively, the

British government initiated the 1912 National Health Insurance policy to compensate salaries of workers who have lost their jobs due to sickness (Tripp, 1981).

Multidisciplinary interventions are required to promote health financing, health care and disease prevention (Low, 2008). In Malaysia partnership between public sectors and private sectors should be encouraged to maximize resources and minimize duplication of health delivery and provide equitable health care (Yadav, 2000). Subsequently community engagement in self-care, planning, organizing and management will lead to self-sufficiency in health (Yadav, 2000). Countries need to get communities involved through social networks to address these problems. One effective way to improve the shortage and distribution imbalance especially in rural areas which is practiced in China is to rely and train the locals as paramedical workers (Hu, 1981). Another option proposed by World Health Organization (WHO) is providing additional alternatives rather than replacing existing ones (McEvers, 1980). Three interrelated strategies to help the poor access health care are to design appropriate training for village health workers (preventive and promotive intervention), design appraisals on programs implemented and introduce community participation (McEvers, 1980). The proposed NHFA would be a feasible option as a health care financing mechanism in Malaysia with vested authority in providing equitable and quality services both in the public and private health care services (Kananatu, 2002). This has also been urged by The Federation of Malaysian Consumers Associations (FOMCA) which has pointed out the benefits that will be gained in implementing the National Health Financing Scheme (NHFS), one of which will be regulating fees charged by the private hospitals and providing the public the freedom of choice to seek treatment either at public or private hospitals in Malaysia ("Healthcare Financing Scheme Long Overdue", 2010). Another suggestion of intervention is to establish a National Health

Insurance Fund (NHIF) to be the main funding source for the public health care sectors which allows compulsory contribution from employers and employees (Citizen's Health Initiative, 2000).

Yadav (2000) also commented that the traditional support systems in some countries have been taken for granted and governments need to mobilize these social networks to take care of these problems. In this respect the development of traditional medicine should also be encouraged. In China traditional medicine complements western medicine and this practice is allowed in hospitals in order to give the people the choice (Yadav, 2000). In Australia, the demand for alternative medicine is increasing steadily (Zhu, Carlton, & Bensoussan, 2009) and findings have shown that the consumer expenditure have doubled from $A1 billion in 1993 to $A2.3 billion in 2000 (Myers, 2002). A survey conducted by the Malaysian MOH in 2004 has concluded that 70% of Malaysians use traditional and complementary based medicine to improve their health or to treat illnesses (Lee, Izatun Shari, Teh, & Yuen, 2010). The most popular fields include Malay traditional medicine, Chinese traditional medicine, Ayurvedic medicine and Natural medicine (Lee et al., 2010). Utilization of cross-cultural traditional medicine by the various ethnic groups in Malaysia is also gaining popularity (Kamil Ariff & Khoo, 2006; Talib, 2006). This has raised significant issues in public health policy (Siti et al, 2009). According to Siti et al. (2009) and Talib (2006) even though the practice of alternative medicine is recognized in statutory form under section 34(1) of Medical Act 1971 (Act 50), the safety and efficacy of these medicine must be ensured through strict regulations and public education forums.

Since the goal of medicine is essentially helping people to improve their health, therefore it is important for medical health professionals to work together with social

workers from traditional and complementary medicine by respecting each others' beliefs and training and working as a team (Zhu et al., 2009). Currently guidelines and the passing of the Traditional and Complementary Medicine Bill for the various fields in traditional medicine are being studied carefully by various organisations in Malaysia (Citizens' Health Initiatives, 2000).

Immigrant health is another concern in Malaysia whereby according to Ismail Merican and Rohaizat Yon (2002), 5% of the Malaysian population which consists of about one million people are immigrant workers. These foreign workers may harbour communicable diseases which originate from their country and this incurs health care cost when they use the health facilities in Malaysia (Ismail Merican & Rohaizat Yon, 2002). Moreover, there are many cases whereby foreign workers who have been admitted have defaulted in settling their bills. Therefore collectively with a number of other reasons, the unsettled hospital bills in public sectors are increasing (Kananatu, 2002). To address these issues, more comprehensive preventive measures and plans must be taken by designing and implementing conducive national health care financing scheme under the National Health Financing Authority (NHFA) within the realm of MOH (Kananatu, 2002).

During the Sixth Malaysian Plan (1991 -1995), the government introduced one-stop health services to the urban health clinics which is similar to those provided at the rural health services. One-stop health services include maternal child health clinics (MCH), health polyclinics, pharmacy services, x-ray, laboratory and dental clinics (Ismail Merican & Rohaizat Yon, 2002).

However the Seventh Malaysian Plan (1996 – 2000), MOH was building an information and communication technology (ICT) system for hospitals and health clinics leading to the creation of paperless hospitals. This would be achieved through electronic medical records, telemedicine and teleconferencing. The government plans to expand its nationwide projects in phases in line with the government's effort to develop Malaysian Multimedia Super Corridor (MSC) (Mohd Hishamudin Harun, 2001; Rohaizat Yon & Abu Bakar Suleiman, 2000).

As for the Eight Malaysian Plan (2001 – 2005) the focus was on safeguarding and improving the health status of individuals, families and communities. The government has undertaken efforts to enhance the delivery system and to improve the scope and quality of health care. The emphasis was to integrate health care services through greater cooperation between the public and private sectors as well as non-governmental organisations (NGOs).

However in the Ninth Malaysian Plan (2006 – 2010) the government focused on improving healthcare facilities and services. This included building eight new hospitals, replacing fourteen old hospitals and building specialist centers. Mobile clinics would be increased to improve healthcare services in rural areas. Primary, secondary and tertiary healthcare services would be integrated through an efficient and effective referral system. A human resource action plan would be drafted and RM1 billion allocated to human resource development in healthcare ("Full text of the PM's 9MP speech to Parliament", 2006).

The Malaysian Medical Association (MMA), the Malaysian Medical Council (MMC) and the MOH form as the regulatory bodies to maintain quality in the medical

profession and as well as take necessary measures in improving the delivery of health care services and facilities in the country. The challenge is to showcase that these structures and mechanism work to the advantage of the public.

However the Malaysian government has encouraged the private hospitals to take on more social responsibility of the country. The private sectors are responding well to this in which more private hospitals are getting involved with public education, free medical screening and other activities. Over the last couple of years, there has been an increase in efforts to improve systems and attract foreign workforce. Nevertheless efforts are also taken by the government to improve facilities and services in the public sectors. With all the Malaysian Plans and mechanisms in place, it is hoped that the government will continuously improve the health care delivery further.

1.5 Health care system and challenges faced in other countries

Health needs and challenges have changed over the past decade. According to Amar (2004), professionals in health care and the health care systems have changed at a much slower pace and are not usually suitable for the present health needs of the population. Throughout the world there seem to be fundamental changes in the medical care delivery system. Asia Pacific region is the most varied health region with the largest population in the world. However, it also contains countries that are fighting with epidemic obesity (Binns & Boldy, 2003). Asia is recognized as having increased incidences of diabetes by 2.5 to 3 times compared to other regions (Binns & Boldy, 2003). This includes Malaysia which has about 8.3% of the population above 30 years of age suffering from diabetes and 29.9% from hypertension (MOH, 1997). In the less-developed countries in the region, women suffer from malnutrition, high mortality and morbidity (Low, 2008).

Although a large percentage of the population is moving through the economic transition, 70% of the deaths are due to chronic diseases (Binns & Boldy, 2003). United Nations Development Program (UNDP) has published projections for changes in populations over the next 50 years. For population over 60 years; Japan will have an increase from 23% to 43%, Cambodia will have an increase from 4% to 11% (Binns & Boldy, 2003), Malaysia will have an increase from 5.7 % from 1996 to 11% by 2020 (Yadav, 2000) and China will have an increase of 300 million people (Binns & Boldy, 2003).

Other problems such as malaria and tuberculosis still persist in many regions (Binns & Boldy, 2003). Lam, Ho, Hedley, May, and Peto (2001) commented that China is on the verge of a massive epidemic caused by smoking which will lead to death unless certain measures are taken. Lam et al. (2001) also found that 33% of all deaths in Hong Kong are caused by tobacco. Another biggest threat in the region is the problem of HIV and AIDS and China has been identified as one of the countries showing an increased number of this disease spreading (Lam et al., 2001).

Another indicator of health among regions is under-five mortality which reflects nutritional intake, the knowledge of health by mothers, the level of immunization and the use of oral rehydration fluids (Yadav, 2000). Countries that have low under-five mortality include New Zealand (8.3), Australia (7.1), Japan (6.9) and Singapore (6.0). Countries with high under-five mortality are Cambodia (181) and Lao (170) (Yadav, 2000). Dickinson (2006) commented that the narrow administrative focus and ineffective task is one of the problems faced in Thailand in ensuring optimal nutrition and growth for the children. Another nutrition problem in Beijing is deficiency in

thiamine and riboflavin. The cause of beriberi was also discovered in Beijing. Although the disease disappeared in a short term, but without constant reinforcement and lessons this disease will reoccur again (Dickinson, 2006). Polished white rice is preferred in Asia compared to the western countries where brown rice is easily available (Dickinson, 2006). According to Yadav (2000) countries seldom tap into their natural resources and the best approach is educating children and parents to eat a healthier diet (Dickinson, 2006).

There are many parts of the world that are still ravaged with water-borne diseases, high death rates and new strains of infectious diseases (Twaddle, 1996). According to Amar (2004), even though the health mortality in terms of maternal, perinatal and infant mortality has declined however, the morbidity of the population has increased. For example, Amar (2004) explained there are more accidents now compared to before and infectious disease such as the dengue epidemic has become more virulent. Some of the common threats faced in Malaysia are seen in Table 1.5.

Table 1.5: Current health care challenges (The "new morbidities)

Problem	Size of the problem (one example)
Unintentional Injuries (especially Road Traffic Accidents)	Road traffic injuries are a leading cause of death and burden of disease for children, adolescents and young adults in the Asia-Pacific Region.
Intentional Injuries (Child Abuse, Rape, Domestic Violence)	Most epidemiological studies detected child sexual abuse rate in any community of between 10-15%.
Disability and Genetic disorders	3% of any community will comprise children with significant disability requiring assistance.
Chronic illnesses	12-14% of all children have asthma.
New viral epidemics and re-emerging diseases	Rising HIV rates, recent dengue epidemics and new viral epidemics like Nipah and SARS.
Malignancy	Emerging as a major concern of the average individual.

Problem	Size of the problem (one example)
Behaviour related problems	Adolescent issues, education and sexuality related concerns are common parental concern.
Lifestyle related and adult illnesses with a onset in childhood	Smoking, sexually transmitted illnesses and obesity impact large segments of the population.

Note. The list above has a paediatric bias. Adapted from "Current Challenges in Health and Health Care," by Amar, 2004, *Asia-Pacific Journal of Public Health*, *16*, p. 87. Copyright 2004 by the Asia-Pacific Academic Consortium for Public Health.

The WHO and individual countries are taking control of the progress by primary health care. Although the definition of primary health care varies from country to country but it cannot be denied that accessibility, quality of basic health care and equity within countries has improved (Yadav, 2000). Nevertheless according to Amar (2004) and Low (2008) the population most in need are the aboriginal, the poor, the disadvantaged and the disabled because the health care system tends to operate based on active market forces (Hart, 1971). The fact that these groups have the least access to health services has led to *'the inverse care law'* which explains that every individual has a right to health care services and it is essentially the responsibility of the government to ensure this access (Malaysian Medical Association, 2010). However, meeting their needs will be very challenging (Shigeru, 2002).

Health care financing is a main challenge in many countries. These countries should consider providing a safety net for the poor (Yadav, 2000). United States (US) spends 14% of GNP compared to Asian countries that spends about 4-8% of GNP on health care. According to Getzen (1997), health care is a trillion-dollar business in US with an average expenditure of US$4226 per person. Whilst in UK, according to Henderson (2002) the National Health Service ran an overall budget of £50 billion in 2000 which accounts for 5.8% of the country's GDP (WHO, 2000, as cited in Noor

Hazilah Abd Manaf, 2005). With new technologies, capitalization of expensive hospital facilities and specialization has increased the cost of medical services. Most importantly whether the country's medical expenses are financed by the state or market driven, the cost containment in health care system has become a problem for most countries (Noor Hazilah Abd Manaf, 2005). Furthermore, commercialization of health care is not financially viable for majority of the consumers and is inappropriate because any framework of health care provision must be in line with the needs of the consumers (Amar, 2004). As a result of this, it has undermined the trust of individuals towards the health care profession and the government (Amar, 2004).

The Medical Price Index has increased more than the Consumer Price Index (Twaddle, 1996). In some parts of the countries, where the force of the financial crisis is bigger, structural adjustments to high costs of debt servicing and reduced rates of exchange have caused cuts to the public health budget. Consequently many of the countries anxiously look for cost-containment measures and different sources of financing which also include cost sharing mechanisms (Phua & Chew, 2002). In doing so, no one should be denied access to health care due to financial reasons. Thus, Malaysia should not adopt solutions from failed regions that have failed in health care delivery (Amar, 2004). Despite the high-tech medical technology in the health care sector in the United States, 45 million residents are lacking health insurance, including 10 million children who are uninsured (Chan, 2000). One possible suggestion in managing long term health problems is by looking at the Chronic Care Model (CCM) that leads to improved patient care and better health care systems which is widely practiced for ambulatory care improvement in the United States and many of the countries internationally (Coleman, Austin, Brach, & Wagner, 2009).

In Australia, it is compulsory for all General Practitioners (GP) to go for vocational training. The value of continuous professional development (CPD) for all medical practitioners is acknowledged internationally and can be attained by attending workshops, conferences and training sessions (Khoo & Richard, 2002).

The Asian economic crisis in 1998 has increased 50% of the poverty level in several countries which increased the difficulty for the poor and middle class in accessing health care. Fortunately through privatization in Malaysia, the weight of the cost of care was moved to a sizeable proportion of the population that could least afford it. Comparatively, the provision of medical care through the National Health Service in Britain is committed to horizontal equity which describes equal treatment for equal need (West, 1981) while the Australian experience in health care financing is described as the classical liberal manner in which the government operates (Tripp, 1981). Fortunately countries such as Malaysia and Thailand provide a safety net for primary care which ensures minimal essential care for the high risk group (Patrick & Cadman, 2002).

To conclude, it is important to understand the diversity of the disease and the diversity in the regions. There are many challenges faced in health care and it is important to continuously evaluate the clinical practice and review reforms that will be equitable and affordable to all the different people in all the countries (Khoo & Richard, 2002).

1.6   Pre-understanding and justification of the research

When I wrote my thesis proposal, I realized I have no knowledge of a clinical setting, nor the skills needed to conduct a qualitative research. I have no idea what the experiences of a typical doctor entails, yet my desire and passion to explore and report

the truth was strong. The first stage of my research journey is to investigate the demands of the medical profession and the hospital setting. Subsequently I evaluated the medical curriculum which provided the fundamental understanding of the demands in the medical profession. The data collected from the Medical School that I was attached to provided me the avenue to embark on various research projects which enabled me to design a suitable research framework which shaped the production of the thesis. This is explained in the following sections.

1.6.1 The start of the research journey

The quest for knowledge started during my undergraduate practical training attachment at the Sultanah Aminah Hospital (now known as Hospital Sultanah Aminah or HSA) in Johor Bahru for six weeks in which I was exposed to the general system of the hospital management. After completing my undergraduate degree, I went on to pursue a career in the field of education. For fourteen years, I have worked in educational institute and held various positions as lecturer and head of program/department. I soon realized my experiences in the education industry would not be sufficient in understanding the health care system in Malaysia. I needed to have an emic approach to understand the insider's view. I needed to understand the common terminologies used in a clinical environment, the culture followed by the practitioners and most importantly I needed to acquire knowledge in data collection and analysis. By being involved gradually in various medical research projects, I believed it will inevitably provide me with the tools I need for my thesis and reduce the risks of premature misinterpretation of the data collected. As Lowe and Guthrie (2011) explain, by multitasking and being involved in other research projects, it stimulates and empowers the PhD student for a smooth path ahead. Lowe and Guthrie (2011) explain that the skills would become honed and the researcher will have a greater depth of

understanding the knowledge finesse. The words of John Clarke 'you need to go back a little to leap further' had also influenced me. So I paced back a little in my career through a professional change in order to take the leap of faith in the hope of completing my thesis successfully in this area.

Subsequently, as I accepted my offer in pursuing my PhD at University Malaya in 2007, I also accepted the position as a Course Development Manager at a newly formed medical school known as Jeffrey Cheah School of Medicine and Health Sciences at Monash University. This provided me the landscape in understanding the medical arena. Initially, my job entails the basic management duties such as recruiting, selecting, resourcing, training, and setting up the administrative procedures for the Bachelor of Medicine/Bachelor of Surgery (MBBS) program. The job enabled me to understand the course structure, study guides, clinical practices, the anatomy resources needed, the various style of teaching and learning, the hospital and community clinic attachments, rural clinical visitation, traditional and complementary medicine and the overall integrated system of the MBBS program. Consequently, because of the strength in my educational background, I was then recruited to another promising career in 2008, as the Lead Coordinator of the School of Medicine and Education Unit (SMEU). As Winston Churchill puts it 'There is nothing wrong with change, if it is in the right direction'.

The position required me to be responsible for the educational projects of the School, evaluation of the teaching and learning activities and the continuing professional development programs for all the staff from the School that includes both campuses at Sunway and Clinical School Johor Bahru. This included various programs such as MBBS, Pharmacy, Psychology, Nursing, Biomedical and BRIMS (Brain

Research Institute of Monash Sunway). Pursuing this job meant I was out of my comfort zone but on the contrary it pushed me towards my main objective which was to acquire knowledge on health care management, data collection and analysis.

1.6.2   The fundamentals: Evaluation of the medical curriculum

My research drove me to look at the fundamentals of medical based research. I was not exposed to qualitative research, yet I was presented with a mountain of data that needed to be processed. So I systematically collected data about the MBBS curriculum through the opinions of staff and students on the strengths and weaknesses of the newly formed program. I was evaluating the program through a questionnaire format using the Pendleton's model of "what went well", "what did not go so well" and "any further suggestions". This open text format allowed the staff and students to write freely about the course and issues faced. The raw data collected were tabulated and studied using line-by-line coding. Glaser (1978) explains although this is arbitrary but this step will examine implicit concerns and explicit statements. After the initial coding, the open axial coding proposed by Strauss and Corbin (1990) was used. According to Creswell (1998) this strategy will sort, reassemble and synthesize large amount of data. The data was broken down to selective coding that was categorized into positive and negative statements. These statements were further broken down into four major themes that were colour coded and categorized into teaching resources/ pedagogy, teaching methodology, group dynamics, management and the running of the course. The data was systematically keyed in through EXCEL spread sheet according to the groups of students, year, tutor and type of subject. Thereafter the data was analysed manually since there was no software purchased by the School at that time. The raw data was then collated and compiled and distributed to all the academic staff to examine the

curriculum. The data also provided vignettes and responses from both students and tutors which was helpful to pursue their research interest.

Thus by seeking to understand the medical scenario the findings revealed to me the different cultures and practices in the clinical environment compared to industrial management and hospitality services. Concepts such as medical education, medical communication, history taking and bedside care were eventually grasped for deeper understanding.

Following the gathering of qualitative data from staff and students, the questionnaire was continually modified and improved in the following years to correspond with the needs of staff and students. Following each of the evaluation the staff members were supplied with a summary of his/her feedback. This feedback is retained in their professional portfolio and was used as evidence of evaluation quality for the staff members' annual performance review. This process proved to be an encouraging developmental and reflective practice to be used by the practitioners. As a result of my hard work, the Australian Medical Council (AMC), the MMC and the Malaysian Quality Assurance (MQA) highly commended the SMEU for the work in evaluation and the analysis of the feedback and consequently accredited the MBBS program. This was an epiphany for me because it was a breakthrough in understanding the culture in a medical organisation and techniques involved in a research process.

1.6.3 The next stage: Putting together the research framework

Even though the academic staff had the raw data, but only a few were equipped with the knowledge of academic research, especially in qualitative research methods. Their strengths were centred on scientific and fundamental research. This led to an

adventurous faith in collaborating within the School to pool together different expertise in the field to produce research papers and subsequently gave me the opportunity to progress into the next stage of my research quest. As Charmaz (2006) puts it, writing reveals the choices authors make and we can make use of rhetorical devises and writing strategies to broaden our publishing possibilities and advancement in grounded theory approaches.

In January 2010, I was invited to be a co-project leader of another form of evaluation on peer review of teaching which was funded by an Australian University. Peer review is confidential to the tutor and includes opportunities for staff to discuss their teaching evaluation(s) by students. Other opportunity in research from a local University was also presented in relation to the evaluation tool. There were suggestions to evaluate the practice of the medical communication framework for bedside teaching within the medical curriculum of local universities.

With the opportunities presented, I worked with the experts and curriculum coordinators in trialling and recording some of the qualitative research approaches using document analysis, focus group interviews, in-depth interviews, observations, open-ended questionnaires and field notes which led publication opportunities. Furthermore the uses of qualitative methods maximized the opportunities for respondents to open up to the researcher and add value to make change happen (Thomas, S et.al, 2012). According to Grbich (2007) the researcher needs to investigate the advantages and disadvantages of trialling different research approaches and publish the outcomes so that other investigators will be able to see the choices and thus the research field will be able to move forward inevitably.

As a result of the experiences, pieces of puzzles emerged from the integration of meanings that were attached to patient care. This was the main aim of the research I was pursuing. The start of the research journey is seen in Figure 1.3.
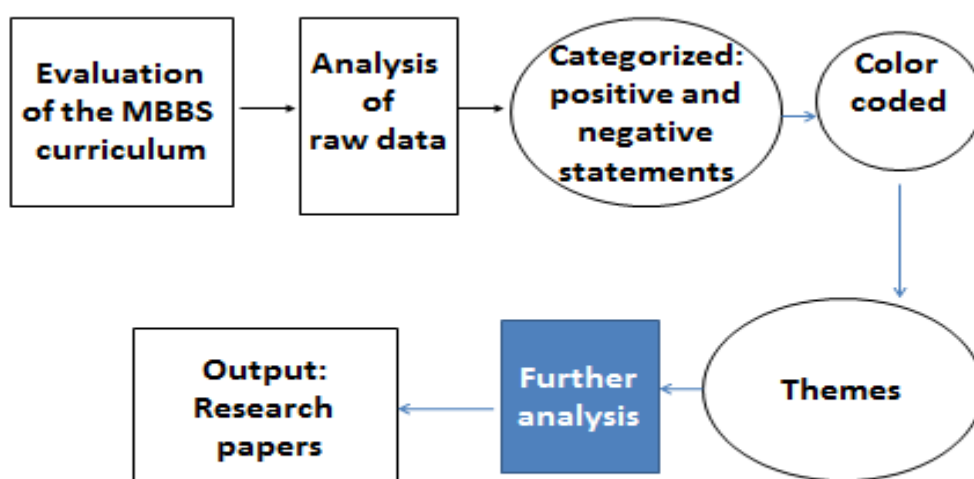
Figure 1.3: The start of the journey

1.6.3.1 Shaping the future of medicine through 'Selective' choices[2]

Bearing this in mind, the first research paper was a pilot case study that examined the motivation behind Selective choices taken by medical students from Monash University in preparing them as future doctors (Thomas et al., 2012). The selectives are short courses which is a variation of the traditional elective experience. The courses are designed to provide Year One medical students with opportunities to acquire skills and develop knowledge both inside and outside the traditional areas of medical education. In reality, in addition to medically-related problems medical professionals also encounter a spectrum of non-medical related problems. These include dealing with underprivileged patients, problems faced when working as a team,

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[2] Part of this have been published in Thomas, S., Dhanoa, A., & Palanisamy, U. D. (2012). Shaping the future of medicine: The effect of 'selective' choices on tomorrow's doctors. *International Journal of Institutions and Economies*, *4*(2), 151-164.

lack of self-esteem, problems in communication, inefficient time-management, managing staff and dealing with social problems at workplace and the community. Therefore, there is a need to prepare medical students to think outside the traditional medical curriculum. Hence, opportunities should be given to students to acquire certain skills and knowledge such as teamwork, empathy, communication skills and personal development. In order to teach outside the traditional medical curriculum, various innovative teaching methodologies were required. These included; lectures by invited guest speakers, tutorials, field trips, hands-on practical sessions, mini workshops, ward rounds and audio-visual presentations. It was also important to ensure the educational activities organised were well-structured and to shape their thinking as future doctors.

The study also considered the beneficial outcomes of Selective choices and educational activities that proved most useful. Qualitative approaches were used through triangulation methods such as semi-structured questionnaires, observation and document analysis. A total of 90 medical students took part in this research. The choices of Selective courses offered were varied from field work, classroom oriented topics to laboratory-based teaching. The Selective courses ranged from the following themes: palliative care, indigenous people, complementary and alternative medicine, surgical anatomy, marine conservation and coral reef monitoring, laboratory-based research, zoonotic diseases, exploration of ethical and social issues relating to movies and mind, body and soul enrichment. Before pursuing the Selective course, students were given the opportunity to rank the Selective courses in order of their preference; after which they were allocated to one of their top three choices.

The study revealed that student choices were influenced by the opportunity to acquire new knowledge and skills (35.5%), the prospects of having fun and excitement

(24.4%) and a general interest in the topic chosen (20%). The educational activities found to be most useful were external visits (47.8%) and laboratory practical based topics (34.4%). A significant proportion (48.9%) indicated that the Selectives taken have created awareness, provided new knowledge and valuable exposure to different educational experiences. The students reported that the courses have enhanced their personal development (13.3%) and have given them new insights. The results of this study provided valuable insights into future improvements to the Selective courses. Thus creative ways in designing the teaching and the delivery of the courses were implemented. With the implementation of the Selective courses the School hopes to develop future doctors who practice holistic medicine and preserve the altruistic motivations for becoming a doctor in the first place. In conclusion, the study revealed that the Selectives provided valuable exposure to students, widened their knowledge and skills both inside and outside traditional areas of medicine.

1.6.3.2 Problem Based Learning delivery for medical students[3]

In understanding the medical curriculum another research was also pursued. This longitudinal (5 years) research focused on action research which the primary objective was to compare and evaluate between the single day Problem Based Learning (PBL) sessions with the two-day sessions that were offered to medical students. The secondary objective was to propose solutions for more effective resource utilisation (Badariah Ahmad, Thomas, & Dunseath, 2013). Mix method approaches were used in the collection of data. The timeline for this action research was four years; from the conception of the idea and evaluation in 2007-2008, implementation and reassessment in 2009 and final review of outcome in 2010 (see Table 1.6).

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[3] Part of this have been published in Badariah Ahmad., Thomas, S., & Dunseath, T., (2012). A leap of faith: Innovative changes in Problem Based Learning delivery on a Malaysian campus, *Journal of World Universities Forum*, *5(2):35-48.*

Table 1.6: Data collection methods and analysis

No	Year	Data Collection Method	Analysis
1	2007	Questionnaire	Qualitative
2	2008	Document analysis	Qualitative
3	2009	Focus group discussion	Qualitative
4	2010	Survey form	Quantitative - SPSS

Although the original PBL was introduced as a whole curriculum (Barrows & Tamblyn, 1980), the PBL implemented in Monash was more structured with resource sessions such as lectures, practicals and small group tutorials which were advocated by Taylor and Miflin (2008). PBL model includes the use of case problems, small group tutorials and self-directed learning activities. It was designed to help students to become effective problem solvers, communicators and life-long learners (Hmelo-Silver, 2004; Schmidt, Vermeulen, & Van Der Molen, 2006). PBL process provides opportunities for students to develop qualities such as shared responsibilities and working effectively within a team (Blake & Parkison, 1998). The PBL scenarios were categorised into system modules. There were approximately three to four PBL scenarios for each system. For example, cardiovascular module has scenarios covering concepts from biomedical science, clinical and psychosocial aspects of the disease. These PBL scenarios were contextualized to accommodate the cultural differences in Malaysia. There were also some content contextualisation with regards to common tropical and congenital diseases found in Malaysia such as dengue and thalassemia.

This action research is best illustrated with Kurt Lewin's theory on the change process. In order for change to be successful, it must be planned and accompanied by increase in driving forces (Robbins & Coulter, 2002). The change process requires three steps which are *unfreezing mode* which prepares for the change that is going to occur and then followed by *changing mode* which is the change itself and finally *refreezing mode* which is the last step to stabilize the situation in order to be permanent

(Robbins & Coulter, 2002). This is the cycle the PBL action-research has established. As a result of this research, several issues were identified in the running of the two-day PBL sessions which led to the proposal of a single day session. This was the *unfreezing mode*. The *changing mode* took place during the implementation of the single-day session. Finally the *refreezing mode* took place at the end of this research when recommendations were made to the overarching Curriculum Committee in Australia and Malaysia in order to improve the current PBL sessions and to continue with single day PBL sessions.

The results showed the new approach in PBL delivery through single day session was favourably accepted both by students and tutors. The main limitation of the single day session appeared to be logistical rather than educational issue. Most students preferred to have the PBL session in the middle of the week compared to the end of the week, for fear of becoming tired and having a full workload at the end of the week. This issue was taken into consideration for the second cohort of Year Two students. As a result of this research the single day PBL delivery which was initiated by the Malaysian campus was positively received by students and tutors and adopted by both campuses in Australia and Malaysia.

This research resonates the importance of PBL; an integrated medical curriculum which is taught to the health care professionals. The PBL is structured to place importance to working as a team, understanding the Malaysian culture and taking responsibility and autonomy in professional development.

In pursuing this research I came to realize that the basis of the medical curriculum in shaping future doctors is through the integration of cases discussed in PBL. This

forms the backbone in medical training and how doctors respond and investigate a medical issue. Through the PBL cases, medical students are trained to think critically, work in teams and investigate symptoms of diseases presented by patients and research on other compounding evidences such as ethical issues, medical law and social responsibility. It dawned on me that these may be the elements for my research in patient care management.

1.6.4   Summary of the trail that shaped the thesis

In the beginning of this research, I was looking at culture and norms of the medical environment through the lens of an etic perspective. In other words, I was an outsider looking into the medical curriculum, trying to comprehend the role of the health practitioners and the terms used in the medical and health sciences scenario. Subsequently I was involved in several research projects with some of the medical staff and eventually over the years I managed to look at the medical scenario through the lens of an emic perspective. This experience allowed me to trial various research techniques and provided me the insights into medicine and health sciences. In short, the experience provided me the pre-understanding of the medical practice and enabled me to broaden the range of possibilities in using qualitative techniques and analysis. As Charmaz (2006) advocates researchers to do is to critically look further into the analysis of acts and facts and to think ahead to what the research background states. By exploring these approaches, Patton (2002) explained "diversity is desirable in qualitative studies because 'any common patterns that emerge from great variation are of particular interest and great value in capturing the core experiences and central, shared dimensions of a setting or phenomenon'" (p. 235).

This tactic, according to Charmaz (2006), will help enhance the power of writing and narrative exposition. In short, this experience enabled me to understand the organisational climate in the hospital, the gamut of expressions and terminologies used by the doctors and the logic of organizing the analysis of my thesis. Overall, my experience in this journey by looking into the etic and emic approach as a researcher was useful in deciding the direction of my thesis and the framework of the methodology. My research trail can be seen in Figure 1.4.
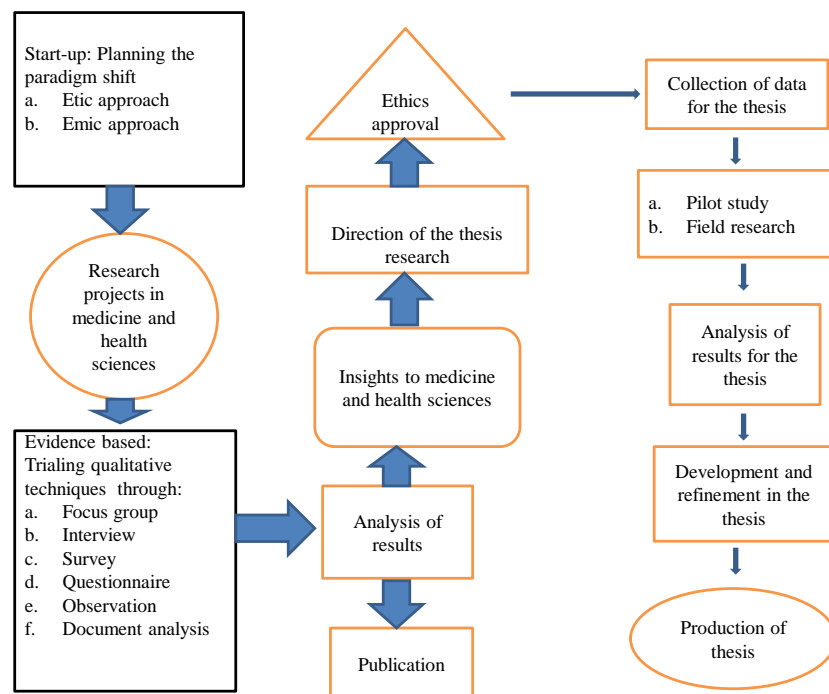
Figure 1.4: The trail that shaped the thesis

1.7   Significance of the research

There are a number of reasons why this research is significant. The MOH is the main provider of health care services in Malaysia. Currently almost four per cent of the GDP is allocated for the healthcare sector (Department of Health Selangor, 2007). The Malaysian government heavily subsidizes about 98% of all public medical expenses. The question is; is this enough to provide patient care and warrant satisfaction? The escalating health care costs also raise the question whether the high cost would lead to

better quality of care received by the patients in the government hospitals. Do the hospitals have sufficient resources to provide quality of care? This research hopes to find the answers to this by looking at the management of the resources such as sufficient number of health care providers, the satisfaction of the participants towards the comfort of the environment, the availability of the physical resources and the responsiveness of the staff in managing the problems.

There have been a number of studies that have been carried out on quality management in manufacturing and hospitality sectors but to date there is lack of evidence to show that a comprehensive study in patient care management has been conducted in public hospitals. However, evidence through literature show there are a number of studies conducted in Malaysia pertaining to health services and policies but only limited studies on patient care related areas. One study conducted by Noor Hazilah Abdul Manaf (2003) focused on opinions of health care providers towards quality of services in government hospitals in Malaysia. This quantitative research was carried out by using questionnaires which were distributed to public hospitals in Malaysia. Another study in Malaysia was carried out by Khor (2007) was qualitative in nature emphasizing on doctor-patient communication by analysing the verbal language used through the VRM (Verbal Response Mode). The respondents from this study were recruited at the outpatient clinics in the waiting area. Therefore this research is significant because it will add to the body of knowledge in finding out the quality of patient care management at public hospitals in Malaysia. This research is important as it provides useful information about the management of the wards, leadership qualities presented by the doctors, socio-cultural aspects, quality of the services provided and doctor-patient communication. Most of these factors were researched separately in the west. Past review of literature also show patient care management has not been explored

in-depth in a qualitative approach by looking at the four main factors discussed in this research, especially in the Asian country. Therefore the answers to this research will provide a holistic picture in understanding the experiences on patient care especially through the bedside care provided in Malaysian hospitals.

Furthermore, this study is significant because the findings will reveal how care is provided to patients in a multiracial and multilingual country. The evidence will show the type of measures taken by the doctors in communicating effectively to their patients. The study also provides a means of empirically assessing the practice and implementation efforts of patient care management through the experiences shared by the health care providers and the patients in hospitals under MOH. This research will be able to gauge the factors that influence quality of patient care practiced by the care-givers particularly the doctors from the government hospitals and provide a comprehensive assessment from both patients' and doctors' perspective.

For centuries the traditional practice demonstrated by doctors has been a system of inquiry through the clerking procedure which consists of close-ended questions that fulfil the doctors' need in collecting information. This process which has been part of the medical curriculum for years had little concern if patients understood the information provided or how they truly felt about the care given. Nevertheless over recent years, studies have shown a revolution in doctor-patient communication in many of the medical schools in the west which resulted in large improvements towards patient care management. It is hoped that this independent study will also be able to fill the void in understanding the doctor-patient communication in Malaysia.

This study will also benefit MOH officials, directors of hospitals and medical practitioners. It is envisaged that this study will strengthen the understanding of care given to patients in a tertiary hospital setting and provide the health professionals a deeper understanding on the management of patient care which includes planning, medical education and role modelling. The study is significant because the data derived from the study will allow reflection and re-examination of the medical education curriculum, the patient care management in the hospitals and the communication processes involved. As a result of the rigour in conducting this research, the study can be used as a yardstick for evidence based medical practice when improving or designing the medical curriculum to train future medical doctors in Malaysia to respond better to patients.

Furthermore the findings from this research may provide valuable information which can be applicable in other parts of Southeast Asian countries that is influenced by culture and religion. In addition, this research can also facilitate health care professionals in MOH and teaching universities to collaborate and find out other evidences that can be gathered from hospitals or wards that are not included in the research framework. The information from this thesis can also trigger similar type of research in other countries in understanding the experiences faced by patients in the countries concerned.

Finally it is hoped the findings will contribute useful information and evidence to MOH to make applicable changes in improving the health care management and services including encouraging a multidisciplinary interventions in order to strategize further course of action for upstream policy modifications in the future.

1.8   Research problem

By looking into an etic approach, I had several opportunities to take part in medical research in order to gauge the clinical setting, the processes involved in providing care and the management of patients in the wards. After several years in the field, I developed an emic perspective in understanding the culture and the experiences of the participants in my research which enabled me to produce this thesis. There were strong emotions in the wards and in many instances this meant life and death to the participants who are care givers and care receivers. As a positivist I needed to break away from these strong emotions from the wards and focus on the research purpose.

Patient care looks at the clinical setting and the scenarios at the ward. It also looks at the medical and health care services provided to the patients. In order to fully comprehend this research, it is important to understand the hospital care management provided by the health professionals in the hospitals. How do the doctors communicate and understand the patients, given the background of the patients that come from different walks of life? The population in Malaysia is composed of different ethnic background with a diverse consumer group. In a multicultural country like Malaysia, patients come from different background, race, religion and culture. Thus, they also speak different languages. This pluralism is recognized in government bodies, schools, organisations and at public forums. It is interesting to find out how the doctors provide explanations to patients with these differences which may pose as a major barrier to them. If minimum information is provided because of constrains of the language, patients may not be able to fully comprehend the situation and may make the wrong decision. As communication with patient is critical in the provision of care, hence the insight to communication is needed. Does cross-cultural communication occur in the hospital? Do our health care practitioners speak different languages? What are their

experiences of communicating with culturally diverse patients in a clinical care setting?

What strategies do they use with culturally and linguistically diverse patients?

Besides the differences in understanding language used in the wards, there are also other religious and cultural practices by different ethnic group such as the intake of *halal* food by the Muslim patients and the non-consumption of beef by the Hindu patients, the non-consumption of *halal* food by the Sikh patients, the observance of prayer and clean prayer facilities, privacy for female patients, the taboos in breaking bad news, the observance of the *yin* and the *yang* by the Chinese patients, believing in miraculous healing and making decisions according to cultural beliefs. Given the dynamics of the multicultural nature in our country, both the patients and doctors may practice different faith, beliefs and cultural orientations. Therefore they may lack the knowledge needed in adequately identifying cultural differences and rituals which is important. If there is inadequate awareness in this area, then it will render patient care a challenging task for the doctors. The question raised here is the provision of care flexible enough to incorporate all the priorities and needs of patients which are culturally diverse?

Another aspect that must be considered is that the doctors are trained based on the western health care system. Therefore it is practical to assume the reasoning approach, treatment and medical care are adopted from the western influence. As a result all aspects of care may not have been fully explored according to the bioethics practices. There is also lack of literature in individualized care based on cultural needs (Mohammadi, Evans, & Jones, 2007). As a result, the health care practitioners may face dilemma when there are clash of cultures when dealing with patients in the clinical setting. In developing appropriate strategies there might be danger in creating a

standard checklist for clinicians on different cultural traits and practices of the various ethnic groups because it is not a straightforward solution. Although it is possible to train doctors the techniques in dealing and communicating with these patients but doctors should also be aware that there are different compounding variables.

Whilst tradition is strong among the Malaysian ethnic group, there are still reservations in the usage of both traditional and allopathic medicine. Unfortunately the cross-cultural utilization of these medicines is still unclear. It is imperative that when care is managed in the hospital that the risks and benefits of these practices are explored. In addition it is important for the doctors to fully understand other holistic approaches in providing care and treatment. What do the health care practitioners inform the patients when there is no hope or when patient is at the end of life? How do they provide faith and hope in the treatment given. Unfortunately this aspect of care has not been fully explored.

The practices of patient care, not only serves the physical nature of treatment but also transcend into much more. It includes advice, council and emotional support given to the patients who look up to the doctors. In some culture, a doctor is upheld and looked up and considered like a "God" because of their ability in saving lives. Is this ideology a supporting factor that influences patient care management in Malaysia?

The power and authority of a doctor's role as a healer is influenced by social legitimization. The doctor who is empowered to diagnose and treat the patient usually end up controlling the consultation process and patients are expected to abide by the medical advice given by them (Freidson, 1970, as cited in Mitchell & Cormack, 2006). With the focus of specialist knowledge, patients' role is reduced and there is a loss of

reliance on social and family network (Mitchell & Cormack, 2006). This concept is looked at differently in social sciences perspectives in which patients are seen as people with opinions. Some patients are even looking for equal healing relationship (Radley 1994, as cited in Mitchell & Cormack, 2006). Is this also happening in Malaysia?

Medical doctors often tend to seek answers from readily available sources (Ely et al., 2002). Instead Sackett, Richardson, Rosenberg, & Hayes (1997) explains that doctors are urged to practice evidence based medicine by asking questions that can be answered with evidence and evaluate the results when they are faced with questions on patient care. However this is difficult to follow when there is pressure of busy practice (Ely et al, 2002), constraints in time (Wadey & Frank, 1997), erosion of personal satisfaction and the rise of medical monopoly in the control of health care (Mitchell & Cormack, 2006). One of the potential criticism is doctors may not be able to effectively communicate with patients on surgical procedures or medical treatment to an increase level of understanding. They may claim that they have no time do so or this may not be the normal consultation protocol. The question is; are we also observing a "quick fix" solution and neglecting the human skills needed in patient care. Is this because of the lack of resources or lack of skill? However we know that keeping patients informed is important and patient verbalization during consultation can enhance understanding.

Even with the rising number of doctors in our country, we have not reached a stage of oversupply. It takes five years to train in the medical profession. Soon after that, the medical graduates work as houseman (HO) for two years. During this tenure, they will be trained by the medical officers (MO) in the hospital to expose them to the practical aspects of medicine. However, the number of MOs in our country is insufficient. Recent reports from MMA have shown that the ratio of HO to MO have

increased from an ideal number of 5:1 to 12: 1 ("Ministry Emphasises Quality of Medical Training", 2012). Does this show that we are just churning out doctors who are not properly trained?

Long hours, irregular diets and constant stress seem to be the reality of junior doctors' life. They face a hectic working life and may not be able to balance their social life efficiently. As of the case of a young junior doctor who died of a drug overdose in Malaysia even though he is soon to be engaged to be married (Entaban, 2012). Whatever the cause, it shows that some of the doctors may be able to adapt well while the others could not. The question that remains to be answered is that, is the medical profession challenging that they cannot opt out? Is their work overwhelming that they cannot cope with unrealistic expectations from patients? Is this affecting the quality of care given to their patients? If they are coping with their profession, what is the drive and motivation behind this?

The process of medical interview is very important in collecting data for the doctors. During this process, the doctors barrage the patients with close-ended questions with little concern on how the process felt to the patients (Silverman, Kurtz, & Draper, 2008). The intriguing question is that, are our doctors equipped in conducting medical interviews in a more humane way? There are many medical institutions that have devoted training future doctors the skills that are necessary for conducting medical interviews. Some have even come up with written text on doctor patient communication but sadly they are not convincing enough. So how do we make best of the situation? What is recommended in Malaysia?

Instead of moving parts through an assembly line, we tend to move patients from emergency rooms, to CT scan rooms, to waiting rooms, to X-Ray rooms and then to the hospital beds. Instead of integrating work we have fragmented work and have created micro-specialties such as respiratory care, phlebotomy and intra-venus therapy (Dershin, 1994). The health care professionals communicate using patient's charts rather than communicating face-to face (Dershin, 1994). Are they highly trained assembly line workers? Do they take their jobs seriously and want to take control over the aspects of care they are delivering? Compare this role with doctors of our ancestors who used to take house calls (Dershin, 1994). No wonder Ali with a stomach pain has become "appendix case", bed 34.

With the rapid technology and the discovery of new drugs and treatment, health professionals need to keep abreast with developments that are taking place. Therefore, they need to be trained and retrained in order to provide quality service. With the increase of life expectancy of patients, the expectations have also increased and as a result have an influence over patient satisfaction (Eiriz & Figueiredo, 2005). Patient would feel disappointed when their expectations have not been met. Eventually they would perceive that the care provided is of lower quality. Can the doctors provide quality of care to keep the patients satisfied? What is the quality of care patients are looking for? It can be argued that patients may not understand the complexities of the health care system nor have the technical knowledge of the clinical measures undertaken by their doctors. Thus the quality, management and effectiveness of patient care should not only be assessed by the patient and his/her family but also be assessed by their doctors. Can peer review of bedside care be part of the assessment? This probably will give a complete picture on patient care management provided in the hospitals.

With the rise and speed of internet technology, information from Twitter, Facebook and Google Scholar can be accessed at every household. Thus patients and their families are better informed compared to yesteryears. Medical doctors should also be well informed with the latest medical technology and treatment. They should be at the forefront in educating their patients in understanding the disease and care needed. With the easy access in acquiring information, patients are generally aware of their rights and would be able to question the treatment given if they feel it is against their religion or culture. Furthermore, if they are not comfortable with the process, they would seek alternate treatment and services elsewhere. Eventually this would affect the reputation of the hospital. There are also medical litigations in the healthcare landscape. If there are insufficient information provided it will result in negligence. This raises the question if the doctors are aware of this? Are they ready to respond to the changes in how quality is defined for their patients? Does the patient care vary between countries and different cultural and religious background? Will MOH embrace the changes and train their health professional even with the burgeoning cost of health care?

The hospital is not about the sale of goods and services. It is not about the satisfaction of the service and merchandise. It is about the experiences, fulfilment and individualized care and how these are managed in the best professional manner as possible. In other words, if goods are broken, they can be replaced. If a service is not rendered satisfactorily, it can be improved. However, this is not the same in dealing with human lives as emotions, knowledge, skills, feelings, culture and religion is involved.

Furthermore, this ethnographic research uses iterative inquiry with a series of actions in data collection to explore the meanings from the feedback provided by the

participants. Consequently in understanding ethnographic research one must understand the hospital environment and management. How can one understand the hospital experiences if one has never been hospitalized, if one has never faced death of a family member in the hospital and if one has never worked in the hospital environment before? Lincoln and Guba (1985) describe this as tacit knowledge and explain "it is not possible to describe or explain everything that one "knows" in language forms: some things must be experienced to be understood" (195).

This research recognizes a gap in what is provided by the doctors and what is received by the patients. Given the taxonomy of the situation it is important to understand the patient's circumstances or predicament and how the doctors communicate and build relationship with their patients in this research. Recommendation will be given based on the views of all participants and the facts derived.

1.9   Purpose of research

The main purpose of this research was to explore the views of the patients and doctors on patient care management. The research also explored in-depth the supportive issues and barriers that influence patient care management at selected public hospitals in Malaysia. With reference to the overall focus of the study, several research questions were formulated as follows:

1.   How are the patient's bedside care managed?

2.   What are patients' views on care given by doctors?

3.   What are the doctors' views on the care provided?

4.   What communication processes do doctors demonstrate?

5.   To what extent do the communication process influence patients?

6. How do doctors initiate the medical sessions?

7. How do doctors gather information in exploring patient's problems?

8. To what extent do doctors build relationship with patients?

9. How do doctors provide explanation and planning to patients?

10. What do doctors demonstrate when closing the session?

11. To what extend are patients satisfied with the care given by their doctors?

12. To what extend are the doctors satisfied with the care provided?

13. What recommendations can be developed in providing patient care?

The specific purposes of the research were as follows:-

1. To explore the practices of patient care management in a clinical setting at the hospital wards

2. To find out the supportive issues that influence patient care management during bedside care

3. To find out the barriers that influence patient care management during bedside care

4. To identify areas of improvements in the implementation of patient care management

5. To provide recommendations for further improvements in medical communication and patient care management

1.10   Definition of terms

Several terms were defined in order to understand the research better and they are as follows:

1.10.1 Doctor

A doctor is defined as trained personnel who provide treatment and care to patients through the preventive, promotive, curative and rehabilitative aspects of health care (Goel & Kumar, 2002). According to Kumar and Clark (2005), doctors are expected to treat their patients with care and are required to be active partners in their healing process. In this study doctors consisted of housemen, medical officers, specialist, physicians, Obstetrics & Gynaecology specialist and surgeons.

1.10.2 Patient

The term patient is defined by Dorland (2007) as "a person who is sick and requires care and treatment for his disease" (p. 1386). Another terminology describing patient is the recipient of care known also as consumer, client, purchaser, customer or user (Deber, Kraetschmer, Urowitz, & Sharpe, 2005).

1.10.3 Patient care

The World Health Report (WHO, 2000, as cited in Goel & Kumar, 2002) explains that patient care begins from the safe and healthy delivery of a baby until the dignified care given to the elderly. This includes a continuing responsibility to the healthy development of individuals, families and societies throughout their life span.

1.10.4 Bedside care

Bedside care refers to the care and treatment provided at the patient's bedside in a clinical setting by the health care professionals.

1.11   Summary

The health care delivery in Malaysia has improved over the years. There is better network of services and increase in facilities throughout the country. The doctor-patient ratio serving the public hospitals has also reduced. Health care delivery is also moving from a curative model to a wellness service. Although there is an overall improvement the situation in the wards is still not appealing. To a non-medical person the views towards bedside care might be different compared to a medical person. The patients are seen as helpless, troubled and desperate beings. One would feel sadden to observe many patients who are sick, in pain and in a helpless state. I also wondered how a medical team would cope with the situations in the ward. It would be interesting to explore these experiences from both the perspectives of doctors and patients who are in the wards using different lens.

I used the etic and emic approach in this research to understand the culture in the wards. Even though there were many limitations in this research, nevertheless my role as a positivist researcher was embedded from the start of this research process as I was keen to determine what was going on. In providing bedside care, what are the experiences of patients and doctors in Malaysian hospitals? What meanings are hidden? This is the question that has motivated me in this research.

CHAPTER 2 : LITERATURE REVIEW

2.1   Introduction

Health care is defined by the World Health Organization (WHO) as "a 'complete state of physical, mental and social wellbeing' and not merely the absence of a disease and infirmity" (Pendleton et al., 2003, p. 13). Therefore, health is articulated by Pendleton et al. (2003) as a resource for everyday living and not just an object of living, which emphasizes the social, personal and physical capacity. If health care is defined as making choices and control of one's life then the role of the healthcare professional is to help their patients develop their capacities by providing information, deliberating options and promoting autonomy during consultations (Illich, 1976).

Goel and Kumar (2002) who quoted Mahatma Gandhi explain that treating a patient at the hospital provides an opportunity for the care givers to serve humanity. Patients admitted at the hospital and the doctors providing the care at the hospital wards were the main focus of this study. This is because according to Van Cott (1994), hospitals form a multifaceted socio-technical health care system in which health care providers and the hospital teams provide quality patient care.

This chapter will present theories and past literature on patient care management in a hospital environment. The key issues addressed in this chapter include the factors that influence patient care, the methods used by the doctors to establish working relationship with their patients in a clinical setting and the difficulties faced by the doctors and the patients. Various models and framework in patient care have also been explored to adequately address the theories.

