CHAPTER V

DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

1. Introduction

Researches in the domains of health care services are few and far between in Bhutan. As a modest attempt towards answering some vexing questions related to patient dissatisfaction that remained unanswered in regards to health care services rendered at the National Referral Hospital at Thimphu, a cross sectional hospital based study was carried out during Jan-Feb.2004. It aimed as one of its objectives to characterize the level of dissatisfaction among inpatients of this centre, which serves as the national referral hospital of the kingdom besides catering to general population of the town and Thimphu district. The other objectives were to find out the main factors for satisfaction or dissatisfaction in the socio-cultural, economic and political context of Bhutanese patients of the NRH, to characterize satisfaction levels in respect to various services in different wards and finally to seek recommendations from patients and care providers for improving services and patient satisfaction in this centre.

180 in-patients were surveyed using interviewer-administered questionnaires as the main study instrument. 20 moribund/critically sick patients in this 200-bed centre were excluded. To substantiate and corroborate findings of this quantitative survey, in-

interviews of five key informants and a questionnaire survey of sixteen physicians involved in inpatient care were also carried out.

2. Salient Socio-Demographic Characteristics of Sample Population

The study found out that there was equal number of males and females patients of 90 each. However, since all inpatients were taken in the survey including those in maternity ward, male female ratio in rest of the wards would be an indicator towards this ratio. Analyzing this, it was found out that males formed 59% of the total inpatients of the sample population, females forming other 41%. Other studies, by and large have found out that more females than males utilize health care services (Kohn and White 1976). Since there were no studies carried out previously, it is difficult to infer any conclusions out of this. This trend has to be followed for some time to say definitely that more males than females are admitted in NRH implying that more males have serious conditions that warrant hospitalized care.

The youngest patient was a one year old infant and oldest was a ninety years old male. The mean age of the study population was 32.04 years, SD being 20.46 years respectively signifying that most of inpatients were in younger age group. This was also due to the fact that 58.3% of patients were admitted with acute conditions.

55.6% of the sample population was illiterate. About 44.4% of patients had education from non-formal to college and above levels implying that more and more of educated people are seeking health care in this hospital as compared to some years ago. This is in agreement to Caldwell (1993) who said that educated people have more tendencies to

use health care than less or uneducated ones. It may also imply that educated people are more empowered to negotiate admission and hospital based care as compared to the less educated or illiterates.

In terms of occupation, farmers formed the highest number of patients at 35%. This is so as Bhutanese economy is basically an agrarian one and about 80% of population is rural and engaged in agriculture. Others closely following at 21.7% were mainly house wives who could be lumped in the same class except if they were spouses of civil servants or wives of workers in semi-government organizations. Monks formed the least representation of all at 2.8%. This is an indication that the religious class is a privileged one and enjoys better health than rest of the Bhutanese society.

78.2% of patients came from low-income group of less than Nu. 5000 per month. These were mainly farmers, housewives, students and monks; the latter two without any income. As per Freeman and Corey (1991), low-income people use health services more often. This is one reason for the royal government of Bhutan to continue free health care as a noble policy towards "Gross National Happiness" that is so dear to our king and the government. For still some time to come, our poor rural masses may not be able to pay even a bare minimal for health care services that are provided free to them now. Key informants during their interviews made this amply clear.

In terms of ethnicity, Ngalongs, the western Bhutanese, formed about 36.2% of the bulk of the patients in the sample population. This is mainly because of accessibility factor as NRH is situated in the western part of the kingdom and is also the western regional

referral hospital. The rest of the regions have their own regional referral hospitals, which serve their own catchment areas. Though not as developed as NRH, most of the patients are screened and referred from these regional hospitals for advanced or specialized care at the NRH. One of the recommendations from the patients was to have these centers developed so that patients need not be referred all the way to Thimphu. Of course, we do not have any policy to deny care at NRH even if they skip local health facilities. The least (9.4%) were the Khengpas, the central Bhutanese and the reason for this are because most of them reside in mediocre sized districts with adequate health infrastructure and most of them may not be able to go to Thimphu on economic grounds if not referred through the proper channel.

