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PERCEPTIONS OF QUALITY IN A PUBLIC HOSPITAL: THE CASE OF THE SALMANIYA MEDICAL COMPLEX KINGDOM OF BAHRAIN

BY

JAMEELA MANSOOR AL SAMMAK

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DR RICHARD K COMMON
HEAD OF ORGANISATIONAL BEHAVIOUR/HUMAN RESOURCE MANAGEMENT

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ABSTRACT

The aim of this thesis is to improve the quality of healthcare for patients who use Bahrain's secondary health services. The issue of quality management can only be understood within the wider context of political and social change in the Kingdom of Bahrain. Thus, the dissertation begins by mapping out some of key political and administrative changes from 1999 onwards; a year which marked the cautious beginning of democratisation within the Kingdom. Using Donabedian's framework of analysis, the thesis presents the findings from primary empirical research which establishes the quality of healthcare in Bahrain. This study elicits the views of both patients and professionals at the Salmaniya Medical Complex, Bahrain's only general hospital. However, to provide a theoretical and practical basis for future quality management initiatives within the Bahraini health services, these views will greatly assist in the preparation of high quality processes and physical settings of a proposed new hospital. Based on the results of a questionnaire with over a 50% response rate, the majority of respondents appeared satisfied with the quality of healthcare. However, a number of key suggestions were made, including concern over staffing levels and the quality of administration at the hospital. Therefore, the dissertation makes a key several recommendations based on this empirical evidence, but more widely, it is clear that democratisation in Bahrain has made an important impact on the management of healthcare. However, the impact is still not clearly understood. As democratisation proceeds, the findings of this research should help to clarify this process by analysing the perceptions of quality of key stakeholders in the health service; those who provide it and those who use it.

Chapter 1

MANAGING QUALITY IN HEALTHCARE IN BAHRAIN: ISSUES, TRENDS AND DILEMMAS

Statement of the problem

Until the first American hospital was opened in Bahrain in 1902, there were no organised health and medical services in Bahrain; the people only used traditional and herbal medicine. Today, Bahrain has a huge government hospital, the Salmaniya Medical Complex, (SMC), which is a secondary and tertiary healthcare hospital, furnished with approximately one thousand beds. The hospital provides specialised services and is equipped with advanced diagnostic facilities and advanced technology.

The researcher has chosen to study quality management in the health sector due to a personal belief that research which reflects the strategy of the government, will ultimately improve the lives of its citizens. In particular, such research should support and encourage the development of quality service delivery. For example, a major strategy of the Ministry of Health in Bahrain is to improve the health of the nation and deliver essential, quality and cost effective services, (Strategic Health Plan, 1997).

Bahrain is also a member of the World Health Organisation (WHO). This strategy also reflects WHO's 'Health for All' campaign (Strategic Health Plan, 1997). Therefore the researcher believes that this research is not only following and meeting Bahrain's health aims, but also WHO

strategies, because delivering essential, quality and cost effective care cannot be achieved without studying and implementing elements of quality care.

Since Bahrain is following WHO strategies, to achieve "health for all", Bahrain needs to recognise what 'a quality' health service is. As in health services around the world, there is growing recognition in Bahrain of the importance of the views of patients and healthcare providers, when planning services in secondary healthcare. Indeed the opinions of patients and health services providers remain essential to meaningful quality assurance in the health sector.

In other words, quality cannot be optimised without at least some reference to those who use or provide health services – this is a well-established principle (Nehemkis et al, 1984). Indeed, the Bahrain Government, including the Ministry of Health, has embraced the principles of Total Quality Management (TQM). However, the difficulty of putting this principle into practice may lead to a failure to carry out good intentions to have effective quality healthcare, accessible for all.

Being a former nurse manager in Bahrain I am confronted with many local examples of quality problems brought to my attention through the expression of patient or provider opinions. For example: for every 20 patients, there are around 12 to 16 nurses assigned to take care of them (see table 1, page 4). There will be only two nurses per shift taking care of them, because the nurses will be divided into three shifts. Suppose the ward has only 12 nurses divided into three shifts, each shift will have 4 nurses and some of them could be on leave or absent from duty, therefore

there will be only two nurses per shift remaining since most patients are in need of total nursing care, this can be a major problem.

Table 1: Staff/patient ratio on the medical floor in a nursing department, at Salmaniya Medical Complex (Source: Salmaniya Medical Complex, Management Information, 2004)

Ward number	*Number of patients*	*Number of staff*
51	22	16
52	15	12
53	10 (highly dependent patients)	22
54	22	13
55	18	13
56	22	15

All the patients on this floor are medical patients with similar problems, except ward number 53, which contains highly dependent patients. Furthermore, what the table shows, is that the number of staff is distributed blindly with no criteria or scientific measures; some of the wards are suffering from a shortage of nurses while others have a sufficient number. Table 1 will express that ward 52 has 12 nurses for 15 patients but on the other hand, ward 54 has only 13 nurses for 22 patients. Based on my personal experience, although ward 54 has more critical patients than ward 52, it has less staff.

There are no clear criteria to justify the need for nursing staff. The nursing personnel are calculated as follows: the total number needed per shift for the unit / ward x 106 = the total nursing personnel (SMC,

Nursing Administration Record, 2001). The problem is that no one knows from where they brought the number (106) to multiply with! This apparently arbitrary approach to staffing leads to shortages of key hospital employees such as doctors and nurses, which in turn leads to more patient complaints and to staff stress and job dissatisfaction.