The first step undertaken in this chapter was drawing on past literatures on patient care management. More than 100 sources from books, journals, reports and theses were referenced to form the initial analysis to comprehend what patient care entails. Keywords such as *'health care measurement', 'doctor-patient communication', 'health care policy', 'patient satisfaction', 'quality of care'* and *'hospital culture'* were searched in the database. As a result a literature mapping from the secondary data analysis was drawn up at the beginning of this research (shown in Figure 2.1) to identify the contributing factors that influence patient care management.
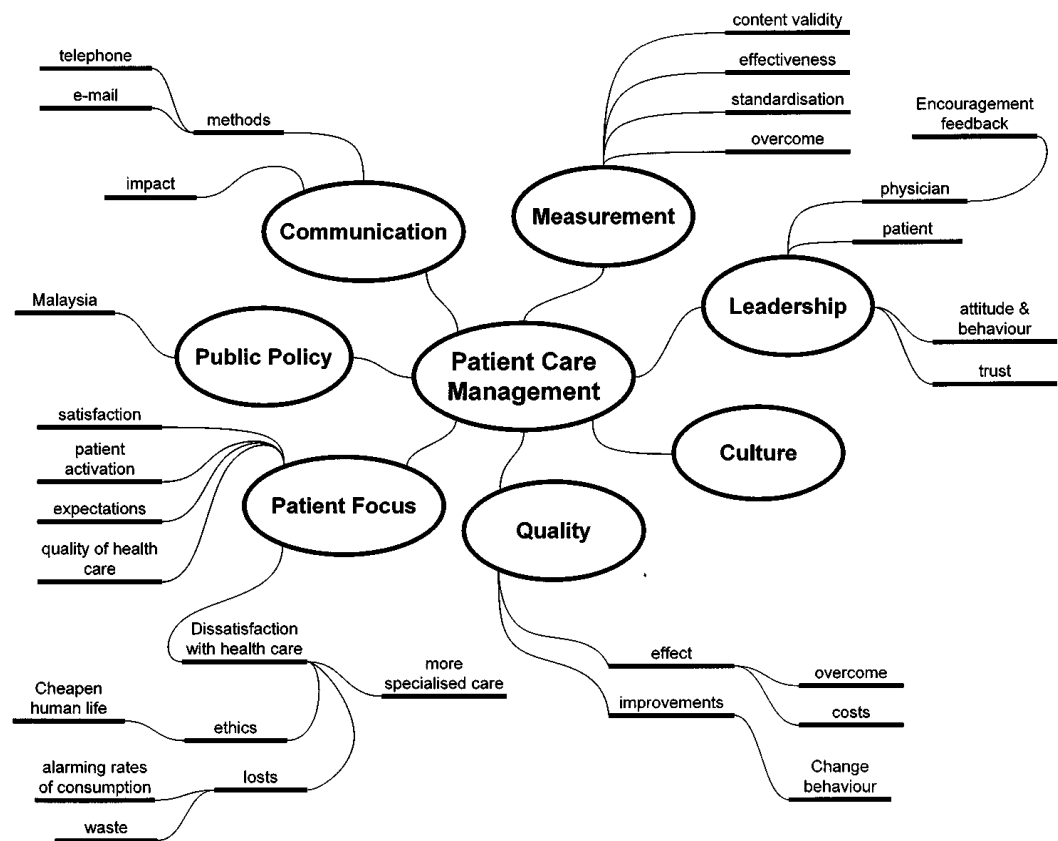
Figure 2.1: Literature mapping on patient care management

The literature mapping placed patient care as the central focus. Other contributing factors (in bigger circles) such as communication, measurement, leadership, culture, quality, patient focus and public policy were connected to the centre through curvy

lines. Sub-factors that support the findings were also connected to the bigger circles. The results from the initial literature mapping showed there was no specific literature describing culture in the hospitals that was related to patient care management. Since this was the initial mapping of the literature, the search was probably too specific and required extensive online database search.

As the research progressed, more keywords were explored further throughout the research using in-depth focused literature search from numerous databases such as Taylor and Francis Online, Elsevier, Emerald, EBSCOhost, SAGE Journals online and ProQuest. The keywords used were '*bedside communication*', '*decision making*', '*patient care*', '*patient-centered care*', '*healthcare management*', '*health reforms in Asia Pacific*', '*technology in healthcare*', '*healthcare planning*', '*patient safety*',' *patient care planning*', '*public hospitals in Malaysia*', '*patients' rights and dignity*', '*religion*', '*cultural beliefs*' and etcetera. The selection criteria for inclusion in this review were resources in English language that had (a) empirical and conceptual studies related to patient care management from 1990 to 2013 and (b) framework in medical practice. Exceptions were made in some earlier studies that had historical relevance. There were no limitations on studies done in different geographical locations.

2.2 Factors that influence patient care management

2.2.1 Clinical communication

Communication is the transfer and understanding of meaning from the sender to the receiver. If the parties concerned understand each other, then there is an agreement with the message (Robbins & Coulter, 2002). This vital ingredient is called feedback and it is imperative in a communication process (Mullins, 2007). Otherwise, the sender might misjudge the receiver and the communication can be unsuccessful (Mullins,

2007).   There are five basic levels of communication which are interpersonal communication, intra-personal communication, group communication, organisational communication and societal communication (Hardy, 2006).   Out of these five levels, studies have shown that the doctor's interpersonal communication is the most effective in influencing positive health outcomes (Simpson et al., 1991).

Besides verbal communication, there is also non-verbal form of communication such as body language, posture and tone of voice (Mullins, 2010).   According to DiMatteo & DiNicola (1982a, 1982b) and Friedman (1982) the nonverbal communication is also very important to patient care.   Linstead, Fulop, and Lilley (2009) who cited Hall (1959) explained that non-verbal languages correspond to time, agreements, space, things and relationships which are related to the cultural background of a person.   However DiMatteo, Hays, and Prince (1986) explain that emotions expressed through the nonverbal cues such as facial expressions, gestures, body language and the tone of voice is also essential for doctors to understand their patients. Other studies have shown non-verbal communication includes sitting while talking to patients, tone and tempo of speech (Sanghavi, 2006).   There have been many empirical studies that have shown doctor's nonverbal skills are highly co-related to patient's satisfaction (DiMatteo & Hays, 1980; DiMatteo & Taranta, 1979).   In fact the quintessence of health communication is the interaction between the health professionals and their patients (Watson & Gallois, 1998).   Therefore it can be postulated that clinical communication is the vehicle in patient care and can form as a treatment in its own right (Salmon & Young, 2011).

Interestingly however, perception and communication are interrelated because according to Mullins (2007) the framework of communication is dependent on the

perception and the emotional state of the person. Sometimes communication at the point of conversation can have different effects (Salmon & Young, 2011) and patient's opinions may diverge from the expert opinion of their doctors (Hatem, Mazor, Fischer, Philbin, & Quirk, 2008; Wright, Holcombe, & Salmon, 2004). A possible explanation for this is different patients come from different social background and experiences (Egener & Cole-Kelly, 2004). A correlation was demonstrated in a study conducted by Stewart (1995) between doctor-patient communication with improved health outcomes for patients and this included emotional status, health symptom resolution, physiological measures and pain control. This explains the reason why communication has different effects because the meaning is subjectively shaped (Egener & Cole-Kelly, 2004).

Several studies have shown high dissatisfaction among patients in regards to quality of the communication with doctors especially during history taking and during discussion on patients' problems (Loescher, Crist, Cranmer, Curiel-Lewandrowski, & Warneke, 2009; Stewart 1995). The contributing factors toward the dissatisfaction during the medical interview were indirect and incomplete discussions with the patients (Loescher et al., 2009; Smith, DeVellis, Kalet, Roberts, & DeVellis, 2005). The findings from Smith et al. (2005) and Zickmund, Hillis, Barnett, Ippolito, and LaBrecque (2004) research show the dissatisfaction among patients generally occur among the high-risk groups. In another study on risk communication among high risks families of cancer patients' show that doctors usually have one-way communication with their patients (Loescher et al., 2009). Risk communication usually consists of messages on risk reducing actions and prevention behaviours such as advising patients and their family members to apply sunscreen when in outdoors, seek shade, cover their body with protective clothing, check for lesions and go for regular skin examination

checks with their doctors (Loescher et al., 2009). However, the findings from Dolan et al., (1997) on family members of high risk patients' show a low rate of counselling measures undertaken. For example evidence show 20% only received counsel for sunscreen usage and 6% for sun protection measures. However, the findings also show that most doctors believe that risks communication messages should be provided (Dolan et al., 1997) and can potentially extend the survival of the patients (Loescher et al., 2009); and yet there is lack of evidence that shows that this care has been successfully provided.

The study by Hardy (2006) shows that 50% of the psychosocial and psychiatric problems are missed, doctors interrupting patients every 18 seconds and 54% of the problems are neither elicited by the doctor nor disclosed by the patients. There are many factors that contribute to the deficiency in the limited time for doctors to care for the patients individually. A key factor described by Fukui, Ogawa, Ohtsuka, and Fukui (2009) and Loescher et al. (2009) is the busy practice of the doctors; whereby they are usually at the mercy of competing clinical demands that involve extra paperwork for treatment and the complexity in the nature of the situation in which the patient and the doctor think about health in different orientations (Hardy, 2006).

For this reason Simpson et al., (1991) suggested during consultation, doctors encourage patients to discuss their problems for about 2 ½ minutes, without premature interruptions (during history taking and closure) while striving to elicit patients perceptions of illness, feelings and expectations. However, Loescher et al., (2009) disagrees with the timing and explains that doctors require an average of 20 minutes for primary care especially in persuading the patients and collecting information on patients' behaviour, beliefs, values and attitude. Beckman and Frankel (1984) explain

in his study that if patients are interrupted when presenting their problems, this might lead to failure in disclosing significant concerns. Although there are various limitations in health care, risk messages for general population and the high risk group are needed to persuade them to adopt protective behaviours (Loescher et al., 2009). This raises the question on the importance of time in patient encounter. This also reflects the impact of effective communication in the clinical function and the health care delivery system because it influences healthcare outcomes (Howells, Davies, & Silverman, 2006; Simpson et al., 1991).

Clinical communication also acts as the primary process to gather and disseminate relevant health information which is essential in health care and health promotional activities (Kreps, O'Hair, & Clowers, 1994). However, ineffective clinical communication does not only reduce the quality of care but also causes harm to patients concerned. Del Vento et al., (2009) mentioned in their studies by conveying to the patients their diagnosis in a blunt way such as "you have cancer" may cause them to lose hope. Even by not informing the patients so as not to hurt their feelings would also be dishonest. This deficiency can lead to distrust and greater risk in organizations (Burke, Boal, & Mitchell, 2004). In fact, the right diagnostic information arises from clinical interviews through clear, open and honest communication (Hardy, 2006; Howells et al., 2006; Mullins, 2007; Simpson et al., 1991). This is supported from a survey of cancer patients conducted by Kutner et al., (1999) that illustrates that 100% of the patients wanted their doctors to be honest and 91% wanted them to be optimistic. This includes breaking bad news by using implicit language through the usage of gentle but serious tone (Del Vento et al., 2009) and with hope (Kirk, Kirk, & Kristjanson, 2004; Parker et al., 2001). With reference to this, honesty and awareness (Hughes, Bamford, & May, 2008) influences patients' trust and acceptance of the messages

provided by their doctors (Gurmankin, Baron & Amstrong, 2004) and emphasizes patient-centeredness (Hardy, 2006; Mullins, 2007).

In other words, the patient and doctor communication is an ideal case of partnership which portrays professionalism and caring attitude (Back, 2006). The longstanding condition of the patient would eventually build the doctor patient relationship which is considered as therapeutic relationship (May, 2005). According to (Holman, 2005) this prevalence has led to a professional work model in disease management. This has practical importance in the health care business (Hughes et al., 2008). In summary, the key to communication according to Mullins (2007) is to develop all the collaborative skills needed such as rephrasing the message, showing compassion to others and becoming better listeners. Most patients are usually hesitant to disclose their psychological concerns spontaneously to their doctors (Fukui et al., 2009). It is essential that the psychological distress of patients be recognized and addressed at an early intervention. The common anecdotes are active listening and empathy towards patients' distresses which are also among the qualities desired in determining patient satisfaction (Simpson et al., 1991).

In addition, other important skills that add value to the doctors' experiences are giving clear explanations, negotiating treatment plans and checking patients understanding and compliance (Brown, Weston, & Stewart, 1989; Riccardi & Kurtz, 1987). Communicating and sharing of information is one of the most important activities in any organisation (Robbins & Decenzo, 2004) particularly in a health care setting. Doctors are urged to deploy their skills to ensure patients are sufficiently involved and informed about their health (Rider & Keefer, 2006). Patient develops anxiety and dissatisfaction when there is lack of information, explanation and feedback

from their doctors (Rabinovitch, Hamill, Zanchetta, & Bernstein, 2009; Simpson et al., 1991). Failure in transferring information among the doctors and the organisational groups will also contribute to medical errors (Frank, Lawless, & Steinberg, 2007; Leonard, Graham, & Bonacum, 2004; Sutcliffe, Lewton, & Rosenthal, 2004).

Desmond and Copeland (2000) explain that patient would be more interested if doctors narrate the procedure as they examine the patients. It is an opportunity to educate their patients and as a result, patients would feel satisfied. Some researchers call this *humanism* in patient-doctor relationship because the patients value highly the information given to them (Kaplan, Greenfield, & Ware, 1989). Most importantly sufficient information is equally crucial in order for the patients to follow the regimen that is agreed upon by both parties (Kaplan et al., 1989). Some techniques proposed by Desmond and Copeland (2000) are using analogies, similes, simple metaphors, drawing pictures, handouts from computer, using plastic models of body parts, videotapes, graphs and charts. The findings by Rouwenhorst (1996, as cited in Desmond and Copeland, 2000) have shown that an average person remembers 20% of what they hear, 40% of what they see and 70% of what they see and hear. The finding in this research is in tandem with other researches that have shown that majority of people are visual and auditory learners (Thomas, Dhanoa, & Palanisamy, 2012). Therefore it is necessary for doctors to use innovative ways to communicate and educate patients so that patients understand and follow through their treatment plan. These combined factors greatly emphasise the importance of peer review in bedside care so that fellow colleagues in the medical profession may be able to give advice to improve their clinical teaching.

Peer review is an intentional observation process of a teaching session by a fellow colleague with the aim of providing honest feedback (Kinchin, 2005). This is an

excellent way to engage professionals in discussion (Bingham & Ottewill, 2001) and reflection on the teaching practice (Gosling, 2002; Thomas, Chie, Abraham, Raj, & Beh, 2013). Peer review has shown to foster improvements in teaching practice (Smith, 2009). Although peer review is generally utilised in educational institutions one would ponder if this concept can be applied to doctors who are clinical teachers to patients in the wards as the benefits are numerous. Peer review is also a strategy to demonstrate professional responsibility and accountability (Al Qahtani, Kattan, Al Harbi & Seefeldt, 2011) as well as assuring work quality over the teaching (Kell & Annetts, 2009).

Salmon and Young (2011) explains that greeting a patient by his or her name or explaining a complex clinical procedure in a creative way is unique and follows the principle that originality in communication should be a normal practice. Originality in practice should not be reduced to rules and techniques (Salmon & Young, 2011), instead doctors should be creative artist that improvise and experiment (Danvers, 2003; Eisner, 2003, 2004) using creative pedagogy to educate patients (Edstrom, 2008).

Another research by Korsch, Gozzi and Francis (1968, as cited in Desmond and Copeland, 2000), revealed that when a patient didn't seem to understand, their doctor would normally repeat over and over again or say the same words louder. Sometimes the language the doctors' use is vague to the patients such as the use of jargon and unclear terms (Faden, Becker, Lewis, Freeman, & Faden, 1981; Simpson et al., 1991). Clearly this method does not seem to be helpful but rather an ineffective way to convey information and may lead to medical errors.

In a study by Scholl and Ragan (2003) using ethnographical methods have found that humour increases patient-centered care. Humour in medicine is an anecdote that

has found to increase doctor-patient relationship (Scholl & Ragan, 2003). According to Penson et al. (2005), humour involves laughter, smile, joy and entertainment to the patients who are listening. The humour messages can be verbal or non-verbal (Granek-Catarivas, Goldstein-Ferber, Azuri, Vinker, & Kahan, 2005) which can illicit positive or negative outcome such as attachment, self-improvement, cynicisms and hostility (Romero & Cruthirds, 2006). Humour can be healing and therapeutic (Scholl & Ragan, 2003) if the doctor uses it to "break the ice" in order to build rapport with the patients (Oliffe & Thorne, 2007). Alternatively it may also function to criticize the patients (Penson et al., 2005). In a qualitative study by Oliffe and Thorne (2007) among prostate cancer patients, it was reported that patients felt less anxious when their doctors used humour. It was also observed in the study that humour was able to reduce the power disparity among the patient and his doctor. However, there are limited evidences that verify the co-relationship between patient satisfactions with humour.

So in order to communicate better, doctors must avoid using jargon, rephrase their explanation, use simpler words and adopt positive humour (Scholl & Ragan, 2003). In addition they should also use gestures and expressions that reflect they care (Desmond & Copeland, 2000; DiMatteo, Taranta, Friedman, & Prince, 1980; Mullins, 2007).

2.2.1.1 Medical communication framework

There are a number of helpful frameworks in medical communication that are used in training doctors. Various instruments were designed to provide structural groundwork for efforts to teach, assess, study and improve communication skills. These instruments include checklists, framework, guides or models that are developed for numerous contexts (Makoul, 2001). One such framework is the Disease-Illness Model (Figure 2.2) proposed by McWhinney and his colleagues (1989) which uses *patient-*

centered clinical interviewing approach. This model has been tested by Levenstein et al. (1989) and Stewart et al. (2003, as cited in Silverman et al., 2005). Although this model uses everyday clinical practice in a practical way but it emphasizes the patients' illness from the doctor's viewpoint of disease and the underlying pathology. However in recent years there has been a move away from biomedical model of health communication to the emphasis of patient as central focus (Sharf & Street, 1997).

```
                          Patient presents problems
                                    ↓
                           Gathering information
                                    ↓
                      Parallel search of two frameworks


Disease framework                              Illness framework
(Biomedical perspective)    Weaving back and   (Patient's perspective)
                            forth between the two
                            frameworks
Symptoms                                       Ideas
Signs                                          Concerns
Investigations                                 Expectations
Underlying pathology                           Feelings and thoughts
                                               Effects on life

Differential diagnosis                         Understanding the
                                               patient's unique
                                               experience of illness




                    Integration of the two frameworks
                                    ↓
                        Explanation and planning:
                  Shared understanding and decision making
```

Figure 2.2: Disease-Illness model

Note. After Levenstein et al. (1989) and Stewart et al. (2003). From *Skills for Communicating with Patients* (p. 63), by J. Silverman, S. Kurtz and J. Draper, 2005, UK: Radcliffe Publishing Ltd. Copyright 2005 by Jonathan Silverman, Suzanne Kurtz and Juliet Draper.

Segue Framework (Makoul, 2001) is another example which uses a checklist of medical communication tasks to facilitate teaching and assessing doctor-patient communication. Another instrument is Maastricht History Taking and Advice Checklist known as MAAS-Global (Van Thiel, Kraan, & Van Der Vleuten, 1991) that looks at

medical interviewing skills. MAAS-Global was initially used for undergraduate medical curriculum but now it has been adapted for rating simulated-patient consultations and actual consultations in general practice (Van Thiel, Ram, & Van Dalen, 2000).

The BARD model (Warren, 2002) tries to consider the wholesome relationship between the roles of General Practitioner (GP) and the patient during the medical encounter. This model encourages reflection and emphasizes the importance of GP portraying their best personality and behaviour for the benefit of the patient. The four areas of analysis in this model are behaviour, aims, room and dialogue.

Another approach is known as the Narrative-Based Medicine (Launer, 2002) which explores the way people tell stories. In this approach the questioning style is very important. The questions must be asked with respect and care. In this context the GP will try to help the patient to look at the problem at a different point of view. Narrative-Based Medicine is originally from family systems therapy. Six key concepts in this approach are conversations, curiosity, circularity, contexts, co-creation and caution.

Another framework to communication skills teaching is the Calgary-Cambridge Observation Guide which was developed as practical teaching tool. The guide was improved into a structured consultation guideline. It was also used as an aide during teaching sessions (Kurtz & Silverman, 1996). Over the years a comprehensive clinical method of the Calgary-Cambridge Guide was developed in 2002 that places the Disease-Illness model at the center of gathering information and combines this with the Calgary-Cambridge Observation Guide (Kurtz, Silverman, & Draper, 2005). This framework was further improved to an evidence based approach to communication

skills in medicine and is known as the Calgary-Cambridge Guide (Figure 2.3). The name of the guide is based on the authors' originate. Silverman comes from University of Cambridge and Draper is from University of Calgary, Alberta, Canada. The guide provides a foundation for communication programmes for training in medical education. This framework has also been validated by research and theoretical evidence in providing a comprehensive repertoire of skills (Silverman et al., 2008). The elements taken from this framework take into account the move towards patient-centered and collaborative style of medical communication that is expected in health care industry.

The Calgary-Cambridge Guide describes effective doctor-patient communication skills which are taken from two books entitled *Skills for Communicating with Patients* (Silverman et al., 2008) and *Teaching and Learning Communication Skills in Medicine* (Kurtz et al., 2005). According to Suchman (2003), it is the first completely evidence-based textbook that has structure for the analysis of skills in a medical interview. It also promotes a comprehensive clinical method that specifically integrates traditional clinical method with effective communication skills (Silverman et al., 2008).
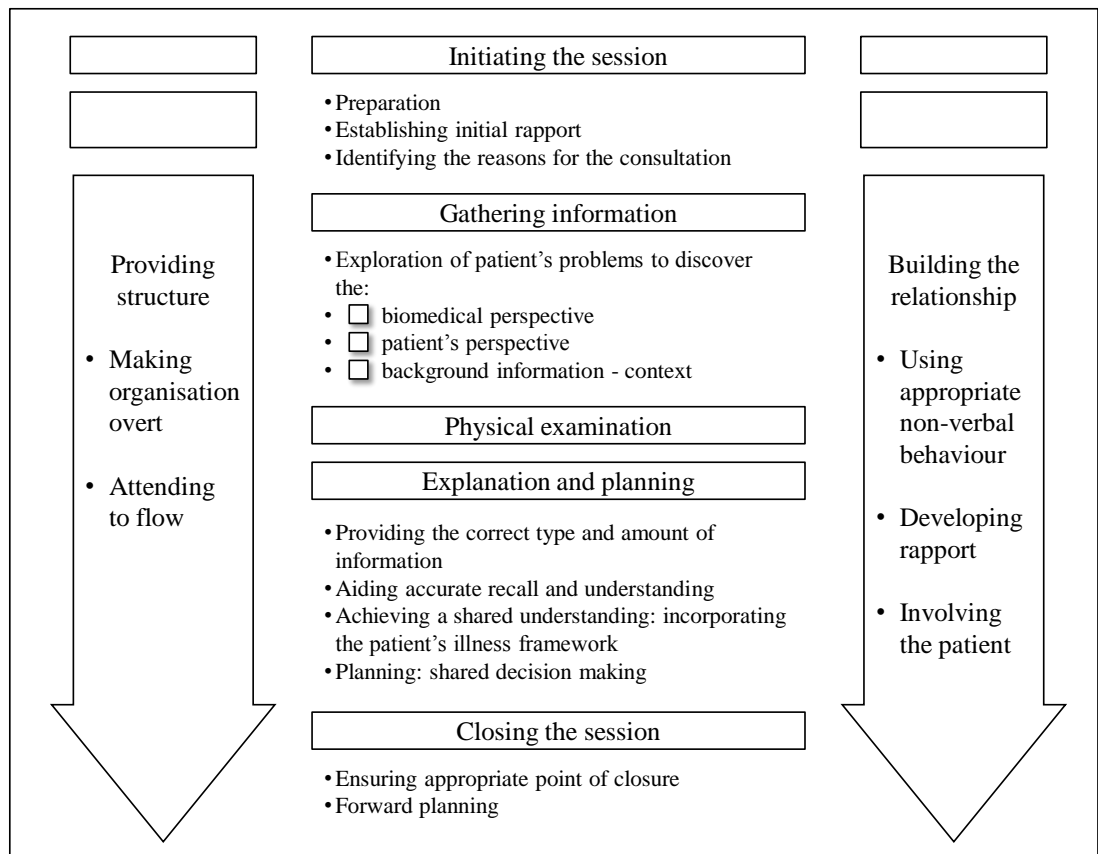
Figure 2.3: Expanded framework
Note. From *Skills for Communicating with Patients* (p. 19), by J. Silverman, S. Kurtz and J. Draper, 2005, UK: Radcliffe Publishing Ltd. Copyright 2005 by Jonathan Silverman, Suzanne Kurtz and Juliet Draper.

2.2.2   Quality of care

The Institute of Medicine (IOM) in US (2008) has described quality of care as the extent to which the health services provided to the society increases with the desire for better and current services and professional knowledge provided.   Woo and Sultzer (2009) cited the characteristics in quality of care described by the Committee on Quality Health Care in America (2001) as elements which include "safety, effectiveness, timeliness, efficiency, equitability and patient-centeredness" (p. 503).   The reports discuss the quality of health care of the users and providers.   In their study on psychiatric emergency service, Woo and Sultzer (2009) reinforces the importance of benchmarking care.   The authors also explained that the documentation in the busy emergency setting of the psychiatric emergency service may not provide an accurate

overall picture of how the care is delivered to patients. They noted that the median time from triage to discharge was about 6 hours and 2 out of 400 psychiatric patients ran away from the facility. Therefore Woo and Sultzer (2009) suggested that clinicians should continue to improve on timeliness without compromising on safety and accuracy especially since patients from the psychiatric emergency service are the most vulnerable population. With the development of benchmarking in health care, optimal and appropriate care can be given to improve the patients' quality of life.

Early researchers such as Wyszewianski, McNeil, and Ginsburg (1988) proposed a model in quality assurance which is:

Quality Assurance = Quality assessment + Quality improvement and control
(measurement)   (action)

In their study, Donabedian (1988) and Renwick (1992) proposed three categories in assessing the quality assurance received by the patients which are structure (resources such as facilities, equipment, manpower and finances), process (patient's activities seeking care and doctor's technical performance and interpersonal relationship) and outcome (improvements in patient's physical and physiological wellbeing). Although these categories are important and are commonly assessed in health care (Benbassat & Taragin, 1998), Renwick's (1992) research has concluded that health outcome are the result of many factors that are dependent on many network, mechanism and approaches which constitute a total care and commitment by all personnel involved with the care.

Herzlinger (1997), Morrison and Heineke (1992) and Renwick (1992) explain that health care is difficult to define, measure and control compared to a manufacturing sector or financial outlets because of the complexities in the health problem that requires high level of customer solutions. On the contrary, health care is most important

because it is the life of a human being that is being evaluated (Eiriz & Figueiredo, 2005; Herzlinger, 1997).

Various models have been created by Juran, Deming, Ishikawa and others to assess quality of care but these are relatively new to health care delivery compared to service sectors or manufacturing (Berwick, 1989). The perpetual sequence in identifying a problem, planning for improvement and taking remedial actions is part of the continuous improvement plan (Benbassat & Taragin, 1998). However, there are many views on continuous improvement in health care sectors. Deming's (1986) approach emphasizes meeting the current and future needs of patients and constantly improving the system and service. Deming (1986) stresses the following which is cited in Batalden & Nelson (1990):

> Satisfying customers is not enough, it is necessary to delight them. If merely satisfied, your customers may take the business elsewhere. However, if they are delighted, they will remain loyal and will tell their friends and colleagues about the value your organisation delivers. (pp. 8-9)

According to Evans and Lindsay (1996), Deming's cycle shows the methodology for improvement. It consists of four stages which are plan (planning for improvement), do (implementation on a trial stage), study (to check if it's working), and act (final stage where it is practiced). This process will again lead back to plan stage for further improvements and the cycle repeats again.
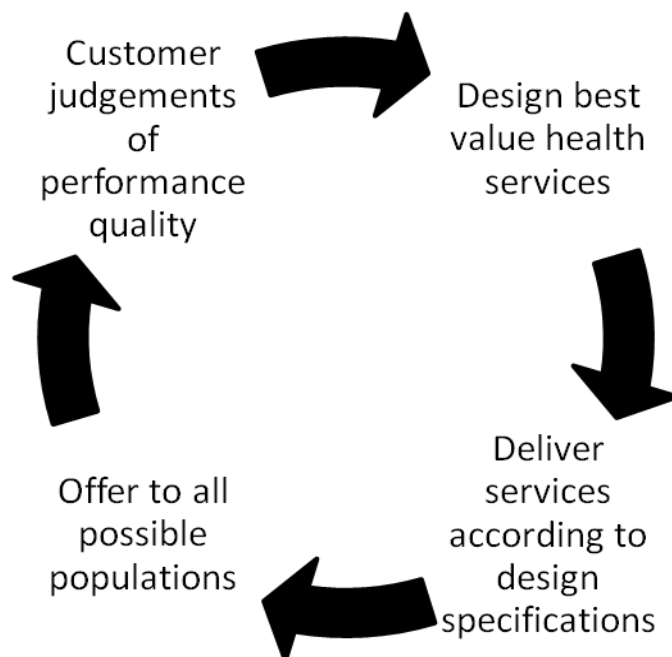
Figure 2.4: Deming/Shewhart cycle for continuous improvement

Note. From "Hospital quality: Patient, Physician and employee judgements," by P. B. Batalden and E. C. Nelson, 1990, *International Journal of Health Care Quality Assurance*, *3*, p. 9. Copyright 2007 by Emerald Backfiles.

Figure 2.4 is adapted from Deming's cycle which is known as Deming/Shewhart cycle that is used for continuous improvement in health care organisation. Batalden and Nelson (1990) cited the work of Deming (1986) and Shewhart(1986) and explained that the cycle begins at a point where the *customers will judge the performance quality of the health care* received, then the health care professionals will *design the best value of the health services*. These services are *delivered according to the patient's specifications* and then it is *offered to all intended populations*. Finally it is returned again to the patients who will make the judgment if their needs and expectations are met.

A study conducted by Heinemann, Fisher, and Gershon (2006) on patients who have lost their limbs requiring orthoses and prostheses (O&P) medical care echoes the need of outcomes measurement and clinical pathways in the context of continuous quality improvement process. The study shows that despite the on-going efforts from

the health care providers in US, health care organisations have not yet produced the quality revolution that is needed. Many health care workers view quality improvement as "an ethical responsibility or social good, rather than as a business strategy for improved financial performance and competitive market positioning" (Coye & Detmer, 1998, p. 764). Non-compliance on healthcare will affect the quality and subsequently efficiency of the healthcare delivery systems. According to Severens (2003) quality improvements and implementations methods will enable the change of behaviour of individuals or organisations in response to inefficiencies. This comes with monetary costs, which will offset profit (Cleemput & Kesteloot, 2002, as cited in Severens, 2003). However the duty of quality lies on the organisation and not on the individuals. Donabedian (1989) and Renwick (1992) highlight the importance of performance monitoring (or medical audit) and accreditation as a mechanism for improving and controlling quality of care. According to Williamson (1991) medical audit is useful in service developments and professional integration within the organization. Furthermore, the process of accreditation in the healthcare system is used widely in the U.S, Canada, and Australia (Wyszewianski et al., 1988). In U.K the Royal Colleges and English National Board uses the accreditation process for training purposes (Renwick, 1992).

Health care delivery must be managed in order to sustain the quality of care given to patients. Robbins and Coulter (2002) defines management "as the process of coordinating work activities so that they are completed efficiently and effectively with and through other people" (p. 6). Johnson (2005) agrees with this and states that management is about people. The primary activities of management processes include planning, organizing, leading and controlling (Robbins & Decenzo, 2004) in which these activities are critical to the health care institutions (Johnson, 2005).

There are several reasons why health care workers find it hard to make a business case for quality since health outcomes vary between countries (Eiriz & Figueiredo, 2005) and are often difficult to measure (Renwick, 1992). According to Fisher, Harvey, Tayler, Kilgore, and Kelly (1995) and Heinemann, Linacre, Wright, Hamilton, and Granger (1993), firstly it is because industries pursue perfection in quality through mathematical measurement. Secondly industries produce their preferred outcome by directly managing their measures such as through accreditation. Thirdly industries share and may easily control the same reference for evaluating quality which is product definitions. In comparison health care is restricted in dealing with individual's health and overlapping issues with patient's health behaviour that makes it difficult to deal with promoting basic improvements in population health. Therefore return-on-investment model is usually not quality improvement focus instead ensuring cost-avoidance (Heinemann et al., 2006). Unfortunately the narrow focus on clinical indicators tends to devalue human and social outcomes which are some of the reasons Bond and Fox (2001) explains are the difficulty faced in research when measuring qualitative intangible human outcomes of health care. This is concurred by Eiriz and Figueiredo (2005) who further explain are due to the size of the hospital, the characteristics and the range of medical specialization.

Hansson (2000) explores the notion of total quality management (TQM) in public health care sector in Sweden. His research explores the creation of *hospitals without boundaries* which means patient would remain in the same bed and in the same ward and do not need to move to different departments for various treatments. His research emphasizes patients as tax paying customers who have legal right to receive *value for money* service. Thus according to Hansson (2000) through the introduction of TQM has

led to a more service-minded and customer focused perspective that measures quality management and the design of instruments for continuous improvement. One instrument mentioned in Hansson's (2000) research is the *local incident report* with a TQM objective of *zero defect*. According to Koch (1991), TQM involves the total management and coordination of facilities and services throughout the entire organisation. Dershin (1994) cited Juran's model that shows many techniques for doing this, which are through cross-functional teams for quality improvement, planning and control, using re-engineering process, expanding business process management, understanding customer supply chain and practicing strategic quality planning.

However, Koch (1991) pointed out some difficulties faced by most hospitals in UK in introducing TQM such as lack of support from top management, different culture and management style for each service provided, poor appreciation of the principles and practices of TQM, lack of organisational framework for TQM activities and ineffective leadership. However, there seem to be changes over the years as many organisations have started using proprietary measures of quality that hospitals can utilize to advertise their ranking to the stakeholders (Lehrman et al., 2010). In the U.S, there are many medical organisations that publish their quality of care data on hospital performance and make them publicly available for national comparisons. For example Centers for Medicare and Medicaid Services (CMS), Hospital Quality Alliance (HQA), and the Joint Commission for Accreditation of Healthcare Organizations (Lehrman et al., 2010). Furthermore, Lehrman et al. (2010) also cited Green (1997) and the U.S News & World Report (2008) that this has led to an annual list compiled by the news agency on "America's Best Hospital" which includes hospital structure (technology, volume, nurse) and outcome (results from the measures of process of care).

Another measurement in health outcome is patient satisfaction. Traditionally, researchers such as Parasuraman, Zeithaml, and Berry (1988) studied services based on the SERVQUAL model which includes tangibles (the physical factors), reliability (dependable and accurate performance), responsiveness (on time, prompt), assurance (politeness and competence) and empathy (understanding and communication). According to Sohail (2003) the SERVQUAL model has been tested and adopted by various industries which have shown to be a valid and reliable model. Sohail's (2003) research on the measures of quality services provided by Malaysian private hospitals in terms of expectations and perceptions by using a comprehensive scale adapting from SERVQUAL indicate that patients perceive value of the services exceed their expectations for all the variables measured. However, the modified version of the SERVQUAL model by Parasuraman, Zeithaml, and Berry (1991) was not accepted by the academics and medical practitioners after an initial evaluation of the questions which showed eight pairs of questions irrelevant to the hospital services and caused confusion and aggravation to the patients (Sohail, 2003). This was also supported by other researchers such as Babakus and Mangold (1992). However Sohail (2003) suggests that the SERVQUAL model can be adapted to fit to specific research needs within the guidelines.

Recent literature has shown that the variables of qualitative measurement of health care are doctor's communication and interpersonal relations (Eiriz & Figueiredo, 2005). According to Heinemann et al. (2006):

> Patient satisfaction reflects expectations, prior health care experiences and quality of health care. Patient might measure high on a satisfaction scale less as a result of quality care than as a result of being impressed with a prosthetist's authoritative opinion, an orthotist's caring touch, or an expensive device (para. 10).

However, Eiriz and Figueiredo (2005) cited other researchers' studies such as Brown and Swartz (1989), Sage, (1991) and Singh (1990) who have discovered other factors such as "convenience, access, waiting time, choice, quality of information, patient's medical problems, and patients' demographic background" (p. 408). Coddington, Fisher, Moore and Clarke's (2000) research discovered value added services such as "convenience, access, relationships with doctors, innovation, unit prices and volume of intensity of use of certain resources" (Eiriz & Figueiredo, 2005, p. 408). According to Hogarth-Scott and Wright (1997) in their study on quality service for general practice in the United Kingdom, patients are not only concerned with the outcome of the general practice experience but also the environment in which the service is provided such as if the doctor is listening, can the patient see the same doctor again in the next visit, can an appointment be made within two days and can the doctor solve the patient's problem. All these factors potentially impact the quality of patient care in general practice (Hogarth-Scott & Wright, 1997).

The study by Eiriz and Figueiredo (2005) explains there are many actors who are involved in the *customer-provider* relationship for the health care sector. He describe the customers as the patients while their relatives are the citizens (public) and the service providers are the doctors, managers, technical and non-technical team. See Figure 2.5.
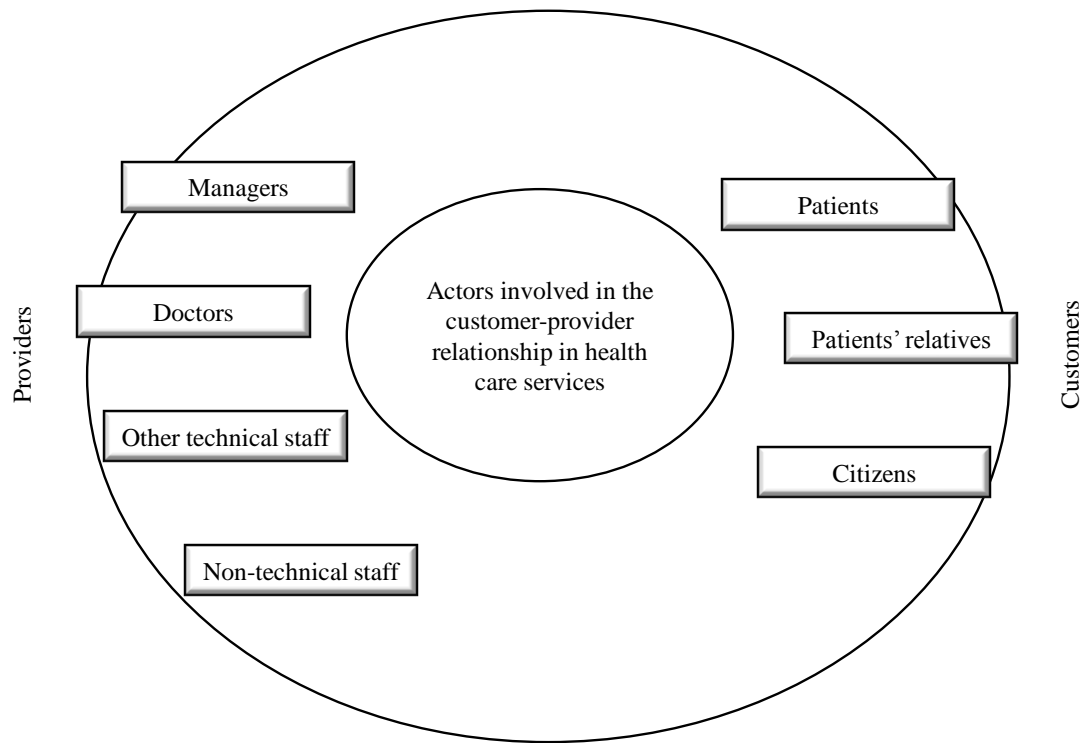
Figure 2.5: Actors involved in the customer-provider relationship in healthcare services
Note. From "Quality Evaluation in Health Care Services Based on Customer-Provider Relationship," by V. Eiriz and J. A. Figueiredo, 2005, *International Journal Article of Health Care Quality Assurance*, *18*, p. 409. Copyright 2005 by the Emerald Group Publishing Limited.

Eiriz and Figueiredo (2005) also explain that these actors have different expectations and perceptions for different quality items which he categorize as *customer service orientation*, *financial performance*, *logistic functionality* and *level of staff competence* (Table 2.1). In some cases the perception of patients or their relatives towards the providers may be higher than their expertise and technical knowledge. In another situation, patients' perception of their needs may be different from their relatives. The level of expectations and perceptions varies among the actors according to the different quality items. Therefore in order to gauge the quality of the health care services it is necessary to create specific weights of these perceptions and expectations for each of the actors (Eiriz & Figueiredo, 2005) which may be important for future studies to consider.

Table 2.1: Relevance of quality items by actor

Quality items	Expectations and perceptions						
	Service providers				Customers		
	Managers	Doctors	Other technical staff	Non-technical staff	Patients	Patients' relatives	Citizens
Customer service orientation	M	L	L	L	H	H	H
Financial performance	H	M	M	L	L	L	H
Logistic functionality	M	H	H	H	M	M	L
Level of staff competence	M	H	H	M	H	H	H

Note. Relevance of each quality item may be H (High), M (Medium) or L (Low). From "Quality Evaluation in Health Care Services Based on Customer-Provider Relationship," by V. Eiriz and J. A. Figueiredo, 2005, *International Journal Article of Health Care Quality Assurance*, *18*, p. 410. Copyright 2005 by the Emerald Group Publishing Limited.

Ideally the research on quality of health care should be longitudinal rather than cross sectional research designs so that the problem of causal ordering can be addressed (West, 2001). The way that care is organized, affects patients' experience of the healthcare systems. West (2001) proposes using statistical methods such as multilevel modelling, which include variables at different levels of analysis on the influence in patient care. The variables identified in the research conducted by West (2001) are organisational structure, organisational processes and relationship to the environment. The findings show that these variables influence staff outcomes and organisational outcomes, which becomes the indicators of quality of care given. Other variables that have significant relationship with quality is size, teaching status, the degree of specialization, staff number, skill mix, training, education, experience and length of service of top management team (West, 2001).

There are other researches that use both qualitative and quantitative methods in finding out patients' view in evaluation and improvements of quality of care. For example, Wensing and Elwyn (2002) used mixed methods for their research. The qualitative research methods used are individual interviews and focus group with open ended questions. Whilst in the quantitative methods, consensus methods such as Delphi and nominal group techniques in the form of questionnaire are used to collect data. Patients have to evaluate experiences in health care which are translated into satisfaction. The in-depth interviews are analysed to explore patients' views in areas that have not been elaborated. The results of the study have shown that patient involvement is crucial in the outcome of the health care. Doctors would be more receptive to patient preferences and contribute to a better implementation of clinical guidelines which result in better adherence to treatment, health status and satisfaction with care (Wensing & Elwyn, 2002). The outcome measures would reflect the effects on process and the outcomes of care that are expected (Wensing & Elwyn, 2002). This can be seen in Table 2.2 on the use of patients' views for quality improvement.

Table 2.2: Use of patients' views for quality improvement

Provision of data to those who seek health care:
• Health education
• Internet communication
• Public reports
Eliciting patient preferences in episodes of care:
• Needs assessment
• Tailored patient education
• Shared decision making
• Patients-held records

Patients' feedback on medical care:
• Written surveys
• Complaint procedures
• Patient participation groups
Patient involvement in healthcare systems:
• Assessment of priorities
• Involvement in guidelines
• Patient organizations

Note. From "Research on Patients' Views in the Evaluation and Improvement of Quality of Care," by M. Wensing and G. Elwyn, 2002, *Quality and Safety in Health Care*, *11*, p. 156. Copyright 2002 by BMJ Publishing Group Ltd and the Health Foundation.

Stein-Parbury (2005) suggests that all patients should have a say in their healthcare and argues that it is both an ethical ideal and a practical reality if patients participate in their health care. Wensing and Elwyn's (2002) research has also indicated the importance of patients being viewed as "co-producers of health care because their decisions and behaviour influence health care provision and its outcomes" (p. 156). This is shown in Table 2.3.

Table 2.3: Objectives of patient involvement and relevant measures

Objective	Relevant Measures
Adhere to ethical principles	Assess the impact of the processes of involvement at different levels (service design, clinical interactions, feedback systems) with criteria derived from ethical principles
Meet patients' preferences	Same as above, but with patient based criteria
Provide improved care process	Assess doctor-patient communication, medical care, organization of care, etc.
Provide improved patient outcomes	Assess patient compliance, health status, anxiety, coping, satisfaction with care etc
Achieve political or strategic aims	Assess the position on healthcare market, democratic organization etc

Note. From "Research on Patients' Views in the Evaluation and Improvement of Quality of Care," by M. Wensing and G. Elwyn, 2002, *Quality and Safety in Health Care*, *11*, p. 156. Copyright 2002 by BMJ Publishing Group Ltd and the Health Foundation.

The relationship between the health care provider and the patients grow when patients are involved in decision-making and their opinions and preferences are considered (Robinson, Callister, Berry, & Dearing, 2008). This is because health outcomes are more likely to be successful when patients have input in that care (Stein-Parbury, 2005). Epstein (2000) beliefs healing will take place when the patient is recognized as a human being and be given the importance while diagnosing the illness.

There are several types of fixed costs associated with the health care delivery system such as cost involved in developing optimal care procedures, cost involved in organizing quality improvement and costs involved in the execution of the quality improvement strategies. On the other hand the changes in health care provision are known as variable costs (Severens, 2003). Variable costs on the quality improvement strategy are dependent on the intensity. Variable costs have to be measured empirically and cannot be calculated through a simple division per measuring unit such as calculating practice, primary care doctor or patient (Severens, 2003).

However "a combination of both fixed and variable costs approximation is possible: visitors' time that is not directly related to a doctor's clinical work (such as work meetings and reading of a literature) are considered fixed (overhead) costs and attributed to each specific visitor by using a division calculation" (Severens, 2003, p.367). The model that is described by Mason et al. (2001) converts time into monetary units. With a proper clinical guideline, doctors will be able to see patients more regularly and longer time is emphasized to do more elaborate tests and there would be more possibilities of quicker referrals to the specialist. Patients can take this opportunity in the medical care given. Furthermore, patients' costs for time taken from

work and travelling can also be analysed at this stage by using the same model presented by Mason et al. (2001).

Nevertheless research has shown that there are hidden costs such as consumption of raw and processed materials (e.g. wood, steel, plastic, petroleum), which are producing large quantities of medically generated waste (e.g. radiological, chemical synthetic and biological) from America's best hospitals (Carrick, 2005). These wasteful ways will leave environmental footprints and undermine all human life, which cannot be quantified.

A better understanding of quality of care can be seen through patient-centeredness. Centeredness reflects the increase in sensitivity in social, psychological, cultural and ethical behaviour towards others (Hughes et al., 2008). According to Epstein (2000), patient centeredness has its origin from holistic health care which is a move away from the traditional disease-oriented model. Robinson et al. (2008) cited the definition of patient centeredness by IOM (2001) as "a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patient's wants, needs, and preferences and that patients have the education and support they need to make decisions and participate in their own care" (p. 601).

In this context, patient-centeredness has become increasingly important in health and social care (Hughes et al., 2008). Therefore health care professionals are trying to seek various ways to be patient-centered (Hughes et al., 2008). Hughes et al. (2008) cited Balint's (1969) definition of patient-centeredness as "understanding the patient as a unique human being" and focusing on "joint understanding of illness and its management" (p. 457).

Measuring patient-centeredness or patient activation is fundamentally significant in patient care management. Heinemann et al. (2006) argue on the content validity of the patient's self-report surveys that are assessed must match with what have been diagnosed. Subsequently the results should represent the entire population.

Hibbard, Stockard, Mahoney, and Tusler (2004) listed four important aspects of the patient-centeredness attitude and behaviour, which are; the patient should believe in the importance of taking an active role, the patient should have confidence in his ability, the patient should participate actively and the patient should have the perseverance to stay in the course. Stewart (1995, as cited in Heinemann et al., 2006) agrees that patients are more likely to be activated when their health care providers motivate them to be activated and thus this can be used as a tool to locate, engage and move patients along.

Furthermore providing high quality of patient care in health care delivery is of importance to stakeholders such as patients, policymakers, employees and purchasers. Balanced scorecard approach was recommended by Mitchell and Lang (2004) to determine the elements of quality, which is shown in Figure 2.6 on Quality Health Outcomes Model. This model shows that the care system is understood and measured at multiple levels. According to Mitchell and Lang (2004), categories linking care delivery are achievement of appropriate self-care, demonstration of health-promoting behaviours, health-related quality of life, perception of being well cared for and symptom management to criterion. Radwin and Fawcett (2002) however used the model to identify patient characteristics, intervention and system care of oncology patients.
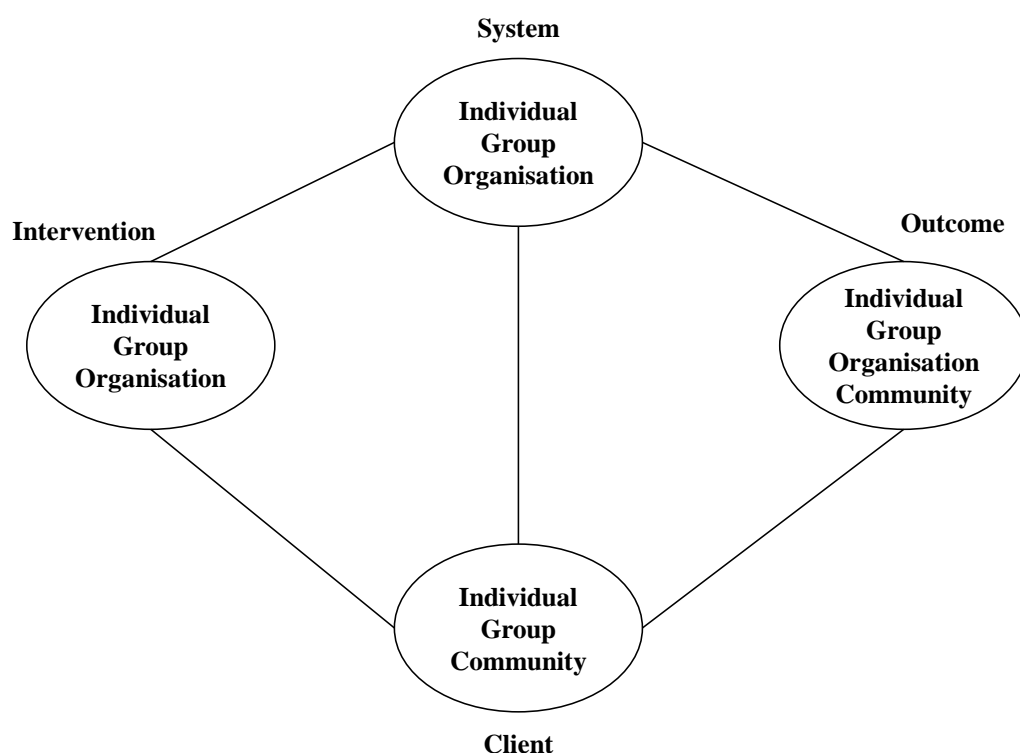
Figure 2.6: Quality health outcome model
Note. Adapted from "Framing the Problem of Measuring and Improving Healthcare Quality: Has the Quality Health Outcomes Model Been Useful?" by P. H. Mitchell and N. M. Lang, 2004, *Medical Care*, *42*, p. II-5. Copyright 2004 by Lippincott Williams & Wilkins.

When quality of care improves, it increases doctors' productivity as well. Technology is another important tool to enable doctors' to connect with their patients such as through e-mails, short messaging systems (SMS), fax and telephone. For instance through technology medical caregivers are able to identify patients who are due for their appointments, routine check-ups, medical screening and prescription of a new drug can be notified immediately to take actions. In this way, patients can be served better and connected in a more effective and efficient way. This is in tandem with Heinemann et al. (2006) research that states that patients who are more likely to be activated when their medical care givers encourage them to be activated.

Therefore measures must be taken to assess quality of health care from both the patient and the doctor's point of view. In short, quality of health care will make a difference if organisations operate on benchmarking care, continuous improvement, total quality management, involve patients and their family members to make decisions and provide the necessary skills for the doctors to practice patient-centered care.

2.2.3 Leadership

There are many studies that examine the leadership roles of health care practitioners and yet the quest to find a common and acceptable definition seems to be futile (Linstead et al., 2009), just like searching for the *Holy Grail*. According to Linstead et al. (2009) in recent years the mainstream view on leadership has changed dramatically with the incorporation of the concept of followership and the study on the process of leading. McAlearney (2006) explains the complexity of leadership especially in health care emphasizes the role of the doctors as providers, controllers and consumers of healthcare resources which influence their ability to increase revenues, prescribe patient care and build leadership relationship as compared to a typical stakeholder's relationship in other industries. Health is viewed as a commodity by various stakeholders and it is imperative that doctors establish working relationship with their patients (DiMatteo et al., 1986; French & Sim, 2004). In this context, the people-organisation relationship is an integral part of management (Mullins, 2007). This reflects the role of the health care providers as managers who are managing their everyday activities through a structured organisational setting with prescribed roles such as developing and working with people, achieving objectives and results and managing social impact and responsibilities while making sure there is continuous improvement (Linstead et al., 2009; Mullins, 2007). For the clinicians this means the complete care given to patients and not specific to treating the disease (Hardy, 2006).