About 56.1% of inpatients were self admitted; about 43.9% of the patients were referred through the referral system. This is a noteworthy finding and must be appreciated. Referring patients across difficult terrain of the Bhutanese landscape is expensive, fraught with weather and topographical hazards and often referrals involve even sending medical escorts. The other possibility is that many patients are bypassing local health facilities and accessing services at the NRH directly. This will have implications in the future in terms of over burdening referral hospitals and under-utilization of local facilities though there is no policy to address this as of now.

About 58.3% of study population had acute forms of diseases or health conditions. 41.7% of them had chronic disorders. During the summer and other seasons, this ratio may be in same order but with a wide variance as acute conditions usually far exceed chronic ones and patients may not be able to get admissions easily in the wards.

The longest admitted patient during the survey was 210 days followed by some for 90 days and 78 days. These could be because some patients in orthopedic ward require long term physiotherapy and some have no one to look after them on being discharged. This is another point highlighting "Service with Humane Face".

66.7% of respondents were first time admissions. About 33.3% were repeat admissions mostly for chronic conditions. These admissions for chronic conditions could be reduced in future with the initiation of hypertension, diabetes and chronic disease clinics as part of outpatient services on daily basis.

3. Summary of Satisfaction Levels of Different Services in the Wards of NRH as Rated by Study Population

All the wards were assessed for different service ratings as responded by inpatients and parents and guardians of pediatric patients. This was one of the objectives of the study.

3.1 For whole sample population

98.3% rated physicians' competencies at high satisfaction levels. This is perhaps our patients may be incapable of judging this aspect of their care and rate it high in the satisfaction scale. Patients usually accept physicians' superior status and medical skills without any doubts and questions (Talcot Parson, 1964). Studies elsewhere have also shown this (Z.Ben Sira, 1976). 96.1% of respondents also rated nurses' competences at high satisfaction level. Competencies here were referred to mainly instrumental aspect of their work. Attitude of care providers too was rated at high satisfaction levels by 92.2% of respondents. This had been a consistent finding across all wards and is

important as recipients of care are more dissatisfied with manner and means of processes of care rather than outcome and competencies of health care personnel (H.R.,Kelman, 1976). In manners, those pertaining to support staff are laudable in the Bhutanese context. Only about 70% of patients rated waiting time, doctor-patient relation and comfort in wards at high satisfaction level. These are areas for improvement in future.

3.2 The EENT ward

All patients rated support staff attitude, competency of physicians and nurses at high satisfaction levels. Over all, many other domains have also been rated at high satisfaction levels. The high level of satisfaction in EENT ward may be as a result of two specialized doctors each for both these specialties. Ophthalmic and ENT patients usually experience rapid improvement in their conditions e.g. after cataract/other operations. Studies have proved that good therapeutic outcomes are important factors for satisfaction of ophthalmologists and this may further drive them for better care and satisfaction of patients (Petrozzi, M.C. et al, 1992). Also most of the patients were in older age groups and many were referred patients as this is the only full fledged ophthalmic and ENT center in the country. Other strong service domains for high satisfaction were competencies of physicians and nurses, social support, support staff attitude and general cleanliness in the EENT ward. Over all satisfaction was 67.0% and both hospital and provider aspects had high satisfaction at 52.9% and 67.6% respectively.

3.3 The Medical ward

Competencies of both physicians and nurses were rated at high satisfaction levels by all patients. Support staff attitude followed this at 97.0%. Medical problems depend a lot on investigations and the ward is on top floor of inpatient complex. Admissions and investigations involve a longer waiting time, which was reflected accordingly at 30.3% rating at low satisfaction level for this domain. 42.4% of respondents rated doctor-patient relationship at low satisfaction level too. Studies have shown that physician dissatisfaction was high with those who deal with infectious diseases and internal medicine is exactly that (Leigh,.J.P. et al as cited by Abigail Zuger). Their dissatisfaction may be reflected in their work and affect patient welfare and satisfaction. Medical ward is one of the busiest wards with rapid turn over of patients and with a heavy out patient load. There is also lot of inter-ward referrals for medical evaluations. Two or three physicians only manage medical ward and hence they are usually overworked. Over all, 63.3% rated satisfaction here at low level.