Research by Hardy (2006) who cited Schon (1983) explained that in a clinical setting, doctors often deal with complex situations which may not be fully explained in medical textbooks and therefore they need to draw on their own skills, experience and knowledge to serve the needs of the patients.

According to Thomas (1987) the old authoritarian way in traditional treatment has given way to a new flexible and equal relationship. Most often in this new consultation approach, even in uncertainty the doctor would make an attempt for rational negotiation. However, Thomas (1987) cited Pendleton's et al. (1984) warning that there would be consequences if patients are deprived of their "powerful healer". In this fact, the communication between the doctor and patient can be a source of motivation (Kaplan et al., 1989). Instead of dictating, the doctors can influence the patient's technical care, perceptions of their health status, beliefs and reinforce their self confidence in a positive way (Kaplan et al., 1989). In a study by Fukui et al. (2009) on cancer patients with psychological distress, shows the importance of early detection and support given by the health care professional in influencing quality of life of patients. This supportive behaviour indicates the kind of leadership needed in health care industry. As pointed out by Thomas (1987), a doctor is a powerful "therapeutic agent" and a "placebo" (p. 1200) that influences patients at every consultation. Nonetheless the risks of unrecognizing patient's with distress can be reduced through training and practice (Fukui et al., 2009).

Some of the major issues that have risen in these studies are role misunderstanding, change in power, position (impact of hierarchy) and respect (Larson, Hamilton, Mitchell, & Eisenberg, 1996). There are also studies that attest the power difference between doctors and patients (Beisecker, 1990). According to Robinson

(1998) the power difference can be seen through the behaviour shown from greetings to goodbyes, naming rights and the interaction. In fact, Watson and Gallois (1998) believe there should be a balance between the two roles. Most importantly the doctors should portray a *nurturing behaviour* in which their main tasks should include making sure the patients understand their diagnosis and treatment, supply information (Kaplan et al., 1989) and give attention to their emotional and relationship needs (Watson & Gallois, 1998). Most importantly the relationship between doctors and patients should be based on respect, understanding and mutual trust. When relationships are built a doctor is able to influence the patients to take appropriate treatment and consequently enhances patient care (Hewett, Watson, Gallois, Ward, & Leggett, 2009).

Gray and Snell (1985) views effective leadership practices as interventions which facilitates in the process of leadership development and learning. In this context the approach outlined by Conger and Benjamin (1999), development of the individual leader, the socialization of company values and vision, action learning and strategic leadership initiatives are integral aspects in leadership development. One unmistakable role of a doctor is to take lead in creating a culture that is conducive to work and working as a team among all parties concerned (Robbins & Decenzo, 2004). Undeniably the leadership role is extremely challenging even within clinical ranks because there are distinctions between the doctors and nurses, pharmacists and doctors, and so on (McAlearney, 2006). Therefore studies examining the role of communication as part of the leadership practices are not only relevant but crucially important.

However, doctors should not be seen as exceptional people or a "great man" with innate qualities who are destined to lead. There is always the danger of them being perceived to symbolize heroism and greatness (Linstead et al., 2009). In the context of

Indian traditions and culture the doctor is viewed as someone of authority and given great respect by the family (Chattopadhyay & Simon, 2008). Therefore the Indian families and patients expect their doctor to assume the role of a 'friend', 'philosopher' and 'guide' (Desai, 2000).

As the role of the doctor becomes more challenging, it is important to find out if they understand their roles clearly and provide the necessary care needed for their patients. At a Continuing Professional Development workshop (March 22nd 2010) at Monash University on the topic of professional behaviour of clinicians it was put forward by Paediatrician Dr. Paul Fullerton that during bedside teaching doctors need to provide a 'clinician role model'. He explained this can be done through respect for patients especially in getting their consent, providing care, and respecting their confidentiality and privacy. Managers assume various roles as they perform their duties, and health care professionals' roles are even more crucial when they are involved in many important decisions that affect the lives of others. In a study by Mintzberg (1973) on managerial roles, manager's activities consist of 10 managerial roles which are categorized into three main groups, interpersonal, informational and decisional roles. The interpersonal roles consist of figurehead role, leader role and liaison role. These roles describe the relationship between the manager and others arising from the position of the manager. The informational roles on the other hand comprise of monitor role, disseminator role and spokesperson role that refer to the sources and communication of information (Mullins, 2010). Finally the decisional roles describe the strategic decision making of managers. The roles consist of entrepreneurial role, disturbance handler role, resource allocator role and negotiator role. The roles do not function as isolated elements of managerial practice but forms as an integrated whole (Mullins, 2010). Doctors face various critical situations in the ward where they

need to exercise their authority and position in providing patient care that mirrors the different roles as portrayed by Mintzberg's managerial roles.

A study conducted by Johnson (2005) viewed the characteristics and skills of doctors in South Georgia in comparison to traditional and contemporary management theories. Likert type of scale were used to evaluate managers on attention, meaning, trust, self, vision and feeling. The result of this findings show that it is not only trust which is significant among the doctors but also technical skills which enable them to get things done effectively and the ability to work well with others. This is in tandem with Robert Katz's theory that describes the three skills of managers which are conceptual skill, technical skills and human skills (Robbins & Decenzo, 2004). Another study by DiMatteo et al. (1986) also explains the relevance of technical skill for doctors to conduct physical examination as well as decide and assess the correct type of diagnostic tests in order to make the right diagnosis for appropriate treatment. According to Del Vento et al. (2009) it is imperative that a doctor possess skills in communicating bad news. Unfortunately this is a challenging task and most of them are not formally trained in this area (Del Vento et al., 2009). There are also evidences that show technical skills combined with interpersonal skills of doctors lead to significant relationship in patient satisfaction with the medical care received (Doyle & Ware, 1977; Hays & DiMatteo, 1984). This explains the importance of doctor's skills in influencing satisfaction and cooperation among patients especially with the rise in competition within the medical marketplace (DiMatteo et al., 1986). On the contrary, Kaplan et al., (1989) describe dissatisfied patients to go "doctor-shopping", initiate complaints and be non-compliant towards treatment. For this reason, satisfaction has been described as part of patient's attribute (Linn & Greenfield, 1982).

Other management approaches in health care delivery system are innovation, coordination, growth and creative delegation (Shireman & Kiuchi, 2002). Irrelevant of the organisational setting, managers must be able to lead. According to Gautam (2005), managers should also have strategies to lead. The "strategies for hospital board leadership should include preparing to lead, self-education, visible participation in quality activities, activism, role clarification, increased informal dialogue with physicians . . . creation of a quality management department . . . and external quality audit" (Gautam, 2005, p. 18).

Mullins (2010) emphasises that leadership today is all about teamwork. As a result of teamwork, cordial relationship with others is established. Teamwork also creates a shared vision that inspires others to identify with it (Mullins, 2010). In analysing leadership styles among various leadership theories, a general observation is the emphasis on team management, delegation, support and participative leadership traits. If leaders communicate their vision and strategies clearly to their staff, it will create an understanding among them and eventually induce commitment and bring about the desired changes (Mullins, 2010). Furthermore, McCormack et al. (2002), who cited Kitson, Harvey, & McCormack (1998) and Senge (1990), explain that if staff feel valued and given choices to make, they would more likely participate in organisational activities which eventually result in effective teamwork. In the context of behavioural approach to leadership the Blake and Mouton's Managerial Grid clearly indicates the ideal leadership style of team management.

The emphasis on social skills and relationship among people highlights the importance of working together and mastering "soft skills" (Mullins, 2007). In a study on teamwork associated with clinical efficiency it was found there is more to a team

than a sum of its part. The study also show teamwork is not about clinical knowledge and skills of team members but the significance in efficient coordination of clinical performance. When this is poorly managed it can contribute to poor patient outcomes (Siassakos et al., 2011). There is clear indication of patient satisfaction when healthcare organisations develop a culture emphasising teamwork and de-emphasising aspects of bureaucracy which are not essential in assuring efficiency and quality care. This is evident from a study conducted at Veterans Health Administration (VHA), Department of Veterans Affairs among 125 study sample on the relationship between team-work culture in hospitals and patient satisfaction with the care they received (Meterko, Mohr & Young, 2004). Teams must develop trust to work in a collaborative process based on reciprocal dependence and familiarity, where knowledge is used in a better way, and decisions are unanimous and valid (Kvarnstrom & Cedersund, 2006).

In many instances employees work as groups in making decisions and administrating care to the patients. Here every care giver is responsible to provide service or care that is needed for the patients and the leader should be concerned for the patients and the success of the treatment. Therefore, the relationship between group communication processes and decision making outcomes, in terms of the role that communication plays is very vital in teamwork and collaboration (Hardy, 2006; Hewett et al., 2009). Doctors in their capacity as health care professionals and managers of hospital wards are regularly involved in crucial decisions made in consultation with other specialist to see what is best for the patients. Linstead et al. (2009) explain that "there is the need to formalize and codify management work, promote communication between managers and others in organisations, and be able to justify a selected course of action from a range of perceived options" (p. 669). The assumption is doctors use a specific frame of thought in the decision process and in an ideal situation the rational

decision model approach provides *one best way* in coming to a decision. In this model crucial steps taken by the doctors are to identify the problems, evaluate the alternatives, choose the best alternatives, implement chosen alternatives and monitor decision environment (Linstead et al., 2009). However, according to Hopwood (1974, as cited in Linstead et al., 2009), in practice, time and cost frequently rule out the search for optimal solutions and profit maximization is not the only criterion applied to choice situations. It is unrealistic to assume that doctors operate in conditions where there is "finite choice situation, relevant and unproblematic data, and clear and uncontroversial choice criteria" (Linstead et al, 2009, p. 674). In understanding decision making by leaders, studies done by Cray, Mallory, Butler, Hickson, & Wilson (1988) found that there are basic ways in how strategic decisions are made:

> Sporadic processes tend to be interrupted, informal and drawn out. Fluid processes are much smoother, quicker, and more formally structured. Constricted processes are bound by few formal structures but proceed around a single individual and are authorized at a relatively low level in the organization. (p.31)

Linstead et al. (2009) illustrates that sporadic decisions are informal and face various problems of interruptions such as resistance, information not being available on time; the sources of information collected from various sources may have credibility issues; fluid decisions are predictable, fast and distributed through formal channels and constricted decisions are narrow and technical. Doctors are usually in a position where they face different categories of decisions in their work scope. Consequently the leadership approach taken in making these decisions affect their relationship with the patients, nurses and others who play a part in the health care environment.

A successful leader is about knowing one self and what the person does, rather than about the intellectual capabilities. Using authority without arrogance is the secret to being in touch with peoples' feelings, knowing ones' own strengths and weaknesses,

and being humble (Reeves & Knell, 2009). In a study by Del Vento et al. (2009), the qualitative results show there is no concept of "one size fits all" in medical communication because there is a wide range of personal style. Therefore Del Vento et al. (2009) proposes doctors to be adaptable leaders in all types of situation. Fiedler's Leadership Model, Hersey Blanchard's Situational Leadership Model and Path Goal Theory of leadership are some of the Contingency Leadership theories that argue effective leadership should suit the context such as the situation, people, task, organisation and environment. The basic concept of Contingency Leadership theories is a successful leader should know about one self and use authority without arrogance. This will help them to be sensitive to feelings, understand ones' own strengths and weaknesses as well as keep them grounded. Furthermore, doctors who are considerate and democratic, engage patients to participate in the decision making process. This action demonstrates the importance of being able to suit the situation variables which is the hallmark of contingency theories of leadership (Reeves & Knell, 2009).

Meanwhile the Leader Member Exchange (LMX) theory of leadership (Graen & Uhl-Bien, 1995) proposes that health care providers should be viewed as part of a dyadic relationship where leader behaviour will vary with different followers rather than exceptional people with innate qualities to lead. The dyadic relationship between doctors and patients should be based on respect, understanding and mutual trust.

According to the Transformational Leadership theories, leaders should be empowering, motivating, inspiring and create a passionate belief towards change among followers, articulate vision, build relationships and establish a sense of belief and trust while ensuring organisational expectations and goals at all levels are met (House, 1977; House & Shamir, 1993; Kouzes & Posner, 1993, 1995). McCormack et al. (2002)

believe that the health care system today recognises all staff as leaders, which is the hallmark of a transformational leadership culture. In 1975, Mintzberg stated that the transformational leader requires emotional intelligence, rationality, motivational skills, empathy and inspirational qualities and the intellectual qualities of strategic sensing, analytical skills and self-confidence (McCormack et al., 2002).

According to Bass, Avolio, Jung & Berson (2003), there are three factors that define transformational leadership: (a) charisma-inspiration: encouraging subordinates through a clear goal and act as a role model for ethical conduct, (b) intellectual stimulation: encourage subordinates to question and improve existing problem-solving strategies, and (c) individualised consideration: help subordinates understand their individual needs and capabilities. Transformational leaders in health care practice need to embrace a visionary style of leadership to integrate the application of science and technology with the different forms of practice knowledge. This will create an environment that supports shared understanding of knowledge within a clearly defined set of organisational values and beliefs (Kramer & Hafner, 1989). Transformational leadership will also lead the staff to consistently exercise positive and professional judgement towards other staff and their own patients.

Great leadership is not labelling one-self as "superman" but rather being transformational by empowering, motivating, inspiring and creating a passionate belief towards change among followers, articulating a vision, building relationships and establishing a sense of belief and trust while ensuring organisational expectations and goals at all levels are met (Bass, 1985; Bennis, 1989; Bono & Judge, 2003; Burns, 1978; Gardner, 1990; House, 1977; House & Shamir, 1993; Kouzes & Posner, 1993, 1995). McCormack et al. (2002) cited Mintzberg (1975) and McClure, Poulin, Sovie, &

Wandelt (1983), emphasized that health care today uses transformational leadership which induces a culture that recognizes all staff as leaders. As a result this will lead the staff to consistently exercise positive and professional judgement towards patient care (McCormack et al., 2002).

Keith Grint in his book, *The Art of Leadership* (2000), terms leadership as a *constitutive approach to leadership* where he views it as the *arts of leadership* and is essentially an interpretive affair. Linstead et al. (2009) who cited Grint (2000) explains:

> There are four arts of leadership that is useful in explaining success and failure of leadership across all organisational setting: 1) the who (constructing a sense of identity for followers); 2) the what (the inventiveness of a future or strategy (or vision) that can stir imagination of followers and resonates with their desires); 3) the how (devising tactics that use power creatively); 4) and the why (having the rhetorical and negotiating skills as well as skills of persuasive communication, to engage followers and make them believe in the world the leader creates for them with words and props, as one would for stage performance. (p. 515)

In the book *The Wisdom of Teams* by authors Katzenbach and Smith (1994), they emphasise several critical elements in leadership behaviour which are important in developing a more effective leadership in health care which are: asking questions rather than giving answers; providing opportunities for others to lead you; doing real work in support of others instead of only the reverse; becoming a match-maker instead of a central switch and seeking a common understanding instead of consensus. However, leadership development practices in health care industry lags far behind other industries (McAlearney, 2006). In the study by McAlearney (2006) on leadership development in healthcare, the author proposes that a model of commitment for leadership development is influenced by three factors: (1) organisational culture, (2) organisational strategy and (3) organisational structure. The proposition by McAlearney (2006) include some of the factors as follows: (1) emphasis in leadership development is closely linked with

organisational leaders who value learning and growth, (2) organisations with strong commitment to leadership programmes have a better integrated programme in the organisation and (3) organisations leadership programme success is based on organisation-wide metrics including employee satisfaction, employee turnover, doctor satisfaction, financial performance instead of programme attendance, credit hours accumulated and so forth. It is evident that the factors discussed are an integral part in the overall development of effective leaders in healthcare. Doctors in the end would lose out in modern healthcare systems if they feel uncomfortable with leadership, systems thinking, negotiation, genuine team work and organisational development, strategy, economics, and financial situation (Smith, 2003).

2.2.4   Culture in health care environment

2.2.4.1 Organisational perspective

The culture in health care environment is an unchartered territory because it is unique in nature even if it is influenced by modernization, technology and scientific inquiry (Graber & Johnson, 2001). The variables in organisational culture include shared beliefs, attitudes, values and norms of behaviour. Organisational culture is reflected as how things are understood, judged and appreciated (Davies, Nutley, & Mannion, 2000). In relations to health care, such differentiations of cultural levels are both important and helpful. Examples of different levels of culture within National Health Services (NHS) in United Kingdom can be seen in Table 2.4.

Table 2.4: Examples of different levels of culture within NHS

Assumptions are the basic "taken for granted" views of the world and how one can understand and intervene in it–that is, ontology and epistemology. For example, medical research has traditionally been predicated on the use of rational scientific methods as the basis of generating and accumulating knowledge (controlled trials rather than qualitative and interpretative methods). Thus, assumptions about measurability, aggregation and transferability of knowledge are deeply ingrained in medical care.
Values constitute the basic foundations for making judgements and distinguishing "right" from "wrong" behaviour. In the medical profession conduct has traditionally been based on the Hippocratic principle of placing needs of individual patients above broader economic and corporate objectives; this, in turn, has led to clinical freedom being a highly prized cultural "value".
Artefacts include the physical and behavioural manifestations of culture. In the medical profession these may include such diverse issues as dress codes (the doctors' ubiquitous white coat and tie), standard ways of running services (the physician's beds, the surgeon's list, juniors attached to seniors), or methods of performance assessment (the dominance of confidential peer review, the reliance on professional self-regulation).

Note. From "Organisational Culture and Quality of Health Care," by H. T. O. Davies, S. M. Nutley and R. Mannion, 2000, *Quality in Health Care*, *9*, p. 114. Copyright 2000 by the BMJ Publishing Group Ltd & The Health Foundation.

Organisations in health care face an increase in bureaucratization. As illustrated by Max Weber (1968, as cited in Graber & Johnson, 2001), one of the benefits in bureaucratization is objective centred. Health care managers have assumed their role as facilitators instead of corporate managers and the most influential authority figure is the doctor who is at the top of the hierarchy (Graber & Johnson, 2001).

Unfortunately both health care managers and corporate managers have different professional cultures and dealings which may result in resistance from the organisation itself and the subgroups (Davies et al., 2000). The differences can be seen in Table 2.5.

Table 2.5: Managerial and medical cultures: points of divergence

	Managerial	**Medical**
Structure	Bureaucratic	Collegial
Group loyalty	Low	High
Job security	Low/medium	High
Disciplinary base	Social sciences	Natural sciences

	Managerial	**Medical**
Evidence base	Case studies on organizations	Clinical studies on patients
Focus	Patients as groups	Patients as individuals
Skills	Managerial/human relations	Biomedical/technical
Allegiance	Organization/corporate goals	Patient/professional
Discretion	Low(rules/procedures)	High (clinical freedom)
Success measure	Efficiency	Effectiveness
Quality emphasis	Consumer rated quality	Technical quality
Performance review	Public	Confidential
Professional status	Emerging	Established
Social status	Medium	High
Public trust	Low	High (but vulnerable)

Note. From "Organisational Culture and Quality of Health Care," by H. T. O. Davies, S. M. Nutley and R. Mannion, 2000, *Quality in Health Care*, *9*, p. 116. Copyright 2000 by the BMJ Publishing Group Ltd & The Health Foundation.

Therefore, organisations need to be more coherent and devise strategies that take into account the needs, fears and motivation of their staff in order to bring about the successful change in the culture (Davies et al., 2000). The key is to find the right fit between both professional cultures. Organisation perhaps should consider devising strategic alliance between both these professionals. Attempts should be made to look into innovation and openness during the cultural shift (Davies et al., 2000).

2.2.4.2 Socio-cultural perspective

So what is culture in a clinical setting? Culture is defined as "the set of distinctive spiritual, material, intellectual and emotional features of society or a social group and encompasses, in addition to art and literature, lifestyles, ways of living together, value systems, traditions and beliefs" (UNESCO, 2002, p. 68). Culture is also associated to the human behaviour, social structure and ideology of a social group (Reid & Trompf, 1990, as cited in Mohammadi, Evans, & Jones, 2007) that shares beliefs, norms, values, lifestyles and assumptions within the group (Leininger, 1983; Mohammadi et al., 2007). According to Allotey, Manderson, & Reidpath (2002), culture is never static and therefore changes over time. For this reason, Mohammadi et al. (2007) explain there

are many sides to cultural diversity such as religious faith, gender, language and political stand. Koenig and Gates-Williams (1995) cautioned that gender differences must be approached in a sensitive way. As for races, Koenig and Gates-Williams (1995) explain they do not exist independently rather they are part of a social construction which is part of a historical context and subject to change. Therefore in order to elicit culture Koenig and Gates-Williams (1995) describe culture as constantly "redefined and negotiated, meaningful only when interpreted within the context of a patient's unique history, family constellation and socioeconomic status" (p. 245).

In Mohammadi et al., (2007) research, the authors investigate the impact of the cultural diversity towards the health care system in Australia. The research cited the Australian census in 2001 that identified 125 religious categories within the population in which 68% are recorded as Christians and 1.5% of them are Islam. The research explains there are two different groups within the Islamic faith which consist of the majority of Sunnis and the minority Shias. The Islamic faith is guided by their "Articles of Faith and the Five Pillars of Islam" (Mohammadi et al., 2007, p. 311). The researchers highlight the clash of cultures between the western culture and Islamic culture in the health care system mainly because of the ignorance of the two philosophies, values and mission. The Islamic culture does not fit easily based on western values, beliefs and expectations. This causes a dilemma because the health care system is primarily based on western culture (Aldeen 2007; Mohammadi et al., 2007) and causes an uneasy fit (Aldeen, 2007).

There are potential difficulties faced by a Muslim patient when adhering to the practices of a non-Islamic health-care environment such as the observation of prayer time, direction of the prayer towards Mecca, rituals of washing parts of the body

(known as *wudu*), fasting and abstaining from certain food (which is known as *haram* food), gender interactions and dressing modestly with arms and legs covered especially for Muslim women known as *hijab* (Mohammadi et al., 2007). According to Aldeen (2007) the Islamic concept of modesty upholds that men and women who are unmarried and unrelated should not view the area of the body that is not publicly exposed (known as *awrah*). Therefore Aldeen (2007) stresses that doctors should be sensitive to the patients' beliefs and accommodate their requests for doctors of the same gender. However the issue here is; what if there is a patient who is sick and there are no available doctors of the same gender. This issue has been debated by many Islamic scholars. The doctor is allocated to the patients based on their expertise on the disease and not based on gender. As a result this may cause discomfort to the patients (Mohammadi et al., 2007).

The Muslim societies in Bali and Egypt have different practices when mourning for the dead. According to Koenig and Gates-Williams (1995) in Bali, a person mourning the death must remain calm and cheerful whilst in Egypt a woman who has lost a child and remains "withdrawn, mute and inactive" for seven years is considered sane and healthy. In the western culture, these practices would be considered as unhealthy disorders (Koenig & Gates-Williams, 1995). Therefore the Islamic principle can be very challenging and pose difficulty to both the patients and the doctors (Mohammadi et al., 2007).

In another research to assess GP paying attention to their patients, Kuyck et al., (2000) found out that doctors who are more religious tend to pay more attention towards patients' religious beliefs. From the questionnaire posted to 120 GPs, the result show 16% of the GPs enquired about their patients' religion during registration and 25%

enquired during routine rounds. In addition, religious information was brought up more frequently during cases of bad news (56%), requests for abortion (60%) and euthanasia (79%). This survey shows only limited attention is given by the GPs during their routine daily practice to enquire about their patients' religious background compared to other circumstances (Kuyck et al., 2000).

In today's borderless society, the crux of trans-cultural care is competence in communication (Cioffi, 2003; Purnell, 2000). The communication between the patient and his family with his doctor and how they make decisions in the healthcare setting is influenced by the interchange of meanings used in health and disease treatment, social norms, values, culture and duty of care towards patient. (Berger, 1998, Klessig, 1992, Searight & Gafford 2005, Thomas, 2001, as cited in Chattopadhyay & Simon, 2008).

A study by David and Rhee (1998) focused on the relationship between the Spanish speaking-only patients with their doctors. The results concluded language barrier has negative correlation with patient satisfaction and medication compliance. David and Rhee (1998) suggest that this obstacle can be prevented if the health care providers are bilingual. In addition, Aboul-Enein and Ahmed (2006) suggest providing enhanced health care is through culturally competent care by using simple everyday words instead of complex medical jargon, hand gestures and facial expressions and seeking the assistance of trained interpreters or family members. Unfortunately, Timmins (2002) describes using patient's child as an interpreter can add tremendous stress in the conversation that can affect family relationship. In the absence of the interpreters, Cioffi (2003) suggests that health care providers can use charts, draw on sheets of paper, communicate slowly without any slang and intervene when there is any misunderstanding. Aboul-Enein and Ahmed (2006) and Timmins (2002) suggest hiring

trained interpreters, training volunteer interpreters from the community, hiring bilingual health care providers and encouraging health care providers to attend language classes to be familiar with everyday medical terms.

Since cultural competence is necessary (Purnell, 2000), a four phase model developed by Howell (1982, as cited in Cioffi, 2003) describes the development as *unconscious incompetence* to *conscious incompetence* then to *conscious competence* and finally to *unconscious competence*. According to Cioffi (2003), Australian health care providers are challenged to provide competence care in a multicultural perspective.

Nevertheless, Aldeen (2007) suggests that doctors should be non-judgmental and acknowledge the patient's cultural beliefs and discuss openly the logistic realities faced in the hospital. Health care providers should avoid Western imposition and understand that other people have diverse values (Purnell, 2000). They should be aware of their own cultural biasness and beliefs plus have the cognitive ability to recognize that meanings can differ for different people (Cioffi, 2003). This also includes the practices and approaches in the type of treatment used by the patients that are influenced by their ancestry beliefs and teachings. To some, complementary medicine has become the alternative option in treatment (Freckelton, 2003).

According to Siti et al., (2009), there is an increase in popularity in the usage of traditional and complementary medicine (TCM) in both the developing and developed countries. The WHO (2001, cited in Siti et al., 2009) defines TCM as:

> A sum total of the knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness. (p. 293)

Western medicine or scientific medicine is known as allopathic medicine whilst traditional medicine refers to healthcare practices based on non-allopathic medicine which includes using "herbs, plants and minerals and even animals" (Talib, 2006, p. 1). Alternative medicine means using all types of non-allopathic medicine and treatment. While the term complementary medicine means using allopathic treatment (western medicine) together with traditional or any other alternative medicine (Talib, 2006).

A local study was conducted by Siti et al. (2009) to find out the prevalence and frequency of various TCM modalities used by Malaysians in urban and rural areas, through the survey method (interviewer-administered questionnaire) using multi-staged and stratified method. The results from 6947 respondents show the various TCM modalities used by the Malaysian community as recorded in Table 2.6.

The initial findings from the Malaysian Morbidity Survey II in 1996 reveal that 2.3% of the Malaysian population visited TCM providers and 3.8% visited both the modern and the TCM providers (Siti et al., 2009). The findings from WHO (2001 cited in Siti et al., 2009) also reported 50-80% of the population in the developed and developing countries use TCM in the prevention of diseases and promotion of health. Furthermore, the results of the survey conducted in Malaysia show that the prevalence is within the estimation of the WHO (2001 cited in Siti et al., 2009). This shows there is potential in tapping the usefulness of the practices in TCM.

Table 2.6: Categorization of modalities used by the Malaysian community

No	Sub-group	TCM
1	Mind-body medicine	Meditation
		Hypnosis
		Prayer for health reason
		Exercise dance and leisure, e.g. yoga, *chi qong*
		Energy healing therapies, e.g. magnetic healing

No	Sub-group	TCM
2	Biologically based therapies	Herbs
		Vitamin and supplements
		Animal parts
		Application/beauty/hygiene product
		Diet based therapy, e.g. nutrition therapy
3	Manipulative and body based practices	Midwifery
		Bekam/cupping
		Massage
		Bone therapy, e.g. *rawatan patah tulang*
		Reflexology
		Temperature based, e.g. *demah*
		Rawatan resdung
4	Whole medical systems	Acupuncture
		Ayurveda
		Homeopathy
		Traditional Chinese medicine

Note. From "Use of Traditional and Complementary Medicine in Malaysia: A Baseline Study," by Z. M. Siti, A. Tahir, A. Ida Farah, S. M. Ami Fazlin, S. Sondi, A. H. Azman, … W. C. Wan Zaleha, 2009, *Complementary Therapies in Medicine*, *17*, p. 293. Copyright 2009 by Elsevier Ltd.

Since the goal of medicine is to improve health (Zollman & Vickers, 1999), the demand for TCM is also growing steadily in Australia (Zhu et al., 2009). For the past two decades, acupuncture has been absorbed into the Western medical system and even unto the Australian Medicare rebate item (Freckelton, 2003). However, Ismail Merican (2002) cautioned the need to have public education on the usage of the herbs and extensive scientific research in this area to avoid side effects. Finally while there is no indication that consumer's demand will slow down, Zhu et al., (2009) suggest a bridge between the two paradigms using western biomedicine and TCM. As proposed by researchers this can be achieved through evidence based medicine, dialogues, research trials and legislations (Freckelton, 2003; Ismail Merican, 2002; Talib, 2006; Zhu et al., 2009) and continuous professional training programs in medical education.

Several studies have shown that attitudes and beliefs about disease, end of life, medical care, and preference for treatment and healthcare practices have ethno-cultural

correlations (Klessig, 1992; Koenig & Gates-Williams, 1995; Searight & Gafford, 2005). The Asian perception of health is "harmonious balance between individual, society and the universe" (Berger, 1998, as cited in Chattopadhyay & Simon, 2008, p. 166), whereas the traditional Navajos rest on the harmonious balance of "one's physical self with one's family, community and nature" (Bell, 1994, as cited in Chattopadhyay & Simon, 2008, p. 166). In another scenario the South Asians accept their pain and sickness as part of life and usually don't seek medical treatment for some of their ailments (Uba, 1992, as cited in Chattopadhyay & Simon, 2008). McEvers (1980) explains that even though the possibility of a technological fix is more appealing, different people in different cultural setting perceive health differently. They evaluate the illness according to their own criteria based on their social environment and attitudes to life and death and the supernatural which correspond with different therapeutic interventions (McEvers, 1980).

According to Turner (2004) the discussion on cultural issues, medicine and bioethical perspective are often marginalized. Even though in recent years, the literature on bioethical issues and treatment on patients who are terminally ill, palliative care, end of life, euthanasia have increased but how it is dealt across different cultures have not been sufficiently addressed (Chattopadhyay & Simon, 2008). In other words, there appears to be a lacuna in understanding end of life in a socio-cultural perspective (Chattopadhyay & Simon, 2008).

According to Graber & Johnson (2001), illness often brings people closer to their God and forefront of consciousness, especially if it affects someone who is close to them. Therefore patients can draw strength from their religious faith (Kuyck et al., 2000). Unfortunately many values such as sympathy and selfless service are limited to

social workers and counsellors which result in no clear guidelines in spiritual support for patients (Graber & Johnson, 2001) and it is unsure that doctors take into account the religious beliefs of their patients when care and treatment are provided (Kuyck et al., 2000).

There are cultural variations in providing care and support during end of life of patients (Klessig, 1992). In some cultures the principle basis for non-disclosure to patients are sense of responsibility and filial duties. For example, in a research by Koenig and Gates-Williams (1995) on cross-cultural medical care to patients of different ethnicity revealed that Chinese families prefer to use a more neutral term such as *tumour* instead of the term *cancer* when discussing the illness with the patient. They believe that the patient will be sicker and will not be able to tolerate if the illness is disclosed. The findings also revealed that the Chinese family prefers a blend of Chinese herbal medicine with biomedical therapies for the terminally ill. This belief is similar to the Italian belief. According to Berger (1998) disclosing the diagnosis of cancer to the terminally ill Italian patient is believed to affect their peacefulness. The researchers, Chattopadhyay and Simon (2008) also agree that disclosing the "naked truth" to the Hispanics and Asians would have severe repercussions and may be harmful to them. In Japan, the doctors will not reveal a diagnosis of cancer to the patients since it is an accepted practice in this homogeneous society (Tanida, 1994, Gordon, 1990, as cited in Koenig & Gates-Williams, 1995). The Chinese also belief in the avoidance of death at home due the traditional beliefs that the ghost of the departed will dwell where the patient has died (Evelyn, 1992, as cited in Koenig & gates-Williams, 1995). Substantially, studies have shown the African American and Hispanic patients are more desirous for their doctors to keep them alive regardless if they are terminally ill compared to the whites who agree to stop life-prolonging treatment (Berger, 1998;

Caralis, Davis, Wright, & Marcial, 1993; Chattopadhyay & Simon, 2008). However the Roman Catholics are more likely to use life-prolongation measures (Belgum, 1983).

Whilst in the Indian culture, "death is viewed not as opposite of life, rather opposite to birth" (Desai, 2000, as cited in Chattopadhyay & Simon, 2008, p. 169). As long as there is hope, the family would like to sustain and prolong the life of the patient because to the Indian beliefs, life is considered precious (Balakrishnan & Mani, 2005). If there is no hope of betterment or recovery and the patient is in a vegetative coma, the decision not to prolong the life will be made by the head of the family which is either, the father, husband or eldest son through consultation with the rest of the family (Deshpande, Reid, & Rao, 2005; Desai, 2000). Even in the Hippocratic Oath *do not harm* might be doing harm if the dying process is prolonged which inevitably adds to the patient's suffering (Belgum, 1983). These combined factors greatly emphasize Asian ideas about *selfhood* which vary from the Western perspective of an autonomous individual (Koenig & Gates-Williams, 1995). Koenig and Gates-Williams (1995) describe this as "socio-centric or relational sense of self often leads to decision-making styles at odds with western bioethics ideals" (p. 247).

Many researchers believe that religion and medicine are intricately woven together (Orr & Genesen, 1997) and ultimately life and death is also related to patient's need for respect and dignity which are essential in patient care (Henderson et al., 2009). From the findings, Baillie (2009) defined patient's dignity as "feeling valued and comfortable psychologically with one's physical presentation and behaviour, level of control over the situation and the behaviour of other people in the environment" (p. 33).

Other findings from Gallagher and Seedhouse (2002) also show that staff behaviour, the environment and resources affect patients' dignity. In this context, studies by Randers and Mattiasson (2004) and Turnock and Kelleher (2001) show that privacy is important for patients. The patients feel it is important if patients of the same sex are "warded" in the same bay area. A study by Turnock and Kelleher (2001) and Matiti (2002, as cited in Baillie, 2009) reveal that dignity is about modesty and keeping the body covered. Furthermore the findings from Baillie (2009) show that patient's illness and age render them vulnerable to the loss of dignity. In addition being curt and authoritative breach patient's dignity because it makes them feel uncomfortable and not valued. This also includes how patients are treated by their family members when they are sick. This is also a social problem in Malaysia. Reports show there are a rising number of senior citizens who are abandoned by their families at public hospitals in Malaysia (Lim and Yuen, 2012). The report also states that up to June this year, 157 patients above 60 are abandoned compared to 205 by end of last year. More than 95% of those abandoned come from poor families who have financial constraints. Other reasons are due to changes in the society in which younger generation prefer their own space and privacy (Lim and Yuen, 2012).

Baillie's (2009) findings also show conducive environment in the hospital setting, providing privacy, interacting with humour and building a relationship with the patient rendered positive outcome and promoted patient dignity. Figure 2.7 shows how the hospital environment which includes staff behaviour and patient factors affect patient's dignity. The model shows that patient is placed in the central area and is surrounded by the environment and staff behaviour. The upper half portrays the reasons for patients' vulnerability to loss of dignity in the hospital whilst the lower half portrays how patient

factors the hospital environment and staff behaviour which promotes dignity despite the patient's vulnerability.
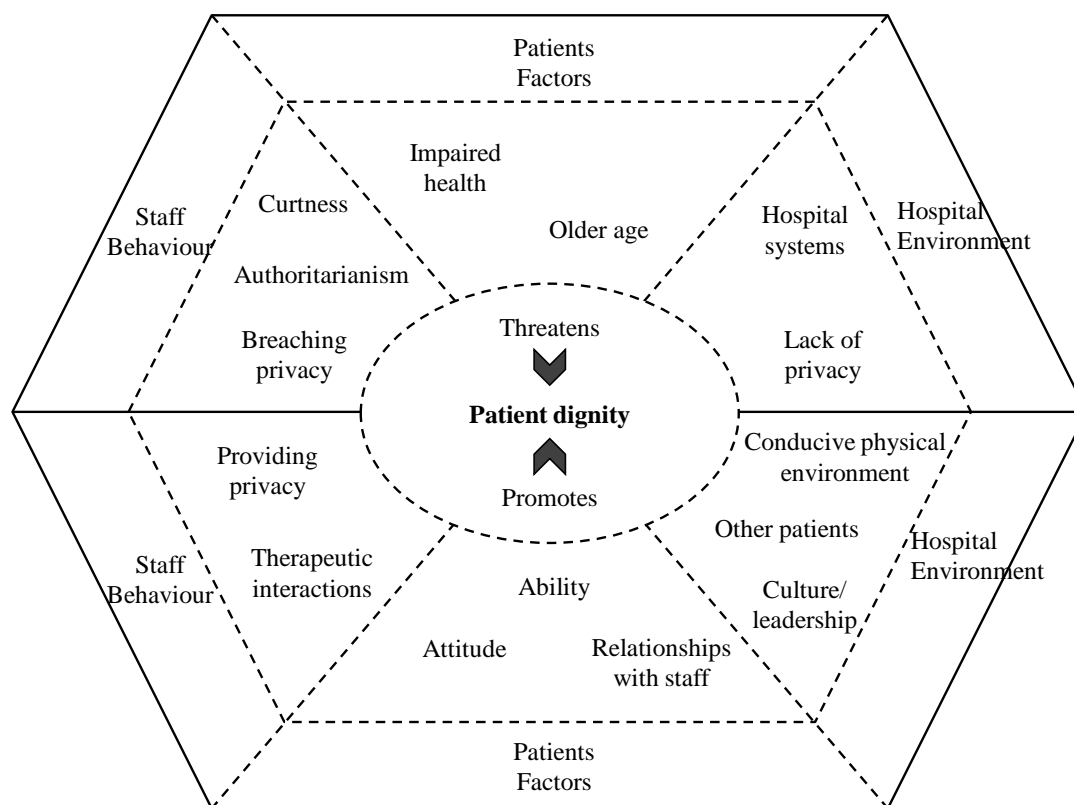
Figure 2.7: How patients' dignity is promoted or threatened in hospital
Note. From "Patient Dignity in an Acute Hospital Setting: A Case Study," by L. Baillie, 2009, *International Journal of Nursing Studies*, *46*, p. 33. Copyright 2008 by Elsevier Ltd.

Patients should be given proper informed consent and the right of informed refusal which allows them to understand the risks involved in leaving out a part of the medical evaluation (Aldeen, 2007). This gives greater equality and balance between doctor patient relationship which is a standard practice in bioethics and law (Aldeen, 2007; Deber et al., 2005). Consequently this gives patients empowerment and autonomy (Deber et al., 2005). Studies by Wadey and Frank (1997) show that verbalization of the risks and benefits during a surgical consultation demonstrate a greater understanding for patients. Moreover, working with patients and being sensitive

to their needs and beliefs will also enable the provision of holistic nursing care (Anderson, Loudon, Greenfield, & Gill, 2001). However inability of surgeons to keep patients informed will lead to legal implications.

According to Thomas (2009) in order to have a meaningful relationship between a doctor and a patient, it is essential that the relationship is built on mutual respect, trust and confidence. To achieve this, Thomas (2009) cited Breen, Plueckhahn, & Cordner (1997) and Kerridge & Mitchell (1992), who explained that it is the patients' right to decide whether to accept or reject advice given by doctors on their treatment and procedures. This respect must be evident even if the doctor disagrees with the patient's informed decision. In other words doctors must give the patients "proper informed consent and right of informed refusal" (Aldeen, 2007, p. 277). In 1980 the Supreme Court in Canada made a ruling that doctors must disclose reasonable information about their management plans and answer questions posed by the patients, and failure to do so will constitute negligence (Wadey & Frank, 1997). Sulmasy et al., (1994) cautioned that simple disclosure of information may not be sufficient for adequate informed consent and may lead to litigation that doctors encounter in their practice.   The traditional medical training only teaches the doctors to inform their patients but does not incorporate specific communication strategies to communicate effectively to patients in order to increase their understanding (Wadey & Frank, 1997). However, this skill has only recently been incorporated in the medical curriculum (Wadey & Frank, 1997). This raises the question if the patients would be able to comprehend and process the information, given the medical condition of the patient in the ward.   In Malaysia, Thomas (2009) proposes a more appropriate framework to protect patient's autonomy which allows "the convergence of the legal and ethical principles relating to a patient's

right to know about material risks and one that recognizes this right as an extension of the right to life guaranteed by the Malaysian Federal Constitution" (p. 182).

There are several recommendations to reduce the risk in litigation and increase the patient's understanding and informed decision. One way is to enlist family members and trained interpreters (Aboul-Enein & Ahmed, 2006; Cioffi, 2003) as mentioned earlier. However, there is ethical dilemma if family members are not trained to understand complex words or medical jargon used during the consultation. Furthermore there is the issue of role conflict and confidentiality issue when the case is sensitive which may also affect the family relationship and compromises the quality of patient care (Aboul-Enein & Ahmed, 2006; Cioffi, 2003).

As in all situations, if there is any disagreement towards treatment and medication, good communication is the best way towards resolution (Orr & Genesen, 1997). This may require repeated discussion between the care-team and the patient and family. A religious interpreter or a support person may assist in being the middle person to articulate and explain the situation so that patients understand and does not suffer in any pain nor his integrity is violated (Cioffi, 2003; Orr & Genesen, 1997). The cross-fertilisation between the Western and Asian socio-cultural philosophies, ethics, theologies and beliefs would enrich both spheres of human experience (Belgum, 1983).

2.3   Conceptual framework

The initial literature mapping (seen earlier in Figure 2.1) suggest seven areas that influence patient care management such as 'communication', 'public policy', 'patient focus', 'quality', 'culture', 'leadership' and 'measurement.' Further review of literature over the years has redefined the areas into four main factors that influence patient care

management which include clinical communication, quality of care, leadership and culture in health care environment. 'Health care policies' constitute indirectly towards patient care management and is discussed in the first chapter as an overarching premise. Similarly, 'communication' is redefined as clinical communication and 'quality' is redefined as 'quality of care' in order to be more specific since this research focuses on bedside care. Likewise 'measurement' is discussed at length from past studies in the second chapter because it examines the different types of assessment measures used in different researches conducted in hospitals. In addition since the area on 'patient focus' is the central focus of this research, it is discussed in all the factors highlighted. To conclude the conceptual framework of patient care management from past literature is shown in Figure 2.8.
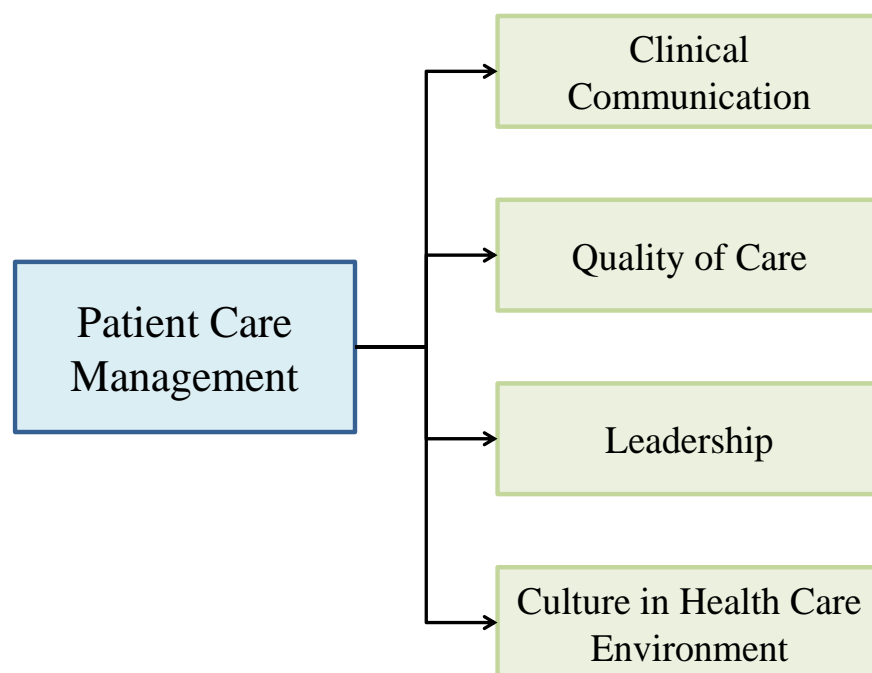
Figure 2.8: Conceptual framework of patient care management

2.4   Summary

Findings from the literature review enabled me to redefine the seven areas into four main factors which are specific to health care environment. The main factors that

influence patient care management are clinical communication, quality of care, leadership and culture in health care environment. Clinical communication examines the verbal and non-verbal communication between the doctors and their patients. Past studies have shown this is the main vehicle in patient care. Various models are discussed to assess quality of care but these are relatively new to health care delivery. However by including patients in decision making and emphasizing patient centeredness shows significance in improving patient outcome and quality of care. Likewise this chapter also focuses on the role of doctors as leaders in their own way. They are highly considered by the patients, patients' family and society. Finally literature shows culture in health care environment is an unchartered territory but equally important. There is cultural variation among patients and aspects such as privacy, patient's right, beliefs and religion must be understood to have a meaningful relationship between a doctor and a patient.

The findings from past literatures show there is a lack of literature on each of the factors that influence patient care management especially in the Malaysian context. There are several good studies referenced in this thesis on clinical communication by Silverman (2008), Salmon and Young (2011) and Desmond and Copeland (2000), but they are mainly carried out in the west. Although there are numerous empirical research in the west which discuss the importance of communication between the doctor and patient but they are mostly focused on terminally ill patients and lack emphasis on other factors such as patient's religion and culture. Therefore there is a huge vacuum in research on doctor-patient interaction and the socio-cultural aspects in health care delivery particularly in the Asian perspective. There are also limited studies in patient care management using qualitative approach. In lieu of this, it is hoped this research will try to fill in some of the gaps to the existing knowledge.

CHAPTER 3: METHODOLOGY

3.1   Introduction

Methodology is defined as a "way of thinking about and studying social reality" (Strauss & Corbin, 1998, p. 4). Methodology is also referred to as choices made by the researcher in the study, how the data is gathered and the analysis used (Silverman, 2006). Another view of the definition is the plan of action, strategy and processes that links to the outcomes (Crotty, 1996). This chapter looks at both these views and describes the research framework and the methodologies employed. The research methodology includes the data collection methods, the development of the in-depth interview questions, the format of the questions and the determination in the direction this research undertook. Preliminary investigations which include pre-testing methods, pilot study and some quasi-statistical analysis are also discussed.

The review of the literature in the previous chapter led to a number of research questions particularly on the communication processes between the doctors and patients, views on patient care management and the impact towards patients. The purpose of this research is to explore the practices of patient care management provided by the doctors at the patients' bedside in a clinical setting. The main focus is to explore the supportive and non-supportive issues that influence patient care management. Attempts are made to give recommendations to improve patient care management in public hospitals in the final chapter.

3.2   Approaches in qualitative research methodology

Many researchers believe that qualitative research is of great value to any research whereby it leads to a voyage of discovery and stimulate further avenues of research

instead of verification of data (Miles & Huberman, 1994). In addition the central idea in using qualitative research method is to take into account the participants' views and practices which is relevant to this study. As Flick (2002) explains:

> Qualitative methods take the researcher's communication with the field and its members as an explicit part of knowledge production instead of excluding it as far as possible as an intervening variable. The subjectivities of the researcher and of those being studied are part of the research process. Researchers' reflections on their actions and observations in the field, their impressions, irritations, feelings and so on, become data in their own right, forming part of the interpretation, and are documented in research diaries or context protocols. (p. 6)

Unlike quantitative research approach that emphasizes on numbers, Miles and Huberman (1994) emphasize that:

> "Words are fatter than numbers and usually have multiple meaning…Numbers are less ambiguous and can be processed more economically… We argue that although words can be more unwieldy, they can render more meaning than numbers." (p. 56).

Literature has shown various approaches and methodology in qualitative studies. According to Creswell (2007) researchers are usually baffled with the number of choices in the approaches given. Therefore Creswell (2007) has compiled various qualitative approaches mentioned by these authors according to their discipline which is seen in Table 3.1. With so many choices, it was difficult to decide which approach was best suited for this research. Creswell (2007) strongly encourages researchers to try various approaches that reflect the study. The following (Table 3.2) are some views of possible qualitative approaches.

Table 3.1: Qualitative approaches according to the discipline

Authors	Qualitative Approaches	Discipline/Field
Jacob (1987)	Ecological Psychology Holistic Ethnography Cognitive Anthropology Ethnography of Communication Symbolic Interactionism	Education
Munhall & Oiler (1986)	Phenomenology Grounded Theory Ethnography Historical Research	Nursing
Lancy (1993)	Anthropological Perspectives Sociological Perspectives Biological Perspectives Case Studies Personal Accounts Cognitive Studies Historical Inquiries	Education
Strauss & Corbin (1990)	Grounded Theory Ethnography Phenomenology Life Histories Conversational Analysis	Sociology, Nursing
Morse (1994)	Phenomenology Ethnography Ethnoscience Grounded Theory	Nursing
Moustakas (1994)	Ethnography Grounded Theory Hermeneutics Empirical Phenomenological Research Heuristic Research Transcendental Phenomenology	Psychology
Denzin & Lincoln (1994)	Case Studies Ethnography Phenomenology Ethnomethodology Interpretative Practices Grounded Theory Biographical Historical Clinical Research	Social Sciences
Miles & Huberman (1994)	Approaches to Qualitative Analysis: Interpretivism Social Anthropology Collaborative Social Research	Social Sciences

'Table 3.1, continued'.

Authors	Qualitative Approaches	Discipline/Field
Slife & Williams (1995)	Categories of Qualitative Methods: Ethnography Phenomenology Studies of Artifacts	Psychology
Denzin & Lincoln (2005)	Performance, Critical, and Public Ethnography Interpretive Practices Case Studies Grounded Theory Life History Narrative Authority Participatory Action Research Clinical Research	Social Sciences

Note. From *Qualitative Inquiry and Research Design: Choosing Among Five Approaches* (pp. 7-8), by J. W. Creswell, 2007, Thousand Oaks, CA: Sage Publications, Inc. Copyright 2007 by Sage Publications, Inc.

Table 3.2: Data collection activities by five approaches

Data Collection Activity	Narrative	Phenomenology	Grounded Theory	Ethnography	Case Study
What is traditionally studied? (sites or individuals)	Single individual, accessible and distinctive	Multiple individuals who have experienced the phenomenon	Multiple individuals who have responded to an action or participated in a process about a central phenomenon	Members of a culture-sharing group or individuals representative of the group	A bounded system. Such as a process, an activity, an event, a program, or multiple individuals
What are typical access and rapport issues? (access and rapport)	Gaining permission from individuals, obtaining access to information in archives	Finding people who have experienced the phenomenon	Locating a homogenous sample	Gaining access through the gatekeeper, gaining the confidence of informants	Gaining access through the gatekeeper, gaining the confidence of participants
How does one select a site or individuals to study? (purposeful sampling strategies)	Several strategies depending on the person (e.g., convenient, politically important, typical, a critical case)	Finding individuals who have experienced the phenomenon, a "criterion" sample	Finding a homogenous sample, a "theory-based" sample, a "theoretical" sample	Finding a cultural group to which one is a "stranger", a "representative" sample	Finding a "case" or "cases", an "atypical" case, or a "maximum variation" or "extreme" case
What type of information typically is collected? (forms of data)	Documents and archival material, open-ended interviews, subject journaling, participant observation, casual chatting	Interviews with 5 to 25 people (Polkinghorne, 1989)	Primarily interviews with 20 to 30 people to achieve detail in the theory	Participant observations, interviews, artifacts, and documents	Extensive forms, such as documents and records, interviews, observation, and physical artifacts

‘Table 3.2, continued’.