3.4 The orthopedic ward

96.7% rated competency of physicians and nurses at high satisfaction levels. 93.3% rated "Service with Humane Face" and care providers' attitude at high satisfaction level. Overall, from accessibility point of view and waiting time for admissions and investigations, this ward has the advantage of appropriate location. Expatriate physicians from outside often work here and poor rating for doctor-patient relation as reflected here may be as a result of language barrier. Comfort in the ward rated at low satisfaction by 30% here is one area for improvement. Over all orthopedic ward had low satisfaction levels in both hospital milieu and provider factor domains; more so in

the former where 76.7% rated low satisfaction. Over all 70% of respondents here had low satisfaction.

3.5 The maternity ward

Satisfaction level here was indeed high and ten service domains had been rated at high satisfaction levels by 90% and above patients. Maternity ward is one of the busiest wards in the NRH. Since there are well-trained gynecologists and pediatricians in this centre, most high-risk obstetric cases are referred here from across the country. Only 80% rated waiting time at high satisfaction level but waiting is part of normal process of birth. And unless indicated, obstetricians in NRH do not opt for caesarian sections. High satisfaction ratings for service with humane face and support staff attitude were very positive findings here. In a busy ward where many critical events occur in respect of neonatal and maternal health, rating for comfort at 23.3% at low satisfaction level will be tall order for improvement. Over all, maternity ward had better satisfaction scores in provider domain at 56.7% and an over all high satisfaction level of 60%.

3.6 The surgical ward:

All patients rated accessibility at high satisfaction level as this ward is accessible from two entry points most of times. 96.6% rated attitude of support staff and physicians' and nurses' competencies at high satisfaction levels. Doctor-patient relation, general cleanliness and comfort in wards were some areas for attention as more than 24% rated these at low satisfaction levels. Social support was also rated by 20.7% at low satisfaction level. These pertained to visitors restriction but this sis important to maintain aseptic conditions in a department where there is no separate ward for post

operative cases. Surgical ward had better scores in the provider domains with 62.1% at high satisfaction level.

3.7 The pediatric ward:

Pediatric ward had 15 patients enrolled for the survey and parents/guardians/attendants were the respondents. Due to some physical structural changes that were taking place during the time of survey, only 15 patients out of stipulated 40 were available for the study. Also in the winter, patient load was quite less. 3 infants who were critically sick were excluded from the study as advised by physician in-charge.

This is, otherwise another busy ward during other seasons. All respondents rated physicians' competence and comprehensive care at high satisfaction levels. The former may be because physicians carry most of practical/instrumental works by themselves. The latter may be the output of integrated management of childhood illness (IMCI) that we follow in Bhutan. 26.7% had rated social support and comfort in the ward at low satisfaction level and these were mainly due to some structural changes that were taking place during the time of this study. Visitors control was stricter or parents/attendants were not able to find the ward easily. The over all satisfaction matrix for pediatric ward was 53.3% at low satisfaction level. Social support, comfort in the ward, waiting time, hospital diet and provider factors other than competencies and comprehensive care were domains for improvements in future.

3.8 The cabins

All patients rated eight service domains at high satisfaction levels. Conspicuously five of those were in the provider domain except doctor-patient relationship. 44.4% rated hospital diet and waiting time at low satisfaction levels. Most cabin patients do not eat hospital diet and perhaps rated as uncertain (score 3) in the likert scale as this question pertained to taste, quantity and timing of meals. Waiting time was rated thus as patients usually have to wait a long time for getting cabins. The over riding observation here is that despite paying for lodging, patient satisfaction was very high. It may also be that if a single health worker cares for fewer patients, patients are more satisfied. Also this may drive home the fact that minimal payment that cabin occupants make does not affect their perceptions towards dissatisfaction. Cabin had higher satisfaction matrix in both hospital and provider domains at 55.6% and 77.8% respectively and an overall high satisfaction at 66.7%.