Data Collection Activity	Narrative	Phenomenology	Grounded Theory	Ethnography	Case Study
How is information recorded? (recording information)	Notes, interview protocol	Interviews, often multiple interviews with the same individuals	Interview protocol, memoing	Fieldnotes, interview and observational protocols	Fieldnotes, interview and observational protocols
What are common data collection issues? (field issues)	Access to materials, authenticity of account and materials	Bracketing one's experiences, logistics of interviewing	Interviewing issues (e.g., logistics, openness)	Field issues (e.g., reflexivity, reactivity, reciprocality, "going native", divulging private information, deception	Interviewing and observing issues
How is information typically stored? (storing data)	File folders, computer files	Transcriptions, computer files	Transcriptions, computer files	Fieldnotes, transcriptions, computer files	Fieldnotes, transcriptions, computer files

Note. From *Qualitative Inquiry and Research Design: Choosing among Five Approaches* (pp. 120-121), by J. W. Creswell, 2007, Thousand Oaks, CA: Sage Publications, Inc. Copyright 2007 by Sage Publications, Inc.

3.2.1 Grounded theory

Grounded theory approach created by Glaser and Strauss (1967) is a social justice inquiry. Strauss and Corbin (1998) emphasizes that grounded theory looks at meanings, actions and processes. The original structure of grounded theory proposed by Glaser and Strauss (1967) included generating theoretical sensitivity, theoretical sampling, theoretical memos and the inter-changeability of indicators, substantive coding, theoretical coding, the constant comparison method, sorting and the emergence of the core variable (Lowe, 2011). Grounded theory puts aside all prejudices, presuppositions and previous knowledge to find new themes in the data (Denzin & Lincoln, 2005). Glaser (1992, as cited in Charmaz, 2005) who gave the original objectivist emphasis explained grounded theory as "logic, analytic procedures, comparative methods and conceptual development and assumptions of an external but discernible world, unbiased observer and discovered theory" (p.509).

This general inductive approach can be applied in quantitative methods, qualitative methods or mix methods to conduct diverse studies (Charmaz, 2006; Glaser, 1998). However, much to Glaser's objection, Strauss moved the grounded theory method towards verification and technical procedures. Strauss also authored books with Corbin in this direction (Charmaz, 2006). According to Glaser, Strauss and Corbin's procedures in data analysis opposes the fundamental tenets of grounded theory which has preconceived categories (Charmaz, 2006). Over the years, Glaser defines grounded theory research methodology as *latent pattern indicator* (Glaser, 2007; Lowe, 2011). Denzin and Lincoln (2005) explain that grounded theory involves simultaneous data collection and analysis throughout the research process. Glaser views data as separate from the researcher (Denzin & Lincoln, 2005). According to Glaser, the data must be untouched by any interpretations (Denzin & Lincoln, 2005). Glaser also views that by

recording these data systematically will prompt the researcher to follow leads (Denzin & Lincoln, 2005). According to Glaser, everything relevant to the general topic is considered as data (Glaser, 1998) and therefore is continuously analysed using constant comparison method. In the comparative process, theoretical memos are written in the form of diagram, text or figures in order to theorize the ideas and their relationships as they emerge (Glaser, 1998).

Theoretical sampling is done in grounded theory (GT) whereby the researcher would collect the data, code and analyse them and then would decide what data should be collected next in order to develop the emergent theory (Glaser, 1978). In grounded theory, the categories and the properties are emergent from the data derived and ultimately becomes part of a hypotheses in a theory (Glaser 1978, 1998, 2003). The theory is probability statements that explain patterns of human behaviour of the participants (Glaser, 2003). In short, Glaser (1978) explains:

> The credibility of theory (derived using the GT methods) should be won by its integration, relevance and workability, not by illustrations as if it were proof. The theory is an integrated set of hypotheses, not findings. Proofs are not the point. (p. 134).

3.2.2 Narrative

Narrative is also considered another form of inquiry in qualitative studies (Chase, 2005). Clandinin and Connelly (2000) describe narrative inquiry as the stories that the narrators have lived and told. Originally narrative research is used in literature, sociolinguistics, education, anthropology, sociology and history. However, now it is used in different fields of research (Creswell, 2007). Narratives focus on stories that individuals explain concerning their life, work or condition they are in (Holloway, 1997; Polkinghorne, 1995). According to Denzin (1989), narratives have got a plot and storyline. Holloway (1997) explains through narrative approach, the researcher and the

readers can gain access to the individuals' world and experiences. Some examples of questioning style are "'tell me what happened', or 'tell me about your feelings and thoughts at that time'" (Holloway, 1997, p.106).

Riessman (1993) distinguishes three types of narratives which are habitual narrative (routine events and actions), hypothetical narratives (an imaginary story) and a topic-centered narrative (past events connected thematically). However Polkinghorne (1995) distinguishes between *narrative analysis* and *analysis of narrative*. *Narrative analysis* is descriptions of events and activities that are shaped into a story using a plot line whilst *analysis of narrative* is using paradigm thinking to create descriptions of themes that hold across stories or classifications of different types of stories (Polkinghorne, 1995). The transcript from *analysis of narrative* is analysed line by line to discover the particular hidden (covert) or unhidden (overt) themes. Whilst the data gathered from *narrative analysis* begins with the data that is not necessarily a storied account but leads the researcher towards explaining the creation of a narrative (Polkinghorne, 1995).

Chase (2005) explains that narratives studies can use exemplary reasons to describe how interpretations are developed and how individuals are enabled or constrained by their social resources. According to Creswell (2007), there are a variety of forms in narrative research practices such as biographical study: where the researcher records and writes about another person's life (Flick, 2002), autobiography: which is written by the person who is the subject of the study (Ellis, 2004), life history: which is written about a person's entire life and oral history: which is written about the reflection of an event gathered from an individual or small number of individuals (Plummer, 1983). As described by Hermanns (1995, as cited in Flick, 2002), the basic principle of

collecting the data is through narrative interview where the individual "presents the history of an area of interest, in which the interviewee participated in an extempore narrative (…). The interview's task is to make the informant tell the story of the area of interest in question as a consistent story of all relevant events from its beginning to its end" (p.97).

However, according to Clandinin and Connelly (2000, as cited in Creswell, 2007), narratives stories can be collected through observation, journal or diaries, letters, memos, photographs and personal-family-social artefacts. These stories can be analysed by *restory* (a process of placing them in order of sequence that has the beginning, middle and end) and framing them into themes and a meaningful story (Clandinin & Connelly, 2000; Creswell, 1998, 2007). A postmodern view of narrative analysis would also include examining silence, exposing dichotomies and attention to disturbances and contractions (Czarniawska, 2004). During this encounter both the researcher and subject in question will learn and change and this process will lead to negotiation of the meaning of the stories and eventually add to the validation check to the analysis (Creswell & Miller, 2000; Creswell, 2007). Therefore, narrative research is a challenging approach to be used (Creswell, 2007).

3.2.3 Phenomenology

Edmund Husserl (1859 – 1938), a German Mathematician is the founder of phenomenology (Crotty, 1996). This approach explores the meaning (Holloway, 1997) of the human lived experiences (Van Manen, 2003). There are different patient encounters and approaches used by the health care professionals and it is important to look at the phenomena whether the patients are viewed as an error to be fixed or has a

problem that affects their lives and health (Rosenqvist, Theman, & Assal, 1995). However Grbich (2007) defines phenomenology as:

>An approach which attempts to understand the hidden meanings and the essence of an experience together with how participants make sense of these. Essences are objects that do not necessarily exists in time and space like facts do, but can be known through essential or imaginative intuition involving interaction between researcher and respondents or between researcher and texts. (p. 85)

The phenomenological text should portray the quality and the significance of the lived experience (Van Manen, 2003). The key dimensions of Husserl's phenomenology are intentionality, inter-subjectivity and bracketing (Crotty, 1996). The concept of intentionality described by Moustakas (1994) refers to consciousness while Husserl describes it as intuition (Holloway, 1997). The concept of inter-subjectivity means, that the world of the people and the environment are not separate (Holloway, 1997). The third dimension which is bracketing (epoche) means eliminating preconceived ideas so that fresh perspective of the experience of the phenomenon can be seen (Crotty, 1996; Creswell, 2007).

Often data are collected through in-depth interviews or multiple interviews with participants, observation, journals, art, poetry, music (Creswell, 2007) as well as formally written responses, taped conversations and explanations of second hand experiences (Van Manen, 1990). Polkinghorne (1989, as cited in Creswell, 2007) recommends that the researcher interviews between 5 and 25 participants who have experienced the phenomenon. Open-ended questions are used to gather textural and structural descriptions (Creswell, 2007; Moustakas, 1994). Phenomenological data is analysed by looking at significant statements from the sentences or quotes that explains how the participants experience the phenomenon (Creswell, 2007) which is clustered into similar meanings known as themes (Moustakas, 1994; Polkinghorne, 1989). Then

the clusters of themes are examined again by looking at the data (Holloway, 1997). According to Creswell (2007) the themes are also used to write the description of what the participants have experienced (known as textural description) and the setting or context that has influenced the participants who have experienced the phenomenon (known as imaginative variation or structural description). Moustakas (1994) advocates the researcher should add another step by writing their own experiences and the context or situation that has influenced them.

3.2.4   Case study

Holloway (1997) describes case study as a research that studies a single unit and has clear boundaries that investigates an organisation, an event, a process, a program or as Babbie (2007) explains a social experience. Babbie (2007) also explains that case studies in grounded theory can form the fundamental development of more general or "nomothetic theories" (p. 298). Merriam-Webster's dictionary (2009, as cited in Denzin and Lincoln, 2011) defines case study as "an intensive analysis of an individual unit (as a person or community) stressing factors in relation to environment" (p.301).

According to Stake (2008), case study focuses on a bounded system and Denzin and Lincoln (2011) explains that the definition stipulates that it is intensive. In case study, any approaches of data collection and analysis can be applied such as grounded theory, phenomenology or ethnographic (Denzin & Lincoln, 2011; Holloway, 1997). Case study could also be used as a pilot study before embarking on a larger scale project for quantitative research (Holloway, 1997) or, as Denzin and Lincoln (2011) explains, a preliminary investigation to generate hypothesis testing. According to Marohani Yusoff (2011) and Creswell (2007), before choosing a case study, the researcher needs to do preliminary work to determine the social access of the case, determine who are the

gatekeepers and investigate the procedures for obtaining approval. Permission need to be sought to avoid unnecessary complications such as risk to the researcher and individuals being studied or disclosing information that might be a negative influence to the organisation (Creswell, 2007). Therefore when choosing this approach, multiple strategies is necessary to validate the data collection (Creswell, 2007).

3.2.5 Hermeneutics

According to Holloway (1997) hermeneutics is an approach in interpreting human behaviour in an empathetic understanding. According to Holloway (1997), the modern proponents of hermeneutics are Gadamer (1960/1998) and Habermas (1973/1974). As cited in Laverty (2003), Heidegger (1927/1962) claims that "to be human is to interpret" which stressors that individual's encounter is influenced by experiences and background. The interpretive process is achieved by using text (Annells, 1996; Polkinghorne, 1983) to find the intended or expressed meanings (Kvale, 1996). Understanding these texts takes time because it goes through a cognitive process to make coherence and most people tend to make inferences of the outcome to themselves (Wilson, 2011). Wilson (2011) believes that the articulation of the narratives is the hermeneutic circle which Annells (1996) and Polkinghorne (1983) explains is an interpretive process that is gathered by moving back and forth from the experience to increase the depth of understanding.

In hermeneutics study, texts can be interpreted in various ways (Holloway, 1997). These texts include visual arts, music or written and verbal communication (Kvale, 1996). Gadamer (1960/1998, as cited in Holloway, 1997) explains that the reader cannot separate himself from the meaning of the texts. There is difficulty in suspending prejudices and wholly bracketing oneself in hermeneutic inquiry (Holloway, 1997).

Therefore, Holloway (1997) who cited Habermas (1973/1974) stresses the importance of human communication and meaningful understanding in hermeneutic study. There is also a fusion between phenomenology and hermeneutics which began by Heidegger (1927/1962) which is called hermeneutic phenomenology. Smith (1997) identifies hermeneutic phenomenology as another research methodology that Laverty (2003) describes as a combination of descriptive and interpretive approach in studying a lived experience. This occurs according to Smith (1997) through rich descriptive language and Holloway (1997) explains that researchers who use hermeneutic phenomenology collect data from language, texts and action.

3.3   Selecting a research design

Selecting a research design will have a direct implication to how the data is collected, analysed (Silverman, 2001) and the theoretical construct achieved. The methodology will define how the research is studied (Silverman, 2001). Under the umbrella of qualitative study, various research techniques were used to conceptualize the patients' and the health care providers' experiences, actions and interactions in the clinical setting in order to relate with the purpose of the research. In summary an ethnographic research was chosen as the prescribed approach in this exploration.

This approach was chosen as it does not examine the text to interpret human behaviour as the hermeneutics study does. Ethnographic research explores the experiences of patients and doctors in the hospital and it is not bounded to explore a single unit as described in a case study. Although this research uses an iterative approach which is similar in practice with the grounded approach, but it does not conform to the tenets of grounded theory approach. This is because this research does not look into the *latern pattern indicators* and theoretical sampling. The participants

come from different gender, ethnicity and socio economic background and they use different languages. With a diverse background, the true essence and meaning of their experiences may not be captured effectively if a *theoretical sampling* is carried out. Verification of questions and improvements of the way the research is carried out by using pre-test and pilot study are also important for ethnographic research as the participants are in a highly vulnerable situation. The verification process is against the grounded theory and phenomenological approach as the data must be untouched by any interpretations to allow the participants to describe their experiences. Narrative inquiry is not suitable for the purpose of this research as it does not look into plots and story lines that invite the patient to discuss their life story. Even though the participants are encouraged to narrate their ward experiences there is a tendency the participants will get carried away in narrating their personal stories and dilemmas which might lead to a counselling session if it is not focused appropriately. Therefore the most suitable approach chosen is ethnographic research in order to address the situation in the hospital environment and to gather enough evidences to explore the participants' experiences.

3.3.1   Ethnographic research

First and foremost, before looking into ethnographic research, the background of ethnography must be understood. Ethnography is a study of culture and subculture (Holloway, 1997). Ethnography is a qualitative design that aims to study the culture of a group, their values, behaviours, beliefs and language (Harris, 1968; Atkinson, 1992). It is part of a research method in anthropology (Holloway, 1997). Data is collected through observation, interviews and examining documents (Holloway, 1997). The study which features the ethnographer's dimension as an emic and etic participant (Harris, 1976) has detailed description and a naturalistic stance (Holloway, 1997). Flick

(2002) cited Hammersley and Atkinson (1983) describe the following in which the observation and participation of researcher is interwoven:

> The ethnographer participates, overtly or covertly, in people's daily lives for an extended period of time, watching what happens, listening to what is said, asking questions; in fact collecting whatever data are available to throw light on the issues with which he or she is concerned. (p. 146)

Ethnography methods is differentiated into two types of which are *conventional ethnography* (traditionally concentrates on culture and groups (Sarantakos, 1994; Thomas,1993)) and *critical ethnography* (focuses on macro-social factors that include power and hidden agendas (Sarantakos, 1994; Thomas, 1993) as well as empowerment, inequality, dominance, repression, hegemony and victimization (Creswell, 2007)). However, Van Maanen (1988) characterizes the traditional approach as *realist ethnography* which is written as a third person in an unbiased manner. The emphasis is cultural description on status, family life, communication networks, work life and social system (Creswell, 2007). One of the earliest researchers in this area is William Foote Whyte (1943). His ethnographical study focused on the insider's perspective on the lives of the street-gang leaders in a community, in which he reported on the reality of the people of Cornerville. His naturalist approach is based on "their stories the way they are" instead of what the researcher understands (Babbie, 2007).

However ethnographic research focuses on exploring experiences of an identified group that is being studied in which the results are expressed thematically (Hill, 2001 & Hill, 2003). According to Spindler and Spindler (1987 cited in Creswell, 2007, page 217) ethnographic research explains the behaviour in the 'native's point of view'. This methodology systematically records all significant information such as field notes, tape-recording interviews, preparing interview agendas, making observations, and taking photographs (Van Mannen, 1995). At the same time the researcher is cautioned not to

predetermine the responses from the questions posed (Spindler and Spindler, 1987 cited in Creswell, 2007). According to Jalal and Shah (2011) ethnographic research is non-participatory method that does not rely on simple 'yes' or 'no' answers instead uses techniques such as taking notes using semi-structured questionnaires, focus group discussions, documentary analysis and in-depth interviews. Furthermore, building trust among the researcher and the participants is very important in ethnographic data collection (Jalal and Shah, 2011). LeCompte and Schensul (1999) refer this as building rapport or special kind of friendship; as trust is not built overnight and it takes time and a lot of effort. This will enable the researcher to get insights into the participants' lives, understand the relations, local language, equipment or artefacts and local culture (Danyuthasilpe, Amnatsatsue, Tanasugarn, Kerdmongkol and Steckler, 2009). In ethnographic research the data collected is usually a longer period of time (LeCompte and Schensul, 1999).

According to Denzin and Lincoln (2011) the "subjects of ethnographic studies are invariably temporally and spatially bounded" (p.592). The researcher needs to draw on the tacit dimensions provided by the participants to make sense of the meanings as the participants sometimes may know more than what they are allowing us to see and likewise the researcher also might know far more than what is articulated (Denzin and Lincoln, 2011). Therefore the basic idea in ethnographic realism described by Denzin and Lincoln (2011) is that

> Human social life is meaningful, and that it is essential to take these meanings into account in our explanations, concepts and theories; furthermore, to grasp the importance of the values, emotions, beliefs, and other meanings of cultural members, it is imperative to embrace an interpretivist approach in our scientific and theoretical work (p.582).

As part of my qualitative research style, I used ethnographic approach in periodically analysing the data received by looking for significant statements and

themes. The ethnographic research looks at different stages of inquiry that provides meaning to the data discovered. Firstly, I was immersed in this research experiencing both an etic and emic perspective in a medical environment. Secondly I examined the literature on past studies and investigated the findings of past research that has relevance to patient care as well as the research design. The findings in the literature described factors such as communication; for example speech, language and interaction as well as management issues such as food, cleanliness and cost were some of the indicators of satisfaction experienced by the respondents. These indicators were included in my research. Next, I explored for interesting statements and common themes upon the completion of the pilot test. I coded and categorized the data received to examine the major concepts and constructs. I linked and found the relationship with major themes that I have discovered. This formed the basis in my research.

After the pilot test, I continued to collect data for the research. Inductive approach was used to deduce meanings. When I found gaps in the themes, I continued collecting the data through further interviews either with elite personnel or with patients or doctors to establish links with the major themes again as well as to reinforce the structure of my analysis. According to Grbich (2007), this approach is known as an iterative inquiry which involves seeking meaning in order to critically reflect and analyse the emerging data to guide the next set of data collection. This process is repeated over and over again until the point of saturation of data whilst keeping in mind the purpose and focus of this research. According to Shi (2008), saturation is a criterion of adequacy in qualitative research and occurs when the same ideas are repeated several times by the participants without any new information being shared.

3.4   Strategies in data collection

3.4.1   Sampling frame and the selection process

There are a total of 130 tertiary hospitals in Malaysia with about 2, 062 925 admission of patients and about 33, 004 beds (MOH, 2009). The focus of this research is to investigate hospitals with the highest bedside patient population. Even though the findings from MOH show (Table 3.3) that Hospital Bahgia and Hospital Permai have high number of beds, these hospitals were not included in this research because they are psychiatric hospitals. The psychiatric patients from these hospitals will not be able to communicate rationally and contribute to this research. Therefore Hospital Kuala Lumpur (HKL) was chosen with the second highest bedside population of 2331 beds. Furthermore HKL was selected because it is also a Referral Centre in Malaysia which is well-equipped with the latest equipment, research facilities and specialist doctors.

Table 3.3: List of government hospitals in Malaysia with highest number of beds

No.	Government Hospitals	State	No. of Beds	Type
1	Hospital Bahgia	Perak	2600	Psychiatry
2	Hospital Kuala Lumpur (HKL)	WP Kuala Lumpur	2331	General Hospital & Referral Center
3	Hospital Permai	Johor	1400	Psychiatry
4	Hospital Pulau Pinang	Pulau Pinang	1090	General Hospital
5	Hospital Raja Permaisuri Bainun	Perak	990	General Hospital
6	Hospital Sultanah Aminah (HSA)	Johor	989	General Hospital
7	Hospital Raja Perempuan Zainab II	Kelantan	920	General Hospital
8	Hospital Tengku Ampuan Rahimah	Selangor	864	General Hospital
9	Hospital Tuanku Jaafar	Negeri Sembilan	850	General Hospital
10	Hospital Sultanah Nur Zahirah	Terengganu	821	General Hospital

Note. Adapted from *Listing Government Hospitals*, by the Ministry of Health Malaysia, 2010, retrieved from http://www.moh.gov.my/gov_hospitals

Secondly the focus of this research is also based on the population size against the number of hospitals within the state. The findings from MOH seen in Table 3.4 show

Selangor and Johor state have the highest number of population size of 5, 411, 324 and 3, 233, 434 respectively. In other words, both HKL and HSA (Hospital Sultanah Aminah) are two leading tertiary level government hospitals in Malaysia serving the highest number of population compared to other states. For this reason HSA, which is situated in Johor, was selected as the second tertiary level government hospital for the purpose of site triangulation.

Table 3.4: Population size and number of hospitals according to state

No.	State	Population[a]	No of Hospital[b]
1	Selangor	5,411,324	10
2	Johor	3,233,434	12
3	Sabah	3,120,040	23
4	Sarawak	2,420,009	22
5	Perak	2,258,428	15
6	Kedah	1,890,098	9
7	W.P. Kuala Lumpur	1,627,172	1
8	Pulau Pinang	1,520,143	6
9	Kelantan	1,459,994	9
10	Pahang	1,443,365	10
11	Terengganu	1,015,776	6
12	Negeri Sembilan	997,071	6
13	Melaka	788,706	3
14	Perlis	227,025	1
15	W.P. Labuan	85,272	1
16	W.P. Putrajaya	67,964	1

Note. [a]Data in column 3 are adapted from *Population and Housing Census of Malaysia: Preliminary Count Report 2010* (p. iv), by the Department of Statistics Malaysia, 2010, Putrajaya, Malaysia: Department of Statistics. [b]Data in column 4 are adapted from *Listing Government Hospitals*, by the Ministry of Health Malaysia, 2010, retrieved from http://www.moh.gov.my/gov_hospitals

Moreover, the strategic location of HKL enables residence from Wilayah Persekutuan (that has a population size of 1, 627, 172) to use its services as well. Although Hospital Pulau Pinang, situated in Penang and Hospital Raja Permaisuri Bainun situated in Perak have more number of beds compared to HSA but both these hospitals serve lower population size. For example Perak which is a bigger state has 15

hospitals that serve a relatively smaller population size of 2, 258, 428 and Penang has got 6 hospitals that serves 1, 520,143 people compared to Johor state which has more number of hospitals (total of 12 hospitals) that serve a larger population size of 3, 233,434 and Selangor which has a total of 10 hospitals but serves the largest population size in Malaysia which is 5, 411, 324 people. Therefore this research focused on the central and southern regions which include Kuala Lumpur, Selangor and Johor State with the highest number of beds (Table 3.5). In addition, hospitals in Perak and Pinang were not chosen for this research because the hospitals are located in the northern region of the country and have different dialect and culture which will pose difficulty in communication.

Table 3.5: List of government hospitals in Kuala Lumpur, Selangor and Johor

No.	Government Hospitals	State	No. of Beds
1	Hospital Kuala Lumpur (HKL)	KL	2331
2	Hospital Sultanah Aminah (HSA)	Johor	989
3	Hospital Tengku Ampuan Rahimah	Selangor	864
4	Hospital Selayang	Selangor	778
5	Hospital Pakar Sultanah Fatimah	Johor	550
6	Hospital Serdang	Selangor	382
7	Hospital Sungai Buloh	Selangor	340
8	Hospital Batu Pahat	Johor	314
9	Hospital Kajang	Selangor	306
10	Hospital Kluang	Johor	244
11	Hospital Sultan Ismail	Johor	236
12	Hospital Segamat	Johor	221
13	Hospital Ampang	Selangor	181
14	Hospital Kota Tinggi	Johor	158
15	Hospital Banting	Selangor	151
16	Hospital Kuala Kubu Bharu	Selangor	150
17	Hospital Pontian	Johor	120
18	Hospital Tanjung Karang	Selangor	114
19	Hospital Temenggung Seri Maharaja Tun Ibrahim	Johor	93
20	Hospital Tengku Ampuan Jemaah	Selangor	93
21	Hospital Tangkak	Johor	69
22	Hospital Mersing	Johor	55

Note. Adapted from *Listing Government Hospitals*, by the Ministry of Health Malaysia, 2010, retrieved from http://www.moh.gov.my/gov_hospitals

It is hoped that these areas will be covered for future research with a larger scale of funding support. Furthermore, as summarized by McCracken (1988) in qualitative research the issue is not generalization, but rather access because as King and Horrocks (2010) explain, access may be problematic if there are "gatekeepers" due to the sensitivity and complexity of the organisation. Since the hospital environment is complex, obtaining ethics approval was a rigorous task and is discussed in detail under the sub-heading 'steps in obtaining ethics approval'.

In order for the research to be conducted in an unbiased way, a sampling frame is necessary. There are various departments in a hospital and each department consists of various heads that are in-charge of the wards. Due to the nature of this research which investigates bedside patients, it is very crucial to identify the right department to do the fieldwork without intruding into the participants' space and interfering with the treatment given. The first step was to investigate the departments that exist in each of the hospitals concerned. This was carried out through phone calls and website research. From the evidence received, the next step was to list down all the departments concerned with their respective clinical heads such as stated below:

1) Medicine

2) Surgery

3) Ophthalmology

4) Neurosurgery

5) Anaesthesia

6) Obstetrics and Gynaecology (O&G)

7) Dermatology

8) Cardiology

9) Orthopaedic

10) Cardiothoracic

11) ENT (Ear, nose and throat)

12) Paediatric

13) Respiratory

14) Psychiatry

15) Urology

16) Plastic-Surgery

17) A&E (Accidents and Emergency)

18) Dental

19) Rehab Medicine

From the total of nineteen wards, a strict elimination process was followed to remove hospital wards that were not feasible to conduct this research because of the ethical and medical conditions of the patients warded in the hospital. The elimination process included patients who were under aged (paediatric), patients who could not talk (ENT, cardiology, cardiothoracic, respiratory, anaesthesia, dental), patients who cannot see (ophthalmology), patients who were too ill and in too much pain (A&E, orthopaedic, urology, surgery and neurosurgery) and patients who had mental anguish or in deep stress (plastic surgery, psychiatry, rehab medicine). This leaves other departments such as Medicine, O&G and Dermatology.

Findings from secondary data investigation (Table 3.6) shows the highest causes of hospitalization in Malaysia are due to deliveries, accidents and medical illness. As a result most patients are sent to the O&G, A&E and Medicine Wards. However as mentioned before A&E ward was eliminated because of ethical reasons. This leaves O&G and Medicine ward. However, approval was only received from O&G ward in

HSA and Medicine ward in HKL. The O&G ward has only female patients and the

Medicine ward has both male and female patients.

Table 3.6: Ten principal causes of hospitalisation in MOH hospitals

No	Causes	Percentage (%)
1	Normal deliveries	13.99
2	Complication of pregnancies, childbirth and the puerpeirum	12.77
3	Accidents	8.40
4	Diseases of respiratory system	8.05
5	Diseases of circulatory system	6.99
6	Certain conditions originating in the perinatal period	6.78
7	Diseases of the digestive systems	5.37
8	Ill-defined conditions	3.63
9	Diseases of urinary system	3.49
10	Malignant neoplasms	3.16

Note. From *Health Facts 2008*, by Ministry of Health Malaysia, 2009, Planning and Development Division, Ministry of Health Malaysia.

3.4.2   Data collection methods

This research focused on triangulation methods using qualitative techniques such

as observation, in-depth interviews, elite interviews and records of field notes and

vignettes. Triangulation is defined as mapping of one set of data against another by

using multiple means of gathering data (Silverman, 2006) which can be seen in multiple

lenses. If the findings correspond or induce the same conclusions then the validity of

the findings are established (Silverman, 2006). In other words triangulation was used as

a strategy to improve the quality of qualitative research (Flick, 2009) and an alternative

to validation (Flick, 2002). In order to accomplish this end, investigators often perform

strategies to ensure validity and reliability of qualitative research that include

triangulation, member checks, feedback from peers, audit trail, multi-site designs and

sampling (Merriam, 1995). The use of multiple methods will attempt to comprehend

the in-depth understanding of the social experiences in the research (Denzin & Lincoln,

2005; Mathison, 1988).

For this research I have used multiple site triangulations by investigating both HSA and HKL in order to strengthen the interpretations. According to Patton (2002), the process of triangulation also enables cross-checking the consistency of data by examining the views of the participants from different perspective. Lincoln and Guba (1985) describe some of the main criteria in determining the validity and reliability of a qualitative research include credibility (internal validity), transferability (external validity), dependability (reliability) and confirmability (objectivity). This will lead to trustworthiness of the data which is termed as rigor (Lincoln & Guba, 1985).

According to Akkerman et al., (2008) it is difficult to judge the quality of the research if there is an absence of validation process. Wolf (2003) explains it is the responsibility of the researcher to convince the scientific community that the analysis and findings are systematic, objective and worthy. Therefore for this research, I have included peer feedback, membership checks, multi-site design, sampling process and audit trail management as part of the assessment procedures in determining the validity and reliability of the research. Chapter 4 will present a detailed version of this procedure.

3.4.2.1 In-depth interview

According to Seidman (1998) interview is a method of inquiry which is related to the interviewer's ability to make meaning through language. Therefore in this ethnographic research, face-to-face in-depth interviews were conducted to collect feedback from the   patients and doctors at the wards. The main purpose described by Merriam (2001) is to find out things that cannot directly be observed such as feelings, thoughts and intentions. The interviews were tape-recorded and verbatim notes were

taken. Prior to that, permission from the participants was sought. Upon receiving

consent, both audio taped transcribed summary and verbatim summary were prepared.

However in order to carry out the in-depth interviews effectively and focus on the

research purpose, two interview schedules with detailed questions were prepared. In

addition a detailed list of questions irrelevant of the research design was also required to

be submitted to the MREC in order to obtain ethics approval. This is to ensure the

rights of the patients are protected as they are in a vulnerable situation. The ethics

committee from both hospitals were also concerned if the questions posed during the in-

depth interview caused any sensitivity or discomfort either to the patients or the doctors.

Consequently this led to the direction of the research focus in which one of the main

objective of the pre-test and the pilot test study was to validate the questions designed.

Consequently the detailed and modified interview schedules were developed using open

and closed-ended questions.

The in-depth interview questions for patients were carefully constructed and

modified after referencing from books, research reports and journals such as Carrese,

Muttaney, Faden, & Finucane (2002), Ely, Osheroff, Ebell, Bergus, et al. (1999), Ely,

Osheroff, Ebell, Chambliss, et al. (2002), Htut, Shahrul and Poi (2007), Marsh and

Kaim-Caudle (1976), Seymour, Gott, Bellamy, Ahmedzai, & Clark (2004), Pendleton's

feedback model (Pendleton, Schofield, Tate, & Havelock, 1984, 2003) and the Calgary-

Cambridge Guide from Silverman et al. (2008). However the in-depth interview

questions for the doctors were formulated based on the Calgary-Cambridge Guide taken

from Silverman et al. (2008) and Pendleton's feedback model (Pendleton et al., 1984 &

2003). Questions from the interview schedules can be seen in appendix A & B. There

were mix structured questions which included open-ended and close ended text for both

the sets. With the open-ended text, the participants had the freedom and the flexibility to answer the questions in their own words based on their understanding and experiences. The questions in the interview schedule with patients had five main parts which were:

A. Build rapport with patients

B. Introduction and explanation about the research. Give information sheet and consent form.

C. Overall questions on hospital management- supportive and non-supportive issues

D. Patient care following the Calgary-Cambridge Guide (initiating the session, identifying the reasons for consultations, building relationship, explanation and planning, planning shared decision making and closing the session)

E. Pendleton's model on what they liked best, what they liked least, how they think it could be improved, further suggestions and overall rating from 1 to 10.

However, the interview schedule with doctors had only four main parts which were:

A. Build rapport with doctors

B. Introduction and explanation about the research. Give information sheet and consent form.

C. Patient care following the Calgary-Cambridge Guide (initiating the session, identifying the reasons for consultations, building relationship, explanation and planning, planning shared decision making and closing the session)

D. Pendleton's model on what they liked best, what they liked least, how they think it could be improved, further suggestions and overall rating from 1 to 10.

Questions regarding building rapport enabled the participants to feel at ease and allowed me to explain about the research and obtain their consent in a non-coercive way. However, participants were always in complete control over the course of the interview to avoid any discomfort. According to Merriam (2001), "it takes a skilled researcher to handle the great flexibility demanded by the unstructured interview." (p. 75). During the in-depth interviews, some of them asked for personal advice on medication and treatment which were quickly referred to the appropriate staff for assistance. The questions on the overall hospital management were omitted for doctors' interview schedule because they were irrelevant, as the questions explore the bedside experiences (such as lighting, meals, bedding, etc) which required description on the consumption of services received by the patients who stayed in the wards.

The in-depth interviews with patients and doctors were gathered through purposive sampling method. The exclusion criteria used was to exclude patients who were very ill, weak and those who were under treatment. The exclusion criteria was also used to exclude doctors who were treating seriously ill patients, 'on call' for emergency and unavailable because of the shift duty. Every opportunity was seized to conduct the in-depth interviews to check and to recheck gaps from the data collected until the point of saturation. Saturation is determined until the information gathered was similar and no longer anything new was reported (Aini Hassan, 2009). The reliability of the interview questions was achieved through the pre-test and pilot tests that were conducted; after which the questions were modified to fit the content and the main

purpose of this research. According to Seidman (1998), planning, technique and skills of interviewing are important in the collection of data.

3.4.2.2 Elite interviews

Although the primary focus of the in-depth interviews were the patients and doctors, but other sources of interviews were also conducted to triangulate the data collected and fill in the gaps discovered. Some of the words used by patients and doctors were examined and checked to look into different perspectives. The data collected were examined during the preliminary analysis and also when all the data have come in, in order to identify further questions to be included in the final interpretations. This 'flip flop' technique according to Grbich (2007) has advantages in keeping the researcher close to the data and "plugging any obvious gaps in information".

The elite interviews were directed to the sisters, matrons and heads of department to understand the management process, the training of the doctors, policies, cases, communication issues and any other gaps that were discovered during the research process. The elite interviews were targeted at the strategic managers who are first line managers in the organisation chart, who understands the mission and the objectives (Hales, 2005; MacNeil, 2001) of the hospitals and are responsible for the running of the wards. According to Flick (2009), participants who fit into this category are "good informants" and are capable in providing insights into the research.

Appointments were made with the sisters and matrons from both hospitals to avoid intruding with their rounds in the hospital. A comfortable rapport was built with them before and during the interview. Furthermore it is important that good rapport was built with the participants of the research to boost the research credibility (Denzin &

Lincoln, 1998). The elite interviews were highly unstructured whereby the questions were open-ended and exploratory in nature. Using qualitative methods also maximizes opportunities for the participants to open-up and provide collaborative strengths to add value to the data and bring about change. As a result, filling up these gaps provided a holistic view of this research (Grbich, 2007).

3.4.2.3 Non-participant-observation

A non-participant observer is not actively involved in the observed field (Flick, 2002). According to Silverman (2006), the main purpose of observation is to get first-hand information about the "social processes in a natural occurring context" (p. 14). Observations were recorded on pertinent information such as physical setting, particular events and activities and my own reactions. The findings of the observation will provide clues and explanation of patient care management.

As the researcher, I acted as the role of a non-participant who used non-evasive technique. This meant I did not require the participants to provide urine or blood samples except to answer a few interview questions. I have observed the patients and the doctors in their natural setting which was at the hospital bedside, hospital corridors, and ward reception area. This approach is usually known as "fly on the wall" approach. The challenge was accurate inclusion of field notes, determining the timing, funnelling the information from broad observations to narrower one in time and avoid from being overwhelmed with the information from the site (Creswell, 2007).

3.4.2.4 Field notes

The field notes describe the journey of discovery in collecting the data, analysing and putting the puzzle together. These were records of fieldwork that consisted of raw

data from observations, comments, impressions, thoughts and jottings on what went on in the hospital. It also included initial evaluation and conversations that I had while collecting the data. I have included all the planned activities, appointments and journal of events in my diary.

3.4.2.5 Vignettes

Vignette is described as a short illustrative story which clarifies a particular case or perspective from the findings discovered (Grbich, 2007). Another meaning to vignette explained by Schoenberg and Ravdal (2000) is a story that provides examples of people and their behaviours that allows the researcher or the participants to formulate their own opinions or give comments on how they would react to a certain situation. There were a few vignettes in this research that constitutes as *episodes* or *cases* in which warrant me to look in-depth into the essential characteristics of the research. In other words, there were critical incidents in which the data collected were based on situations that were unique. I have also noticed the behaviour of participants in this setting and the problems encountered. These observations and stories have been included in the analysis of the findings.

3.5   Participants

The main participants of this research were the doctors and patients from both HSA and HKL. Other participants were the health care managers such as the heads/medical directors, sisters and matrons who were responsible to the ward. They form the elite group that filled in the gap or queries discovered in the research. Ethical situation were considered when selecting a patient; as patients are normally burdened with dilemmas of finances, family issues, side-effects of treatments and fears of dying, physical disability and severity of their medical condition. Other health care

professionals were chosen based on their availability. Given such circumstances, participation from the patients, doctors and health care managers were purely voluntary and limited to purposive sampling rather than random sampling technique.

In normal circumstances, doctors are usually busy with their ward rounds, filing up medical reports and looking after patients with medical emergencies. Therefore steps were taken to develop friendly relationships with the doctors by explaining the purpose of the research. With mutual consent on the availability, interviews were carried out during their lunch breaks, change of shift duties and at late nights when there were minimum interruptions and a calmer environment. Sometimes the interview sessions were carried out in two parts over a period of two days. If I observe they were exceptionally busy at the wards, I would change my research approach and concentrate on interviewing the patients.

Finding the most appropriate time to interview the patients was a challenging task; in lieu of the patients' medical condition. The patients were always busy as they will be examined by a range of doctors from the specialist, MOs and HOs and other times they will be resting, visited by their family members or having their meals. Therefore it was crucial that patients were interviewed at the right time when they were in a "stabilized" condition. For example patients who were admitted at the O&G ward must be carefully selected. If they had labour pain, they will be eliminated from the interview process. In similar context patients who were too ill, too weak to write, undergoing treatment, lost their child and in traumatic experience were also excluded from this research. This was to ensure there was no biasness in the data collected that would affect a meaningful interview.

Guidelines in the actual sample size differ in opinion from different researchers. According to Bertaux (1981) the smallest sample size suitable for qualitative research is fifteen. However Patton (1990) argued even a small sample size could yield rich data. For this research a total of twenty-eight patients and sixteen health care professionals participated in the in-depth interviews from both hospitals. Details pertaining to the participants' demographics and background are discussed in the preliminary investigations.

Assurance on the confidentiality of the responses was highlighted in the covering letter to the participants to avoid any forms of biasness such as the inaccurate disclosure of information by the doctors. The cover letter explained the purpose of the research with a courteous vote of thanks for their valuable input. Precautionary methods were taken to ensure patients volunteered to participate in the research without any coercion, force or for monetary gain. This was because many of them come from low social background with limited education and therefore may not understand the purpose very well and how this research would benefit at a macro level. It is important to ensure patients are not enticed with any means of reward. In this research however, patients were given a small token of appreciation at the end of the interview as 'transportation allowance' for their time and effort in participating in this research. The act of giving a token of appreciation is considered a normal practice at the hospitals and I did not wish to put the patients at a disadvantage. However, the doctors who participated were not given any token of appreciation for their feedback.

3.6 Steps in obtaining ethics approval

This was the most tedious process which took two months to prepare the documents and a further one month to obtain the ethics approval. The Faculty of

Economics and Administration prepared a letter certifying that I was in fact a student from the faculty and provided the authenticity of my student metric number, the title of the research and name of supervisor from the University (Appendix C). However much to my dismay this was not sufficient to conduct any research at MOH facilities and required additional information. I investigated the standard procedure through various channels such as the MOH information desk and the hospitals' research committees. Eventually I discovered the standard workflow in applying for ethics approval (Appendix D). The guidelines in the workflow were 7 pages in length. The following explains the procedure that I went through:

The first step in obtaining ethics approval was by registering through the National Medical Research Register (NMRR) website which was obtained from https://www.nmrr.gov.my/fwbLoginPage.jsp (Appendix E). A unique NMRR registration ID was created automatically unto the Investigator's Agreement with the title of the research, name, identification card number, and institution site.

The second step was to obtain approval from the Director of the Hospitals and the Heads of Departments at the targeted site institution in which the data was collected (Appendices F & G). A letter explaining the purpose and methodology was required in the covering letter which was attached with the research proposal and patient's information sheet. This was followed by various telephone calls and e-mails to find out the names, addresses, booking of appointments and various other correspondences in order to see the research through. Each of these hospitals had their own research committees and requirements. At one juncture, the Research Head from HSA suggested to meet the Head of the Department concerned from O&G to explain about the project personally and ensure that this research would not be a hindrance to their work process,

would not breach the doctor-patient confidentiality covenant and explain the patient recruitment methods (Appendix H). Subsequently appointments were fixed on the 20th and 21th April 2010 to meet both the Head of Research and the Head of O&G department from HSA. Needless to say, this turned out to be a successful encounter. There were exchanges of ideas and several issues were clarified. The Head of O& G department suggested observing the situation in the wards and jotting down the findings before conducting the actual investigation and collection of data through in-depth interviews. Assurance and cooperation from staff members of the ward were given. I was also reminded to abide within the hospital rules, to ensure the confidentiality of the patients interviewed and to detach from being involved with the patients concerned. Upon completion of this research, request was also made to present the outcome of the findings to the hospitals.

The third step in this process was to develop information sheet and consent letters for the participants of the research. The information included in the information sheets and consent letters must protect the participants' rights. The information included benefits to the participants, drawbacks or risks involved (if any), details of the research, purpose and the release of research data. Adequate information must be provided to allow the participants to make informed decisions while participating in this research. Most importantly participants must be informed that the research was purely voluntary and may opt to withdraw at any time without any penalty or risks to them. According to Darlington and Scott (2002), the fundamental principle in research ethics is when the participants have the capacity to give their informed consent freely.

Although a sample information sheet was provided by MREC but a new sheet was prepared to include the opportunity for the participants to contact the University supervisor directly if there were any enquiries or complaints.

The fourth step was translating the information sheet and consent letter into Bahasa Malaysia (Appendix I) and in another language which is either in Tamil or in Chinese (Appendix J). These versions must be checked by a certified translator to avoid and rectify any discrepancies in the translations.

The fifth step in seeking ethics approval was to upload all the documents in PDF format unto the NMRR website which included my curriculum vitae, investigators agreement forms that have been signed, interview schedules with detailed questions, covering letters to the MOH Research and Ethics Committee (MREC), information sheet and consent letter to patients. The completed documents were uploaded and submitted on the 3rd May 2010.

The sixth step was the processing of documents submitted to the MREC. The process to vet through the applications took approximately a month to approve as the procedure required the MREC to schedule a meeting with their ethics committee to examine all the submitted research documents and proposals. The researcher would be contacted if there were any incomplete documents or clarifications needed. Subsequently the approval was obtained in June 2010 (Appendix K).

3.7 Preliminary investigation

3.7.1   Profiling medical practice using etic and emic approach

In 2007, by using an etic approach I began profiling the practice of medicine and medical education in a newly formed medical school. This was conducted through a qualitative evaluation tool designed using Pendleton's positive feedback model which focuses on what went well, what didn't go so well, any further suggestions and a global rating (see Figure 3.1).

CLINICAL SITE VISIT EVALUATION FORM

Date……………………………Semester………………………………Group…………
Session title………………………………………………………………………...……

1. In your opinion, what part or parts of the clinical site visit session went well?	
2. What parts of the clinical site visit session did not go well?	
3. How do you think the clinical site visit session could be improved?	

Any further comments regarding the clinical site visit session?

Finally, please complete the following:

'The clinical site visit session went well and does not require any changes' (tick appropriate box)	Strongly disagree	Disagree	Neutral	Agree	Strongly agree

Figure 3.1: Sample evaluation questionnaire using Pendleton feedback model

This evaluation tool was distributed to staff and students throughout the months in the year 2007. This exploration was centred at a newly formed private medical school

that was set up in Malaysia. The focus at that time was to evaluate the Bachelor of Medicine/Bachelor of Surgery (MBBS) programme which follows an integrated curriculum throughout Year one to Year five. It gave an opportunity to collect rich data and allowed students and staff to express their views and give feedback. The evaluation included areas such as clinical skills practice, tutorials, lectures, problem based learning, bedside teaching, clinical site visits, hypothetical cases, simulated patients, community based projects and syndicates.

Approximately 1000 teaching evaluation questionnaires, over 800 evaluation of MBBS modules and more than 300 evaluation forms on CPD activities were collated and tabulated. *Affective method* of coding using *evaluation coding* was used on the raw data collected. According to Patton (2002) and Rossman and Rallis (2003), *evaluation coding* is the application of non-qualitative codes that assesses the quality and decides the merit of the programme. The raw data was further analysed using axial and selective coding. The results of the preliminary findings showed that the medical students and tutors had concerns in the following areas:

a)   content of the curriculum;

b)   teaching methodology in the clinical environment;

c)   teaching resources;

d)   group dynamics; and

e)   the management and running of the course.

The raw data also provided information on the differences in culture and unexpected scenarios faced by medical students. The findings were useful particularly in examining the demands of the medical students and their profession at the multiple sites where the Medical School is stationed at Sunway and Johor Bahru campuses.

Medical students could also discuss problematic situations openly by using the evaluation tools designed. As a result the management team and tutors took critical actions, made organisational changes and researched further in improving the medical education processes.

By participating in various research projects from the school, my role evolved from an etic approach to an emic approach researcher. Lowe and Guthrie (2011) describe this diversion as *port following* and explain that by doing other research projects stimulates the PhD thesis. Most importantly the findings provided me with an insight on how a medical curriculum is carried out. Hereafter, as a novice in this area, concepts such as site visits, problem based learning (PBL), patient centered learning (PCL), short answered questions (SAQ), medical interviews, clerking patients and etcetera were comprehended better. This led me to investigate further on the aspects of medical education and communication. On the hindsight, it was interesting to note how this is practiced in "real life" situation in a hospital environment.

3.7.2 Pre-test

The pre-test was important because I wasn't sure of the most suitable research approach that I should embark on. Some literatures from the west have used quantitative techniques through questionnaires to collect data. Perhaps this technique is easier to handle since the questionnaires were structured in one language which is commonly spoken in the west. Furthermore, quantitative research method has very little contact with participants in the field and is influenced by clearly defined reliable measures with statistical logic (Silverman, 2006). As a result the data uncovered on social phenomena or behaviour may turn out to be a delusion (Cicourel, 1964, as cited in Flick, 2002) and can amount to a "quick fix" method (Silverman, 2001). However

the question in hand, is the quantitative method a suitable approach for the Malaysian hospital scenario? In other words the quantitative research method may not be able to address all the research questions in hand.

The level of education among Malaysians and the multiracial ethnicity in this country must be considered when designing a suitable approach. Interpreting four major languages in the country to mean the same in terms of accuracy and consistency is an imperative and difficult process. In light of this, the socio-economic levels of the respondents from the public hospitals in Malaysia are varied and therefore the level of understanding can be lopsided or limited. As a consequence, a balanced approach should be investigated to accept the strengths and limitations of the research in question (Silverman, 2006).

The most important factor in my agenda is to look for the most suitable means of conducting this research to achieve the objectives. Therefore, a pre-test of the questionnaire was carried out in December 2008 in order to understand the direction to take in the research approach which is either quantitative or qualitative. This is because different research methods are evaluated differently (Silverman, 2006). The pre-test was carried out using quantitative technique through questionnaires. The questions were taken from previous study on team care in general practice by Marsh and Kaim-Caudle (1976) and were modified to fit into this study (see Appendix L). Research in quantitative studies view the opinion by adopting the same experimental design even in a different environment, replication and generalization can be carried out by using the same questionnaire (Bryman, 1984). Therefore this positivist perspective was trialled in the pre-test questionnaire that was designed.

The structured questionnaires were distributed to two respondents who have experienced care provided by the public hospital in HSA followed by short interview questions. Membership checks were completed the next day when the responses were transcribed and typed and given to patients to check and verify the information provided.

The main purpose of this pre-test is to determine the direction of this study. The findings from the pre-test showed although the pre-test questions were structured as closed ended questions but the patients responded with varied in-depth answers. The session also took about 45 minutes to 1 hour to end. From my observation, the patients were very expressive and had a lot to share about their experiences. There were many non-verbal cues that cannot be measured when the patients were providing their feedback. Difficulty was faced to bring the patients back to the topic discussed and to answer in a structured manner. However, the responses provided interesting information that had deep meaning which was embedded in this research.

The preliminary findings from the pre-test enabled me to decide the direction of this research and the suitability of the questions. It also enabled me to understand the patients and the type of responses they would normally provide with the type of questions posed. As Patton (2002) pointed out, it is important to choose the right tool in order to do the right job. The questionnaire format used as a tool for quantitative analysis was not suitable for this research. Furthermore, according to Flick (1998), quantitative method used in the social science research may not be adequate to explain the complexities of a social experience. Silverman (2006) explains that the choices depend on what the researcher is trying to find out. The conclusive result from this test provided a rationale to investigate the research in a qualitative manner. The approach of

this study has helped in providing an in-depth understanding of patient care needed and the direction this research needed to take, which is qualitative in nature.

3.7.3 Pilot study at the hospitals

A pre-test test was carried out in December 2009 to determine the direction of the research. Upon completing the analysis it was decided in order to gauge a deeper understanding of the participants' experiences it was necessary to embark on a qualitative research. As there are limited research and references on exploring patient care management in the hospitals, it was necessary to take steps to design and validate the questions for the in-depth interviews. This included content validation through peer checks by medical professionals and conducting a pilot study.

The pilot study was carried out from June - July 2010 at HKL and HSA. Triangulation methods such as observation, in-depth interviews, elite interviews, and records of vignettes and field notes were used. Upon receiving ethics approval from MREC, both Heads of Department from the O&G wards at HSA and Medicine ward at HKL provided me the support I needed to embark on this research. They discussed several potential problems that would arise during the data collection and provided valuable suggestions to conduct the research in an unbiased manner.

Firstly, introductions were made to the Heads of Department and hospital administrators of the wards such as the Matrons and Sisters in-charge in order to assist me in getting the cooperation needed to carry out this research. I took this opportunity to build rapport with them and explain the purpose and details of the research. As a result of building trust and friendly relationship with them, site tours to all the wards were arranged for me to familiarize with the surroundings. During this time, introductions

were also made to the middle managers who are Sisters in-charge of the administration of the wards.

After the initial orientation in the hospital, the pilot study was carried out. Upon completion of the pilot study, changes were made to the questions in the interview schedule as well as the approach used before embarking on the full research. Again approval from MREC is required to record the changes made. This is because MOH places importance to all types of research conducted at its facilities and the ethics consideration on the rights of patients in Malaysia. The pilot study is important in order to understand the scenario at the wards and refine the in-depth interview questions. All doubts and peculiarities were noted during the pilot study. The results of the pilot study highlighted some of the challenges faced in this research which paved the way to administer the research in an efficient manner as discussed below:

3.7.3.1 Language barrier

According to Parasuraman (2008), PhD students who are doing research in Malaysia should be familiar with a number of languages and be aware of the sensitivities of different culture. However, this is a huge limitation for researchers because not all the researchers are fluent in the different languages in Malaysia. One of the major limitations faced during the pilot study was translating languages from English to Tamil and from English to Mandarin and vice versa during the interview process. Even though I am familiar with four languages (English, Bahasa Melayu, Tamil and Malayalam), there were times when it was difficult for me to translate and explain to the patients confidently. The most difficult barrier was in understanding the Chinese patients. I managed to resolve this handicap for the final research by hiring trained Chinese enumerators to assist me to get better responses. As the Chinese

enumerators assisted me in the hospitals during the interview process, I would take note of the non-verbal cues and understand their behaviour. I was also able to answer any queries provided by the patients related to the research.

Although enumerators were hired and trained to translate the data collected into verbatim, but the interpretation of the information may not be accurate enough for conceptualization because of the cultural differences and unique colloquial expressions between the different races in Malaysia. Approaching this solution also consumed time, especially in selecting and training suitable enumerators.

3.7.3.2 Technical terms used in the bedside

There were a number of technical terms related to the diseases which were commonly used by both the patients and doctors in the bedside. For example: tubal ligation, diabetes mellitus, hypertension, lupus, cardiac problems, in-vitro fertilization, and intubation which relate to the dilemmas faced by the participants. These terms are frequently used in the Medical and O & G wards. Poor understanding of these terms will affect the comprehension and correlation of the facts. Therefore extra efforts were taken to understand these diseases in order to co-relate with the meanings discovered in the findings.

3.7.3.3 Emerging themes discovered

As the research progressed new themes were discovered. The initial conceptual framework indicates the main factors that influence patient care management were communication, leadership, organisational culture, patient focus and quality of care. However, the findings from the pilot study revealed the existence of new emerging themes such as cultural practices, religion and privacy issues. This can be seen from

Figure 3.2. As a result, the framework needed to be re-examined more closely without undervaluing the importance of these factors.
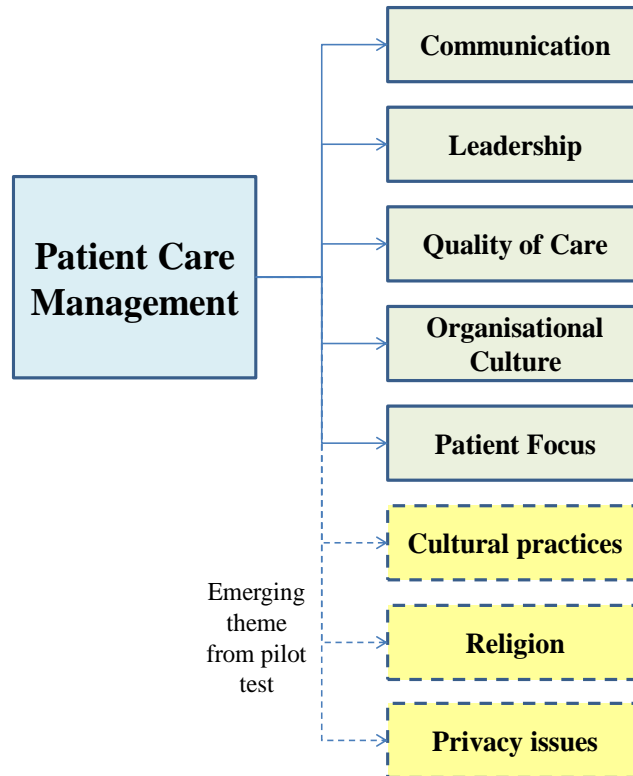
Figure 3.2: Conceptual framework from the pilot study with emerging themes

3.7.4 Improvements to the questions

Several improvements were made to the questions in the interview schedule after the pilot study based on the feedback received through peer checks, observation and interviews. Another reason for the improvements to be made is to explore the new emerging themes discovered. Additional questions in the interview schedule that took note on the cultural practices, religious beliefs and privacy issues were also prepared (Appendix M & N). The in-depth interview questions for doctors also included non-verbal cues and medical communications techniques in certain scenarios such as breaking bad news and providing explanations to patients and their family.

Prior to finalizing the questions for the doctors and patients, several medical practitioners were consulted to peer review the list of questions, information sheets and consent forms in order to assess the content validity and to check whether the participants would be able to comprehend and answer the interview questions well. The feedback received from the peer review formed the preliminary data analysis that offered further suggestions for improvements which was also incorporated into the final interview schedule.

3.7.5   Quasi- statistical analysis

The preliminary findings from the pre-tests and pilot tests undertaken have allowed me to evaluate and decide the next stage of the research analysis. Grbich (2007) explains that preliminary data analysis is an on-going process that evaluates what is emerging from the data and provides directions to investigate the data further. Quasi-statistical analysis was used to enable classification of items by percentages, frequencies and ranked order to give logical reasoning process in the context of the research (Grbich, 2007). Using quasi-statistical approach, descriptive information regarding the patients' and doctors' background were analysed into percentages in order to gauge the general understanding of the data. Common words used by the participants were also analysed to see if the words represent any particular meanings. My initial thoughts and rationale of using this technique were; since the patients come from different ethnic background, the different languages used may signify certain meaning.

3.7.5.1 Participants' background

The main participants from this research were patients who were admitted at the wards and the doctors who work in the wards providing bedside care and treatment.

Other participants were the healthcare providers who manage the administration of care to the patients. A total of 44 participants from HKL and HSA were interviewed. From the total of 44; 28 interviews were with bedside patients admitted at the hospitals and 16 were with the healthcare providers. Despite the sample size being small, researchers such as Schiffman and Kanuk (1997) have reiterated that small sample size provide highly reliable findings, depending on the sampling procedure undertaken.

A total of 28 bedside patients admitted in the HKL and HSA wards participated in this research (Table 3.7). The study design was targeted from O& G and Medical Wards. The majority consisted of 22 (78.6%) of the patients were female. This is because all the patients who were in total 14 (50%) of them from HSA were female patients from the O&G wards and only 8 (28.6%) female patients were from Medicine ward in HKL. On the contrary, all the male patients with a total of 6 (21.4%) were from the Medicine wards from HKL. The investigation also showed there were a good mix of ethnicities from both hospitals which totalled; 8 (28.6%) Chinese, 9 (32.1%) Malays, 10 (35.7%) Indians and 1 (3.6%) Native East Malaysians who participated in this research. In addition the majority consisted of 12 (42.9%) of them stayed between the duration of 2 – 5 days in the wards, followed by 8 (28.6%) patients who stayed between 6 – 10 days and 6 (21.4%) patients who stayed for only one day. Only 2 (7.1%) patients stayed for more than 10 days. This was because the patients had complications and were waiting for further treatment and a complete recovery.

Table 3.7: Demographics of patients

	HKL[a] (n = 14)	HSA[b] (n = 14)	Total (n = 28)
Gender			
Male	6 (21.4%)	0 (0.0%)	6 (21.4%)
Female	8 (28.6%)	14 (50.0%)	22 (78.6%)
Age distribution			
Under 40	6 (21.4%)	13 (46.4%)	19 (67.8%)
40 – 64	7 (25.0%)	1 (3.6%)	8 (28.6%)
Above 65	1 (3.6%)	0 (0.0%)	1 (3.6%)
Ethnicity			
Chinese	3 (10.7%)	5 (17.9%)	8 (28.6%)
Malay	6 (21.4%)	3 (10.7%)	9 (32.1%)
Indian	5 (17.9%)	5 (17.9%)	10 (35.7%)
Native	0 (0.0%)	1 (3.6%)	1 (3.6%)
Duration of stay since admission			
1 day	2 (7.1%)	4 (14.3%)	6 (21.4%)
2 – 5 days	6 (21.4%)	6 (21.4%)	12 (42.9%)
6 – 10 days	5 (17.9%)	3 (10.7%)	8 (28.6%)
More than 10 days	1 (3.6%)	1 (3.6%)	2 (7.1%)
Reasons for admission			
Medical	14 (50.0%)	0 (0.0%)	14 (50.0%)
O&G related	0 (0.0%)	14 (50.0%)	14 (50.0%)

Note. Percentage has rounding up error of 0.1%.
[a]Medical Ward consist of both male and female patients; [b]O&G ward consist of female patients only.

Responses were also collected from the Heads of Department, Sisters, Matrons, Housemen, Senior Housemen and Medical Officers (Table 3.8). The findings showed a total of 9 (56.3%) doctors who are Houseman, Senior Houseman and Medical Officers participated in the in-depth interviews. They were selected because they were the patients' doctors who were directly involved in providing treatment and bedside care. In addition, 7 (43.8%) participants were other health care providers consisting of 5 (31.3%) Sisters and Matrons and 2 (12.5%) Heads of Department. They participated in this research through elite interviews. They were interviewed because of their role in

managing the wards. The elite interviews were unstructured and focused on the management of the wards and to clarify gaps discovered from the research. The results showed most of the participants in the elite interview consisted of 11 (68.8%) female staff and the rest were male which totalled to 5 (31.3%) staff. Ironically none of the healthcare providers were from the Chinese background, instead there were an equal number from other ethnicity which totalled to 8 (50%) from the Malay ethnicity and 8 (50%) from the Indian ethnicity. Majority of the participants which totalled to 8 (50%) staff have more than 3 years' experience working in the hospital. Only a small number which totalled to 2 (12.5%) staff have between 1 – 2 years' working experience in the hospital.

Table 3.8: Demographics of the health care providers

	HKL (n = 9)	HSA (n = 7)	Total (n = 16)
Gender			
Male	2 (12.5%)	3 (18.8%)	5 (31.3%)
Female	7 (43.8%)	4 (25.0%)	11 (68.8%)
Ethnicity			
Chinese	0 (0.0%)	0 (0.0%)	0 (0.0%)
Malay	5 (31.3%)	3 (18.8%)	8 (50.0%)
Indian	4 (25.0%)	4 (25.0%)	8 (50.0%)
Position			
Nurses (Sisters/Matrons)	2 (12.5%)	3 (18.8%)	5 (31.3%)
Houseman	5 (31.3%)	1 (6.3%)	6 (37.5%)
Senior houseman	0 (0.0%)	1 (6.3%)	1 (6.3%)
Medical officer	1 (6.3%)	1 (6.3%)	2 (12.5%)
Head of Department	1 (6.3%)	1 (6.3%)	2 (12.5%)
Duration of work			
Less than 1 year	4 (25.0%)	2 (12.5%)	6 (37.5%)
1 – 2 years	1 (6.3%)	1 (6.3%)	2 (12.5%)
More than 3 years	4 (25.0%)	4 (25.0%)	8 (50.0%)

Note. Percentage has rounding up error of 0.1%.

The NVivo 9 software was used to analyse segments of the data such as word frequency. The data from the interviews were transcribed and keyed into Excel whilst the data collated from field notes, reflection, vignettes, observation, elite interviews and diary of events were keyed into Word. All the data from Excel, Word and audio recordings were uploaded under "sources" in the NVivo. These data were shifted around to fit into the research design. The demographic information such as gender, age, ethnicity and hospital termed as "attribute" were keyed into the software (Appendix O).

The "word frequency" query provided a list of words that were frequently used in the data. It provided a general glance on the "what" and "how" frequent certain words were mentioned in the interview (Table 3.9). The list of words generated from the software using "word frequency" query showed 22 most common words that were frequently used during the interview with the patients and doctors; after eliminating non-sensible words such as "what", "does", "you" and others. The results indicated the most frequent words used from the interview with patients and doctors were "ask", "questions", "explain/explanation" and "care". As a result my initial deductions would explain that these words were commonly practised during the bedside care. However the analysis using the NVivo software for ethnographic research is limited as the software could not interpret the meanings of data. The words were further examined through thematic analysis for interpretation of meaning.

Table 3.9: Most frequently used words in the interviews

Interview with patients			Interview with doctors		
No.	Word	Count	No.	Word	Count
1	Ask	281	1	Ask	103
2	Questions	279	2	Explain/explanation	97
3	Explain/explanation	248	3	Questions	91
4	Care	165	4	Care	58
5	Food	143	5	Make/making	57

Interview with patients			Interview with doctors		
No.	Word	Count	No.	Word	Count
6	Like	140	6	Feel/feelings	57
7	Encourage	134	7	Say	54
8	Understand	123	8	Encourage	51
9	Give	93	9	Show	47
10	Show	88	10	Understand	39
11	Good	87	11	Tell	38
12	Satisfactory	83	12	Think	34
13	Kept	82	13	Family	31
14	Clean	79	14	Need	31
15	Suggestions	78	15	Check	30
16	Check	77	16	Plan	27
17	Take	72	17	Discuss	25
18	Feel	71	18	Know	24
19	Visiting	68	19	Communication	23
20	Use	68	20	Like	22
21	Comfortable	66	21	Working	23
22	Discuss	64	22	Support	20

3.8 Summary

This research emphasised on ethnographic approach at two tertiary hospitals. Data was collected using triangulation methods such as in-depth interviews, elite interviews, observation and records of field notes and vignettes. The purpose of this research is to explore the experiences of the patients and the doctors in bedside care. Other health care providers who administer the wards were also interviewed. A pre-test was carried out to determine the direction of the research followed by a pilot study. The pilot study provided initial analysis on the data collected and the sturdiness of the questions asked.

As a researcher, I was able to make the needed adjustments before embarking on the full research. In addition, I was also able to understand the ward scenario and the participants better in order to ask the right questions. The underpinning notion is that

the pilot study revealed the emerging themes such as cultural practices, religion and privacy issues which needed to be explored in-depth.

Patton (2002) and Saldana (2009) rationalises each qualitative study as unique and therefore there is no perfect way to code qualitative data. The process of the research was lengthy and continuous as it took account of the preliminary investigations and the improvements made. To conclude the preliminary investigations provided a clearer framework on how the final data should be analysed and interpreted to provide a more meaningful and conclusive results.

CHAPTER 4: DATA MANAGEMENT

4.1   Introduction

This research uses ethnographic approach in exploring the experiences of the patients and doctors in the hospitals to have a deeper understanding of both explicit and tacit meaning found in the research. Triangulation methods using qualitative techniques were administered to find out the barriers and supportive issues that influence patient care management in the hospitals. Unconditional ethics approval was obtained from MREC in early June 2010 and thereafter data was collected through observation, in-depth interviews, elite interviews, records of vignettes and field notes.

This chapter discusses how the data collected through various methods discussed in Chapter 3 are handled, logged in and processed. The central tenet in this chapter is to describe how the research data which is gathered in a rigorous and consistent manner is managed to ensure maximum fidelity of the data. Thus, by making these processes explicit the validity and reliability of this research can be judged.

4.2   Data management strategies

Sense need to be made of the data. Therefore, all facts need to be logically linked and pieced together. To attribute to this, an appropriate strategy was formulated to manage these data from the beginning of this research until its completion. Managing the data involves organizing the data through transcribing, logging and initial categorization of the data into appropriate formats before the analysis is shown. According to Lincoln and Guba (1985) these are characteristics to explain the validity and reliability of the research. Furthermore, according to Braun and Clarke (2006), transcribing the data gives an opportunity to thoroughly understand the data.

Since the research was triangulated, the potency of the investigation lies in the evidence presented. Patton (2002) explains that triangulation of data sources helps in cross-checking the consistency of the data derived by "comparing the perspectives of people from different points of view" (p. 559). Hence by administering the data efficiently the data that was collected from different sources was easily converged, double checked and explained in a meaningful way in the analysis process that extends the value of the research process. The following were some of the data management strategies undertaken that portray the veracity of the research.

4.2.1 Audio-recording

The in-depth interviews with the doctors and patients which lasted about one hour were audio-recorded and transcribed into verbatim scripts. Membership checks were done to verify information that was keyed in. According to Richards (2005), membership checking is a technique in which the participants of the research check the validity of the data and the interpretations given by the researcher as it happened in light of the situation presented in the report. To protect the confidentiality of the participants all transcribed scripts were not attached to the thesis for documentary evidence. Membership checks with the participants were ensued as proposed by Lincoln and Guba (1985) as part of the communication validation in the interpretation of the data. However, approximately 10% of the interviews were not recorded through audio-tape as requested by the participants. The reasons given were fearful of management's response and respect for privacy. The transcribed interviews and the handwritten notes on observation, field notes and vignettes were typed into word-processing program which was coded and labelled. Although the patients and the doctors were conscious of being observed, however the overall adherence and behaviour seen during the observation was easy going and non-intrusive.

4.2.2   Peer checks and publication

The data was peer checked through oral presentation at conference proceedings by members of public who were not directly involved in the research process. The presentation in parts through publication in leading peer reviewed journals has been done. Information relevant to the publication was included in the footnotes and references as well as cited in the thesis. The results of the research were presented at two conferences which were held in Dubai, UAE, in December 2011 and in Toronto, Canada, in May 2013. The broad range of ideas and interpretations from the comments received from various parties assisted in the verification of the research.

4.2.3   Data storage and document records

The data collected from the interviews were keyed into an EXCEL spread sheet. Codes were also keyed in for participants and hospitals that took part in this research. The benefits of keying into this spread sheet are: it enables the data to be stored for easy reference, the documents indicate the trail for research continuity and lastly the document provides a convenient method to compare multiple entries across different domains. Table 4.1 and Table 4.2 show a snapshot of the data keyed into the spread sheet for patients and doctors respectively.

Table 4.1: Summary of data on doctors keyed in EXCEL spreadsheet

Code	Hospital	Part A	2.1 Initiating the session	2.2 Identifying the reasons for the consultation
Dr X	Hospital A	1 year MO	Normally see if they are young/old. Call them Cik/Kakak. As doctors, we ask these questions; What is your age? Where's your husband? Why you came late? Why never come on time? When we ask these questions, they feel scared.	Always say do you understand? Most patients would come with ante natal care. Usually patients accept what we say, we ask them, "Do you understand?" They usually reply "yes". They usually ask "baby OK?" If we say OK, they are happy.

Table 4.2: Summary of data on patients keyed in EXCEL spreadsheet

Code	Hospital	Ethnic	Part A:	1.1 Comfort of bedding?	1.2 Quietness of the ward?	1.3 Ward temperature?
Pt Y	Hospital B	Malay	This is my 4th child.	O.K. If I'm not comfortable, they will add more pillows	If compared to before. Now it's more comfortable	Very good. Very windy.

4.2.4   Audit trail

The first step in developing an audit trail is the data management. Data management is very important in qualitative research because data management and data analysis are firmly related to each other. According to Miles and Huberman (1994), managing huge amounts of data is essential because it is part of the process to help researchers make sense of qualitative information with ease.

An audit trail was necessary in this research because according to Akkerman et al. (2008) and Richards (2005) the audit trail documents the process of gathering and handling data for analysis. The audit trail also demonstrates that a qualitative research is dependable (Koch, 1994) and establishes research *confirmability* (Lincoln & Guba,

1985). By logging each step, the data explain how the decision and conclusions are arrived. The association, grouping and patterns within the data could justify claims of research consistency and trustworthiness (Richards, 2005).

Although there was limited information in creating a comprehensive audit trail (Rodgers & Cowles, 1993; Bowen, 2009), Halpern's (1983) six classification of audit trail was used in this research. The six categories were (a) raw data, (b) data reduction and analysis, (c) data reconstruction and synthesis, (d) process notes, (e) intentions and disposition and (f) instrument development. This procedure was adopted by Lincoln and Guba (1985), although they advised caution in use as not all six categories are relevant for a study. The audit trail was made more relevant by following Akkerman et al. (2008) who created an audit trail procedure based on Halpern's (1983) work but changed the order of the components into the chronological order of the research process. The five components were: (a) start document - conceptual framework, the methods and expected results, reflections on the researcher position; (b) final document − thesis, research report, journal article, conference proceeding; (c) raw data − field notes, raw data such as taped conversations and photographs; (d) processed data − memos, coded records, summaries, annotated records, statistical results; and (e) process document − systematic reports on data gathering and analysis, the actions taken and the associated outcomes.

A modified audit trail that combined the six classifications from Halpern's (1983) work and the chronological sequence of Akkerman et al. (2008) audit components was adopted for this research. Thus the order of the modified audit trail for the thesis adopted the following categories:

1. Intentions and disposition;

2.   Instrument development;

3.   Process notes;

4.   Raw data;

5.   Data reduction and analysis;

6.   Data reconstruction and synthesis

The audit trail was categorized according to the date of each action taken and its venue. In addition, references or codes generated were organized into file folders, index cards and computer files which were kept in a secured location for easy retrieval at any time. The files were then converted into text units for analysis using the computer analysis software, NVivo 9. The details of each category in the audit trail can be seen in Table 4.3.

Table 4.3: Audit trail

Classification	File types	Venue	Dates	References/ Coding	Folder Index
(A) Intentions and disposition	(a) Received NMRR ethics approval and MREC approval to conduct research in HKL and HSA	MOH, MREC & NIH	June 2010	NMRR-10-526-6014	2.4
	(b) Documents/letters seeking approval (i) Approval letter for verification of PhD student research	UM	17 March 2010		2.1
	(ii) Investigator's agreement approval from HKL	HKL	16 April 2010		2.2
	(iii) Investigator's agreement approval from HSA	HSA	20 April 2010		2.3
	(c) PhD proposal, budget & supporting documents for research grant (RM5,150)	UM	15 Apr 2010 – 14 Oct 2011	PS170-2010A	1.0
(B) Instrument development	(a) Initial draft of interview schedule	HKL & HSA	June 2009		
	(b) Consent form & Information sheet		July 2009		3.3
	(c) Final interview schedule		March 2010		3.1
	(d) Translated documents – BM & Mandarin (interview schedule, consent form & information sheet)		March 2010		3.2
(C) Process notes	(a) Journal entries (Diary) (i) Field notes – observation				4.1
	▪ Patient approaching doctors	HSA & HKL	30 January 2011	O2	
	▪ Scenario at the wards during public holiday	HKL	4 February 2011	O2	
	▪ Different type of wards	HKL & HSA		O2	
	▪ Scenario at the O&G wards	HSA	15 June 2011	O4	
	▪ Bedside teaching observation	HSA & HKL		O4	
	▪ Construction work in the building	HSA	8 & 9 December 2011	O4	
	▪ Construction work has stopped	HSA	21 December 2011	O4	
	(ii) Diary of events				4.2
	▪ Applied for documents to verify PhD student research	UM	March 2010		

Classification	File types	Venue	Dates	References/ Coding	Folder Index
	▪ Applied for ethics approval from MOH	MOH	April 2010		
	▪ Obtained approval to conduct research at HKL	HKL	16 April 2010		
	▪ Obtained approval to conduct research at HSA	HSA	20 April 2010		
	▪ Arranged for visitation to the wards through SMS, e-mails and telephone calls	HSA	10 June 2010	DI2	
	▪ Orientation of the ward: meeting with Head of Departments, Sisters and visiting the wards	HSA	14 June 2010	DI2	
	▪ Attended morning briefing and reporting. Collection of data	HSA	15 June 2010	DI2	
	▪ Observation and collection of data	HSA	16 June 2010		
	▪ Meeting with Head of Unit 2 and Matron 1	HKL	18 June 2010	DI1	
	▪ Orientation of the ward: meeting Matron 2 and attended monthly meeting	HKL	29 June 2010	DI1	
	▪ Observation, interviewed patients and interviewed two doctors. Collection of data. Loud construction work upstairs	HSA	8 Dec 2010	DI3	
	▪ Appointment made and proceeded interview with Sister 4. Visited wards. Collection of data. Loud construction work continues.	HSA	9 Dec 2010	DI3	
	▪ Appointments made and proceeded interview with Sister 2. Visited wards. Collection of data. Construction work stops.	HSA	21 Dec 2010	DI3	
	▪ Appointments made and proceeded interview with Sister 3. Collection of data	HSA	22 Dec 2010	DI3	
	▪ Notified Matron 2 of visitation. Collection	HSA	27 Dec 2010	DI3	

Classification	File types	Venue	Dates	References/ Coding	Folder Index
	of data ▪ Acquired information about the hospital, and arranged for interview with Doctor 1. Collection of data	HKL	30 & 31 Jan 2011	DI1	
	▪ Interviewed a few patients and 2 doctors	HKL	3 Feb 2011	DI1	
	▪ Interviewed doctors and patients. Visited all wards.	HKL	4 Feb 2011	DI1	
	▪ Appointments made and proceeded interview with Matron 2	HKL	7 Feb 2011	DI1	
	(b) Critical incidences (vignettes) ▪ Making a scene at a ward (fight among employees)	HSA	28 December 2010	CI	4.3
	▪ Patient needing help	HKL	4 February 2011	C2 & C3	
	(c) Reflective thoughts ▪ Development of questions (translation), safety and assurance at the hospital, interviewing patients	HKL & HSA	29 June 2010	R1	4.4
	▪ Different ways of reporting	HSA	15 June 2010	R2	
	▪ Hospital is overcrowded... no toilets that I feel comfortable to go... food (lunch) at the cafeteria isn't that great...	HKL	3 February 2011	R3	
(D) Raw data	(a) Pre-understanding of research background (i) Profiling the practice of medicine & medical education ▪ Evaluation forms ▪ MBBS modules ▪ Feedback forms for Continuing Professional Development (CPD) activities	School of Medicine, Monash University	Feb 2007 – Dec 2009		

Classification	File types	Venue	Dates	References/ Coding	Folder Index
	(b) Electronically recorded materials				5.1
	(i) Audiotapes (and transcripts)				
	▪ Record 1 - 2	HKL	June 2010 – Feb 2011	A1 – A13	
	▪ Record 3 - 4	HSA	June 2010 – Dec 2010	A14 – A20	
	(c) Interview records				5.3
	(i) Interviews with Patients				
	▪ Pre-test	HSA	19 Dec 2009	Pt7 – Pt8	
	▪ Pilot	HSA	15 June 2010	Pt1 – Pt4	
		HKL	29 June 2010	Pt6	
	▪ Research interviews	HSA & HKL	15 June 2010 – 28 Feb 2011	P1 – P28	
	(ii) Interviews with Doctors				5.4
	▪ Pilot	HSA	15 June 2010	D1	
	▪ Research interviews	HSA	9 Dec 2010	D2 – D3	
		HKL	31 Jan 2011	D4 – D9	
			3, 4, 8 & 10 Feb 2011		
	(iii) Elite interviews				5.2
	▪ Head of Unit 1	HSA	14 June 2010	E1	
	▪ Sister 1	HSA	14 June 2010	E2	
	▪ Head of Unit 2	HKL	18 June 2010	E3	
	▪ Sister 2	HSA	22 Dec 2010	E4	
	▪ Sister 3	HSA	27 Dec 2010	E5	
	▪ Matron 1	HKL	8 Feb 2011	E6	
	▪ Matron 2	HKL	29 June 2010	E7	
	(d) Observation notes				4.5
	(i) Notices on the boards				
	▪ Vision and missions	HKL	9 Feb 2011	O1	
	▪ Awards	HKL	9 Feb 2011	O1	

'Table 4.3, continued'.

Classification	File types	Venue	Dates	References/ Coding	Folder Index
	▪ Organisation charts	HKL	8 Feb 2011	O1	
		HSA	28 Dec 2010	O3	
	▪ Policy	HSA	27 Dec 2010	O3	
	▪ Statistics	HSA	28 Dec 2010	O3	
	(ii) Observations in the wards				
	▪ Observations in HKL	Wards	29 June 2010 – 28 June 2011	O2	
	▪ Observations in HSA	Ante-natal & post-natal wards	15 June 2010 – 11 June 2011	DI3	
(E) Data reduction and analysis	(a) Preliminary findings (Pre-test and pilot study) and Quasi-Statistics (b) Research findings (Thematic analysis) (i) Clinical communication (ii) Quality of care (iii) Leadership (iv) Culture in healthcare environment				
(F) Data reconstruction and synthesis	(a) Oral presentation – International GABER Conference (Dubai) and Multi-disciplinary Conference (Toronto, Canada) (b) Publication (i) Journal of Public Health in Africa (ii) International GABER Conference Proceeding (iii) International Journal of Institutions and Economies (iv) Journal of World Universities Forum		December 2011 May 2013 May 2011 December 2011 August 2012 January 2013		5.1 5.2

Table 4.3, continued'

Legend:

Pt1 – Pt6	: Pre-test and Pilot test	O4	: Observation (HSA)
P1 – P28	: Patients' interview schedule	DI1	: Diary of events (HKL)
D1 – D9	: Doctors' interview schedule	DI2	: Diary of events (HSA1)
O1	: Observation (HKL) – Notices	DI3	: Diary of events (HSA2)
O2	: Observation (HKL)	CI	: Critical Incident
O3	: Observation (HSA) – Notices	R1 – R3	: Reflective Thoughts

4.2.4.1 Intentions and disposition

This section includes the research proposal, which provides the research background through literature review and explains the objectives, intended methodology and outcome. It also reveals the sources of funding and approval letters received from the ethics committee.

4.2.4.2 Instrument development

The development of instrument in this section describes the methodology used in the research. For example the interview schedule which were administered to the doctors and patients have been included in this section. A trilogy is noted from the changes made to the question from the initial design to the final format which can be seen through the dates developed. All initial drafts, modifications to the questions, consent forms and explanatory statements were also included in the references. In addition, two translated interview schedules to obtain feedback from respondents with different ethnic background using other languages were also included.

4.2.4.3 Process notes

This section on process notes details the daily activities, observations and reflective thoughts during the research process. Notes were made from hospital observations, interview sessions, reflective thoughts and critical incidents discovered in the hospitals. The notes provide insights on how the research progressed and evolved to the final outcome. Information from journal entries through field notes and diary of events were included in this section. Other information such as briefings and meetings with Head of Departments as well as lists of various contact points that were made were also included here. The information gathered from the multiple sources which were

noted in this section will assist in understanding and make pertinent associations with aspects of healthcare management.

4.2.4.4 Raw data

Data collection, coding and storage are important in a research study. This section details the sources of data collected at different phases of the research. Raw data was recorded extensively through the evaluation forms, MBBS modules, Continuing Professional Development feedback forms, observation notes, as well as audio recording and transcripts from interviews with patients, doctors and other healthcare providers. In other words, this section provides the history of the research, resources used and the people who participated in this research. Codes were created for easy retrieval of data for analysis and recorded under the column, "references/coding" in the audit trail.

4.2.4.5 Data reduction and analysis

This section records how the data was analysed and synthesised. Qualitative methods using quasi-statistics and NVivo 9 were used in the preliminary investigations of this research. Subsequently the final research findings were analysed using thematic analysis. The analysis concluded four main themes, which were clinical communication, quality of care, leadership and culture in healthcare environment. These areas are discussed in Chapter 5.

4.2.4.6 Data reconstruction and synthesis

This section accounts for the results and the final outcome. In this case, the research outcomes were presented at an international conference and was included in

the conference proceeding. Additionally, parts of the research outcomes were also submitted for journal publications.

4.3   Summary

The purpose of data management is to manage the raw data in a systematic and efficient manner. If the data is managed efficiently, it will provide a better understanding when they are analysed. Furthermore the strategies in data management add value to the research process as they are reviewed by others through peer checks, publication and membership checks. Furthermore the documentation illustrated in the audit trail shows the data is organised systematically, keyed in with appropriate references and stored with an identifiable folder indexes. This in turn will ultimately provide easy retrieval and continuity of the research even if it is carried out at a larger scale in the future.

CHAPTER 5: FINDINGS, ANALYSIS AND DISCUSSION

5.1   Introduction

This chapter discusses how the data collected through various methods discussed in Chapter 4 are analysed and discussed. The findings of the research will reveal underlying meanings, patterns and perspectives that are illustrated with examples, quotes and presentation of results. In a nut shell this chapter will explain how the data is connected and built to get to the core of the "what", "why" and "how".

5.2   Data Analysis

The purpose of analysing the raw data is to make sense of the data, identify the main themes and formulate meanings. The data was gathered through triangulation methods using in-depth interviews, elite interviews, observation, records of field notes and vignettes. The data collected from the interviews were keyed into an EXCEL spread sheet while the data from elite interviews, observation, vignettes and field notes were keyed into Word Document. According to LeCompte and Schensul (1999), ethnographic researchers use their eyes and ears for data collection and carefully record what they see and hear as well as how the research is carried out while learning the meanings. The rigor in conducting this will produce scientifically valid and reliable data. After taking note of this, the next stage is the 'sense making' of the explicit, implicit and tacit knowledge of the data recorded. The core findings from the ethnographic research were analysed using thematic analysis.

5.3   Thematic analysis

Although the NVivo software and EXCEL spreadsheet were helpful tools in the quasi-statistical analysis, the data needed to be looked at holistically. Furthermore the

use of software forms another layer that distances between the researcher and the data (Bazeley, 2007). Therefore the second stage of analysis was through thematic analysis because Holloway and Todres (2003) describe this analysis as the foundational technique in qualitative analysis.

Thematic analysis was necessary in this ethnographic research as there were many "hidden meanings" discovered from the mixed languages used by the different races in Malaysia. Besides the English language, different participants spoke in different languages and dialects such as Tamil, Malayalam, Cantonese, Hokkien, Mandarin and Bahasa Malaysia (northern and southern dialects). In addition, majority of them spoke in colloquial languages during the interview. These languages needed to be interpreted to the right meaning to 'what was meant' by the participants. Some of the narratives provided by the participants had explicit and implicit meanings that required a different approach in interpreting and 'sense making' of the data. Therefore the effort in translation was a crucial part in the analysis before the analysis can be investigated further.

According to Braun and Clarke (2006), thematic analysis is a method that investigates, identifies, analyses and report patterns from the data. The thematic analysis examines the everyday experiences of the participants. This method is especially useful when working with under-researched topic that has lack of known evidence on the views of the participants (Braun & Clark, 2006) which is relevant to the clinical setting in Malaysian public hospitals. The stages in the thematic analysis are described as follows:-

Stage 1: The data was examined using the *flip flop* technique (Grbich, 2007), by reading and re-reading the data from beginning to the end and vice versa for familiarization, examining the data in a different perspective and organising and the raw data into meaningful groups (Braun & Clarke, 2006). At this point, the data may have issues that are clear and evident or may not have been considered central to the research questions initially but have appeared so later Grbich (2013).

Stage 2: Since the database was considerable the process of data reduction was necessary in the identification of themes (Miles & Huberman, 1994). In this context, the data reduction included the process of selecting, focusing, abstracting and transforming the data. The process of reducing the data were carried out using the *block and file* approach as explained by Grbich (2007) by underlining the words, or italic or colour code them. For this research, the data was grouped in segments using colour code highlighters and sticky notes that looked for meanings of specific words embedded in the text. For example for this research, the responses were grouped according to the main factors that influence patient care management such as clinical communication, leadership, quality of care and culture in health care environment. This formed the descriptive themes. The description of themes were not emphasized from the theoretical frameworks instead were explored based on structures and truths from the data.

Stage 3: From the data, major themes and sub-themes were identified by looking at all the information gathered from the transcribed interviews, observation notes, field notes, diary of events, vignettes and reflective thoughts to examine interlinking concepts and central themes. Writing descriptive comments (Grbich, 2013) next to the major themes were also an insightful way to take note of the sub-themes. In this research the

data was meticulously examined for supportive issues and barriers which were compared with the factors that influence patient care management.

Stage 4: In this stage the central themes were synthesized for its interpretive meanings to form constructs and explanations, as proposed by Thomas and Harden (2008) in addressing thematic synthesis. Finally the 'experience' from the participants' perspective together with the literature formed the conclusive explanation in this research.

5.4 Comparisons between hospitals

HKL and HSA were chosen as two respondent hospitals for this research. HKL is a national referral centre and located in the heart of the city whilst the HSA is located in the southern region of Malaysia. Both these hospitals are tertiary level public hospitals. Approvals were obtained from the Director General of the hospitals and heads of department to collect the data from the Medicine ward at HKL and the O& G ward at HSA. The statistics shown in Table 5.1 were obtained from elite interviews with the Head Sister at HSA and the Matrons at HKL.

The results indicate both these hospitals service large number of patients daily with strong support provided by their health care professionals. Even though both these hospitals are tertiary level hospitals, but HKL has larger number of health care professionals and resources compared to HSA. This is because HKL is also a national referral centre in Malaysia. This means the hospital cannot turn down any referred patients by other hospitals even with high capacity in operations.

Table 5.1: Comparison between HKL and HSA

Description	HKL (Medicine)	HSA (O&G)
Number of wards	14	4 wards, 1 labour room and 1 Intensive Care Unit (ICU) labour room.
Number of beds	450	233 (including labour room and ICU labour room
Number of doctors	133 (20 Specialist, 33 Medical Officers and 80 Housemen)	62 (3 Consultants, 2 Specialists, 17 Medical Officers and 40 Housemen)
Average number of patients in a month	2,000	1251
Average number of patients in a year	Between 27,000 to 28, 000	Between 15000 – 16000
Number of Matrons in-charge	3	1
Number of Sisters in-charge	35	3

5.5 Field notes and observations

The collections of data were carried out stage by stage to manage time and resources effectively. Some of the factors considered when visiting two field sites that are geographically distanced were availability of accommodation and flight bookings, appointments with sisters, matrons and heads of department and time-off from work to collect data.

During my observation in the wards, I've noticed statistical information placed on the notices to educate the public, visitors and employees. Some examples of these notices were total admission of patients in the wards, total number of patients who were discharged and total number of patients who were discharged but returned home at their own risks (Appendix P). Even though staff were busy with their practice and daily duties, but the effort put in to produce these notices is highly commended, especially since these data were manually calculated. This is a good practice to make information

publicly available as it reflects the hospital performance. Other notices which provide interest to the public were the organisation charts, awards received, mission, vision and policies of the hospitals (Appendices Q, R & S).

In addition, field notes were also prepared to assist me to be more organised in my work and to help me in my reflections. The field notes were my journal entries consisting of diary of events, impressions and jottings from observations as recorded in Table 5.2. The details of the field notes with codes and folder index references are found in the audit trail discussed in Chapter 4.

The field notes show prior appointments were needed before interviewing the participants in order to maximize the input of data. Furthermore, it allowed me to understand the work structure in the hospital. The hospital staff usually take turns working in rotation and are ''on call'' on certain days. They are the busiest in the morning during the specialist's visit whereby they ensure all patients' medical records are in order and updated. They are also involved in bedside teachings for the MBBS students, Nursing students and HOs during the morning rounds. Patients however, will be having their meals and getting ready before their morning consultations. It was very crucial not to interfere with the daily routine of treatment and consultation during this period.

From my observations in both hospitals, there are different types of educators in the wards such as the Specialist, Matrons and MOs who teach the patients and junior staff. The clinical treatments provided to patients are discussed regularly during meetings to review cases transparently with all the team members. Each case with issues is discussed openly, prompting suggestions from members of the team. This

management style in peer reviewing the cases encourages reflective practice and transparency in clinical teaching. This practice clearly defines the transformational leadership style that is instilled among the staff from both hospitals which consistently exercises professional judgements, continuous improvements and teamwork.

Table 5.2: A snapshot of the journal entry during data collection at HKL and HSA

Date/Time	Journal entry
10th June 2010	Received approval from MHREC to conduct research at HKL and HSA. This was followed by several communications via short messaging system (SMS), e-mails and telephone calls to arrange for appointments to view the wards and meet with the Head of the Department.
14/6/2010, 2.00pm, HSA	Meeting with the Head of O&G at HSA, Johor Bahru. Introductions were made to the Head Sister and I was invited to attend the regular reflective meeting held the next day.
15/6/2010, 8.00am (Seminar room, HSA)	Meeting was held with all the sisters, consultants, specialist, trainee doctors, housemen and medical officers to discuss the previous cases in the wards. Summary reports of the type of cases ie total births/delivery, deaths etc were reported. The Medical Officers who were on duty the day before provided a verbal report. Explanations on the type of diseases, treatment given, peculiarity of the cases, screening procedures, reasons for certain procedures and the decisions made were reported. It was observed that the consultant and specialist seeked clarifications from the MOs on the cases reported. The consultant asked the MO to describe how the disease looked like. "What can you see through your naked eye? How does the 'mass' look like? Please remember the basics of medicine, which is history taking, in order to find out enough information to make decisions." When a second case was discussed concerning the death of a baby followed by a normal delivery, the doctors were reminded by the consultant on the follow-up care which was: 'What do you tell the patient? What do you tell the husbands? Do you think that was enough? When a third case was discussed concerning the pain in one of the patient's eye, the other doctors were contributing to the discussion. Some were either agreeing to the treatment or adding information that was lacking. Through the sharing of information, I noticed the HOs and medical students were taking notes on what to look for when similar symptoms arise. Finally the MOs were advised to refer the patient to an ophthalmologist to follow-up on the pain on the eye.

Date/Time	Journal entry
15/6/2010, at HSA, 9.30-11.30am	Orientation of the wards given by Head Sister of HSA
11.30-5.00pm,	Collection of data and interview with patients and doctors
16/6/2010, 8am-5.00pm	Interview with patients and doctors
18/6/2010, 12.30pm, at HKL	Meeting with the Head of Medicine, HKL, Kuala Lumpur. The Head explained that a survey on patient satisfaction was conducted recently and it was reported that patients were generally satisfied even though there were other hospitals in the vicinity. He explained this was because the strategic location of the hospital which is situated at the heart of the city and the cost of treatment that is reasonable which has value for money. He also explained that the doctor patient ratio is not optimal in the 3rd class ward compared to the 1st class ward. He asked to take note of the severity of the illness in comparing data in patient care. He explained that more care is given to patients with complicated cases compared to patients with less severe cases. The doctors treating patients with less severe illness, for example patients with diarrhoea, ensures the patients are treated and are stabilized before discharging them. This might have less effect on the patients compared to the others.
12.30-1.30 pm, at HKL	Meeting with Matron in-charge of CCIW, CCU and ICU. Introductions were made. The do's and don'ts of the hospital regulations were discussed.
2.00pm	Meeting with the hospital security on making the student pass.
29/6/2010, at HKL, 11.00am	Meeting with Matron in-charge of General Ward at HKL. Orientation to hospital wards was given. Visits to the male and female wards, first class and classless wards, coronary rehabilitation ward, geriatric ward, CCIW, CCU and ICU wards were shown. The researcher was introduced to some doctors at the ward.
2.30pm	Attended the monthly meeting with the Head Nurses/Sisters from the Medicine ward. A brief introduction about the research objective and purpose were given. Initial rapport was built with them
2.45- 5pm	Collection of data
8/12/ 2010 at HAS	Observation, interviewed patients and interviewed 2 doctors that were available. Loud construction work upstairs.
9/12/ 2010 at HAS	Appointments made and proceeded interview with Sister 4. Made observations. Loud construction work continues.
21/12/2010 at HAS	Made appointments and proceeded interview with Sister 2. Made observations. Construction work stopped.
22/12/2010 at HAS	Made arrangements and interviewed Sister 3. Made observations
28/12/2010 at HAS	Made observations of critical incident at the ward – a fight among employees
27/01/2011 at HKL	Notified Matron 2 of visitation and made arrangements for interview. Made observations.

'Table 5.2, continued'

Date/Time	Journal entry
30-31/01/2011 at HKL	Acquired information about the hospital. Interviewed doctors and patients. Made observations.
3/2/2011 at HKL	Made arrangements and interviewed doctors. Visited all wards
4/2/2011 at HKL	Interviewed the patients and made observations. Critical incident at the ward- patient needing help
7/2/2011 at HKL	Made arrangements and interviewed with Matron 2. Interviewed patients and made observations.

Another important observation was the layout of both the Medical and the O&G wards which enable the staff to manage the patients in a systematic way. Even though both HSA and HKL are old buildings and have high number of patients admitted, the management of the patients' beds are arranged in an orderly structure. Figure 5.1 shows the layout at one of the O&G ward that was drawn from the observation at HSA. The layouts of beds are divided into a 'T' shape to differentiate between the ante-natal ward (women in labour pain but are not ready to deliver) and the post natal ward (women who have delivered). There is a 'staff post' which is situated in the middle in order to monitor and respond to emergencies in the ward. This reflects the approach in maintaining quality of care and patient-centeredness with timely responsiveness, especially during emergencies.
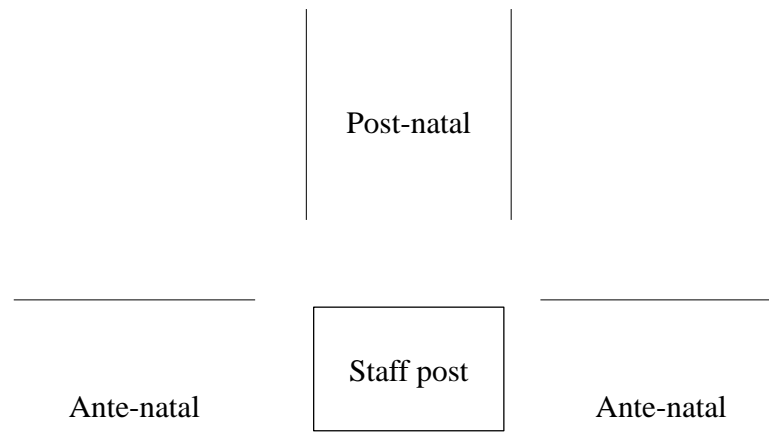
```
                    |                |
                    |                |
                    |   Post-natal   |
                    |                |
                    |                |

 _____        _____     _____
              |     |            |
 Ante-natal   |     | Staff post |     Ante-natal
 _____ |     |_____|    _____
```

Figure 5.1: Layout of the classless ward at O&G

At HKL, patients who are terminally ill were placed nearer to the entrance so that they can be monitored closely while patients that have infectious disease such as symptomatic tuberculosis or dengue are separated in a different area with star coloured labels on their bed panels which can be easily identified and monitored by the care givers. Whereas at HSA, patients who have lost their child, raped, unwed and pregnant with psychiatric problems are allocated to different areas from the common O&G ward in order for them to receive special care and assistance in counselling and psychiatry. This identification and segregation is necessary because not all the staff may recognise all their patients with the associated diseases. This is because the nature of the work in the hospital requires staff to work in shifts. When a new shift reports for duty, the staff may not recognise patients with contagious diseases if there are no indicators. In addition there are high turnover of patients because many of them are either transferred to other wards due to health complications or may be discharged. So with the limited space and resources in the wards staff from both hospitals are able to think of creative and improved ways to organise patients who need constant supervision from the rest.

This structure identifies with Deming's cycle of *plan, do, study and act* for continuous improvements and the quality of care elements of ensuring safety for staff and patients in the wards.

5.6 Findings from the thematic analysis: Supportive issues and barriers in patient care management

The data from the transcribed interviews with patients and doctors were keyed into EXCEL spread sheet while the interviews with sisters, matrons and heads of department were keyed into Word Document. About 13, 359 words from the open-ended transcribed interviews from the patients and 7, 084 words from the open-ended transcribed interviews from the doctors were analysed using thematic analysis. The transcribed interviews, field observation notes, vignettes and incident reports were articulated and analysed line by line. According to Dewalt and Dewalt (2002) careful reading and re-reading of the data will enable connections to be developed to provide insights.

The in-depth interviews managed to probe the participants into explaining the details on the care they received (patients) or provided (doctors) by describing incidences from their experiences in the wards which were analysed according to the supportive issues and barriers that influence patient care management. The connections and analysis from the other approaches together with the in-depth interviews formed the framework of the discussion which is described in the next section.

5.6.1 Clinical communication

Generally the results from the observations and interviews showed patients were given explanations on their illnesses. During the interviews the patients explained about

the care received and how it formed different meanings to them. In fact the most comprehensive explanation was when one of them said that her doctor treats her like a 'friend.' One of the patients at HSA actually pointed out which doctor was the most helpful. In most cases, the patients explained they could freely ask questions without facing any difficulties. Two of the patients commented:

> "*They explain to me. If I ask questions they will explain again. If I don't, they don't explain to me. I feel comfortable asking them questions.*" (P1, HSA)

> "*They told me because I lost a lot of fluid. It will affect my health. I will be sick; I will not have energy, will have vomiting and so on. They encouraged me to ask question.* (P25, HKL)

Feedback is an important element to ensure the success of the communication process. There were many incidences in the wards that showed doctors check on the understanding of the patients and their family members. They recapped some of discussions and repeated their explanations.

> "*Yes, I reconfirm what they are saying. I look at them and use words that are simple. Then I confirm again.*" (D3, HSA)

> "*We confirm with the patient. We confirm with the family and ask again. Yes, I explain how come they have this. After my rounds, I go back to them and explain again.*" (D9, HKL)

> *Yes. I always summarize and repeat what they've told me and then I check again with them.* (D5, HKL)

There was one case whereby one of the doctors explained his technique in getting his patients to pay attention and repeat after him as soon as he had given explanation.

This method of recapping and quizzing the patient is a good way to enable the patients to be corrected and form a deeper understanding of the information.

> "*I get them to repeat the important points. A lot of patients would test the water, you need to direct them. A lot of time they would be able tell me. (…) I ask them to repeat and correct them if they misunderstood.*" (D4, HKL)

Many of the medical terms were too technical and therefore efforts were made by majority of the doctors to explain to the patients in layman's term as patients do not understand the scientific language used.

> "*Bila dia guna 'bahasa sains' saya tak fahamlah! (Translated: When they use scientific language, I don't understand!)*" (P19, HKL)
>
> "*Yes, I use layman words.*" (D9, HKL)
>
> "*Yes. I have to change everything. Some terms are so complicated. So I speak in layman terms. Example hypertension in layman terms it's 'ikat hempedu'.* "(D5, HKL)
>
> "*Sometimes when they don't understand I use the layman terms.*" (D8, HKL)

There were also incidences in the bedside in which the doctors asked questions by using a scenario. One doctor explained the following:

> "*I do ask 'berulang' (Translated: repeatedly). Do you have asthma? Then I will ask further questions like when you had the attack, did you have cats at home? So you need to ask thorough questions.*" (D8, HKL)

Thus, by communicating to the level of the patients' understanding enabled the doctors to comprehend their patients' diseases. As a result, this avoids medical errors and misunderstanding.

The results also showed assistance in translating the language to explain the procedures and treatments given. Either some of the doctors find other health care providers to translate for them or attempt to learn different languages on their own in order to communicate with their patients. Some of the comments made were:

"The Indian doctors speak to me in Tamil, so I understand." (P1, HSA)

"They spoke to me in Malay. I couldn't understand that well. They called up a Chinese doctor also to explain to me further." (P2, HSA)

"If I didn't understand, they translated in Malay until I understood." (P3, HSA)

"I get the help of translators. I learn Chinese words to help them understand." (D2, HSA)

During initiating the consultation sessions all the doctors claimed to have built rapport with their patients by asking them their names or through gentle greetings by addressing them as 'Mak Cik' (aunty) or 'Pak Cik' (uncle) or 'Kakak' (sister). Some use body language such as sitting beside their beds, looking at them earnestly and face to face and even starting the conversation with a joke. It was interesting to note some doctors commented, by using jokes they can break the ice with their patients and reduce their pain. There are many researches that show humour is significant to the patients as a form of anecdote in patient care. For example School and Ragan (2003) describe humour as healing and therapeutic. Some patients also felt comfortable with this approach. The following were some of the comments made by the doctors and patient regarding humour:

"I joke with them that I'm a vampire and I want to take their blood. So they won't feel so bad. If they are obese, I won't say you must reduce

weight. I say, if you reduce your weight, you can have more

girlfriends." (D9, HKL)

"*I'm not so serious with them. I make them feel comfortable by being*

humble. I joke with them; I break the ice and laugh with them. This

has been working well." (D8, HKL)

"They seem to be passionate. They crack jokes and make me laugh"

(P11, HSA)

From my observation, I noticed majority of the MOs and HOs were young clinicians. Most of them hail from the generation-Y and were internet savvy. They utilised the internet services and their hand phones as medium of instructions to educate patients. Since the hospitals have limited teaching resources such as models, flip charts, mannequins and white boards; they improvised by downloading medical information such as the anatomy of the body unto their tablets or hand phones to illustrate and explain to their patients. From the interviews some of the doctors described they drew and showed diagrams while explaining to their patients. In exploring this, I came to understand visual and auditory explanations assisted the patients in understanding their symptoms and diseases better. The following were some of the narratives by the doctors:

"*Will draw or use diagram for certain cases such as gynea cases.*

Such as breach and ectopic pregnancy. There are not enough aids

provided in this hospital." (D1, HSA)

"*I use visual methods. We don't have models to go around. I have*

downloaded pictures and videos on my phone and use them for my

patients. I use a lot of multimedia. It's good to have a good phone!"

(D4, HKL)

"They don't have models in the ward. I sometimes take a picture with

my hand phone and show them. I show my book that has the picture."

(D6, HKL)

Sometimes I draw to make them understand." (D8, HKL)

Communication also involves educating patients. Some doctors used symbols and stories when explaining and relating to their patients. These stories and simple analogies were considered creative ways to help educate patients.

"I use stories to relate to my patients by using simple words and

sometimes I give symbols. I call up someone who speaks the language

(for severe cases) and communicate with them. For example the

patient with asthma, I find out if she only has shortness of breath and

not asthmatic. Then I give advice on the post procedures." (D2, HSA)

Other methods in educating patients were by explaining the pros and cons of taking care of themselves.

'They do tell me how to get better, how to stay healthy. They explain to me about

diet & exercise. (...) They explain to me, what will happen if I don't take care of

my diet, if there are blocks, what will happen if there's an operation. They tell

me it's your responsibility to stay healthy. The hospital is there to help you."