4. Salient Features of Dissatisfied Patients in the NRH.

As reflected in table 15, 80% of the dissatisfied patients were females as against 20% male. This conformed to many other studies and also as found in physicians' survey. One study, however found that females were more satisfied than males (Al-Doghaither A.H, Abderhman B.M., Saeed A.A., 2000). About 73% of the dissatisfied patients were in their 20s and 30s. This was conforming to other studies (Ray Fitzpatrick, Anthony Hopkins, 1983). More illiterates (67%) were found to be dissatisfied in this study contrary to the general belief that educated ones are more prone to be dissatisfied. About 67% of the dissatisfied were from low-income bracket of Nu. <5000 per month. Studies else where have found out that patients with higher income groups rated

satisfaction about 5% higher than patients with lower income (A.G. Zweir, D.Clark, 2001). In our context, this could be that poor are also the illiterates who may not be able to put a value to the free health services that government is providing to them. This was also highlighted by most of the key informants. Housewives, as one of the occupational groups in this study, formed the highest percentage among dissatisfied. This formed about 46.7% of them. Sharchops, the eastern Bhutanese formed 40% of dissatisfied followed by Ngalongs at about 26.7% while Khengpas were the least at 13.3%. The Sharchops could be dissatisfied as they are usually referred from their regional referral hospital in the east, involves traveling across the country and finally some local factors at the NRH may also come into play. In other studies, ethnicity was not proved to have any association whatsoever with satisfaction (Dinesh Bhugra, Janet la Grenade, Paola Dazzan, 2000; Callan Allison, Littlewood Roland 1998)).

Self-referred/admitted patients formed 80% of the dissatisfied lot. Referred patients in the Bhutanese context may rarely complain as they are provided with government transportation with night halts in hospitals along the travel routes and at times even with medical escorts. 60% of dissatisfied patients were admitted with acute conditions. One of the dissatisfied was 78 days in the hospital, next for 19 days; the shortest being one month in the pediatric ward whose mother was very dissatisfied. Repeat admissions formed about 60% of dissatisfied among the study population; this may be so as satisfaction is an evaluative process and needs some time. Also it may be that they are aware of their chronic conditions, which may not have any cure due to which they may remain dissatisfied. However, studies have found out that patients with previous

admissions were more satisfied and less in conflict with staff (Dinesh Bhugra, Janet la Grenade, Paola Dazzan, 2000).

5. Factors for Satisfaction

Identifying factors for satisfaction among the patients of NRH was one of the objectives of the study. It is not sufficient to know that patients are dissatisfied but why they are is crucial(Williams and Wilkinson, 1995). This was dealt from three aspects.

5.1 Statistical associations between patient factors and satisfaction in respect to different domains.

5.1.1 In Hospital milieu aspect

Associations between age, ethnicity, duration of hospital stay and satisfaction with Accessibility domain (Table 21, page 52).

- Age and satisfaction with Accessibility:

There was a significant association between these with p 0.003. Those below 15 years and above 31 had higher satisfaction and the group in between these ages was less satisfied with accessibility. In terms of younger patients here in the NRH, satisfaction in terms of accessibility may be higher as elders usually accompany them during hospital admissions and other investigations.

- Ethnicity and satisfaction with Accessibility:

The significance here was with a p value of 0.003. Lhotshampas and Ngalongs were highly satisfied followed by Sharchops and Khengpas. Both first two have easy access

to the capital as most of roads run from south to north. As for the Ngalongs the hospital is in the western region itself. Also both these groups may have some body or the other in the capital for facilitating access, care and admissions here. The Khengpas were the least satisfied as from the accessibility point of view, their region is far-flung and remote. They may also be handicapped in terms of having some relatives in Thimphu for facilitating consultation and admission in the NRH.

- Duration of hospital stay and satisfaction with Accessibility:

There was a significant association between them at a p value of 0.014. Those with shorter duration of stay had a higher satisfaction level. This may be because satisfaction is an evaluative process and shorter the stay, shorter the time to evaluate and form a perception of dissatisfaction.

Associations between genders, referral status and admission history with waiting time (Table 22, page 53-54)

- Gender and waiting time.

The association had a p value of 0.047. Males were more satisfied than females. Literature says that it is the quality of waiting time and outcome of consultations or investigations after waiting that matter which affects the perceptions of satisfaction (Chanking Hong, Tsang J, Chen KYH, 2003). Bhutanese males are more outgoing than females and would have met and interacted with more patients and had a better time spent while waiting.

- Referral status and waiting time.