(P26, HKL)

"They told me if I don't do tubal legation, I have to do family planning and

there's cost involved and there's effect. They explained this to me." (P15, HSA)

"My baby is pre-mature and underweight. They inform me after delivery, there

are regular checks. Before leaving there is also one more check. Sometimes I

worry about my child, but they tell me not to worry. When I ask them how my

child is doing, they will check the baby and report to me the details and I will

ask my husband to go and find out. They will inform where the baby is. They

explain why the baby's heart rate is fast because the liver is not fully developed.

They told me to register at the district clinic when I am discharged so that the

"Bidan" (Translated: Midwife) will come over to check on me in my house."

(P13, HSA)

Despite the fact majority of the responses by the doctors were positive, there still remain some areas that indicate barriers in patient care management. Firstly the data revealed there were many cases doctors did not initiate the sessions by introducing themselves. Although the patients felt there were eye-contact and the doctors generally seemed concerned with their illness, but they felt it was done in a "business" like manner and straight to the point. Some comments made by them were:

"*It is business like.*" (P8, HSA)

"*They went straight to the point because they don't have time. I was in*

labour and felt like fainting (…)" (P2, HSA)

(…) Sometimes they come quickly and go quickly. So I can't ask them

any questions. They don't tell me about my overall health unless I ask

them. They go straight to the point and check for other things (…)

*They just straight away examine." (*P14, HSA)

"*(...) Some are okay. Some speak like a 'matter of fact manner'.* (P22,

HKL)

Secondly some of the doctors commented the hospital is usually overwhelmed with patients and due to the busy schedule they were unable to spend the extra time in

talking to their patients. As a result of this problem they were unsure what to do and how to resolve this.

> *"Sometimes when I'm busy, so many patients to finish this morning. I had a patient who just want to talk and talk and talk. But I had to stop her and tell her that I have a lot of work to do. I do not know how to handle that."* (D8, HKL)
>
> *"(…) Because of surplus of patients and inadequate doctors, there is lack of time with patients so we don't have the downtime to ensure we have adequate patient contact time. Currently this is getting better."* (D4, HKL)

A common observation in all the wards at HKL and HSA showed there was lack of free time for doctors to talk to their patients. They seemed pre-occupied with filing up medical records, clerking patients, attending meetings or training junior staff. On the contrary, patients want their doctors to spend more time with them. Most patients were lonely and wanted someone to talk to, whom they could trust and feel comfortable with. There is also a danger that patients would feel anxious and dissatisfied if there is lack of information, feedback and explanation (Rabinovitch et. al, 2009). However the doctors do not have the extra time needed nor understand if this is the role they need to take.

Thirdly the results from interviews with patients showed there were major gaps in the following areas during the communication process:

- Explanation and planning and

- Planning shared decision making

Although patients were generally satisfied with the explanations given to them, but there still lacked efforts from some doctors in finding out if patients understood the explanations. To this, one of the doctors explained the following:

"Usually patients accept what we say (…) We ask them 'do you understand?' and they usually reply 'yes'." (D1, HSA)

Following this, one patient expressed she felt very fearful when one of the doctors explained the complications of surgery. She commented that the doctor was rude and threatening which caused her to be afraid of the surgical procedure as described below:

"(...) You nak matikah kalau tak buat operation ni (Translated: You want to die if you don't do this surgery)" (P4, HSA)

This form of expression did not encourage the patients to ask questions. Instead it insinuated that patients had no alternatives and the opportunity to make decisions. There were also studies that show more aggressive communications from male doctors who spoke to the patients firmly and have appeared to produce greater compliance with patients (Burgoon, Burk, & Hall, 1991). It was discovered from the findings, some doctors communicate firmly to noncompliant patients with serious medical health issues. In this circumstance, the doctors failed to plan, negotiate and share the decision making process with their patients and their family members. When patients fail to comply the doctors feel frustrated and usually blame the attitude of the patients as the main reason for this problem. One such comment made by one of the doctors who failed to see the importance of communication is seen below:

"Sometimes, the patient can be arrogant or sound irresponsible and they want to be discharged. Sometimes, they complain they don't want to take the blood. Sometimes, we can convince the patients but sometimes we can't, because they are very stubborn. Sometimes, we want to do a test on pathological problem and they miss their appointment. It is difficult then. When the patient has an attitude problem, the communication doesn't work well." (D6, HKL)

However, when I asked the medical staff 'what methods do they use to alleviate patients' fear?' The responses given by some doctors were they explain by providing statistics of the complications, risks that might arise and also suggests ways to overcome the problems. However this technique does not always produce the desired outcome in convincing patients. The underpinning reason may be due to lack of knowledge and skills among doctors in negotiating treatment plans appropriately with their patients.

The fourth barrier discovered in the findings were not all of the doctors were creative or aware of alternative ways in communicating with their patients using visual methods through hand phones or ipads, or technical drawings using charts, diagrams and models. They were more familiar in using layman terms to help patients understand.

> *"(....) Some terms are so complicated. So I speak in layman's terms".*
>
> (D5, HKL)
>
> *"Yes sometimes those who don't understand medical terms, I explain*
>
> *to them. We use normal terms to explain a procedure and then we get*
>
> *their consent."* (D7, HKL)

Finally the fifth barrier discovered were not all the doctors were skilful in using humour in communicating with patients. In one incident during the interview, one of the patients pointed out to me her doctor. She informed me that she felt her doctor was cynical whenever he communicates with her in a jokingly manner. In this context, she failed to understand the humour in the message that was being conveyed; instead she felt resentful and hurt. The following was postulated during the interview:

"There is one particular doctor that speaks to me like he is teasing me.

'Nan solein antha oru doctor kindle pannuvangha' (Translated from

Tamil: I told you, that is the doctor that teases me). When I ask when

can I be discharged, he said 'why you want to go? Why not you bring

a radio & listen to it". (P22, HKL)

To sum up clinical communication requires the doctors to be skilful communicators and creative artists. The findings revealed majority of the doctors communicated effectively with their patients. Some sought assistance in translating the different languages in order to communicate effectively with their patients. Most of the doctors also displayed empathy, took efforts in building rapport with patients through humour and attempted to educate patients by using visual aids and simple languages.

Despite that, there were also some doctors who instilled fear when communicating with their patients especially in getting consent and negotiating treatment procedures. Many of the patients complained the main barriers in communication were using humour in the wrong context and lack of clear explanation. They were also unhappy when family members were not included during discussions on treatment and decision making.

5.6.2   Quality of care

The literature explains quality of care has elements of measurement and action. The results of the study showed the various services provided by the hospital management in maintaining quality of care. For example the sanitation at both the hospitals was generally clean. These included the environment at the wards, the temperature and the lighting at the wards. Patients also described they were generally

comfortable both at day time and at night. In addition, patients also felt the temperature of the food served were satisfactory. The following were some of the comments given by the patients:

"This is all O.K. No need to queue up. They wash the toilets twice daily. It is clean." (P12, HSA)

"(...)Reasonably clean. They clean straight away for 3rd class." (P24, HKL)

"There is always someone cleaning the toilets." (P17, HKL)

"It's not hot here. My bed is under the fan." (P20, HKL)

"They change my bed spread once in 2 days, because it's not that dirty. If it is dirty, they will change." (P20, HKL)

"O.K. If I'm not comfortable, they will add more pillows. If compared to before, now it's more comfortable. Last time all the beds were very near to each other. Now each bed is far." (P1, HSA)

"(...) Quiet in the night. They help to switch off the lights here at night in my room." (P16, HSA)

"The food served is reasonably hot." (P12, HSA)

The feedback from patients also indicated quick responsiveness of the hospital staff when patients faced problems.

"The technical staff changed the lights in my room. It was spoilt. They were fast in their service." (P16, HSA)

"Initially my bed was too high. I asked for a change of bed. I wanted the one with rollers. Then they changed it." (P4, HSA)

The results showed safety of patients and staff were looked after. Patients with contagious disease and critical illness were closely monitored with good planning and

organising of the layout system. As a result both hospitals have good management system. In addition HKL showed exemplary measure by receiving ISO 9001 in 2000, accreditation by MSQH and Guinness Book of Awards for safety of patients.

The findings also revealed most patients felt the closing session was good because they were encouraged to take responsibility and be self-reliant. Patients from O&G were encouraged to walk after delivery and to care and nurse their babies as soon as they were strong enough. One patient who had dengue was asked to record the number of times he had consumed water in a chart drawn for him. He also had assistance from his family member. This helped him identify his total liquid consumption for the day to monitor his recovery.

Patients were also advised on long-term consequences and to continue follow-up sessions. Explanations were also given to patients and their family without discriminating if they were Malaysians or foreigners.

"We explain to them what is going on with them. We tell them if they don't control, the implications such as kidney can go, cataract, etc. I feel when I explain to them, they understand. They can continue to manage, as long as they understand their illness and complications." (D6, HKL)

The findings revealed patients' welfare was constantly monitored by the hospital staff. The doctors also ensure patients return to a safe environment at home with good social support system before they are discharged. Patients with psychological, financial or social problems were referred to relevant departments by the health care providers. This follow-up until the end reflect customer-provider relationship in bedside care. The following quote from one of the doctors demonstrates this:

"Ensure the environment that you are sending them back to is a secured one. If not, we need to refer them to welfare department." (D4, HKL)

The findings from HKL; especially from the HDU (High Dependency Unit), ICU (Intensive care Unit) and the CCU (Critical Care Unit) showed many of the staff volunteer during their free time to help patients go for walks, assists them in shaving and teach them special rehabilitation exercises. All the factors discussed above translate into patient-centeredness of care. The following quote describes patient-centeredness through an elite interview with a Matron in the hospital.

"(...) the nurses go out of their way to help patients and use special rehabilitative techniques to care for their patients. For example they communicate with them to cheer them up, take them for walks, (...) buy small gifts and assist them by shaving the patients." (E6, HKL)

Although there were many evidences from the interviews that demonstrate quality patient care management at both hospitals, the findings also revealed there were strong dissatisfaction expressed by patients towards the cleanliness of the bathrooms, shower rooms, washbasins and toilets.

"There is no cleanliness here. A lot of pampers are all over the place, there are blood here and there, tissue papers are here and there, they just throw their hospital gown all over the place in the toilet; even the cleaning staff complaint about this." (P18, HKL)

"The toilets are smelly. There's always a smell, I feel uncomfortable." (P19, HKL)

"The bathrooms are clogged and the water is coming out. I've been here for 5 days." (P2, HSA)

Furthermore, I have witnessed one particular critical incident that showed the struggle of an elderly Chinese woman. The following vignette was recorded in my diary entry:

> 4/2/2011
> (...)
> *As I was walking along the beds, I noticed an old Chinese woman saying something in her language. She was sitting at the edge of the bed and pointing to the middle of the bed. When I passed her, she was looking at me intently and stopped speaking. I thought she wanted some acknowledgement or company. I looked at her and greeted her 'Chow Ann Aunty' (which means good morning Aunty). Then she immediately responded to me in Mandarin and her voice became louder. She seems weak to move but her voice became louder and louder. She repeatedly said something in Mandarin to me, 'Ta Pian', 'Ta Pian', which I finally understood. She passed motion on the bed and she needs help cleaning up. She feels uncomfortable and needs help. So I called one of the nurses and translated what she said. Thank goodness what little I learnt from my Mandarin classes 20 years ago came in handy.* (C2, HKL)

One of the crucial points in this diary entry was the dilemma of the woman who could not communicate in English or Bahasa Malaysia. She was desperately looking for someone who could assist her as she was frail looking and too weak to clean after herself. Unfortunately no one could understand her. Since it was Chinese New Year holiday, all the Chinese doctors and nurses were on leave that day. Consequently I reflected on my own mother who was also about her age. She would require assistance if she was sick and weak and admitted at the hospital. Who would help her? This was lacking as a crucial point in the quality of care provided for patients who could not communicate well and have no family members to accompany them. However, there are some hospitals that have got strict policies which will not allow patients to be admitted without the accompaniment of a family member. However, this would pose a big problem with the current situation in HKL and HSA as the hospitals face lack of space and resources to allow family members to stay in the hospital. Therefore in terms

of quality of care, the health care policies in Malaysia should be re-examined and benchmarked with best services provided in bedside and hospital care within the region.

As demonstrated from the examples, the quality of care is described as the quality of information and quick responsiveness of care, access to a safe and sanitary environment as well as good doctor-patient relationship that is built. In addition the findings also showed other forms of quality of care such as religious care and respect for patients' rights and dignity that will be discussed in the subsequent sub-headings. These expressions of care are perhaps uniquely found in Malaysia. To sum up these expressions of care are the illustration from an elite interview with one of the Senior Sisters at HSA:-

> "*We must have 'sentuhan, sebab ia adalah penting' (translated: touch*
>
> *is important). We need to care for them like 'family'.*" (E5, HSA)

5.6.3   Leadership

Overall, the results showed both hospitals have doctors with good leadership abilities. Many of them portray good role models to junior staff and demonstrate different forms of patient care management. The findings revealed there were frequent trainings conducted in the hospitals such as, how to do; plotting of pathogram, cervical vagina examination, suture, documentation and pistomy. Monthly reflective meetings were regularly carried out on areas such as critical incidents, seminars, workshops and weekly presentation of cases (i.e. on Apgar score, morbidity rates, mortality rates). The meetings and trainings assisted fellow colleagues at the hospitals to share information and latest discoveries.

The data revealed different leadership styles of doctors such as democratic, laissez-faire and autocratic in both hospitals depended on the different encounters with their patients. Some of the doctors explained sometimes they were cautious and would examine the situation before managing their patients. This was because some patients would use their vulnerability to take advantage of their doctors. The following were some of the narratives conveyed based on the different scenarios the doctors were in and why the different styles of leadership were necessary:

> "(...) *With some patients we need to give more attention and with some we have to be more firm. Some patients take advantage and exaggerate their disease. I've been manipulated before in my previous work experience.*" (D2, HSA)

> "*A lot of patients would test the water. You need to direct them. A lot of time I would be able to tell if they do that.*" (D4, HKL)

> "(...) *Trust me, it's not nice to see patients again. Sometimes we need to be harsh and make them feel scared or guilty. Example, my diabetic patients. I explain to them, you have 2 feet and 10 toes. Now if you don't take care, we've got to cut.*" (D9, HKL)

> "*Patients tend to take things for granted if we tried to reduce to the patients' level. Certain patients we give extra care, especially in labour room.*" (D1, HSA)

The findings also revealed majority of the doctors portrayed human skills as described by Robbins and Decenzo (2004) through their demonstrations of care, empathy and assurance given to their patients in alleviating their fears. For example in the cases narrated by the patients below:

"When they checked, my baby's heart rate was low, the doctor quickly alerted the specialist. I was brought to the operation room. He kept assuring me 'not to be afraid'. They didn't straight away cut me up. They asked if I was alright and felt any pain, when I was bleeding before the operation theatre." (P2, HSA)

"(...) I was scared because my baby was breach, but he explained clearly. The doctor kept saying "don't be scared", "all the doctors are good here. If you have any pain, they will help you. Then I was relieved. I was scared in the beginning but after explanation, I felt better." (P3, HSA)

"I have eczema on my leg because of long term effect taking neulin and ventolin (...), but the doctors just check straight away. They put their hands on my leg and check and they don't show if they feel disgusted." (P20, HKL)

Other examples described by some of the doctors in demonstrating care were through verbal assurance and their body language:

"I give assurance when they are scared. Telling is normal. A lot of patients go through this." (D3, HSA)

"(...) Body language is important. If the patient is open to me. I will sit by their bed and hold their hands or stand close proximity unless they have infections. When you have eye contact, they know you are serious. If you don't, then they start putting up a wall. Then it's difficult." (D4, HKL)

"By touching when sad, maybe a pat on their back when they are sad, I give assurance." (D8, HKL)

"I like to sit by their bedside and hold their hands and listen to them.

If one of the patients cries telling their story, I will hold their

shoulder; I will ask Mak Cik (Translated: Aunty) okay, ya? Then I will

keep quiet and listen. When they stop, I will reassure them that they

can tell me anything." (D5, HKL)

The experiences in the wards suggest if the human skills are lacking, there will be serious repercussions such as end of life. Therefore, the findings showed listening skills and touch seemed the most reassuring way in patient care management in the wards. As described by one of the doctor:

"I'm afraid if they don't express, there would be suicide attempts,

depressions etc. I feel this works by listening to them." (D5, HKL)

Some of the patients also described examples that showed their doctors listened to them as shown below:

"I told them I have pain. They did something about it. They quickly

attended to my pain. Otherwise I would be in high risk." (P1, HSA)

"(...) The doctor said I can't go back until I'm better. They listen to

me. When I was walking & I can't breathe, one of the doctors lifted

me & put me on the chair. He said don't walk." (P23, HKL)

Besides the human skills, there were also some doctors with special technical skills such as picking up other languages beside their mother tongue such as Mandarin, Indonesian and Tamil in order to communicate and respond better to their patients. Others picked up local words for common terms in order to make the patients understand. For example as mentioned by one of the doctors, *hernia* is called *pasang*

surut in the Malay language. This term was widely used in the wards to help patients understand. This behaviour sets as a precedent at the wards as the senior doctors become role models to junior doctors especially in acquiring a new skill.

Motivation was the key factor in the leadership portrayed by the doctors in bedside care. The doctors explained they motivate their patients throughout their treatment procedures. Some even motivate them to open up and talk to them about their troubles and dilemmas. By doing this, the doctor would be able to engage with them on discussions about treatment procedures. Consequently patients would be more willing to follow the advice given. The following explain the experiences narrated by the doctor and concurred by the patient:

"(…) *Very important to let them talk, be patient. They have a lot of stories to tell. When you hear the whole story you will know about their lifestyle. They will reveal a lot about themselves such as their diet history, decision making process and so on. (…) Personally I am very uncomfortable if they are silent. I ask them more questions. When they are interactive, they feel more comfortable and you can discuss treatment that works best for them."* (D4, HKL)

"(…) *It's the way they talk. Some of them are empathetic. If there is sympathy when they ask me questions, then I feel easy to talk to them. Some are too serious, Those who are serious, I don't feel easy to talk to them (…) I feel lazy to ask them anything, even if I ask, they would just give me one answer."* (P19, HKL)

Some of the doctors described their experiences on how they motivate their patients to have a goal in their lives in order to look forward to their future. In doing so, the doctors encouraged their patient to take care of themselves. They associated 'inspiration to be with family' as the main 'push factor'. The doctors used this approach

to inspire their patients so that they can treasure their lives. From the in-depth interviews, some of the doctors explained that if the patients saw the relevance of this, they would feel their life was important and worth living. The doctors also emphasized the important roles of the patients' family members as care givers. From the interviews, the majority of doctors encouraged family members to provide extra support system needed at home.

In addition, the findings from the interview also revealed motivation skills were most crucial toward patients who were vulnerable such as the elderly, those in critical conditions and when breaking bad news. The following were some of the narratives expressed by the participants:

"*Sometimes I tell them, you must live. Don't you want to see your children get married? Don't you want to see your grandchildren get married? This motivates them. Sometimes I have patients with cancer; I had to deliver bad news to them. I counsel him by telling him this isn't the worst thing in your life. You tell them to live life to the fullest.*" (D9, HKL)

"*I have an amputated case. The patient was giving up in life. I encouraged him and told him to fight for your life. It's not the end yet.*" (D7, HKL)

"*I will try to encourage my patient, like my patient who was paralysed from the leg downwards, I told him; you can still use your brains and hands.*" (D5, HKL)

"*This is important. The doctor would make me feel confident with myself. They give me courage. The mentality here is different.*" (P28, HKL)

"(...) They were sympathetic with my situation and gave me encouragement." (P12, HSA)

The most important characteristic of a leader who motivates is to follow-up until the end. They also do not discriminate, instead they treat every patient the same, irrelevant of gender, religion or race. Most of the patients from the public hospital came from middle to lower income families. They were not aware of various services provided by the hospital such as special consideration for financial assistance, welfare service, counselling and physiotherapy. The findings revealed many doctors referred their patients who faced financial difficulties to the relevant department for assistance. Below were the narratives from some of the doctors on the support given to the patients followed by a comment given by a patient regarding this:-

"Especially the older patient, they come hospital with complications or a chronic disease. It's my job to find out their social problem, financial background, family support, and lifestyle. I refer them to welfare if they have financial situation or social problem. If they have a psychological problem, they will be referred to the counseling unit. It is important that you are consistent. If you see through it until the end, it makes a big difference. If you say you want to refer them to the welfare, make sure you see through the end." (D4, HKL)

"I had a patient, 32 years single mother who has 4 children, who had recurrent stroke because she has been non-compliant in taking her medications. So I had advised her to take her medications consistently, otherwise she will die and her children will be without a mother. She is too poor to buy medicine outside and she cannot leave her children to go for her appointments. She is single mother who is

working and supporting her children. (...) I told her not to be sad. I

will refer her to the social worker." (D8, HKL)

"We also refer them to a physiotherapist. We don't discharge them,

we still make sure for every problem he has a definite plan and he is

seen through. We encourage patient to go through rehabilitation

therapy, physiotherapy, massage. (...) Sometimes they don't follow

and they don't go. We advise them to go and we check if they have

gone. We check their progress." (D7, HKL)

"(...) I told I don't have enough money to pay, so the doctor is

arranging with the welfare department to take care of this." (P26,

HKL)

This supportive behaviour explored in the wards showed the powerful influence

the doctors have during consultations, which was described by Thomas (1987) as

"therapeutic agent" and "placebo", whereby the doctors draw on all their skills,

experiences and knowledge to serve the needs of their patients.

The findings also revealed that many of the doctors teach the patients to be self-

reliant and take responsibilities. This empowers them to make decisions and take care of

themselves. The following were some of the comments that were noted:

'We advise them to take responsibility with themselves. The stitches

are dissolvable but they must take care. If the patients smell a puss,

they must quickly go to the nearest clinic. We also advise about

contraception and doing intercourse. We tell them if they have

stopped contraceptives, they must stop intercourse. Some patients'

listen, some don't." (D2, HSA).

"We give them a book to check their glucose level and we tell them to record it in their book and we can see if they are progressing. We make sure every problem has a definite plan and we see through."

(D6, HKL)

Overall the findings showed doctors in both the hospitals portrayed leadership qualities in their profession. They utilised their technical and human skills in providing quality service to their patients and their family members. Another important discovery in this research was the crucial roles of doctors as motivators and educators. The role of doctors as clinical teachers seemed vital in providing bedside care in the wards. In this context, the hospital wards were seen as the classroom and the patients were the students. Therefore the creativeness of a clinical teacher was important as the patients come from different background and levels of education. In addition, there were evidences from the participants' responses that the doctors took every opportunity in teaching their patients to be self-reliant and responsible for their well-being. The findings also revealed limited evidence indicating barriers in patient care management in terms of leadership abilities of the doctors in bedside care.

5.6.4   Culture in health care environment

In this research I have divided culture in health care environment into two main areas which are the organisational and socio-cultural perspective. In this context, the organizational perspective examines the norms of behaviour, artefacts, values and assumptions that shed some light into patient care management. Further exploration into the hospital setting revealed new emerging themes. These themes are known as socio-cultural perspectives. The socio-cultural perspectives are sub-divided into religion,

traditional complementary medicine, cultural beliefs and the dignity and rights of patients.

5.6.4.1 Organisational perspective

According to Davies, Nutley and Mannion's (2000) the different levels of culture in health services are assumptions, values and artefacts. The findings of this research reflect this which can be seen in the framework shown in Figure 5.2.
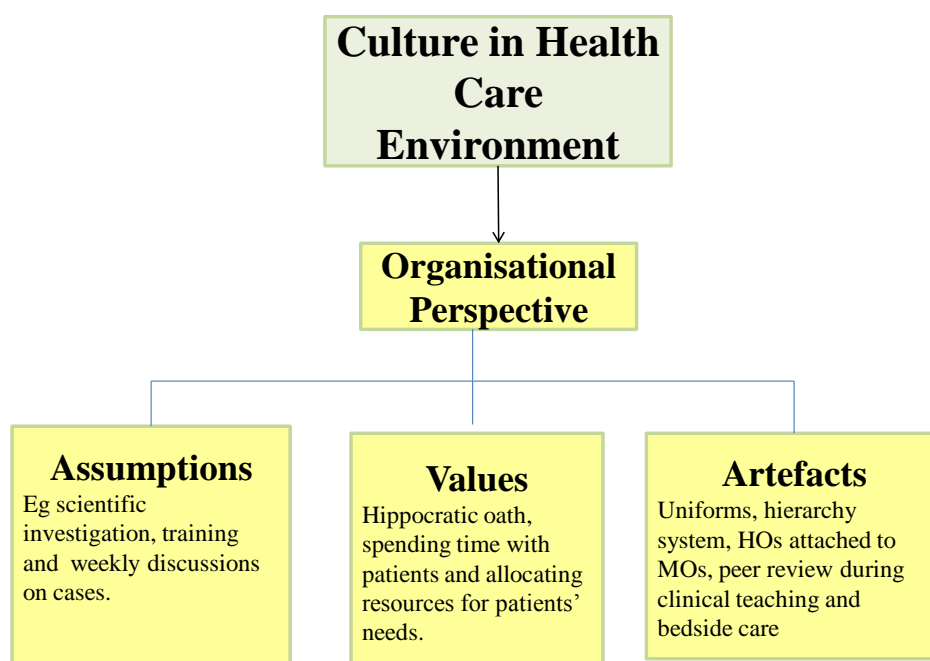
Culture in Health Care Environment

Organisational Perspective

Assumptions	**Values**	**Artefacts**
Eg scientific investigation, training and weekly discussions on cases.	Hippocratic oath, spending time with patients and allocating resources for patients' needs.	Uniforms, hierarchy system, HOs attached to MOs, peer review during clinical teaching and bedside care

Figure 5.2: Culture in health care environment - the organisational perspective

Overall the organisation of both hospitals was well managed with regular trainings and meetings to improve the health care providers' skills and knowledge. I have illustrated this point in the journal entry from the field notes and observation. The employees in the hospitals are well dressed in uniforms according to their profession. The doctors wear shirts, slacks and white coats and carry a stethoscope and patient's chart with them, whilst the nurses wear their white uniforms with their nursing caps.

I was asked to wear a white coat by the HOD of the wards in order to elicit the interviews with patients. However, after two days of wearing the white coat, I felt this was not ethically correct. I felt that I was disguising as a doctor to deceive the patients. The patients associate the white coat as a symbol of medical practice and a doctor's occupation. I had to explain in great detail that I was a PhD student looking for answers for my research. Subsequently I did not wear the white coat to the hospitals and thankfully this did not make any difference to the cooperation I received from the patients.

The organisation structure of patient care management in the ward consist of three levels of hierarchical system of responsibilities; which are top, middle and lower level managers. Being in the top level managerial position required the consultants and the specialist to craft the overall direction of the management and provide appropriate medical care plan for treatment and services to be administered in the wards. The treatment and services were discussed in great detail during the weekly staff meetings. The MOs are the middle level managers who train, support and supervise the HOs to carry out the treatment plans. The HOs who are the lower level managers are the implementers in the system. There is also clear succession planning for medical doctors in the hospitals. The HOs will be promoted to MOs after 2 years of sufficient experience in the wards.

The findings from the observations in meetings and discussions revealed senior staff practices peer review and reflection on patient's cases presented. I also observed clinical teachings provided by senior doctors to junior doctors during bedside care, meetings and discussions. This practice is passed down over the years. The junior

doctors seemed to value the advice given by their peers as it enables them to make better judgments toward the treatments provided. There were many incidences that prove during situations when there were limited resources such as drips, equipment and screens, the hospital staff go out of their way to other wards in search of these resources. This allowed me to correlate the fundamental purpose of medicine which ultimately is based on the Hippocratic Oath. The oath places the need of the patients above all else to ensure the best services in patient care management were executed effectively. There were also occasions observed that some doctors walk around the wards to spend quality time with the patients, over and above their consultation time. The findings showed this practice is a norm and a value shared by the medical staff in both hospitals.

One of the major barriers in the organisational perspective was the congestion in the Medical Wards at HKL. From my observation, there were times when the wards were overcrowded. Newly admitted patients were placed on stretchers due to insufficient beds. The high volume of visitors and patients in the Medical Wards also affected the cleanliness of the toilets although there were regular cleaning services. The situation was unbearable during the holidays and weekends especially during the visiting hours. I reflected this in my diary of events:

> 3.2.2011
> *The hospital is overcrowded, too many beds, too many people everywhere. Some are on stretchers. If I'm claustrophobic at the wards, I would not be able to cope. I feel a little claustrophobic at times in the wards. (....) There are no toilets that I feel comfortable to go. The office at the CME is closed for the holiday. Collecting data at the wards today is very depressing. I'm too afraid to use the patients' toilets. (R3, HKL)*

I further explored this situation to find out the reason behind it. The findings from the elite interviews indicated that the overcrowding in the hospital was because HKL is popular among the local residents due to the fact that it is located at the central area of

the city. HKL is also popular because it is a national referral tertiary hospital which has a policy that does not refuse any patients who are referred and admitted to the hospital. However, the overcrowding of patients was not found in HSA.

A small number of the patients have expressed their dissatisfaction towards the dull colour of paint on the existing walls in the O& G wards. The patients feel a fresh coat of paint adds aesthetic value to the environment especially when their child is born. The following was postulated by one of the patient:

> "*Paint the hospital white or light colour because it is pure. I want my baby to see something pure and nice when he comes out into this world. Not seeing something that is dull.*" (P3, HSA)

Another barrier was the loud construction noise above the O&G wards. This lasted for a few weeks. The patients voiced their dissatisfaction because they had difficulties putting their babies to sleep. The following were some of the complaints by the patients:

> "*(...) There is hammering in the ward, like some kind of construction going on. They are fixing something and so the babies cry because it's noisy*". (P2, HSA)

> "*The construction is very noisy. Even though there is time to rest.*"(P13, HSA)

I also witnessed a loud argument in the O&G ward between two maintenance workers. Although the workers were not employees of the hospital, but I considered this conduct a barrier as it was noisy and gave a negative impression towards visitors and patients. If sufficient resources such as a discussion rooms were provided, staff could

utilize it for private discussions. This vignette was recorded as a critical incident in my

diary.

> 28.12.2010 (9.00 - 9.20am)
> At the entrance of the O&G ward, East Wing, there was a big commotion between the maintenance/cleaning supervisor and her cleaning staff. The issue was about taking some cleaning equipment without asking permission. This went on for about 15 minutes and was very noisy in the ward. The patients were resting and were rudely awakened by this argument. Some of the staff reminded the two ladies patients were resting and after a further 5 minutes of arguing, they stopped. Some racial sentiments were also mentioned by the supervisor. Perhaps if there was room was available, they could discuss the misunderstanding privately. (C1, HSA)

Other insufficient resources recorded in the findings were bedside screens, breastfeeding rooms, heaters in shower rooms, toilet papers and soap dispensers in the bathrooms. The following were some of the comments by the participants on the lack of resources:

"There is no heater. It is O.K. for the Malays to bath in cold water. The Chinese need to boil the water or use heater to bathe. They don't bathe in cold water." (P13, HSA)

"You need to bring your own tissue papers, the toilets don't have toilet paper." (P2, HSA)

"The toilets lack toilet papers." (P13, HSA)

There is no soap, it is empty. So can't wash hands. So I have to come out all the way to the wards to wash hands. So it's not unhygienic to touch the babies after going to the toilet. (P13, HKL)

"There are no special rooms for breastfeeding because the condition of the ward does not permit it. I think it is necessary to have one. By right, curtain screens will also be ideal for each of the beds. But we don't have such bed sets." (E5, HKL)

One of the reasons the hospitals faced lack of resources was because both the hospitals have high volume of patients and were normally referred to by district hospitals and clinics. This is a known fact by the patients. However due to the financial constraints many of the patients could not afford to go elsewhere as postulated by some of them.

"(...) There is overload. There are too many people here. Because of that the toilets & sinks are not clean enough." (P26, HKL)

"(...) It depends on my financial situation. If I can afford something better I would go there. I spent 22,000 at IJN for my past sickness." (P15, HSA)

Cost of supporting oneself for treatment, medicine and hospital stay was a major barrier to many patients who come from low socio-economic background. Some of them also feel homesick and anxious to return home. From my observation and interview I reflected and recoded an episode in the ward in my diary concerning a troubled elderly woman who faced financial difficulties and her reactions in the ward. The following vignette was recorded from her story:

4.2.2011 (4-430pm)
(…)
This patient was poor. She received things from other patients who were discharged from the hospitals like cups, mineral water, food (e.g. mandarin oranges). In her broken Malay, she told me she felt scared all the time. She couldn't sleep well for 1 week as she cannot afford to pay RM48 for her medical bills and she was told she could not go home until she settles her bill. She was very sad as she did not receive her monthly allowance from the welfare department as they closed her account without informing her and she does not know why. She complained she hardly sees her son who works night & day at the gambling arena in Genting Highland. He could only visit her at night after work, but the hospital visiting hours does not allow him to visit her at night. She couldn't eat the food served at the hospital because it's spicy. It had curry and spices. She mentioned 'are they preparing for my death?' in a worrisome manner. She believed the food cooked with spices was bad for her health and subsequently would trigger her

migraine and asthma. Whenever her son came, he brings her some rice porridge with a little piece of meat. She keeps saying that she is an honest woman. She showed me all the evidences such as the letters and the eligibility card for receiving her monthly collection of RM300 in welfare aid. The evidences looked authentic to me. She keeps repeating 'kalau tipu-tipu nanti matilah!' (Translated: If I lie then I will die). I quickly comprehended that this translates into her values and beliefs. She seemed restless and scared. She keeps repeating her ordeal. She said the hospital staff has informed her son, she is 'crazy'. This made her feel even more anxious. She was probably seen as an old woman rattling away her sorrows. I speculated that somehow she was cheated of her money and was seeking help. (C3, P23, HKL)

I discovered from one of my interviews with a doctor that this patient was referred to the welfare department. There was no mention on her sanity or her predicament. The findings revealed some patients place certain values very dearly to them. In this case, the patient values honesty and support from family. She treasured her son's visits and the little gifts he brought. She also felt dishonesty will lead to death. Perhaps she was talking about 'karma' which is a belief by most Buddhist. This will be discussed under religion in the next section. Furthermore she was also not satisfied with the visiting hours practised by the hospital as it was not flexible enough for those working on shift duties.

To summarize, both hospitals have appropriate systems in place such as hierarchical system, professional code of conduct, uniforms and organisation structure to manage their daily operations. The hospital staff resolved treatment procedures and medical services through regular reflective discussions and meetings. Senior doctors also peer reviewed the clinical teachings and bedside care provided by junior doctors to improve patient care management. However, the crucial point observed were insufficient space and resources which indirectly affects the overall outlook of the hospitals. This has led to problems such as overcrowding, noise and lack of privacy for

private discussions. There were also patients who faced financial and social difficulties in the wards. Although they were referred to the welfare department efforts in dealing with this situation was less effective.

5.6.4.2 Socio-cultural perspective

The fourth factor in patient care management is culture in health care environment. The initial understanding of culture in health care environment only consisted of organisational perspective. However as the research explored further new emerging themes were discovered. These are categorised into socio-cultural perspective. The findings from this perspective are sub-categorised into religion, traditional and complementary medicine, cultural beliefs and the dignity and rights of patients as shown in Figure 5.3.
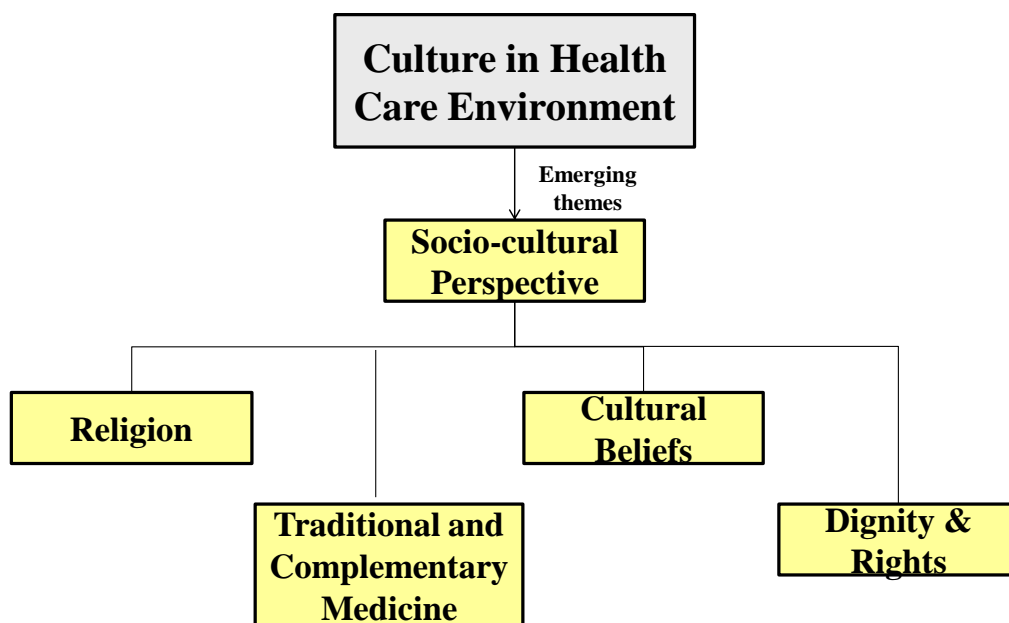
Figure 5.3: Culture in health care environment - the socio-cultural perspective

5.6.4.2.1   Religion

Religion was a significant discovery in this research. The findings show Christian, Muslim and Buddhism religious practices were strongly ingrained in the wards. From my observations, I noticed Christian missionaries and pastors praying for healing and comfort for the sick patients. In addition, the findings from the elite interviews revealed Muslim women, who were raped, molested and with family problems were visited by the female religious advisor known as "ustazah" from time to time to be counselled. The hospital follows a policy in which staff will not interrupt nor discourage anyone providing prayers and support to the patients. The following were results gathered from the interviews:-

"There was one patient who was psychiatric. When the missionary

finished his prayer, I approached the patient. I feel we should never

interrupt their prayers." (D5, HKL)

"We train our nurses to respect the different religions. This is what we see in the

wards and this is how we work. We also allow Christian missionary or priest to

pray for the patient. We also keep the Yasin booklet at the ward to give to the

relatives." (E6, HKL)

From the elite interviews with the matrons and sisters, it was discovered other religious practices such as Hinduism and Buddhism evident in the wards. The hospital allowed such practices as long as they was safe and do not disturb other patients. The following were the comments taken from the dialogue:-

"(...) The Hindu patient's family members bring their "white powder"

to put on their patients forehead. We also allow them to put the lime

that has been prayed under the patient's bed. As long as it is not

combustible and does not affect the ward. The Hindu 'Samiyar' also

are allowed to recite for the patient. As for the Chinese patients, we

allow them to bring calligraphy papers of prayers. They put on the

chest of the patients or put under the bed." (E6, HKL)

The findings from the elite interviews also indicate nurses are trained to respect other religions. Muslim nurses are trained to whisper the Azan recital to newly born Muslim child who has no family, to teach the patients how to pray, assist in distributing the "Yasin" booklets (the Muslim prayer booklet) to families who request them and to teach the patients the techniques in performing prayers while sitting or lying down. There are also nurses who volunteer to assist the "Ustaz" (known as the male Muslim priest) during their free time as mentioned in the dialogue below:

"*Sometimes if the patients don't have relatives and the Ustaz need*

volunteers, they will request for the hospital for volunteers to 'mandi

mayat' (Translated: bathing the deceased). So some of the nurses go

as volunteers." (E6, HKL)

In addition, during my data collection at one of the high dependency ward (Coronary Rehabilitation Ward) at HKL, which consists of patients with acute illness, I noticed religious care provided by the nursing team. One nurse mentioned to the Muslim patient who was unable to talk and move before feeding him:

"*Ucap dulu Pak Cik, sebelum saya suapkan. (Translated: Say your prayers first Uncle, before I feed you.*" (O2, HKL)

Similarly, Muslim patients who are unable to recite the last rights will be assisted by the health care providers. This crucial point was discovered during the elite interview at HKL narrated as follows:

"If a patient has no family and is a Muslim, the nurses at the bedside will read the Azan to the patient's ear and we tell them Pak Cik or Mak Cik ikut saya mengucap dua Kalimah Shahadah, Ash- ha- du- Allah- e- la- ha- il- lal- la- hu- Mohammadur- Rasulullah' (Translated: Uncle, aunty please repeat the Kalimah Shahadah, which means I bear witness there is no one for worship except Allah and Mohammad is the Prophet of Allah." (E6, HKL)

The findings also revealed majority of the doctors who are Christian and Muslim faith from both hospitals religiously pray for their patients. The following were their narratives:-

"During the downtime, especially at night, when it's really quiet, I walk around and I will ask the patient if they feel comfortable and if I can pray for him irrelevant if the patient is Buddhist, Hindu or Christian. I know my God heals (...). If a patient dies, I know I have done my part and I am not a failure." (D4, HKL)

"Whenever I leave my house, I pray to Allah. It is very tiring. Please give me strength and help me to be good to the patients and my colleagues. If I do this, I have pahala (Translated: blessings)." (D8, HKL)

"I had a patient with cancer and I had to deliver bad news to him and his family. I prayed for them. I with keep in touch with some of them and see how they are doing. I tell their family members to pray." (D9, HKL)

I further speculate there are many such incidences like this in the wards. This led me to believe providing religious bedside care shows empathy and provides patients with hope.

It was interesting to note although there were numerous supportive responses on the religious care provided, there were also hindrances due to religious reasons. For example some patients do not wish to use contraceptives even though it may be life-threatening to them. They were not satisfied when their husbands were not included in the decision-making process as shown in this example:

> "*Initially I didn't want the operation, the doctors tried to convince me without my husband. I felt uncomfortable when they discussed the procedure without my husband. I told them my husband need to be there. Only then they got him involved. Another doctor had a discussion with my husband, only then we agreed.*" (P4, HSA)

> "*They do ask about tubal legation. They ask about my Muslim belief on this. Since I have a sickness, I can do this. If I'm alright, I can't do tubal legation. It is not allowed in my religion*". (P15, HSA)

When the question was asked to the doctor who was treating the patient whether family members were included in decision making process, the response gathered was:

> "*Yes, we ask the husband and family. Nothing much in making decision unless is anti-natal cases. (…) Certain conditions need immediate decision making and we need to channel the decision making.*" (D1, HSA)

Overall there seemed to be lack of inclusion of family members in making decision in both hospitals. At HSA there was also lack of understanding towards the Islamic concept that upholds the husband's views and role as the key decision maker in the household. As demonstrated by the last quote, these caused clashes in cultural beliefs especially when doctors in Malaysia follow the western culture and beliefs and are ignorant towards the Islamic culture. Another major setback was the time factor during the consultation period. Family members are usually not available during the consultation period when doctors do their ward rounds. This affects the decision making process especially when crucial decisions need to be made. Nevertheless the clash of cultural and religious beliefs need to be avoided with proper understanding of patients need.

5.6.4.2.2 Traditional and complementary medicine

Using traditional medicine means using non-allopathic medicine. Complementary medicine means using the allopathic treatment together with traditional or alternative medicine. The findings revealed there were high usage of traditional medicine among the female patients at the maternity ward such as taking massages and consuming herbs. Women with normal deliveries were advised by the Community Nurses to go for massages because it assists blood circulation. Findings from the elite interviews explained that ladies who delivered were given advice on remedies for better health care such as using alternative treatment. For example to assist better blood circulation, some of the patients in O&G wards in HSA were advised to lay special heated stones on their stomach. Alternatively they were advised to use hot water bags or go for sauna treatment. The findings also revealed different ethnic group have different practises of traditional medicine. Some ethnic group have mixed practises. The following comment was narrated by one of the Chinese patient:

"It is O.K. for the Malays to bath in cold water but the Chinese don't bathe regularly after delivery. They need to boil the water or use heater to bathe. They don't bathe in cold water. Sometimes they put in certain herbs in the hot water and then they bath." (P13, HKL)

In addition, the hospital staff were also cautious when providing advice on alternative treatment. They considered the health status of the patients before they provide suitable advice. The following comment was taken from one of the elite interviews:

"We recommend massage for normal delivery but we don't recommend for Caesarean cases. They can massage after 2 to 3 months. We also advise them to get Avon herbal products." (E4, HSA)

Comparatively, some of the patients at the Medical Ward in HKL were advised to take massages and acupunctures on top of the allopathic treatment prescribed. Studies by Thomas et al., (2011) and Talib (2006) show cross-cultural usage of traditional medicine is common practise among all ethnic groups in Malaysia. Based on the feedback from participants in both these hospitals, I further speculate acupuncture and massage were the most common traditional medicine used in Malaysia.

The results showed most doctors from both hospitals do not recommend patients to use traditional medicine because there is lack of scientific evidence in this area and they fear complications. Some of them recommend their patients to take massage or acupuncture since they are known to be safe for external usages. These recommendations were based solely on their own personal experiences. Some of the feedback through the interviews with doctors were recorded as follows:-

"(...) We are careful in advising them to take traditional medicine. We don't know the chemical content or if it's safe or not. We do not advise them on things we are not sure. It depends on situation, if it's post-delivery and the patient is just lying down and no blood circulation or there's blood clotting, we tell them to go for a massage." (D2, HSA)

*"(...) We advise not to take traditional medicine like Chinese wine after delivery. It will lead to bleeding. We also advice patients not to take excessive massage."(*D3, HSA*)*

"(...) Homeopathy is only now making its way to government hospitals. I'm not exposed to traditional medicine to recommend to patients. I only recommend from personal experience such as massage and acupuncture." (D4, HSA)

To conclude, traditional and complementary medicine is not widely practiced in the Malaysian hospitals. Patients were only encouraged to take certain types of traditional and complementary medicine such as massage and acupuncture for general types of ailments plus herbal consumption for ladies who have delivered. The knowledge of traditional practices in complementary medicine is passed down from generation to generation. However, the health care providers have limited knowledge of their benefits as there is lack of scientific evidence in its consumption. Therefore they rather not take any risks as patients are under their care. Research and exposure in this area will mutually benefit both patients and doctors.

5.6.4.2.3 Cultural beliefs

One of the biggest complaints by majority of patients was the dissatisfaction towards meals provided. Some patients felt the hospital food was not tasty and suitable for women who have just delivered. There were several cases the patients were unhappy because the food served was too oily. Consequently they had their families bring food for them. It is interesting to note that many of these cases were related to cultural practices according to different races. The findings showed this was more evident at the O&G ward in HSA, for mothers who have just delivered compared to the Medical Ward in HKL. Some of the comments made were:

> "*I'm on special diet after my delivery because of my heart condition. Every Tuesdays they serve me 'nasi minyak'. The first time I had this meal, I had diarrhoea. I'm not satisfied with the food they serve me.*" (P4, HSA)

> "*I'm not used to the food here. After delivery, the Chinese don't eat curry or eat watermelon. They are cold food. After caesarean, we also cannot eat egg. We cannot eat food that has turmeric. Then the baby becomes yellow. So my family brings food from home.*" (P2, HSA)

> "*It's not bad. O.K. But prefer the Chinese way of cooking. Here they give Malay food. We don't take a lot of water. The Chinese believe in taking a lot of ginger in cooking and they drink soup. So I don't eat the food here. My relatives bring food for me. If my relatives can't make it during the visiting hours, then I have no choice and take the hospital food.*" (P13, HSA)

> "*We have 'pantang' (Translated: taboos). They gave me salad which consists of cucumber and pineapples. For Chinese, we cannot eat*

pineapples as it has sour taste. We are only allowed to eat food with

vinegar just before delivery." (P16, HSA)

Most Malaysians follow the rituals in preparing special meals for mothers who have just delivered and for those who are sick. Even though technically, the hospitals prepare nutritious food for their patients, but patients on the other hand felt the food served was not suitable for them. Most of the Chinese patients preferred soups and porridge whilst the Indian patients felt the food was not spicy enough for their taste. Some of the patients even practice the cultural beliefs and taboos of other races. The following was postulated by one of the Indian patient:

> *"I eat home food. Sometimes the food is okaylah. We Indians prepare the food*
>
> *differently. Here it is the 'Malay style' of cooking. I ask my family to bring food*
>
> *from home. (...) I don't have appetite to eat the food here."* (P22, HKL)

Although most of the patients commented they were not accustomed to eating food that is prepared in 'malay style', the findings interpreted from the various dialogues showed; it is not the type or the way the food is prepared that cause patients to be dissatisfied but the deeply established beliefs and taboos they believe regarding food preparation in their culture. As demonstrated through the patients' narratives; all the races irrelevant if they are Chinese, Indian or Malay patients have similar conception on their cultural taboos. This explains the reasons why most patients make arrangements to bring food from home. Therefore this leads to high wastage of food in the wards.

5.6.4.2.4   Dignity and rights

In this research, dignity of patients are seen from Baillie's (2009) definition as feeling valued and being comfortable in the environment the patient is in. The rights of

patients are seen through their right to access information, informed consent and to accept or reject advice given to them (Thomas, 2009 and Aldeen, 2007). There were only a few evidences from this research that prominently showed patients' rights were upheld.

One supportive observation noted was at the high dependency wards. Patients who were immobile required nurses to feed them. During this time, it was noted that the nurses informed the patient they would be feeding the patient before they were fed. Upon further investigation it was discovered through the elite interviews this practice is a norm at the wards as a mark of respect even if the patient is in a volatile and weakest state of health.

Some doctors explained they understand the Malaysian culture and respect patient's space and privacy. The doctors explained patients have rights even if the doctors disagree on the decisions made and lead to a high risk factor. Some of them explained alternatively they try to provide their patients with options to enable them to make better decision. This was described from the feedback below:-

"(...) Very important. I need to respect their privacy. In Russia people are more open with physical contact compared to Malaysians, so it's very important. (D4, HKL)

"We do explore other choices of treatment. Patient with diabetic; we want them to control their sugar level, we give them a choice. Some want pills. As long as they comply. If surgery, we give them alternative." (D2, HSA*)*

"All patients are different. Even if you ask them to stay for extra days, they cry and want to go home because they have a child at home. The

patients take the risks. It's their right, even though it's their life. The

decision is theirs." (D1, HSA)

Another example is reflected from the policy at the O&G ward that allowed patient's husband to have short visits at any time. This provides opportunity for the patient to rest while their spouse takes care of the new born baby. Although the policy showed a positive aspect and supported the patient's right, however it also posed a barrier to other patients who were nursing their babies. Some of them have reported feeling uncomfortable being watched by the visitors when they breastfed their babies. They complained there was no privacy for them.

There were also evidences in the O&G wards indicating the lack of sufficient mobile screens and nursing rooms. The lack of adequate resources and privacy infringes on patient's dignity and rights and consequently affects the quality of service. From my observation, the few mobile screens that were available were too small to completely cover the patient's bedside and as a result did not give the patient full privacy. The following were taken from my observation notes and narratives from interviews with some of the patients.

> 15.6.2010
> *Babies were placed next to the mothers with normal deliveries. (...)
> During lunch (1-2pm), the family visits. There seem to be less privacy
> here or option for privacy. There were other family around visiting the
> patients. This looked uncomfortable for them to breastfeed their
> babies in public. Some mothers do not seem to mind breastfeeding in
> public. Others looked uncomfortable. I have observed some of the
> husbands or male relatives wondering eyes. They seemed excited
> being in the women's ward.* (O4, HSA)

"(...) There is no privacy in this ward. There are visitors, guards,

cleaners and other family members and husbands walking around. No

privacy to breastfeed as well. Each time I need to change, I have to go

to the bathroom. Only if there is an emergency, the doctors will ask

the nurses to bring a screen. Otherwise, there are no curtains." (P13,

HSA)

"The problem is the patients deliver their babies at different times and

when they come in their ward, there are visitors there and they are

noisy. How to breastfeed? Prepare a special room for mothers to

breastfeed their babies in private. Some of us are very shy to

breastfeed in public, especially we Chinese. It is very embarrassing to

breastfeed when there are visitors visiting other patients." (P16,

HSA)

The issue on lack of privacy due to lack of resources was also observed at the

Medical Ward when I noticed one of the patients changing with only one small mobile

screen covering her as noted in the dairy below:-

4/2/2011 (Ward 23)
"I saw another middle aged lady changing her clothes with only half
of a mobile screen covering her. When I looked around, there doesn't
seem to have enough mobile screens other than the one she was using.
When I asked her about privacy, she told me she told the other
patients next to her not to look." (O2, HKL)

The result also showed one of the major concerns related to patient's dignity and

rights was the way patients were treated by their family members. It was observed

during the Chinese New Year holidays, many of the older Chinese patients were

abandoned by their family members during their festival week. Upon further

investigation, I found out this was a common practice at HKL during the Chinese New

Year. This was also highlighted in the newspaper recently as many senior citizens were

abandoned by their families in public hospitals. Changes in the society in Malaysia have

caused young families with financial constraints to opt for more space and privacy in their homes and as a result could not care for their older parents (Lim & Yuen, 2012).

5.7 Discussion on findings

The collection of data was carried out at two different locations and in two different wards. The findings from in-depth interviews, observation and records of field notes and vignettes formed the final analysis of this research. The collection of data from in-depth interviews was not a straightforward process. I built rapport with the participants to encourage them to feel comfortable in sharing their experiences and narrate their encounters with me. As most of the participants were very expressive it was interesting to keep the interviews going to gain insights in understanding their background, behaviour, views, culture, tradition, life style and relationship with the other participants. Both the patient's and doctor's perspectives in each interview were considered.

Firstly the findings generally showed there were many supportive issues compared to barriers that influenced patient care management. In spite of all the supportive issues, the barriers need to be taken into consideration as it reflects how patients are managed in the hospital.

The first factor which influenced patient care management was clinical communication. Most of the doctors gave comprehensive explanations when patients asked questions and even took efforts in speaking in a layman's term or get assistance from other doctors or nurses in translating the languages. Patients also had freedom to ask questions during the consultation period and seemed grateful to the efforts taken by their doctors in translating for them. In order to help patients to have a deeper

understanding, some of the doctors recapped and quizzed their patients. The findings became obvious to me that there was a strong desire to teach the patients about caring and managing their health. Many of the doctors educate patients through negotiation by explaining the pros and cons in order to reach mutually understood common ground. Some built rapport and 'broke the ice' by joking and telling stories. Many used visual methods such as pictures downloaded in their hand phones and drawings to help patients understand better. This elicited most of the patients' compliance and understanding.

Despite that, some patients felt the jokes can be overly sensitive as not all of them understood the humour. They felt the explanations were not full comprehensible and were dissatisfied when family members were not included in the decision making processes. This led me to believe that the doctors lacked communication and teaching skills. In short, clinical communication is a very important factor in influencing patient care management. Special considerations on training doctors in delivering bad news, techniques in negotiating with patients, giving explanations and using appropriate teaching pedagogies would be useful to improve patient care.

The second factor that influenced patient care management was the quality of care provided in the hospitals. This factor has considerable overlap with other areas. Therefore I shall describe the very crucial points. Generally both hospitals had good cleaning services that regularly upkeep the sanitation and cleanliness of the wards. HKL also received accreditation awards for ensuring patients' safety. However, evidences showed majority of the patients were unhappy with the cleanliness and the lack of resources in the wards. The situation seemed unbearable as described in my vignettes and responses from interviews during weekends and public holidays.

Besides the physical outlook, quality of care also looked at the social dilemmas faced by patients who come from low socio-economic background. The first point discovered in the findings was the cost of care. Since both hospitals are public hospitals; the funds are sponsored by the Malaysian government. Therefore the hospitals incur minimum charges for inpatient and outpatient services compared to private hospitals. Despite this, some of the patients could not afford the cost of treatment plus the travel fare to commute to the hospital for follow up check- ups. The second point was the patients' support system. Many of them were physically disabled and elderly. They depend on their family members to take them to the hospitals for their regular check-ups. In most cases, their family members may not be able to take leave and as a result patients miss their appointments. This eventually affects patients' recovery. In another situation, some of the patients were single parent and could not afford to leave their children at home nor take a day off for follow-up treatments. When they fall sick and get admitted they beg their doctors to discharge them as they have young children who are alone at home. These are the common dilemmas faced by many patients in the wards. The findings showed some doctors failed to understand patients' dilemmas. Instead they blame the patients for being stubborn and ignorant of their health. I could only postulate the vulnerability of some patients and the sacrifice by others for their family members. However I feel at some point there should be some compromise by both the hospital staff and the patients as ultimately the well-being of the patient is of importance.

The findings revealed the third factor that influenced patient care management was leadership. Leadership in health care is an integral part of management. The finding showed the doctors were managing the wards, treating the patients, making decisions, working with other health care providers, and continuously making sure complete care

was given to patients. They were constantly required to draw on their skills, experience and knowledge in providing care. Majority of them demonstrated their care through their human and technical skills using verbal and nonverbal communication techniques. Most of the doctors were interactive with patients by spending extra consultation time with patients and motivating them to have a goal in their lives. Some of the doctors also some picked up a third language (most Malaysians know two languages) in order to relate with their patients better. Majority of them demonstrated the ability to teach patients be self-reliant, manage their health and treatment procedures. There were also the 'human touch' demonstrated by the doctors as many of them provided assurance and assistance by sitting beside them on their beds, holding their hands and patting them on the back.

There were different leadership styles portrayed by the doctors in different patient circumstances; the doctors were firm when patients were incompliant demonstrating autocratic behaviour; they were more lenient when patients had moral obligations demonstrating laissez-faire and finally some doctors were more negotiable when there were alternatives and suggestions from patients demonstrating democratic leadership. It became clear in this research that there were strong patterns of Contingency Leadership and dyadic relationship between the doctor and patient in bedside care.

Finally the findings emphasised the many roles of doctors as a friend, healer, teacher and guide in providing bedside care. They can be perceived as heroes and greatness as in many cultures especially among the Indian culture. Their nurturing and therapeutic behaviour combined with their human, technical and conceptual skills demonstrates the innate qualities they possess. Their professional behaviour as clinicians contributes to the clinician role model portrayed by them during bedside care.

In other words their many roles described in this research cannot be isolated; instead they are integrated to perform their duties effectively. I have illustrated these points through the responses given by patients and doctors.

The fourth factor that influence patient care management was the culture in health care environment. The crucial points were the lack of human and physical resources. This was raised by many evidences in the findings. The repercussions to the lack of resources may affect the overall well-being of how care is provided and perceived by not only the patients but also the staff. As shown in the findings, temporary 'make-do' measures were taken to resolve the many problems faced, such as placing the patients on stretchers instead of beds, borrowing screens from other wards, and referring difficult patients to the welfare department. The outcome of these problems affects other impending issues such as privacy, dignity and rights of patients, quality of care and cultural beliefs. However, the source of the problems cannot be directed to the hospital staff as they were merely coping with the situation. The reality is MOH need to step up in providing the necessary allocations in funding tertiary and referral hospitals.

The findings also revealed there were a large number of participants from various ethnic groups in Malaysia who practiced cross-cultural beliefs, taboos and practices of traditional medicine. I discovered a crucial point; although different ethnic groups have different cultural beliefs, taboos and practises of traditional medicine, over the years some of the distinctive practices have merged with the other ethnic groups. For example the use of heated stones from the Malay tradition and consumption of soups from the Chinese traditions for women who have delivered were now practised by all races. As mentioned by Allotey et al (2002), culture is never static and therefore changes over time. The use of massages by the Indian and Malay tradition was also practised by the

Chinese patients both at O& G and the Medical wards. This explains many patients are seeking alternative treatment to allopathic medicine. However the doctors were uncomfortable when patients sought their advice on dosage and health benefits if traditional medicines such as herbs are taken. They explained there was lack of scientific tests in this area.

A very crucial finding in this research was the importance of religious care in supporting patient care management. There were many evidences in the findings that showed the various practices of religion such as Islam, Christianity and Buddhism were ingrained in the wards. The main aim described by the staff was to provide support to the patients and their families in all areas such as mentally, physically and emotionally in enabling the patients to get better.

Finally the lack of privacy infringes on patients dignity and rights and consequently affects quality of care. This is related to the lack of resources in the hospitals wards. Many patients have expressed their dissatisfaction as it causes embarrassment. Some patients who are aged were left in the wards by their family members. This reflects the lack of respect for the elders which is not the norm in the Asian culture. I wonder if this has changed the values and beliefs of the different communities in Malaysia.

5.8 Summary

This chapter explains the ethnographic approach used in exploring the meaning of the behaviour, practices and experiences of patients and doctors in the hospital when care is given and received in the wards. Human engagement was needed in this research to elicit trust and to collect data efficiently. All the facts gathered in this

research were presented logically using data analysis and management strategies. The findings show the factors that influence patient care management are clinical communication, quality of care, leadership and culture in health care environment. Culture in health care environment includes organisational and socio-cultural perspective. The organisational perspective within these hospitals consists of assumptions, values and artefacts. While the research was carefully designed, the findings surpass my expectations with the discovery of the emerging themes under the socio-cultural perspective which includes religion, traditional and complementary medicine, cultural beliefs and dignity and rights of patients.

The data also revealed numerous supportive issues that showcase the strength of the health care providers in managing and providing patient care. Some of the examples provided were respect for patients' religious beliefs, the skills and leadership abilities of the doctors, the operations management of the wards and the service care quality provided by the staff. In terms of barriers in patient care, among others, the evidence show there were lack of explanation and planned decision making provided by the doctors, lack of sufficient resources, the non-compliant attitude of the patients and lack of understanding of the cultural beliefs, religion and taboos practised by patients. The findings can be translated into the research framework which is seen in Figure 5.4.
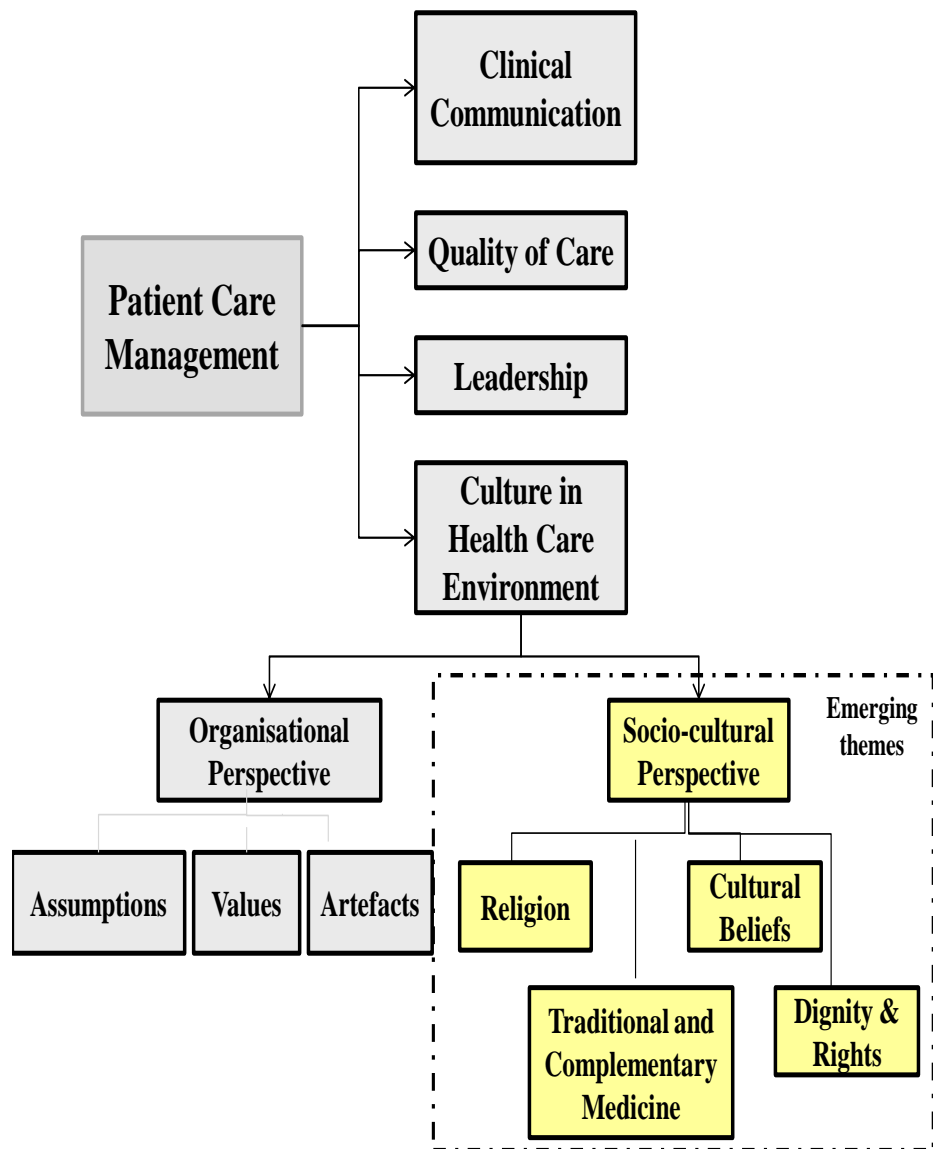
Figure 5.4: Research Framework on Patient Care Management

CHAPTER 6: CONCLUSION AND RECOMMENDATIONS

6.1   Introduction

The findings of the ethnographic research presented in the previous chapter have brought to light several emerging themes that influence patient care management. The supportive issues and barriers in providing bedside care were also highlighted from the thematic analysis. This closing chapter will conclude the summary of the research, practical implications and key findings with recommendations. Ideas on embarking on future research are included to assist the continuum of future development and improvement of patient care management.

6.2   Summary of the research

This research not only looked at the experiences from the perspective of the participants, but also from my research journey from an etic and emic perspective. As described by many qualitative researchers, the researcher is the instrument. Therefore my journey from the perspective of an *etic* to an *emic* allowed me to have a deeper understanding of the meanings in question. Although there were several limitations such as language barriers, health risks and gatekeepers; they were dealt with amicably by establishing trust with the participants and proper planning and scheduling of the research. At the same time bearing in mind the main purpose of this research was to explore the experiences and the practices of patient care management at patient's bedside in order to find out the supportive issues and barriers that influence patient care management as well as to provide recommendations for improvement.

Rigorous data management strategies and methodologies were undertaken to achieve the objectives. Data triangulation using in-depth interviews, elite interviews,

observations and record of field notes and vignettes were carried out. Triangulation puts confidence and trustworthiness in the research results which ultimately was the research goal. Relevant records were documented which showed high reliability and validity of the research. The audit trail showed the research journey that was logged in, which validates the thesis. Keeping these logs enables the continuity and credibility of the research. Other forms of validity were also carried out such as peer checks and publications from several captions of the research.

The findings showed 44 participants took part in this research. The participants of this research were doctors, patients and other health care professionals from HKL and HSA. Form the data a total of 28 bedside patients admitted in the Medicine and O&G wards as well as 9 doctors who were directly treating the patients were interviewed using in-depth interviews. In addition 7 health care professionals participated in the elite interviews to fill in the research gaps discovered. The participants from the elite interviews were the matrons, sisters and heads of departments who were in-charge of the management of the wards.

This research used ethnographic approach to gauge the hidden meaning and experiences of the participants. The findings revealed there were many actions of supportive measures provided by the doctors such as quality of care, leadership and skills of doctors and good clinical communication which built positive doctor-patient relationship in both hospitals. The organisation perspective revealed there were good management systems with regular meetings and discussions to reflect on treatment and services provided. The emerging themes discovered from the socio-cultural perspective showed there were demonstration of respect for patient's religious beliefs, provision of special care for those who were terminally ill, the practices of traditional and

complementary medicine and the practices of different cultural beliefs among the patients. Apart from that the findings also showed barriers in patient care management in both hospitals. Majority of the patients experienced lack of privacy which was due to the limited resources in both wards and the O&G ward policy that allows the patients' husbands to come in at any time. The findings also revealed the start of a social dilemma in Malaysia in which elderly patients were abandoned in the hospital wards by their family members. There were also cultural issues which emerged very strongly in this research because many of the patients were very particular towards how their food was prepared. They strictly followed their taboos and culture in consuming certain types of food they believed was good for their health.

6.3 Limitations and challenges

As a novice researcher, I faced numerous limitations and challenges throughout the course of this research. The area of public health and clinical setting is altogether a new area for me. There were many technical terms and concepts which were unfamiliar to me. The operational processes, hospital management system, the work culture, the practice of ethics, medical communication and manpower management in the wards were all unfamiliar territory. I had to learn these on my own and engage in preliminary discussions with various parties before embarking on this research journey. The approaches used to overcome this were discussed in length under the section 'pre-understanding and justification for this research'. Some of the limitations and challenges faced during this research included the collection of data, the scope of study, the risks entailed and the methods used. The following describes the limitations in detail:-

6.3.1 Scope of research

The MOH has a total of 130 hospitals which are categorised into districts, state and national level hospitals. It also has a large network of health clinics, polyclinics and rural clinics that are spread throughout the country. From the total number of hospitals and health care facilities in Malaysia, only two hospitals (HSA and HKL) were covered in this research because of the constraints in time, human and financial resources. The scope of the research was limited to public hospitals in Peninsular Malaysia and excluded public hospitals from Sabah and Sarawak which was also due to time and resources.

The duration of data collection was a period of two years; from the pre-test to pilot test and the final research data collection. Although the duration is longer compared to quantitative survey design but it was necessary to understand the meaning in question. However problems may arise if new changes are implemented by MOH to the health care system as this may affect the accuracy of the data if it is not captured immediately.

6.3.2 Gatekeepers

One of the major obstacles faced during this research was the complexity in obtaining ethics approval from MOH, Directors of hospitals and Heads of department. This process took about 3 months because the process is extremely bureaucratic and time-consuming. Apart from this, different types of gatekeepers that looked after the safety and security of the patients and the hospital employees were dealt with. The hurdles in dealing with the gatekeepers faced from the beginning until the completion of the data collection were challenging. The gatekeepers included matrons, sisters, heads of department, security personnel, ethics committee, patients' family members and

doctors. From my encounters with them, I noticed there was a communication gap between the top level managers and other employees. Both HSA and HKL staff were not made aware of the research approval I received from NMRR (National Medical Research Register. Even though I tirelessly went through many channels of red-tape in obtaining the ethics approval I also faced the dilemma in repeating myslef by producing the same evidences again to proceed with in-house security clearance.

For instance, in order to enter into the wards freely I was required to wear a security pass, which was issued by the security department. However, the first two weeks I was unable to contact the security office at Hospital Kuala Lumpur (HKL) via telephone because the phone line was not working at that time. With no other alternatives, I went to HKL to meet the security officers' in-charge personally about the requirement needed for the security tag. I returned the next day to submit the documents necessary in order to facilitate the application processes for the security tag. The processing took a further two weeks to prepare. This delay was not anticipated and affected the delay in the research process. As for HSA, although I wore a special name tag but I was rudely stopped on many occasions by some of the staff at the hospitals. Even though this made me feel uncomfortable but I soon came to realize that these procedures were necessary to disallow strangers from entering the wards freely in order to protect the patients and staff. In spite of that, each time I entered the wards, I had to endure stares and funny looks from the patients, relatives and staff. Perhaps they wondered who I was; whether I was a medical staff or a relative visiting a patient. This created an awkward situation for me during my data collection.

Furthermore, the research process also required me to take extra steps which included briefing the sisters, nurses and doctors through comprehensive social

interactions and formal meetings to 'break the ice' and explain about the research process before the collection of data. Despite the hassle, the process deemed necessary to protect the patients' rights who were vulnerable and this relates back to the vital concept of trust and ethics from the researcher.

6.3.3   Finding a suitable time

Finding the most suitable time to interview the doctors, heads of department, matrons and sisters was the biggest challenge faced, given the limitation of free time they had working in two of the busiest hospitals in Malaysia. Several times the appointments with them were cancelled or postponed. This was unavoidable due to emergencies and other priorities at work. To name a few occasions: once the appointment with the Matron at HKL was cancelled because one of the state Ministers was hospitalized. On another occasion at HSA, the sister-in-charge went on training whilst the Head of O &G (Obstetrics and Gynaecology) had a meeting in KL with the MOH. There were only small windows of opportunities for me to utilize to find suitable free time to interview staff.

6.3.4   Health risk

Needless to say hospitals carry germs and infectious diseases. Some of the patients carry contagious diseases such as dengue, tuberculosis, AIDS and pathogenic viruses which pose as risks and health hazards. Knowledge of the diseases would be helpful in order to take precautionary measures when visiting the wards to collect data. Unfortunately I did not forecast this and consequently was unwell on a number of occasions after my site visits. Hence it is advisable to take inoculations as a preventive measure especially for major contagious diseases such as H1NI, malaria and typhoid to avoid dire consequences.

Furthermore, HKL is also one of the referral centres for tertiary hospitals in Malaysia for endocrinology related diseases. Therefore it is imperative that extra precautions are taken when collecting data. Sometimes I relented to wearing masks and gloves and frequent washing of hands as advised by the hospital staff. I also took extra precautionary measures so as not to put my family at health risk when I returned home after my field visits. I adopted these measures at the initial stage but then I discovered it became quite difficult to build rapport and at the same time to gain trust of the participants with my masquerade. However, over time, I stopped using the hospital protective masks and rubber gloves. Although this decision posed a huge health risk but it permitted me to blend into the natural setting of the hospital and allowed the respondents to feel comfortable in talking to me. What mattered the most during this time was that I must not be seen as being bias in collecting the data. The commitment to the research and understanding the truth was the main push for this research.

6.3.5   Challenges in the interview process

Another challenge was the sensitization towards patients' health situation and doctors' busy schedule. Since the interview took place at the hospital wards, many of the patients were unwell and the doctors were extremely busy. Therefore the in-depth interview utilised two different sets of interview schedules to cater to the needs of the patients and doctors. Sometimes the interviews were conducted in parts to cater to their rest breaks and medication needs. The interviews were not prolonged to more than an hour although there were interesting findings that were discovered. A few of the patients were also discharged before the completion of the interviews whilst some of the doctors were transferred to other departments. So there were gaps in the findings which needed to be explored further or verified with other participants and health care

professionals. So an extra step was required in this process which prolonged the data collection.

Another limitation was the non-compliance of a small number of participants in audio-recording the interview sessions. Although anonymity and confidentiality of the research was assured, they preferred not to be coerced. Instead they preferred full verbatim written text of the interview which they signed and checked willingly. When asked why they don't like to be audio taped, I was given grim answers shown through their body language. One comprehensible answer was that patients admitted in the hospital were in a vulnerable situation and as a result felt they were at the mercy of the hospital staff. Ironically I noticed similar reaction from some of the medical staff as well. They rather speak openly to me as long as it was completely anonymous. The more I tried to convince them about the nature of this research and how important it is to record the interview, I noticed they became more distant towards me and some even refused to be interviewed at all. Finally I relented and respected their decision and made the best of the situation.

6.3.6 Experiences with patients

Some of the patients that were interviewed came from low social background that demonstrated poor bedside manners and strange social behaviour. For example some refused to talk, some responses were snobby and irritated and some of them were coughing directly at me during the interview. The most memorable experience was when one of the patients took the consent form and rubbed it against her skin that had rashes! Only after she felt relieved did she sign and returned the form to me. I ignored the pieces of scabs that had fallen on my form and continued to carefully place the form back into my envelope without showing any remorse. My only fear was whether her

skin disease was contagious. Is she having scabies (contagious parasitic skin disease)? Luckily I have survived this.

6.4   Key findings and recommendations

There were little efforts undertaken to improve the quality in health care management compared to other industries (Christian Keeck, 1998 in Davies, Nutley and Mannion, 2000) as assessing quality in health care delivery is relatively new (Berwick, 1989). Therefore health care providers in Malaysia should embrace organisational change through life-long learning and clinical governance. The findings showed the four main factors that influence patient care management which were clinical communication, quality of care, leadership and culture in health care environment. These factors were fundamental in highlighting the importance of patient care management in the health care delivery. This research has brought to surface the patient care experiences that were embedded within Malaysian hospitals. By discussing the findings from the ethnographic research I have synthesised the main themes discovered with the recommendations given by the participants and incorporated them as two profound strategies which I believe are the strengths to build upon better patient care management. These are discussed as follows:

6.4.1   Medical education

Medical education describes a profound way in educating the medical team in understanding the core aspects of patient care and to develop professional competence. Clinical communication requires the doctors to be creative artist in educating their patients. Otherwise the patients would not recover completely. In some severe cases some of the patients may have attitude problems that may hinder effective communication process. The hospital should realize doctors today take the role of

educators or clinical teachers. As clinical teachers they should not only teach junior staff but also their patients. The doctors educate and narrate as they examine patients (Desmond and Copeland, 2000). Although both these hospitals are teaching hospitals, but the reality is that the hospitals in Malaysia places more importance in teaching their peers to be skilful in their clinical craft rather than educating their patients. If that is the case, Malaysian hospitals are still focusing on the *curative model* which is the doctor and illness focus rather than the *wellness service,* which focuses on lifetime health plan for the family. This contradicts with Amar's (2004) argument which states that health care is changing towards *wellness service. Wellness service* which places the doctors as the role of facilitators which fundamentally focuses on preventive issues, healthier lifestyles and risk preventions instead of the role of controllers may not be entirely true in Malaysian tertiary public hospitals. As the results have indicated, the doctors failed to fully comprehend that the wards are their classroom, patients are their students and they are the clinical teachers. In order to change into the *wellness service*, they need to prepare themselves to be good educators in order to teach the patients how to take care for themselves and their family members.

As we know every patient is different and every situation is different. Even though both these hospitals have comprehensive training programmes but we tend to forget every patient is different and every doctor requires different forms of training in order to address patient's different needs. As a result medical education should be a significant form of continuous professional training administered to all health care professionals in order to prepare them for the transformational change towards the *wellness service*. The role of the doctors as facilitators can be clearly defined and understood through proper medical education training programs to provide excellent health care delivery system.

With regards to doctor-patient communication, doctors need to be better trained in the art of communication; especially non-verbal communication during consultation, listening skills, persuasion skills and understanding different languages with explicit and implicit meanings. The skills described by Robert Katz's theory consist of conceptual skills, technical skills and human skills (Robbins & Dencenzo, 2004) are significant in gaining patient's trust (Johnson, 2005) and satisfaction (Doyle & Ware, 1977; Hays & Dimatteo, 1984). When an explanation is given, the medical team should acquire the skills in enquiring if the patients have understood or have any questions to ask at the end of the session. There could be a number of possible reasons why patients don't ask questions. Sometimes patients could be shy, fearful or insecure. Even if they do not have any questions, the medical team should recap what has been said and test the patients' understanding in a constructive way. As an average person remembers 20% of what they hear, 40% of what they see and 70% of what they see and hear (Desmond and Copeland, 2000)

Likewise doctors should not portray impatience, joke about sensitive issues or be dismissive when patients pose questions. There may be important facts that may help the patients to respond better to treatment. In approaching this, the medical team should always be aware of patient's feelings by observing their non-verbal cues and avoid arrogance. By practising this, eventually the doctors will experience experiential learning in clinical practice. As many studies have shown the quintessence of health communication is the interaction between the health professionals and their patients (Watson & Gallois, 1998) and can form as a treatment of its own kind (Salmon & Young, 2011).

In Malaysia patients come from different ethnicities and different languages. Doctors may face language barriers in communicating with their patients. Complaints of poor communication were due to lack of understanding in giving and receiving clear explanation and negotiation from both parties. Likewise because of the different cultural and religious beliefs practiced in Malaysia, strategic communication skills such as negotiation skills and techniques in breaking bad news to patients are vital skills for patient care management. Even though the findings showed most of the doctors were very skilful in their technical and interpersonal skills however, there is much to learn about being sensitive to different cultural beliefs, Asian values, traditional practices and religions. This is because there is much emphasis in the biomedical health care with western influence rather than exploring cross-cultural medical care in the medical training curricula. Therefore it is highly recommended that health care professionals avoid indoctrination and hostility to religion and instead encourage expression of beliefs and faith and support families and patients who believe in faith and recovery (Graber et al., 2001). These areas would be a good guidance to be included in the medical curriculum especially in PBLs to contextualise with the Asian scenarios to train for future doctors as there are changes in the society. To respond to the current health care system, medical education and support must be given to train the health care professionals to understand TCM, religion and cultural beliefs.

Hospitals should invest in teaching pedagogies such as human anatomy models, colourful visual pictures, videos, compact disks, diagrams and charts to assist doctors in educating their patients (Edstrom, 2000). These resources can be utilised by doctors during bedside care as a teaching tool to explain to patients about their diseases as well as negotiate treatment procedures and future health care plan. The effects of using these teaching aids will provide patients and doctors with deeper learning opportunities.

In addition, the O&G ward should allocate special rooms for new mothers to have privacy to breastfeed their babies in a relaxed manner instead of feeling insecure and embarrassed of being watched by others. Furthermore the rooms could also be used to educate patients before and after delivery on areas such as child care, simple exercises and breastfeeding techniques. These topics can also be a reinforcement education for patients after delivery.

Placing large screens or curtains at patient's bedside is crucial as it provides privacy for patients especially for those who are unable to walk due to surgery, change their clothes and breastfeed their babies. Moreover larger screens will also provide complete coverage during physical examination at the bedside which ensures privacy for patients. Currently there are insufficient screens in the wards. The few screens that were available were too small to fully cover the beds. The hospital management should realize that patients have dignity and rights to have access to good screens and private examinations.

As for the Medicine ward, patients suggested hospitals should invest in buying easy chairs or pull-out chairs cum beds so that family members would have the opportunity to stay and care for their loved ones. At the moment, it was extremely cumbersome for family members who stayed in the hospital to bring their own chairs from home. Other types of resources mentioned by patients were placing calling bells or service lights at their bedsides to signal nursing assistance instead of shouting for aid.

Moreover many hospitals in India insist patients who are admitted in the hospital are accompanied by a 'bystander' who is a family member. The purpose in having a

bystander is to provide emotional support and assistance in decision-making. This raises the importance for hospitals in Malaysia to re-examine what construes as a full range of service quality by benchmarking with other health care service providers especially in the Asian region. The drive to differentiate service quality and the quest in understanding the economic and social advantages of services provided can be shared by health care professionals and their peers within the region through open seminars in the continuous medical education training.

Smart application gadgets such as tablets, i-pads, i-phones and etcetera is another form of educational tool that is underutilised in the hospital wards. Doctors should be given tablets with clinical data to better connect with their patients. Many of them use their own hand phones to show models and pictures to explain to their patients. Efforts should be made to improve quality of health care by integrating medical care with smart application gadgets to include medical records of patients, clinical data, prescriptions, lab results, anatomy of the human body, side effects of medications and medical dictionary. The goal is to connect with patients and ensure compliance. Further integration between technology and medical care are necessary and practical in providing better patient care management as doctors today are from the 'Generation Y' who are more likely to be savvy in information communication technology.

Doctors should utilise peer review in clinical teaching as it is another form of improving professional development (Thomas et al, 2013, Kinchin, 2005 Gosling, 2002). However there is limited practise of peer review in clinical teaching in teaching hospitals today. Peer review is usually popular in the educational institution among academics. Much emphasis is placed on the ability of doctors in medicine rather than their ability as teachers. This I fear is the biggest gap faced in the medical profession.

Society failed to comprehend the dual role of doctors today as healers and as teachers. The fundamental nature of peer review is improving staff development through expert opinions based on knowledge and understanding; which inevitably can be used in professional portfolio and performance appraisal (Kohut, Burnap & Yon, 2007). Other advantages of peer review in clinical teaching are it sharpens the communication skills and provides the doctors the avenue to reflect and improve the overall performances (Peel, 2005). Techniques in peer reviewing fellow colleagues and reflection can be included in the medical education training.

6.4.2   Leadership in healthcare

There are countless research and studies on leadership which generally tend to be focused on the west. This dominance is evident in the development and use of leadership theories through books, articles, research papers and also in the field of consultancy. Many of the thoughts, views or assumptions on leadership are based on studies done on prominent western leaders or are written by them; who are either politicians or successful entrepreneurs. From the western perspective their traits, personality and attributes suggest qualities that embody a great heroic and powerful leader. Recently more thought and debate on the Asian concept of leadership has also been developed which is strongly influenced by politics, culture, religious beliefs and family dynamics.

However by seeking out a leader it is important to refrain from associating health care providers as heroic leaders who command respect, loyalty, obedience, trust and possibly worshipped. Many studies have shown the doctors are thought of in some culture as a friend, philosopher and guide who are highly respected (Chattopadhyay & Simon; 2008 and Desai, 2000) and symbolize heroism and greatness (Linstead et al.,

2009. The findings from this research show that many patients highly respect and admire their doctors. However there must be caution on "hero worship" of doctors which can be misconstrued as individualistic and "male centric." Focusing on this can lead to disconnection in relationships between not only the patient and their doctor but also towards other medical staff. It can be advocating silent passivity in patients and staff which is viewed as a lopsided relationship that is biased in favour of the doctors.

Linear leadership styles are no longer applicable as health care leaders in this century must be adaptable to fast pace changes in health settings. To achieve effective patient care management, health care leaders need to communicate effectively with the patient, staff and the patient's family members about the clinical diagnosis, treatment procedures and their vision for quality care. They need to emphasise on teamwork by building trusting relationships with their patients and have mutual respect for their medical team. A culture emphasizing teamwork and de-emphasizing bureaucracy as described by Siassakos et al. (2011) findings is highly recommended in ensuring patient satisfaction and quality of care. These interlinking variables are also clearly demonstrated in Blake and Mouton's Managerial Grid (Mullins, 2007 and 2010).

Since religion and medicine are intricately woven (Orr and Gensen, 1997), ultimately this will relate to patient's rights and respect for their dignity. Patients should not be forced to make decisions; as was the complaint by a small number of patients in the O& G wards. Instead they need to be motivated. According to Aldeen (2007) patients should be given proper informed consent and the right of informed refusal. According to the theoretical model proposed by Aldeen (2007) and Deber et al, (2005) greater equality and balance among doctor patient relationship leads to autonomy and empowerment among patients.

Similarly senior doctors need to be clinical role models and mentors to junior staff and their patients. As a transformational leader they need to embrace visionary style of leadership and exercise good judgment. Since there is much to learn in a changing health care environment, so a transformational leader should empower, motivate and establish a sense of belief and trust with their patients and junior staff which are fundamentally needed in the hospitals.

The main elements of patient care which promotes wellbeing were the emphasis placed by the doctors in developing their patients' capacities in making choices and controlling their lives by providing information, deliberating options and promoting autonomy during consultations (Illich, 1976). Rather than applying this they tend to neglect the role of other actors who can assist them in patient care. As explained by Eiriz and Figueiredo (2005) in their theoretical model, the actors are the public, the patient and their family members who have got different levels of expectations and perceptions towards their health care providers. So it is therefore important to gauge them to increase the quality in patient care management. Thus it is highly recommended that doctors should make use of available resources such as family members, language translators and religious leaders in order to aid complex decision making, interpretations of languages, support and understanding of faith and cultural dimensions of patients.

Adaptability is also essential to leaders as they need to match their leadership style according to the task, environment and situation. The findings showed some doctors complained that some patients take advantage of their kindness. Although doctors seek to have a dyadic relationship with patients their behaviour should vary according to the

type of patients they have which is described in Leader Member Exchange (LMX) theory of leadership.

In exploring situational leadership, even though the findings indicate some patients were unhappy when their family members were not consulted for decision-making however the hospital staff needed to make prompt decisions to save the patient's life in times of emergency. These decisions may seem autocratic but it is based on the urgency of the circumstances. At times these decisions were necessary when family members were unable to decide or be contacted. This is closely linked to numerous Contingency Leadership theories demonstrated in Fiedler's Leadership Model, Hersey Blanchard's Situational Leadership Model and Path Goal Theory of Leadership which explain effective leadership should suit the context of the situation, people, task, organisation and environment.

Finally hospitals should take the lead in increasing sufficient manpower, teaching aids and facilities in order to become more patient-centred. Patients aesthetic and non-aesthetic value and perception of the hospitals could be improved with better services and resources provided. This is because the people's assessment of leadership and patient care management is usually based on their experiences in the wards.

6.5 Implications of the research

The research findings had several implications. First and foremost this research used ethnographic approach which included patients and doctors views on their experiences of patient care management. The collection of the data took a period of two years which included the preliminary investigations and final research. Although it was

tedious compared to quantitative methods but the findings from the qualitative research are relevant to clinical practice of patient care management.

The main weakness in this research was the findings could not be generalised to other research settings even in a controlled manner. Although the results were interpreted and validated through rigorous processes such as triangulation, membership checks and peer review the findings could not be concluded as inferences to a larger population. However the issue in qualitative work is not replicating a study but to make clear how the results and interpretations are reached. As Wittlemore, Chase and Mandle (2001) states qualitative research is more challenging compared to quantitative research because it incorporates rigor, subjectivity and creativity. The qualitative research methods and design used in this research could significantly impact the reliability of the research and add to the body of knowledge for future scholars.

The research findings also have implications towards hospital management. Both these hospitals are popular among the residence in Selangor, Kuala Lumpur and Johor Bahru because they are tertiary level public hospitals which are strategically located. Furthermore the cost of treatment and care for both the hospitals are minimum compared to private hospitals because the hospitals are public hospitals which are funded by the government. In addition HKL is a national referral centre which has a policy that does not turn down patients who are admitted. This makes the research unique as it discovers the burdens faced by the health care professionals in coping with the limited resources and managing over populated patients while providing quality patient care. In other words, with the barriers faced by the staff it may lead to unsuccessful doctor-patient encounter.

However, the qualitative findings from in-depth interviews, observation and records of field notes and vignettes showed patient care management in both Malaysian hospitals were satisfactory. Patients have reported the basic facilities and services provided were comfortable and satisfactory. Both hospitals have strong working dynamics and structure that was able to provide good health care services. Through regular meetings and reflection among staff the hospital was able to offer solutions to complex problems in the management of the hospitals. As the research progressed, new themes have begun to emerge from the data such as the socio-cultural perspective. This included religion, cultural beliefs, TCM and patient's dignity and rights. There were also evidences of cross-cultural practices and usage of bilingual language in patient care management. In short, the development of the themes provided a crucial point to look into the patient care management more closely as each of these factors describes a distinctive expression in the Malaysian scenario that may not be seen explicitly.

In another context, the interview schedule was mainly designed by using Calgary-Cambridge Guide from Silverman et al. (2008). This guide was developed as a fundamental framework to assist doctors when *clerking* patients. However, the findings from the research revealed the framework does not include questions on TCM, religion and culture which is practical and relevant information in the Malaysian and Asian scenarios. In fact the findings revealed gaps in clerking patients which affects how patients are managed in the hospitals. It is important to take note patients from Malaysia come from multicultural and multilingual society and therefore should be managed appropriately. Apart from the different culture, language and religion the practices of TCM is also becoming popular. Further improvements in the clerking procedure and medical curriculum to guide and incorporate them are worth considering.

Another interesting discovery in this research was the starting trend among Malaysians to abandon senior citizens in the hospitals. The findings showed this was mainly due to financial constraints and the need for privacy and space for the younger generation. As a result the burden to care for the elderly has become a social and moral dilemma for the hospital staff. The hospital should not be seen as a dumping ground for the aged and for the families to shed their responsibilities. Instead the government should take actions to curb this by educating the public and providing day care services for the elderly before it becomes a serious social stigma in Malaysia.

Finally in getting closer to the heart of things, it has become quite clear to me that some of the participants need 'pastoral care' or counselling service as the process of care for the sick is a huge responsibility to shoulder by the doctors and nurses. As illustrated in the findings, patients require someone to talk to when they are lonely, lost their limbs and in need of support to carry on with their lives. They rely on their doctors as 'care givers' or therapeutic agents to provide this support. However not all the doctors are trained in this area and afford the time to assist them. Similarly the doctors too require a counsellor, friend, teacher and healer as they shoulder the heavy burden of caring for the sick and at the same time juggling with the stress of their busy work schedule. Therefore 'pastoral care' or counselling service is essential for both parties to fulfil this void which is greatly lacking in Malaysian hospitals.

6.5 Closing remark

There is little information on how to manage and care for patients in a dynamic way as mentioned in the research, especially in developing countries. This goes back to the medical curriculum. Are the doctors of tomorrow prepared to provide the patient care needed in our country? Perhaps the curriculum is not sufficient. This can be

attributed to the changes in the expectation of society, the lack of emphasis in professional training in medical education and changes in leadership role in the health care delivery.

Sufficient opportunities are needed to provide these training, especially in clinical teaching. Society needs to comprehend that doctors are care givers and teachers in their own realm. They educate the patients and their family every single day. They educate the patients during their ward rounds or clinics, when an investigation is conducted, when the results have come in, when they break bad news, when there is a follow-up visits and when decisions are made. This process is never ending as education is continuous. The patients look up to their doctors for counsel and information. The doctors are constantly expected to provide the best care possible. How can they do so when they do not know how? It is imperative doctors receive feedback on their performance through peer review and reflection. Whatever teaching experiences they have gathered over the years are learnt from observations and reflections which are picked up through the '*osmosis*' process from their seniors. This experiential learning must be cultivated through continuous medical education training.

The findings revealed some doctors get frustrated with their patients by threatening and pressurizing them into becoming adherent. Instead of threating their patients they should adopt paternalistic attitude to motivate and counsel them. They should develop a partnership with their patients and communicate with them in a non-judgemental way. Furthermore with appropriate questioning style that takes into consideration of the multicultural and multi-lingual aspects in Malaysia the doctors can strategically help patients will low believability into becoming adherent.

Support must also be given by the government, top management and the public in moving towards a cultural shift in managing patient care. This process requires commitment, collaboration, support and participation of all stakeholders at different levels within the health care service industry. This will ensure quality of care is given in an effective and efficient manner which is the hope envisioned in 1Malaysia.

6.6 Future research

The findings from this research will provide an insight for future researches in this area. There are many areas that can be explored further. To start with each factor that influence patient care management such as clinical communication, leadership, quality of care and culture in healthcare environment can be built upon for future researches either through qualitative or quantitative techniques.

The information gathered from this research were from the past five years using primary and secondary data analysis. Hospitals may have a sudden change in policy and technology in the future that might influence patients' views. A longitudinal study would provide a more in-depth assessment of the practice of patient care management in public hospitals.

The in-depth interviews were carried out with doctors, matrons and sisters in the public hospitals who were directly responsible in treating the patients. Other health care providers such as dieticians, audiologists, biochemists, optometrists, science officers, systems analysts, radiology technicians, clinical physicists, psychologists who are also involved in providing care to patients were eliminated from the study. Furthermore, the research was carried in O&G and Medical wards. Views from patients and doctors from other wards were not captured. As the results of the findings are not easily

generalisable, it would be interesting to find out if there are any differences in the views of staff from other wards. Furthermore family members and friends who accompanied the patients at the wards were also not interviewed. Their views on the practice of patient care management may also add interesting evidence to the services provided and probably give a different perspective towards the research.

The discovery from the emerging themes such as the practices of culture, religion, TCM and patients' dignity and rights in the health care environment can also be explored in-depth through different qualitative approaches. The data from vast information discovered from a multicultural society like Malaysia especially in the utilization of cross-cultural traditional medicine by various ethnic groups will contribute immensely to the knowledge of Asian studies and be a stepping stone for similar research in other parts of Asian countries.

Another area that could be of interest is the communication skills between the health care professionals and the patients which include the non-verbal cues such as body language, facial expressions and hand gestures. How would they interact with patients of special needs at the bedside? What non-verbal cues are portrayed by doctors when communicating with their patients? It would be interesting to take note on the medical communication techniques used by the doctors in certain scenarios such as breaking bad news.

Research can also be conducted to peer review clinical teaching and bedside care provided by the senior and junior doctors. Through peer review and reflections improvement can be made to the medical practises. Distinctions can be made on the effectiveness of the explanations provided by the doctors. The review can be evaluated

from the patient's perspective or the peers. Another area that could be explored in the peer review would be the leadership and management skills of doctors in the wards. Do they lead by example? Do they include family members in decision making? What style of decision making skills do they use?

Crisis management is another area that leadership and management would play an important role. Malaysia, like any other countries has dealt with many types of outbreaks such as hand, foot and mouth disease, dengue, SARS and H1N1. At the moment there is limited research in this area which involves crisis management in hospitals. Staff usually deal with this based on their own skills, knowledge, hospital and national policies and standard operating procedures. Research in patient care management during a crisis would assist in improving the services provided and give clearer guidelines on establishing government policies as well as mould the leadership abilities of all the health care professionals.

This research used ethnographic approach in exploring the experiences of the participants from the O&G and Medical wards from two tertiary hospitals in Malaysia. In exploring participants' responses other research approaches such as grounded theory, phenomenology, case studies and narrative may also be considered as there is much to learn in patient care management. To borrow from the words of Sir Isaac Newton, "if we see further, it is because we stand on the shoulders of giants" (Pendleton et al., 2003, p. 5).

Appendix A – Interview schedule for patients

Interview Schedule for Patients

A. Build rapport with patients and start by asking questions such as:
  i)   How are you?
  ii) How long have you been here?
  iii) How are you feeling?

B. Introduction and explanation about the research. Give information sheet and consent form.

C. Research Questions

Part I – Overall Views on Hospital Management: Supportive and Non-supportive Issues		
Questions	**Answers**	**Explanations/Suggestions**
1.1 Were your bed and bedding comfortable?	YES NO	about the ward:
1.2 Was the ward reasonably quiet by day?	YES NO	
1.3 Was the ward reasonably quiet by night?	YES NO	
1.4 Was the ward temperature kept at a reasonable level?	YES NO	
1.5 Was the lighting satisfactory?	YES NO	
1.6 Did you have enough privacy in the ward?	YES NO	
1.7 Were there enough bathrooms?	YES NO	about sanitary arrangements:
1.8 Were they all kept clean?	YES NO	
1.9 Were there enough washbasins?	YES NO	
1.10 Were they all kept clean?	YES NO	
1.11 Were the meals satisfactory? breakfast?	YES NO	about meals:
1.12 lunch?	YES NO	

1.13	tea?	YES NO	
1.14	dinner?	YES NO	
1.15 Did you have enough choice of dishes?		YES NO	
1.16 Was your food generally hot enough?		YES NO	
1.17 Was your food nicely served?		YES NO	
1.18 Was the right amount of food served? If your answer is NO was there i) too much ( ) ii) too little ( ) Were you on a special diet? iii) YES iv) NO		YES NO	
1.19 Did the visiting arrangements suit you?		YES NO	about visiting, ward time-table and activities:
1.20 Did the time at which you were woken suit you?		YES NO	
1.21 Was 'lights out' at a reasonable hour?		YES NO	
1.22 Had you enough chance to rest undisturbed during the day?		YES NO	
1.23 Was your reception satisfactory when you first reached the hospital?		YES NO	about reception, information and care:
1.24 If you have to go to hospital again would you choose to come here?		YES NO	
1.25 What is your sex? i) man ( ) ii) woman ( ) **1.26** What is your age? i) under 40 ( ) ii) 40 to 64 ( ) iii) 65 or more ( ) **1.27** Did you like your stay here, apart from the discomfort and being away from home? i) very much ( ) ii) in most ways ( ) iii) only fairly well ( ) iv) no ( )			
Part II – Patient Care			
Questions		**Answers**	**Explanations and Suggestions**

2.1 Initiating the session
   a) Does your doctor greet you?
   b) What does he/she say? Eg Good Morning, Good Afternoon etc
   c) Does your doctor introduce himself/herself?
   d) What does he/she say?
   e) Does your doctor demonstrates respect and interest, attends to
      your physical comfort?
   f) Does your doctor show that he/she is generally interested and			

concerned with your disease? g) How does the doctor show that he is interested/concerned with you?		
2.2 Identifying the reasons for the consultation a) Does your doctor identify with your problem? b) Does your doctor listen to you? c) Does your doctor confirms and screens for further problems? d) Does your doctor ask you to explain what you mean? e) Does your doctor use words that you can understand? f) Does your doctor ask you about your belief? g) Does your doctor ask you about your ideas? h) Does your doctor ask you about your expectation/hopes? i) Does your doctor ask you about your worries? j) Does your doctor encourage you to express your feelings?		
2.3 Building relationship a) Does your doctor show any eye-contact? b) Does your doctor provide support, sensitive to your feelings etc? c) Does your doctor encourage your involvement? d) Does your doctor explain rational for questions or parts of physical examination?		
2.4 Explanation and planning a) Does your doctor give explanation? b) Can you understand what they are saying to you? c) Can you ask them questions? d) Do you feel comfortable asking them questions? e) Does your doctor use any other ways to explain visual methods, diagrams, models etc? f) Does your doctor check if you understand? g) Uses easily understood language? h) Does your doctor encourage you to contribute?		

2.5 Planning shared decision making
   a) Does your doctor involve you in making decisions?
   b) Does your doctor negotiate mutually acceptable plan?
   c) Does your doctor explore other options?
   d) Does your doctor check with you if you accept the plan and if all concerns have been addressed?		

2.6 Closing the session
   a) Does your doctor summarizes the session, asks if you have any questions or other issues?
   b) Does your doctor explain long-term consequences?
   c) Does your doctor encourage patient to be involved in implementing plans, to take responsibilities and be self-reliant?
   d) Does your doctor ask you if you have any support system and discuss other supports that are available?
   e) Does your doctor encourage questions; discuss potential anxieties and negative outcomes?		

2.7 Overall what did you like best in the care that was provided for you?		
2.8 Overall what did you like least in the care that was provided for you?		
2.9 How do you think this can be improved?		
2.10 Any further suggestions you would like to say?		
2.11 Overall from a scale of 1-10, how would you rate the care you received from your doctor? 1 describing the least and 10 describing the best.		

Appendix B – Interview schedule for doctors

Interview Schedule for Doctors

A. Build rapport with doctors and start by asking questions such as:
i) How are you?
ii) How long have you been here?
iii) How are you feeling?

B. Introduction and explanation about the research. Give information sheet and consent form.

C. Research Questions

Part I I– Patient Care		
Questions	**Answers**	**Explanations and Suggestions**

2.1 Initiating the session
  a) What do you normally do when you first meet the patient? What do you normally say?
  b) How else do you initiate the session when a patient come and see you?
  c) How do you show that you are interested/concerned with your patient?		

2.2 Identifying the reasons for the consultation
  a) How do you identify with the patient's problem?
  b) What do you do to show patients that you are listening?
  c) Do you confirm list and screen for further problems?
  d) Does your patients ask you to explain what you mean?
  d) Do you use words that your patient can understand?
  e) Do you ask your patient about their
     • Belief
     • Ideas
     • Expectation
     • worries
  f) Do you encourage your patients to express their feelings?		

2.3 Building relationship a) Do you show any eye-contact? b) How do you provide support or show that you are sensitive to their feelings etc? c) Do you encourage your patients' involvement in the discussion? d) Do you explain the rational for questions or parts of physical examination?		
2.4 Explanation and planning a) Do you give explanation to the patient? Use easily understandable language? b) How do you know if they understand what you are saying to them? c) Do you allow your patients to ask questions? d) What do normally say to them to make them feel comfortable asking you questions? e) Do you use any other ways to explain to your patients, visual methods, diagrams, models etc? f) How do you check if they understood? g) How do you encourage your patients to contribute/give their ideas?		
2.5 Planning shared decision making a) Do you involve your patients in making decisions? How do you do that? b) Do you involve your patients' family in making decisions? c) Do you negotiate mutually acceptable plan with your patients? d) Do you explore other options? What do you normally say when you do this? d) Do you normally check with your patients if they accept the plan and if all concerns have been addressed?		
2.6 Closing the session a) Do you summarize the session and ask your patients if they have any questions or other issues?		

	b) Do you explain long-term consequences? c) Do you encourage your patients to be involved in implementing plans, to take responsibilities and be self-reliant? d) Do you ask your patients if they have any support system and discuss other supports that are available? e) Do you encourage questions; discuss potential anxieties and negative outcomes?		
3	**Overall, what parts in patient care and communication do you think has been working well?**		
4	**Overall what parts in patient care and communication do you think has not been working well?**		
5	**How do you think this can be improved?**		
6	**Any further suggestions you would like to say?**		
7	**Overall from a scale of 1-10, how would you rate patient care provided here? 1 describing the least and 10 describing the best.**		

Appendix C – Letter from UM

UNIVERSITY OF MALAYA

UM.E/IT/606/2

17 March 2010

TO WHOM IT MAY CONCERN

This is to certify that **Ms. Susan Thomas**, Matric No: **EHA070017** is a candidate of the **Doctor of Philosophy** programme at the Faculty of Economics & Administration, University of Malaya.

As our record shows, **Ms. Susan Thomas** is now in the fifth semester of her candidature. She is currently working on the thesis in the area of "**Administrative Management**" under the supervision of Dr. Beh Loo See.

She is currently in the process of collecting data for her research. We hope you would kindly give her your cooperation in this matter.

Thank you.