Referred patients were more satisfied than self admitted/referred patients with a statistical association of p value of 0.009. This is very true in our situation as referred patients are helped by ambulance drivers who reach them to the NRH; some times there are even medical escorts to help and hand over patients at the emergency outpatient department of the NRH. They are usually taken care of faster than other patients and thus involve less waiting.

- Admission history and waiting time.

A highly significant association was found at the p value of 0.007. First time admissions were more satisfied than repeat admissions. This finding is contrary to what literatures say. It is said that repeat admissions are more satisfied with services and have less problems with hospital staff (Dinesh Bhugra, Janet La Grenade and Paola Dazzan, 2000). The only logical explanation here would be that first timers would not have been able to compare admission and other waiting times within premises of their previous experiences and be dissatisfied.

Associations between referral status and admission history with comfort in the ward (Table 23, page 55)

- Referral status and comfort in the ward:

These two variables were significantly associated at a p value of 0.026. Referred patients were more satisfied than those who were self admitted ones. This is, because of a sound referral system in Bhutan. These patients are lifted by government ambulances

and are taken better and faster care at the NRH. They are also well prepared and take more of required paraphernalia for a hospitalized stay as transport is available. All these may not be possible for the self-admitted patients.

- Admission history and comfort in the ward.

There was again a significant association between these with a p value of 0.021. First time admissions were more satisfied than repeat admissions. First time admissions are usually due to acute communicable conditions and improvements may be rapid. Repeat admissions may be as a result of chronic conditions. They may have certain fixed expectations based on previous experiences and may be more critical in their evaluations which may affect their satisfaction. They may also be dissatisfied as they are already told of the nature of their diseases.

5.1.2 In Provider factor aspects

There were significant associations between disease status and nurses' competency and ethnicity and doctor-patient relationship (Table 24. page 58).

- Disease status and nurses competence

Here 100% of chronic patients were highly satisfied with the nurses' competency. The significance level was p 0.025. As per Szarsz and T.S., Hollender (1956), chronic patients have major role in taking care of their diseases and here nurses come handy. Nurses in the NRH render care to patients all day long. The physicians do the timely rounds, write orders and it is the nurses who carry out almost all of care related

services. Many a times nurses in our set up even remember previous/chronic patients. Patients thus feel satisfied with nurses in general in the Bhutanese context.

- Ethnicity with Doctor-patient relationship

There was a highly significant association between them at a p value of <0.001(Table 25, page 56). Ngalongs were highly satisfied followed by Sharchops. The least were the Lhotshampas. Dzongkha is the national language of Bhutan and is mostly spoken by the people of west. Lhotshampas are the least conversant in this language. All the government staffs are conversant with it including physicians at the NRH. Studies have found out evidences that race, ethnicity and language have substantial influences on doctor patient relationship. Patients are more satisfied and develop a better relationship with language concordant physicians (Warren J. Ferguson, Lucy M. Candib, 2002). This may be true even in the context of present study.

5.1.3 With combined provider aspect

A significant association was found between age and the over all satisfaction with the provider aspect (Table 26). The p value of this association was 0.014. Those >31 years had higher satisfaction level than those in other age categories. Older age was thus associated with high satisfaction with factors/services domains in the provider aspects.

5.1.4 With overall satisfaction (combined hospital and provider aspect)

Here age and duration of hospital stay had significant associations at p values of 0.046 and 0.045 respectively (Tables 27,28, page58). Age above 31 years was associated with

higher satisfaction than other age groups. However, linear association was not observed as age group of <15 years were more satisfied than the group between 16-30 years. Reasons may be as specified before.

As regards duration of hospital stay, those with stay of <15 days had higher satisfaction than those with >15 days of hospitalization. The significance of the association was with a p value of 0.045. Possible cause could e the evaluative process as explained.

5.1.5 Tests of difference between satisfaction under hospital milieu and provider domains

The difference was significant with a p value of <0.001. Mean of scores of all domains under provider aspect (4.0264) was higher than those of hospital milieu (3.9127) aspects signifying that provider factors were more important towards contributing to patient satisfaction in this study. This also meant that there is need to improve hospital milieu related domains that are more tangible and to which patients associate in terms of satisfaction.