Yours sincerely,

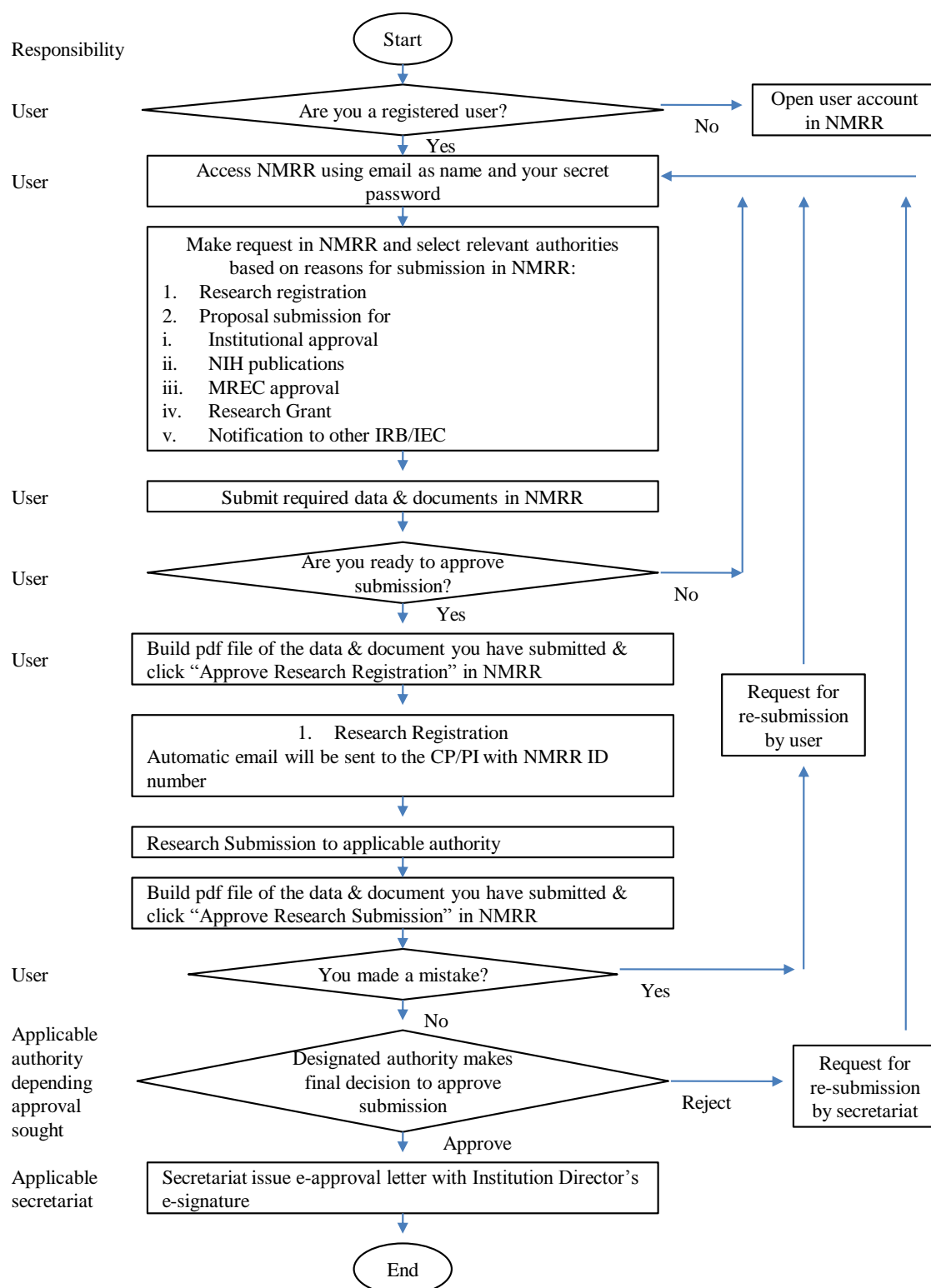PROFESSOR DR. GOH KIM LENG
Deputy Dean (Postgraduate & International)

GKL/sz
ATjrah Tinggi/PhD/Intake/TWitMC/SusanThomasCollectData.doc)

Appendix D – Workflow in applying for ethics approval

NATIONAL MEDICAL RESEARCH REGISTER (NMRR) WORKFLOW CHART

Responsibility	
	Start
User	Are you a registered user? → No → Open user account in NMRR
User	Access NMRR using email as name and your secret password
User	Make request in NMRR and select relevant authorities based on reasons for submission in NMRR: 1. Research registration 2. Proposal submission for i. Institutional approval ii. NIH publications iii. MREC approval iv. Research Grant v. Notification to other IRB/IEC
User	Submit required data & documents in NMRR
User	Are you ready to approve submission? → No
User	Build pdf file of the data & document you have submitted & click "Approve Research Registration" in NMRR
	1. Research Registration Automatic email will be sent to the CP/PI with NMRR ID number
	Research Submission to applicable authority
	Build pdf file of the data & document you have submitted & click "Approve Research Submission" in NMRR
User	You made a mistake? → Yes → Request for re-submission by user
Applicable authority depending approval sought	Designated authority makes final decision to approve submission → Reject → Request for re-submission by secretariat
Applicable secretariat	Secretariat issue e-approval letter with Institution Director's e-signature
	End

Appendix E – National Medical Research Register (NMRR) website

National Medical Research Register
Advancing Medical Research in Malaysia
www.nmrr.gov.my

HOME | FEEDBACK | DOCUMENTS / USER INSTRUCTION | FAQs | CONTACT US

.: About NMRR
.: Documents / User Instruction
.: Research Directory
.: Investigator Directory
.: NIH Home

CRC
◦ CRC

◦ IMR

ikau
◦ IPH

◦ IHM

◦ IHSR

◦ IHBR

.: NPCB Home
.: Links
.: Security Practices

You are visitor
00411927
since 03-July-2007

Notice: NMRR has launched a new interface for the registration of protocol. Please enter as public user to see the changes.

IMPORTANT CIRCULARS FROM THE DIRECTOR GENERAL OF HEALTH MALAYSIA

1. NIH Guidelines on Conducting Research in the MOH
2. Pharmacogenomics/genetics studies
3. GCP Requirement
4. Research on Stem Cell & Cell-based Therapies

MREC MEETING DATES (Please click here to see the dates for MREC Meeting Session for 2012)

MREC MEETING NOTIFICATION
Session 15 MREC MEETING
Date: 14th August 2012 (TUESDAY)

National Medical Research Register

The NMRR is the web based tool designed to support the implementation of the National Institute of Health NIH guideline on the conduct of research in the Ministry of Health Malaysia (MOH)

Current MOH policy on research, as specified in the guideline, requires:

- Registration of all research that involves MOH personnel OR that is to be conducted in MOH facility OR to be funded by MOH research grant
- Review & approval of the research by a designated entity to whom authority has been delegated for the purpose
- In addition, research involving human subjects requires prior review and approval by the Medical Research and Ethics Committee (MREC)
- Approval of all research publications, whether in the form of research report, journal article or conference proceeding, by the NIH initially and thereafter by the Director General of MOH

The NMRR is thus specifically designed to enable:

1. Online registration of research. This brings us in line with international practice which requires medical research, especially clinical trial, to be registered in publicly accessible research registers. This is to ensure transparency and to increase public trust in the conduct of medical research; as well as to inform physicians and prospective volunteers about ongoing research in which they may wish to enroll.
2. Online submission to an appropriate authority for approval, as well as online review of the submitted research by relevant appointed reviewers. The online system ought to reduce the research review time as well as to enable investigators to track the status of their research online
3. Online submission of research publication to the NIH for approval
4. Finally, the NMRR also enable MOH management to document the level of research activity in the MOH, and also to track the progress of the research it has approved and/or provided support such as funding.

The title of all registered research and its associated publications where available will be published in the Directory of Medical Research on the NMRR website.

In the process of registering a research, participating investigators are required to be registered on NMRR too. All such registered investigators shall also be published in a Directory of Clinical Investigator & Medical Researchers on the NMRR website. The Directory should be of help to investigators to locate other potential collaborators, and to sponsor of clinical trial to identify suitably qualified clinical investigators to participate in their multi-centre trials.

■ Documents / User Instruction
■ Create a New Account
■ Check for Existing Account

NMRR LOGIN
To access NMRR web application
Sign in to NMRR

User Email:
Password:
(case-sensitive)

Image Verification:
(case-insensitive)

LAUGHS

Change Image

Public User Login

Reviewer Login

MREC Member Login

Management/Secretariat Login

Forget password?
Sign-in help

Need Assistance?

NMRR Enquiries, MREC Ethics Approval Secretary

Tel: +(603)-2287 4032
2282 9082
2282 9085
2282 0491

NMRR IT Admin
Tel: +(603)-4044 8615 / 2615

MREC Ethics Approval Secretary
Tel: +(603)-2287 4032

Monday - Friday
8.30am - 5pm

Contact Info

NIH Secretariat
Ministry of Health Malaysia,
c/o Institute for Health Management,
Jalan Rumah Sakit, Bangsar,
50900 Kuala Lumpur.

Phone: 03 - 2287 4032
Fax: 03 - 2287 4030
Email: nmrr@nmrr.gov.my
URL: http://www.nih.gov.my

Best view with 1024 x 768 resolution

Versi 2.0 Tarikh: 15 Feb 2008

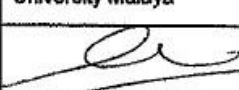## INVESTIGATOR'S AGREEMENT, HEAD OF DEPARTMENT'S AND INSTITUTIONAL APPROVAL
PERSETUJUAN PENYELIDIK, PENGESAHAN KETUA JABATAN DAN INSTITUSI

This document is intended for online submission for purpose of formal research review and approval. It is to be used in lieu of other equivalent manually printed document such as Borang JTP/KKM 1-2 and Borang JTP/KKM 3. After completing the form below and obtaining the required signatures, please scan this document and submit online.
Dokumen ini adalah untuk penghantaraan atas talian (online) mengikut prosedur rasmi semakan dan persetujuan penyelidikkan. Borang ini dikeluarkan sebagai gentian dokumen kebenaran manual yang serupa seperti Borang JTP/KKM 1-2 dan Borang JTP/KKM 3. Selepas melengkapkan borang di bawah dan mendapatkan tanda tangan yang diperlukan, sila imbaskan dokumen ini dan hantar atas talian.

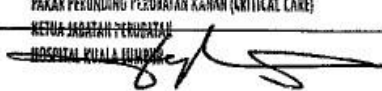| Unique NMRR Registration ID : [Nombor Pendaftaran]	NMRR-10-526-6014
Research Title : [Tajuk]	Patient care management
Protocol Number if available [Nombor Protokol jika ada]	

Investigator agreement *[Persetujuan penyelidik]*

I have understood the above titled proposed research and I agree to participate in the research as an investigator.
Saya faham cadangan penyelidikan yang bertajuk di atas dan saya bersetuju mengambil bahagian dalam projek tersebut sebagai penyelidik.

Name of Investigator : [Nama Penyelidik]	Susan Thomas
IC number : [Nombor KP]	680920015574
Site Institution : [Institusi]	University Malaya
Signature & Official stamp : [Tandatangan dan Cop]	
Date : [Tarikh]	16th April 2010

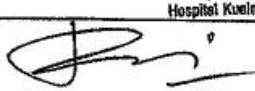**Head of Department Agreement** *[Persetujuan Ketua Jabatan]*

I agree to allow the above named investigator to conduct or to participate in the above titled research.
Saya membenarkan pegawai yang bernama di atas untuk menjadi penyelidik dalam projek penyelidikan tersebut di atas.

Name of Head : [Nama Ketua]	DATO' DR. JEYAINDRAN TAN SRI SINNADURAI DSSA (Reg: 23652)
Name of Department and Institution [Jabatan dan Institusi]	MD, FRCPI, DTM (Lond.), FRAM, TSUM (Ire.), CMIA (Mal.), FCCP (USA) PAKAR PERUNDING PERUBATAN KANAN (CRITICAL CARE) KETUA JABATAN PERUBATAN HOSPITAL KUALA LUMPUR
Signature & Official stamp : [Tandatangan dan Cop]	
Date : [Tarikh]	

Institutional approval *[Pengesahan Institusi]*

This section maybe omitted if one of the NIH institute is authorized to approve on behalf of institution. Refer NIH for further *[Bahagian ini tidak perlu jika salah satu daripada institusi NIH diberi kuasa pengesahan bagi pihak institusi tersebut. Rujuk NIH untuk maklumat lanjut]*

I agree to allow the investigator(s) named above to conduct or to participate in the above titled research. Where applicable, I further agree to allow my institution to be one of the sites participating in the research.
Saya membenarkan pegawai yang bernama di atas menjalankan penyelidikan selaku penyelidik dalam projek penyelidikan tersebut. Jika berkenaan, saya juga membenarkan institusi ini mengambil bahagian dalam projek tersebut.

Name of Director : [Nama Pengarah]	DR. DING LAY MING (MPM: 27260) Timbalan Pengarah (Perubatan) II b.p. Pengarah Hospital Kuala Lumpur
Name of Institution [Institusi]	
Signature & Official stamp : [Tandatangan dan Cop]	
Date : [Tarikh]	

Appendix G - Approval from Head of Department and Director (HSA)

INVESTIGATOR'S AGREEMENT, HEAD OF DEPARTMENT'S AND INSTITUTIONAL APPROVAL

PERSETUJUAN PENYELIDIK, PENGESAHAN KETUA JABATAN DAN INSTITUSI

This document is intended for online submission for purpose of formal research review and approval. It is to be used in lieu of other equivalent manually printed document such as Borang JTP/KKM 1-2 and Borang JTP/KKM 3. After completing the form below and obtaining the required signatures, please scan this document and submit online.
Dokumen ini adalah untuk penghantaraan atas talian (online) mengikut prosedur rasmi semakan dan persetujuan penyelidikkan. Borang ini dikeluarkan sebagai gantian dokumen kebenaran manual yang serupa seperti Borang JTP/KKM 1-2 dan Borang JTP/KKM 3. Selepas melengkapkan borang di bawah dan mendapatkan tanda tangan yang diperlukan, sila imbaskan dokumen ini dan hantar atas talian.

Unique NMRR Registration ID : [Nombor Pendaftaran]	NMRR-10-526-6014
Research Title : [Tajuk]	Patient care management
Protocol Number if available [Nombor Protokol jika ada]	

Investigator agreement *[Persetujuan penyelidik]*
I have understood the above titled proposed research and I agree to participate in the research as an investigator.
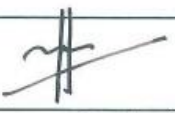*Saya faham cadangan penyelidikan yang bertajuk di atas dan saya bersetuju mengambil bahagian dalam projek tersebut sebagai penyelidik.*

Name of Investigator : [Nama Penyelidik]	Susan Thomas
IC number : [Nombor KP]	680920015574
Site Institution : [Institusi]	University Malaya
Signature & Official stamp : [Tandatangan dan Cop	
Date : [Tarikh]	16th April 2010

Head of Department Agreement *[Persetujuan Ketua Jabatan]*
I agree to allow the above named investigator to conduct or to participate in the above titled research.
Saya membenarkan pegawai yang bernama di atas untuk menjadi penyelidik dalam projek penyelidikan tersebut di atas.

Name of Head : [Nama Ketua]	DR. J.RAVICHANDRAN
Name of Department and Institution [Jabatan dan Institusi]	No. Pendaftaran Penuh MPM: 2631 MD.MED(O&G) Fellowship Maternal Fetal Medicine Pakar Perunding Kanan & Ketua Jabatan Obstetrik & Ginekologi
Signature & Official stamp : [Tandatangan dan Cop	Hospital Sultanah Aminah 80100 Johor Bahru
Date : [Tarikh]	20 th APRIL 2010

Institutional approval *[Pengesahan Institusi]*
This section maybe omitted if one of the NIH institute is authorized to approve on behalf of institution. Refer NIH for
[Bahagian ini tidak perlu jika salah satu daripada institusi NIH diberi kuasa pengesahan bagi pihak institusi tersebut. Rujuk NIH untuk maklumat lanjut]
I agree to allow the investigator(s) named above to conduct or to participate in the above titled research. Where applicable, I further agree to allow my institution to be one of the sites participating in the research.
Saya membenarkan pegawai yang bernama di atas menjalankan penyelidikan selaku penyelidik dalam projek penyelidikan tersebut. Jika berkenaan, saya juga membenarkan institusi ini mengambil bahagian dalam projek tersebut.

Name of Director : [Nama Pengarah]	DR. HJ. DAUD B. HJ. ABDUL RAHIM No. Pendaftaran Penuh MPM 24053 Pengarah Hospital
Name of Institution [Institusi]	Hospital Sultanah Aminah 80100 JOHOR BAHRU
Signature & Official stamp : [Tandatangan dan Cop	
Date : [Tarikh]	23.04.2010

Appendix H – Seeking approval (email)

Dear Ms Susan Thomas

for your project to be successful, the first step will be to approach the departmant head where you want to collect your data... write to them or pay a visit to talk to them about your project to see if they are receptive about your study... being a busy hospital, we were already overwhelm with workload, you need to convince them that you will not be a hinderance in their work process and you will not depend on them to do any of the data collection.... you need to work out how you can identify your subject without breaching the patient doctor confidentiality covernant may be by involving one of the staff doctor as your coinvestigator where patient recruitment and consent can be carried out ethically.... all these issue has not been addressed in your proposal....
bring along the prefilled IA (IA form with printed research title and investigator and unique nmrr no.)

with regards to the investigator agreement (IA) that you attached, it is not valid as it is not a prefilled form with a unique NMRR no. that indicate you hav register your research on that platform..... pls go to www.nmrr.gov.my and follow the instruction carefully.....

a prefilled IA will be downloadable when you hav register each investigation site of your research on NMRR and the HOD and Director of each site of your study hav to sign on it, you are targeting 11 state hospital, then you need 11 IA forms each bearing the site identity.

rgds,
Maria

On Thu, Apr 15, 2010 at 12:05 PM, Susan Thomas, Ms. <susan.thomas@med.monash.edu.my> wrote:

Dear Dr Mariah,

 I have made several telephone enquiries to find out what is the best way to get my research moving and have made the first initial move to contact you first. I'm currently pursuing my PhD titled 'patient care management' from University Malaya and would like to seek your kind permission to allow me to collect my data for my research at the O& G ward of Hospital Sultanah Aminah, Johor Bahru (HSA). The details of my research are in the documents attached. I have attached my proposal, cover letter to the Director of HSA, cover letter to the Head of O& G and the ***investigator's agreement, head of department and institutional approval form***.

With your kind assistance, I would like to proceed with my submission to the MREC (MOH Research and Ethics Commitee). My supervisor is Dr Beh Loo See from the Faculty of Economics and Administration, University Malaya. I also work at the Medical Education Unit, Monash University that work closely with HSA. I'm happy to provide any further details that may be needed to answer your queries. Thanking you in advance.

 Best regards,

Susan Thomas

Lead Coordinator, School of Medicine Education Unit (SMEU)

Doctoral Candidate (UM), M.Sc, B.Sc (Hons), ACELT(Ed, UK), Teaching and Learning (UM))

School of Medicine and Health Sciences, Monash University, Sunway campus

Tel:03-55146366 or 017-3036733

Appendix I – Translated information sheet (Malay)

UNIVERSITI MALAYA
KUALA LUMPUR

MAKLUMAT MENGENAI PENYELIDIKAN

Tajuk: Pengurusan Penjagaan Pesakit

Nama Ketua Penyelidik: Ms Susan Thomas
Nama Penyelia: Dr Beh Loo See

Kepada peserta,
Anda adalah dijemput untuk mengambil bahagian dalam kajian ini. Penyertaan anda adalah secara sukarela. Adalah penting bagi anda membaca keseluruhan maklumat berikut. Maklumat tersebut menjelaskan kepada anda tujuan penyelidikan ini diadakan dan apa yang akan dijangkakan daripada anda. Penyelidikan mengenai manusia adalah bersifat risiko rendah. . Malahan ia tiada berisiko langsung. Jika anda tidak memahami mana-mana perkataan atau maklumat dalam borang ini, sila bertanya kepada penyelidik untuk menjelaskan apa-apa keraguan anda.

Tujuan
Tujuan penyelidikan ini adalah untuk meneroka pendapat para pesakit dan para doktor di hospital berkenaan dalam hal pengurusan penjagaan pesakit ini.

Butiran penyelidikan
Wawancara secara mendalam akan dilaksanakan dengan para pesakit di dalam wad dan para doktor yang merawat mereka di hospital. Wawancara tersebut akan dirakamkan dan akan mengambil masa antara 30-45 minit. Maklumat dan butir-butir peribadi anda akan dirahsiakan dan tidak akan ditulis dalam laporan penyelidikan tersebut. Segala maklumat yang diperolehi akan digunakan semata-mata untuk tujuan penyelidikan sahaja.

Tanggungjawab peserta
Sebagai seorang peserta dalam penyelidikan ini, adalah menjadi tanggungjawab anda sedaya-upaya untuk bersikap jujur dan terbuka dalam menjawab semua soalan dalam wawancara ini.

Risiko yang mungkin dihadapi, kesan sampingan dan ketidakselesaan
Dalam penyelidikan ini, anda tidak akan menghadapi sebarang risiko, kesan-kesan sampingan dan ketidakselesaan.

Manfaat Masa Depan
Dengan menyertai penyelidikan ini, adalah diharapkan, anda akan membantu memberikan maklumat untuk meningkatkan kualiti pengurusan penjagaan dan seterusnya meningkatkan kepuasan para pesakit.

Penyertaan/penarikan diri secara sukarela
Penyertaan anda adalah sukarela. Jika anda memilih menyertai penyelidikan ini, anda adalah juga bebas untuk menarik diri pada bila-bila masa tanpa didenda atau kehilangan manfaat.

Penerbitan data penyelidikan, kerahsiaan dan penguatkuasaan
Dengan menandatangani dokumen ini, kakitangan penyelidikan dari MOH dan Jawatankuasa Etika (MREC), dan pihak yang menjaga peraturan dan undang-undang berhak untuk meneliti maklumat asal dari wawancara tersebut dengan tujuan untuk mengesahkan bahawa data itu adalah betul serta memeriksa bahawa penyelidikan ini dijalankan dengan cara yang betul. Semua data peribadi para peserta akan

dirahsiakan. Data-data akan disimpan dengan sempurna. Jika hasil penyelidikan diterbitkan, nama-nama para peserta tidak akan dinyatakan dalam laporan tersebut.

Maklumat mengenai hubungan:

Jika anda ingin menghubungi penyelidik atas segala aspek dalam penyelidikan ini, sila hubungi:	Jika anda mempunyai sebarang aduan atau bantahan mengenai cara bagaimana penyelidikan ini telah dilaksanakan, sila hubungi:
Ms Susan Thomas Tan Sri Jeffrey Cheah Fakulti Perubatan, Monash University Sunway Campus, Jalan Lagoon Selatan, 46150 Bandar Sunway, Selangor Darul Ehsan, Malaysia. Tel: +603-55146366 susan.thomas@med.monash.edu.my	**Penyelia penyelidikan PhD & Pensyarah Kanan,** **Dr Beh Loo See,** Jabatan Pentadbiran dan Politik, Bangunan Fakulti Ekonomi dan Pentadbiran, 50603, Kuala Lumpur, Malaysia. Tel: +603-79673677 lucybeh@um.edu.my

Pengisytiharan pemberian izin

Saya secara sukarela bersetuju untuk menyertai penyelidikan yang bertajuk: Pengurusan Penjagaan Pesakit.

✓ Saya telah membaca kenyataan di atas dan lain-lain maklumat dalam surat izin ini. Semua pertanyaan saya mengenai penyertaan dalam penyelidikan ini telah pun dijawab. Saya faham bahawa saya bebas untuk menyertai atau menarik diri dalam penyelidikan ini.

✓ Saya memberi kebenaran kepada penyelidik untuk menulis semua jawapan saya untuk diserahkan kepada Universiti Malaya, pihak berkuasa yang menjaga peraturan dan undang-undang dan MREC untuk tujuan penyelidikan ini atau penyelidikan masa depan.

✓ Sekiranya saya meminta, saya faham bahawa saya akan diberi salinan dokumen ini.

✓ Saya memahami saya boleh menghubungi Universiti Malaya pada nombor telepon +603-79673677 sekiranya saya ada sebarang pertanyaan.

✓ Dengan menandatangani dokumen ini, saya tidak menyerahkan apa-apa hak yang patut saya dapat dari segi undang-undang sebagai peserta dalam penyelidikan ini.

_____   _____

Tandatangan Peserta   Tarikh

_____

Nama Peserta (cetak)

No. K/P: _____

GHAZALLI BIN OTHMAN
Tutor Bahasa Malaysia
B.A. (HONS), M.Ed (Malaya)

Appendix J – Translated information sheet (Chinese)

UNIVERSITI MALAYA
KUALA LUMPUR

研究说明

题目：病人护理管理

首席研究员姓名：Ms Susan Thomas
直属上司姓名：Dr Beh Loo See

亲爱的参与者，

您好，我们敬邀您参与这个病人护理管理的研究。在你同意参加本研究之前，请您详细阅读这份受访者同意书的所有内容，以了解此研究的目的及所预期的研究结果。若在内容上有不解之处，请向调查人员寻求解答。此外，要不要受访，完全是自愿性质，若不同意受访，也不会影响到您的正当权益。此项人类研究属低风险性质，因此不会对人体造成任何伤害或不适。

宗旨/目标

本项研究的主要目的是要咨询病人的意见以及医院里的医生对于病人护理管理方面的看法。

研究细节

我们将对临床病人和医生进行深入的访谈，而访谈的内容过程将以录音或笔录的方式记录。整个访谈过程估计 30-45 分钟就可完成。所有的受访者的身份都将被保密。换言之，您的真实姓名及个人资料都不会显示于此研究报告的内容。访谈中所收集到的资料只供于本项研究的用途而已。

受访者的责任

作为这项研究的参与者，请你务必诚实的和尽可能的回答采访中所有的提问。

可预期之风险、副作用或造成不适应的情况

这项研究没有任何的风险、副作用或造成不适应的情况。

可预期之利益

通过参与这项研究，我们相信您将提供更多有益的信息，帮助改善病人护理管理的素质，让病人在住院期间获得更满意的护理管理服务。

研究之参与/退出

您的参与完全是自愿性质的，选择参与者，有权在无任何的理由下随时要求中止参与研究。这并不会减损您的正当权益与法律权利。

研究数据的发布、保密性和权益归属

若签署同意书，卫生部与伦理委员会（MREC）的研究人员和监管当局将有可能向您核实您原先完成的数据是否正确以及检查此研究是否妥善地进行。参与者的个人资料均会保密。有关的资料将会被妥善的存储或存档。如果这项研究的结果得以发表，出版的报告书上将不会署名参与者的名字。

UNIVERSITI MALAYA
KUALA LUMPUR

联络资料：

如果你想联系研究者有关这方面的研究，请联系：	如果你要投诉有关本研究的进行的方式，请联系：
Ms Susan Thomas Tan Sri Jeffrey Cheah School of Medicine, Monash University Sunway Campus, Jalan Lagoon Selatan, 46150 Bandar Sunway, Selangor Darul Ehsan, Malaysia. Tel: +603-55146366 susan.thomas@med.monash.edu.my	**Supervisor for PhD research & Senior Lecturer,** **Dr Beh Loo See,** Department of Administrative Studies and Politics, Faculty of Economics and Administration Building, 50603, Kuala Lumpur, Malaysia. Tel: +603-79673677 lucybeh@um.edu.my

声明及同意书

本人自愿地参与标题为："病人护理管理"的研究。

✓ 本人已阅读此同意书中所有的细节和其他相关内容。有关此项研究的疑问， 我也已得到明确的答复。另外，我明白我有选择不参加次研究的权利。

✓ 本人授权给予马来亚大学研究人员，监管当局和 MREC，同意让他们发布本人在此研究中的结果，作为本研究和今后的研究项目的用途。

✓ 本人明白，按照要求，本人将获得签名并注明日期的同意书的副本。

✓ 本人明白，如果本人有任何关于隐私的问题或投诉， 可以致电+603-79673677 给马来亚大学。

✓ 通过签署这同意书，本人同意成为此研究项目中的参与者之一，并保留任何形式上的法律权益。

受访者签名 日期

受访者姓名(打印)

身分证号码：

Hii Kou Sing
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Bachelor of Arts (Hons) Chinese Studies
Student of Master of Arts (Chinese Studies)

Appendix K – Ethics approval obtained

PEJABAT TIMBALAN KETUA PENGARAH KESIHATAN
OFFICE OF THE DEPUTY DIRECTOR-GENERAL OF HEALTH
(PENYELIDIKAN & SOKONGAN TEKNIKAL)
(RESEARCH & TECHNICAL SUPPORT)
KEMENTERIAN KESIHATAN MALAYSIA
MINISTRY OF HEALTH MALAYSIA
Aras 12, Blok E7, Parsel E, Presint 1
Level 12, Block E7, Parcel E, Precinct 1
Pusat Pentadbiran Kerajaan Persekutuan
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62590 PUTRAJAYA

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JAWATANKUASA ETIKA & PENYELIDIKAN PERUBATAN
KEMENTERIAN KESIHATAN MALAYSIA
d/a Institut Pengurusan Kesihatan
  Jalan Rumah Sakit, Bangsar
  59000 Kuala Lumpur

Ruj. Kami : (2) dlm.KKM/NIHSEC/08/0804/P10-242
Tarikh   : 31 Mei 2010

Dr Susan Thomas
School of Medicine and Health Sciences
Monash University Sunway

Puan,

<u>NMRR-10-526-6014</u>
Patient Care Management

Lokasi Projek: Hospital Kuala Lumpur/ Hospital Sultanah Aminah

Dengan hormatnya perkara di atas adalah dirujuk.

2.   Jawatankuasa Etika & Penyelidikan Perubatan (JEPP), Kementerian Kesihatan Malaysia (KKM) tiada halangan, dari segi etika, ke atas pelaksanaan kajian tersebut. JEPP mengambil maklum bahawa kajian tersebut tidak mempunyai intervensi klinikal ke atas subjek dan hanya melibatkan sesi temuramah..

3.   Segala rekod dan data subjek adalah SULIT dan hanya digunakan untuk tujuan kajian dan semua isu serta prosedur mengenai *data confidentiality* mesti dipatuhi. Kebenaran daripada Pengarah klinik kesihatan di mana kajian akan dijalankan mesti diperolehi terlebih dahulu sebelum kajian dijalankan. Puan perlu akur dan mematuhi keputusan tersebut.

4.   Laporan tamat kajian dan sebarang penerbitan dari kajian ini hendaklah dikemukakan kepada Jawatankuasa Etika & Penyelidikan Perubatan selepas tamatnya kajian ini.

Sekian terima kasih.

BERKHIDMAT UNTUK NEGARA

Saya yang menurut perintah,

(DATO' DR CHANG KIAN MENG)
Pengerusi
Jawatankuasa Etika & Penyelidikan Perubatan
Kementerian Kesihatan Malaysia

Appendix L – Pre-test questionnaire

1   Respondent No: _____
2   Gender: Male/ Female
3   Age:_____
4   Do you think the services provided by the hospital are important to the care given
    to patients? Yes / No
5   Do you have difficulties getting to the hospital? Why?
    Small children at home
    Long journey
    Transportation problems
    Parking problems
    Others:_____
6   Is there anything you like to see changed?
    Yes
    No
    Don't know
7   What would you like to be changed?
8   Do you think the treatment room is well-equipped?
    Very well quipped
    Well equipped
    Poorly equipped
    Very poorly equipped
    Don't know
9   Do the staff appear to be concerned about you?
10 Do you feel they are
    Helping you get what you want
    Neither helpful nor being difficult
    Making it difficult and not helpful
11 Have you ever received advice about your health from the doctor? Yes/ No/Very
    little

12 Are you pleased with the advice given? Yes/ No Why? Why not?
    Do you feel your health suffered because of this?
    Were you:
    annoyed
    indifferent/don't know
    happy to wait
13 Have you ever wished you could consult another doctor in the practice?
    Yes
    No
    Don't know
14 Do you think you can talk to your doctor all you want about your health?
    Yes
    No
    Sometimes
    Don't know
15 Do you think your doctor gives you sufficient time and doesn't hurry you?
    Always
    Often
    Don't know
    Seldom

Never

16 Do you think the doctor explains things to you fully and answers all your questions?
    Yes
    No
    Sometimes
    Don't know
17 Do you feel your relationship with your doctor is businesslike or do you feel it is friendly?

18 Is there anything further you would like to recommend?
19 What were the difficulties that you and your family faced?

Appendix M – Additional in-depth interview questions with sisters/matrons

1. Tell me more on breastfeeding the babies. How is this managed?

2. Can you tell me about the availability of rooms in the ward for mothers who want to breastfeed? Where do they go to if they want privacy?

3. How else we can make this more effective to encourage mothers to breastfeed?

4. Do you have sufficient curtain screenings and where can it be found?

5. How do you capture those who have missed out in the care?

6. How do you teach mothers to care for their child? What do you do?

7. Do you have any suggestions? How do you make your ward a better place?

8. How do you deal with the lack of equipment/supplies? What do you do about this?

9. What do you think is the main problems faced in the wards? What would be your suggestions?

10. Any other comments you want to add?

**Appendix N - Additional in-depth interview questions with doctors**

Take note to explore the following:

1) What non-verbal cues they use when they communicate? Ask for examples

2) What medical communication techniques that are used? Ask for some examples or scenarios in which this technique was used.

3) How do they break bad news?

4) What do they do? How do they handle this? Ask for examples.

5) How do the doctors provide explanations to patients? Do their family members get involved? Are the explanations also provided to their family members?
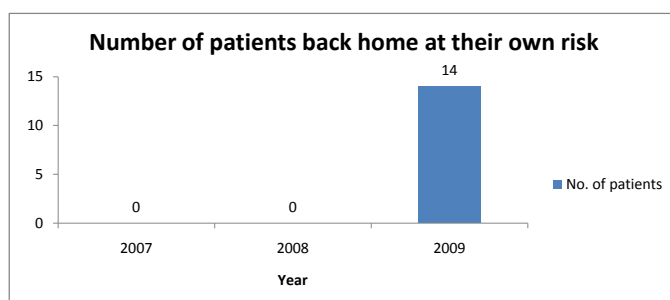
   Others:

6) Are they religious? Do they believe in religious practices? How do they handle them? What do they do? Ask for examples.

7) TCM: Is this practiced the wards? What do they do when patients seek their advice? What is their opinion regarding this?

8) What do they think about patients' rights?

9) What do they think about patient's privacy? Do the patients have any privacy in the wards? What about the doctors?

10) Any suggestions?

Step-by-step analysis using NVivo 9
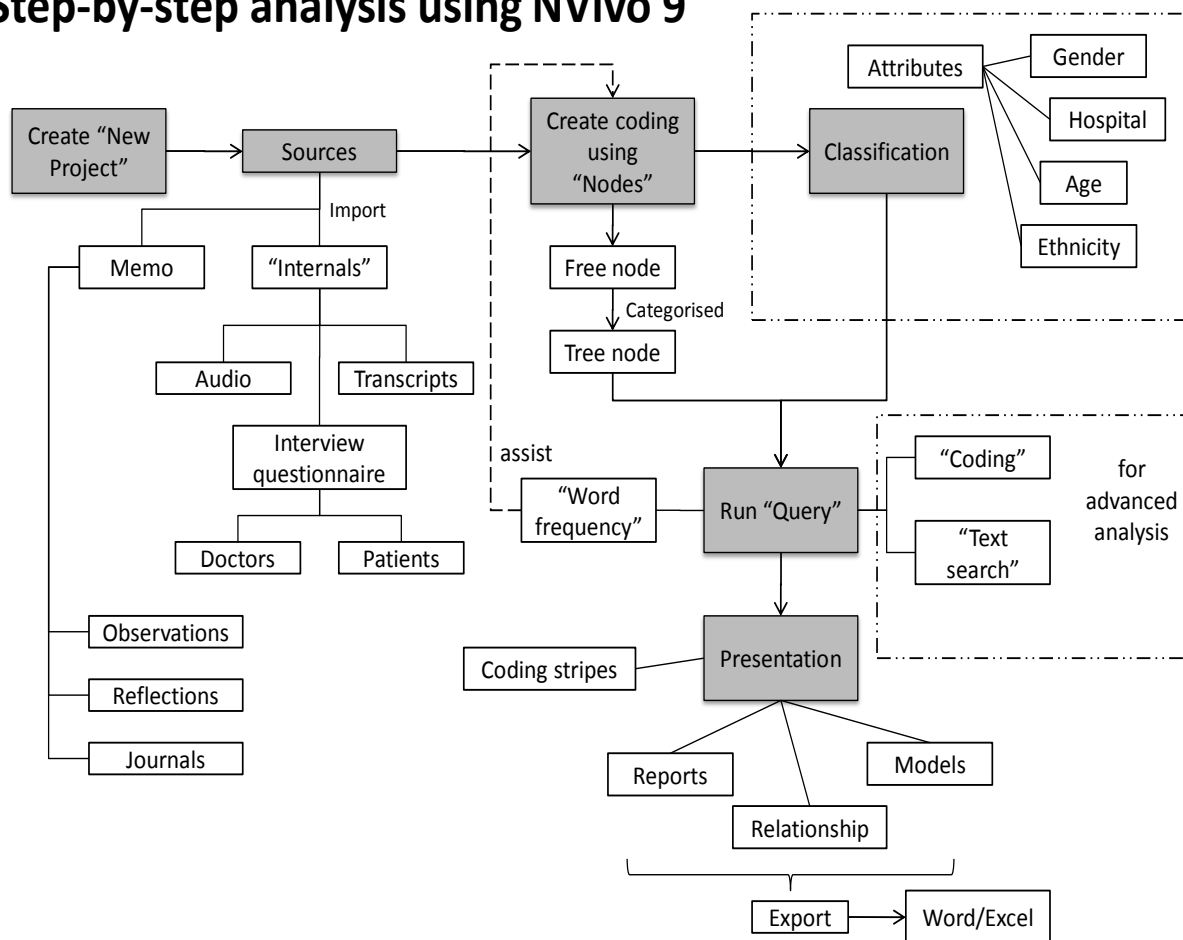
Appendix P – Observation on statistical information on notice boards at HSA

Statistics (HSA) for 1st Class Ward (L&D)

Total admission of patients

Year	No. of patients
2007	2094
2008	1698
2009	1586

Total number of patients discharged

Year	No. of patients
2009	3143
2008	3462
2007	4123

Number of patients back home at their own risk

Year	No. of patients
2007	0
2008	0
2009	14
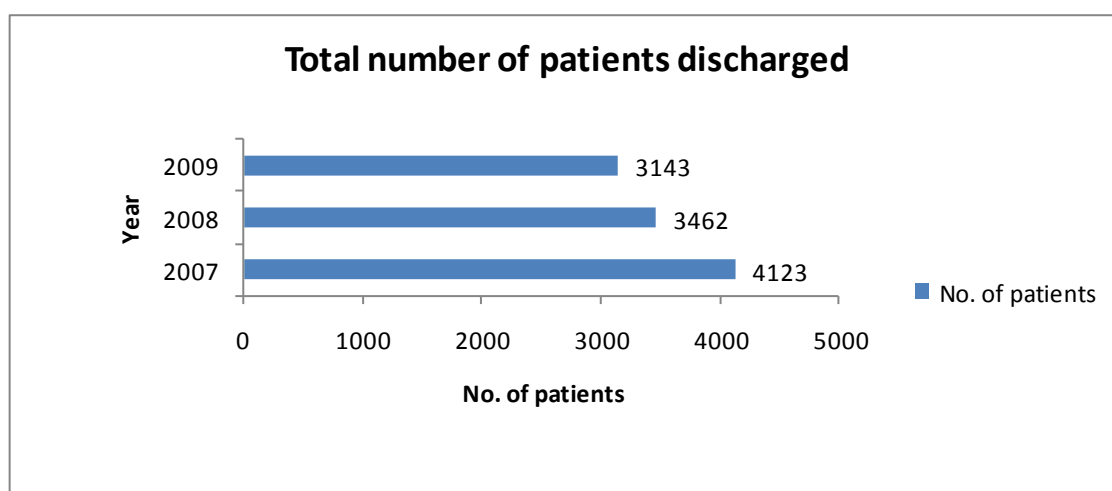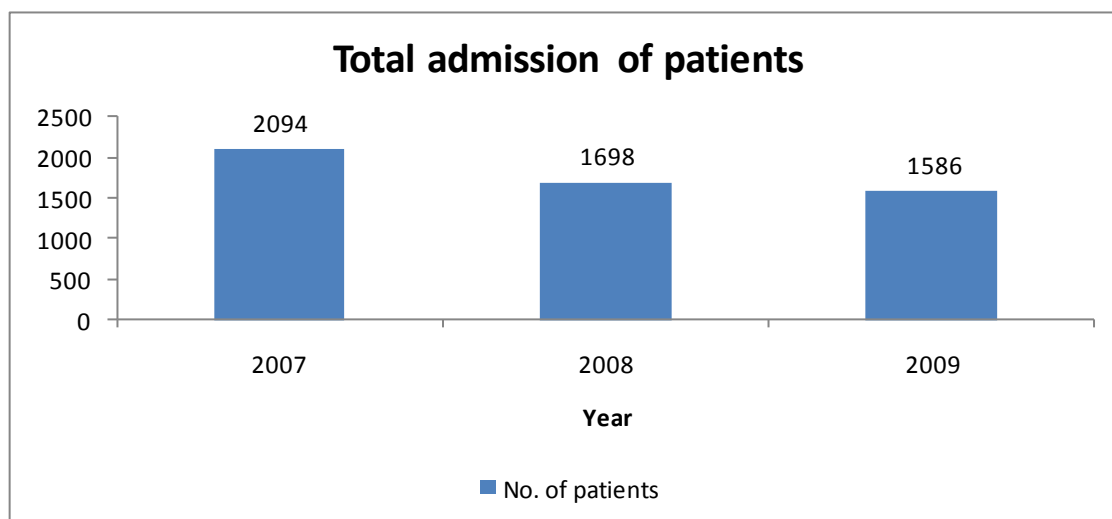
Appendix Q – Organisational charts

General Medicine Department, HKL
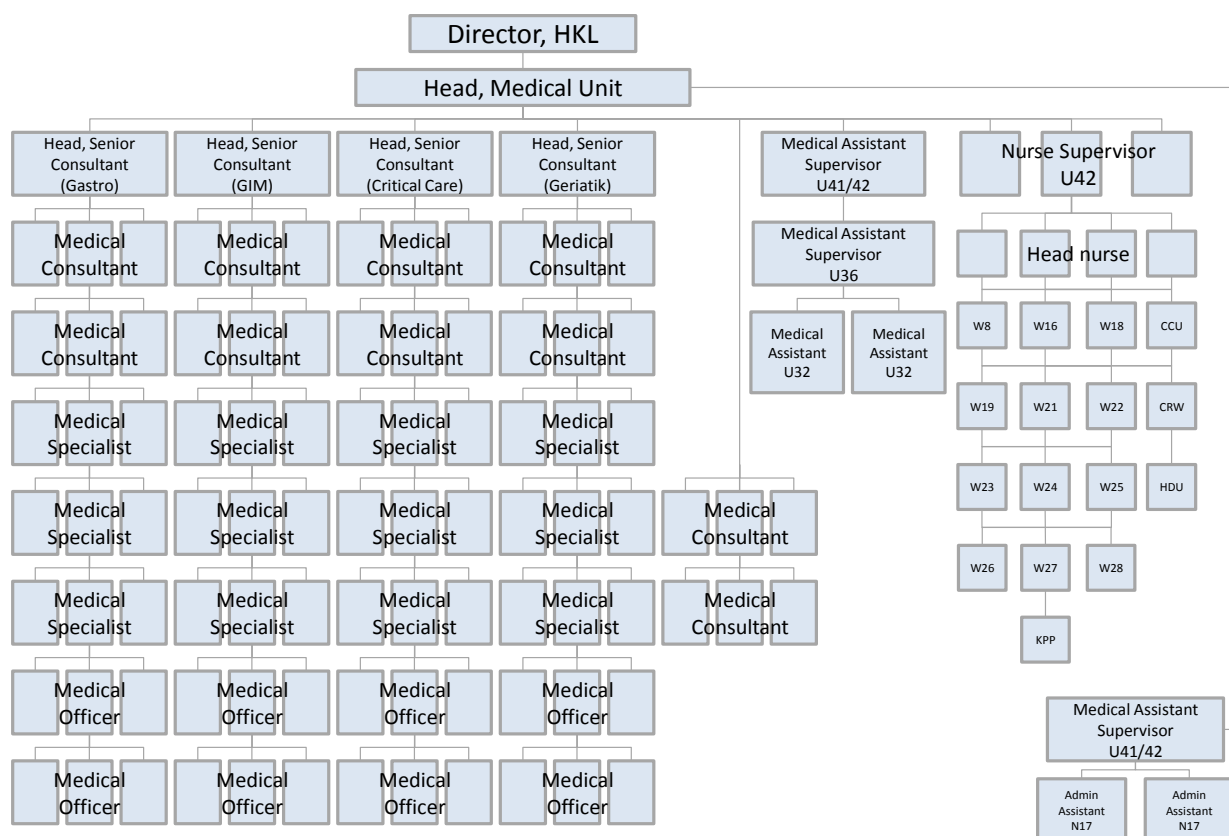
1st Class (L&D) Maternity Ward, HSA

Appendix R – Information on awards received, the mission, vision and policy for HKL

Awards from:
1. ISO9001:2008 confirmed/given by SIRIM QAS International Sdn Bhd untuk perkhidmatan kesihatan untuk pesakit Klinik Pakar, Kecemasan dan Pesakit Dalam termasuk Khidmat Sokongan Klinical dan Bukan Klinikal.
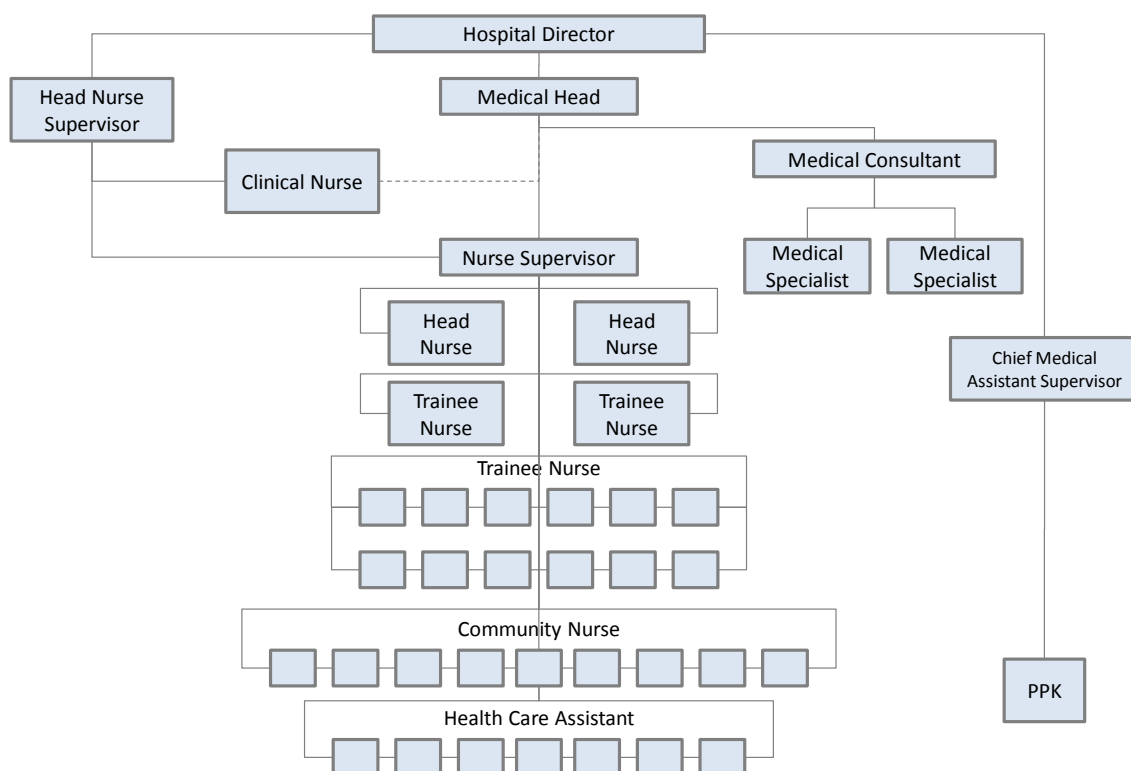2. Malaysian Society for Quality in Health Accreditation Award in recognition of compliance with the Malaysian Hospital Accreditation Standards with respect to:
   a. Organisation and Management
   b. Human Resource Development and Management
   c. Policies and Procedures
   d. Facilities and Equipment
   e. Quality Improvement Activities
   f. and Special Requirement

   This accreditation award is valid from 26 July 2008 to 25 July 2011.
3. "Sijil Kualiti Pengarah" to Jabatan Perubatan Am, 2001 yang telah mencapai kepujian dalam aktiviti-aktiviti Quality Improvement Jabatan.
4. IQNet & SIRIM QAS International certified Hospital Kuala Lumpur with ISO9001:2008 in Quality Management System for the following activity:
   a. 'Provision of Healthcare Services for Specialist Clinics Patients, Emergency and In-Patient Including Clinical and Non-Clinical Support Services'

Missions, Vision and Policy for HKL

<div align="center">Hospital Kuala Lumpur Quality Policy</div>

HKL is committed to provide safe, customer-centered and quality healthcare through continuous improvement initiatives.

<div align="center">Vision for Health</div>

Malaysia is to be nation of health individuals, families and communities, through a health system that is equitable, affordable, efficient, technologically appropriate, environmentally adaptable and consumer friendly, with emphasis on quality, innovation, health promotion and respect for human dignity, and which promotes individual responsibility and community participation towards an enhanced quality of life.

<div align="center">Wawasan Hospital Kuala Lumpur</div>

HKL akan menjadi pusat kecemerlangan dalam penjagaan kesihatan, pendidikan and penyelidikan melalui pasukan yang memberi perkhidmatan professional yang mengutamakan pelanggan.

<div align="center">Misi Hospital Kuala Lumpur</div>

HKL akan menyediakan penjagaan kesihatan berkuality yang:
- responsif kepada orang ramai, pesakit dan keperluan pekerja;
- diberi oleh pasukan personel yang mahir, innovative, komited dan prihatin;
- melibatkan perkongsian dengan individu dan masyarakan bagi promosi kesihatan;
- akan merancang pendidikan dan pembangunan professional; dan
- mengendalikan penyelidikan bioperubatan.

Appendix S – Hospital (HSA) Policy written in BM

POLICY PENYUSUAN SUSU IBU

1. Mengadakan satu polisi bertulis mengenai penyusuan susu ibu. Semua ibu digalakkan menyusui anaknya dengan susu ibu sahaja dari lahir sehingga 6 bulan dan meneruskannya sehingga 2 tahun. Makanan pelengkap perlu dimulakan pada umur 6 bulan.
2. Melatih semua kakitangan kesihatan dalam kemahiran yang diperlukan untuk melaksanakan polisi ini.
3. Memberitahu ibu mengandung tentang kebaikan dan pengurusan susu ibu.
4. Membantu ibu-ibu memulakan penyusuan susu ibu dalam masa ½ jam hingga 1 jam selepas bersalin.
5. Memberikan tunjukajar kepada ibu-ibu cara penyusuan dan cara mengekalkan penyusuan jika mereka berpisah dengan bayi.
6. Menentukan bayi baru lahir tidak diberi minuman atau makanan lain selain daripada susu ibu, kecuali diatas sebab-sebab perubatan.
7. Mengamalkan "rooming in" dimana bayi dan ibu sentiasa bersama setiap masa.
8. Menggalakkan penyusuan susu ibu mengikut kehendak bayi.
9. Menentukan bayi tidak diberikan puting tiruan atau puting kosong.
10. Membantu penubuhan kumpulan penyokong penyusuan susu ibu dan rujuk ibu-ibu kepada kumpulan ini apabila keluar dari hospital atau klinik.
11. Susu formula dan botol susu tidak boleh dibawa ke wad bersalin atau was bayi.
12. Sebarang pelanggaran tata etika penyusuan susu ibu perlu dilaporkan segera kepada pihak berwajib.
13. Ceramah individu atau kumpulan mengenai penggunaan susu formula tidak dibenarkan kecuali pada kes-kes tertentu.

Jawatankuasa Hospital Rakan Bayi
Hospital Sultanah Aminah, Johor Bahru

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