5.1.6 Association between overall Satisfaction ward wise (Table 13)

There were significant differences between wards and over all satisfaction. The highest overall satisfaction was seen in the cabin where 66.7% were highly satisfied. EENT, surgical and maternity wards followed this at 64.7%, 62.1% and 60% respectively. The least overall satisfaction was observed in orthopedic ward at 30%. These differences in the satisfaction levels were statistically significant at p value of 0.029.

6. Factors for Satisfaction as Responded by Satisfied Patients (Table 18)

49.1% of patient responded that a free health care service in NRH was the main reason for their satisfaction. For them other factors were secondary. 25% specified that helpful, kind and friendly care providers were very important contributing factors for satisfaction. Good standard of medical and nursing care at this apex hospital in the country was mentioned by 13% of the respondents. Reputation of the NRH as the pioneer hospital was mentioned as being other reasons by 8% of the respondents. This was consistent with the studies of Young Gary J. et al, 2000 who found out hospital size and reputation had a significant effect on patient satisfaction scores. All these were provider related factors the means of which was higher than those of hospital milieu in this study. And the differences was proved statistically significant by the t test between them at p value of <0.001 (Table 29, page 59). Cleanliness of the hospital environment was the only one factor mentioned from hospital milieu contributing to their satisfaction (2.5%).

7. Scores for Various Services Among Dissatisfied Group of Patients

As reflected in table 16, eleven factors were rated at both levels of satisfaction; rates for low satisfaction levels showing an upward trend. 100% rated competence of physicians at high satisfaction level. Waiting time and social support were rated at low satisfaction by 73.3%. 66.7% rated hospital diet at low satisfaction level. On the other hand, attitude of support staff and nurses' competence were rated at high satisfaction level by an overwhelming 93.3% of respondents. 100% rated doctor-patient satisfaction at low satisfaction level.

8. Factors for Dissatisfaction Among the Dissatisfied Patients

Identifying these will also be important for improving services and patient satisfaction in the NRH in future. Many respondents had multiple factors for the outcome of dissatisfaction (Table 20, page 51). Chief among them as elaborated were in terms of social support due to excessive restriction to their visitors/relatives. They even complained that home cooked food being brought from outside got cold due to this. Toilets attached to the wards were not maintained clean enough. Hospital food, many said was tasteless. Incomplete care in terms of addressing all complaints and some staff attitude towards patients were also highlighted as factors for their dissatisfaction.

9. Recommendations for Improvement as Suggested by Satisfied Patients (Table 19)

Though they were all satisfied with the services, there were rooms for improvement. Seeking recommendations from respondents for improving services and patient satisfaction was one of the objectives of the study. These are reflected in Table 19. Doctor-patient communication in terms of informing and discussing about their diseases was highlighted as one of the weaker domains. Other studies have also demonstrated this as a very valuable attribute (Chao, DVK, 2001). It seems that our physicians are not communicating enough with patients in terms of explaining their diseases, line of management they are receiving and giving opportunity for patients to ask and discuss their problems. Time is an important factor here. A JAMA study showed that 72% of doctors interrupted their patients opening statement after an average of 23 seconds and those who were allowed to continue could do it for only 6 seconds more. Doctors also underestimate the information that patients want and

overestimate how much they give. In one study doctors spent about 1 minute per patient but believed that they spent 9 minutes for the visit (Waitzkin H., 1984). Other domain in provider aspect suggested was the need for improvement of attitude of some staff towards their patients.

Majority of suggestions for improvement were focused on the physical environment of wards and hospital. This was consistent with the findings that general satisfaction levels with hospital milieu were lower than those under provider factors. Provision of a proper sitting/sleeping place for patient attendants at night was one recommendation pointed out by 14% of respondents. Cleanliness of toilets, limiting too much restriction as it exists now for visitors/relatives were others. There was need to decrease waiting time for admission and investigations. There were also some exotic suggestions like provision of television in the wards for education and entertainment purposes. Access to hot water in winter was another recommendation by 7.5%. The food needed improvement in terms of flavor and taste. Decreasing waiting times during admission and investigations was another factor suggested for improving patient satisfaction.

10. Interviews of Key Informants

These interviews were conducted in order to substantiate and complement findings of the quantitative study. The respondents were all those who had years of experience and interactions with patients at the NRH. They said that patient expectations are ever on the rise and since services are free, there is very little value they attach to health care services. They are not yet used to restrictions of any type and demand services as a matter of right. As regards the quality and other service gaps, interviewees were all

clear that the government was trying to provide them the best in the country. Manpower shortages were highlighted as one of the gaps in fulfilling expectations of patients though all those who work in the NRH were serving to the best of their abilities. As regards the complaints that crop up once in a while, all were consistent in assuring that these were taken up seriously at all levels and appropriate actions were taken immediately to rectify them. Some of them felt that the concept of "Bhutanese Doctoring" will require nurturing for a healthy doctor-patient relationship. However, some felt that certain researches may be initiated in terms of cost sharing, user fees, paid clinics etc.

11. Questionnaire Survey of Physicians on their Perceptions of Patient Satisfaction at the NRH.

16 specialist physicians all involved with inpatient care in the NRH participated in this questionnaire survey. They were all unanimous that patient dissatisfaction and complaints have shown a rising trend in recent years. Rough estimate they put for dissatisfaction among inpatients ranged from 5% to 30%; 33% putting it at 15%. There was also high consistency in their perceptions of common socio-demographic factors for dissatisfaction and complaints. However, some of their perceptions did not conform to the study findings. They said that more males, government servants and educated patients complain. Reverse were the study findings. They were clear on factors, other than patient socio-demography that influence patient satisfaction. Some of the bottlenecks that they pointed out faced by them in not being able to fulfill patient expectations were manpower shortages and inadequate continuing education. 91%

affirmed that patient satisfaction is associated with their satisfaction. This is a very positive perception in a system where private practice does not exist.

12. Discussions on Some Factors/Variables Under Certain Domains:

These often cropped up as factors associated with dissatisfaction of patients.

12.1 Toilets

Except for the cabins, all other wards have common toilets, which are cleaned twice a day. On observation during the data collection exercise, toilets were found to be quite clean except when there were water problems sometimes. Many of the respondents were dissatisfied with sanitation in the toilets and rated general cleanliness accordingly. Toilets were often forthcoming as factors for dissatisfaction and recommendations for improvement. The fact may be that general patients are not used to the type of toilets that were installed in the NRH. Solving occasional water problem and educating them about proper toilet use may be looked into as solutions to decrease complaints and dissatisfaction in the domain of general cleanliness.

12.2 Patient diet:

Many patients who have relatives or friends in Thimphu do not eat hospital diet. As such many do not know the characteristics of food served here. This had, thus, biased ratings on this domain as they rated "uncertain" with 3 points and even lower. A free diet provided by hospital may not match home made food by any standards. How ever, regarding taste and flavor, patients need to be informed of the type of patient food that is served anywhere in hospitals. Just because that food is devoid of spices and flavor

does not mean there is lack of necessary nutrients. Educating patients is important in order to avoid complaints and wastages too.

12.3 Waiting Time:

Waiting time referred to time loss during admission and other investigation procedures. This particularly affects chronic patients, which formed 42%, and repeat admissions, which formed 33% of patients as they are usually evaluated at OPD prior to admissions. As inpatients, investigations involve being taken to outpatient complex and investigated along with other outpatients. While waiting, many a times they are left with only the attendant without any pre-occupation. The quality of waiting time seems to be important too for patient satisfaction. Studies have indicated that patient satisfaction seldom hinged on duration of waiting time alone. What happened during waiting period and what followed during consultation or investigations are all important facets for satisfaction. Some studies have found out that long waiting time were associated with increased popularity and high utilization of some clinics in Hong Kong (Chan King Hong, Tsang J., Cheung KYH, 2003). Preferences for inpatients for investigations need to be improved for addressing patient dissatisfaction.

12.4 Noise/crowd control and social support.

These are conflicting perceptions, as many respondents also recommended not enforcing too much restriction to visitors and relatives when they are sick and admitted. Usual observations are that there are lots of visitors in the wards during visiting hours. Visitors often try to barge into wards during even odd hours in the NRH. While some are satisfied to have many visitors, for some it is a matter for complaint. More

education on healing effects of rest and chances of visitors being infected in hospital require emphasis so as to convince patients and attendants on these. Also visiting hours/timing must be made clear to those concerned. How ever, the bottom line seems to be that social cohesion in Bhutanese social fabric is still very strong.