Moreover, there is no scientific evaluation of nursing care related to the staffing programme, which should contain four elements:

1. A precise statement of the purpose of the institution and the services a patient can expect from it, including the standard and characteristics of the care.
2. The application of a specific method to determine the number of staff required providing the care.
3. The development of assignment patterns for staff from the application of personal guidelines, policy statement and procedures.
4. An evaluation of the product provided and judgment reflecting the impact of the staff upon quality, (Willis and Linwood, 1984:123).

The study is required to address issues that occur on a daily basis, such as bed shortages, or professional conduct. However, although these issues could potentially be solved by systematic managerial feedback, what health services lack in Bahrain is a way of acquiring facts and opinions from patients and services planning.

Bahrain's social and political context may have much to do with this. There is a lack of understanding about what can be gained from increased participation in health services planning in Bahrain, especially as 'democracy' and 'transparency' are relatively new to Bahrain. Until recently, people were afraid to participate or ventilate their feeling basically due to the political climate.

On the one hand, patients are clients of a public sector organisation: they are not making an economic transaction and therefore they are in need of services, which might not be based on their choice, but they have no other alternatives. On the other hand, patients might think that they do not want professionals to make care decisions on their behalf. They may refuse to have 'framed' services, for example if a doctor decides on surgery for a cancer patient before chemotherapy treatment, a patient in Bahrain has no choice to refuse the surgery because patient is in a public hospital and has no right to ask for another medical opinion. The doctor's decision must be accepted or a second opinion from the private sector must be sought.

A main dilemma for this research is the influence of the cultural setting within which management reform takes place. For instance, Hood (2000) identified four cultural perspectives on public management reform including an individualist bias which is theoretically associated with new public management style reforms. However, in Bahraini culture, the kind of individualism that guides managerial thinking in the west is largely absent.

These technical, cultural and psychological problems may have all contributed to subtle forms of resistance or denial of the need to plan participative health services, yet there is still a move towards implementing a more participative form of quality assurance by the Ministry of Health in the near future. This project then is a response to the Ministry of Health's policy and is an attempt to find ways to enable patients and service providers to contribute facts and opinions constructively when planning quality health services in Bahrain.

Research Aim

Given the apparent problems and challenges associated with the potential of implementing genuine quality management in Bahrain's health service outlined above, the thesis intends to demonstrate through empirical research that such a goal can be achieved. Thus, the overall aim of the research is:

To improve the quality of healthcare for patients who use Bahrain's secondary health services

To achieve this aim, **the thesis has the following objectives**:

1. To understand and critically analyse the context of health services in Bahrain
2. To undertake primary empirical research to establish the present quality of healthcare in Bahrain
3. To provide a theoretical and practical basis for future quality management initiatives within the Bahraini health services

To achieve the first of these objectives, the thesis will begin by exploring the development of the health service within the political and cultural context of Bahrain. This will be done in this chapter which will also introduce the background to health service and quality management reforms in Bahrain. In chapter two, which reviews the literature on quality management in the health services in particular, it becomes apparent that very little has been published on this topic in Bahrain, let alone the Arab Gulf region. This chapter also provides the framework which informs the empirical research. The second objective is also met in the analysis of the findings to provide the basis for a critical discussion of the viability of future quality management

initiatives in the Bahraini health service. However, we now turn to the unique political and social context of Bahrain.

The Context of Quality Management in Bahrain

Introduction

Before attempting any empirical analysis, it is important to understand the political and social context of Bahrain, which also needs to be considered within the wider political and social setting of the Gulf (Khuri 1980: 1). Important changes have occurred in recent years that impact directly not only on public administration within the Kingdom, but have allowed the promotion of managerial methods and techniques such as quality management to improve organisational effectiveness in the public sector. However, public sector reform is far from systematic.

The reforms appear to be a response to a crisis of legitimacy stemming from chronic fiscal difficulties, international democratisation and domestic pressures. However Apart from violent demonstrations in April, 2001 there were few incidents of political unrest, (Bureau of Democracy, Human Rights, and Labour, 2003).

Thus, the rationales for reform appear to be in line with international trends. However, the political focus in Bahrain is on the role of the King and his government and the King's response to greater stability and democratisation. The King's strategy is intended not so much to satisfy the political demands of his constituents, but to ensure that they are expressed within the system, rather than in the streets (Mohammed, 2002).

This context provides the backcloth for steps towards quality management in the forthcoming part of the chapter. This is followed by a presentation of the health system in the country along with a discussion of the effects of reforms in the health sector. Thus, the overall purpose of this chapter attempts to put the introduction of quality management in the health service within the wider context of political changes in Bahrain.

Political and administrative change

In recent years attention has focused on moves towards democratisation in various regions of the world. In the Middle East it is often seen to be associated with popular demands for political reform, but externally through the commodity of oil (Dimond et al. 1989). Whatever the reason for democratisation, Bahrain's route to democratisation and the restoration of parliamentary life has been rather impressive in the less than three years since Sheikh Hamad bin 'Isa Al Khalifa succeeded his father as king. Many of the country's leading opposition figures who were in exile have returned to the country.

The once notorious security services have been reformed and emergency laws repealed; there has been amnesty for those in exile, and new, more liberal laws in a number of areas. In late 2000, a National Action Charter was introduced, outlining a proposed return to parliamentary life through the election of a new Lower House alongside an Upper House appointed by the king. The Charter was adopted in a referendum in early 2001 (Ministry of Information, 2002).

In 2001, His Highness the King also issued a decree implementing the proposed reforms and calling for elections for municipality governments as well as for an election of the new Lower House later that year. The

decree also declared Bahrain a constitutional monarchy and it did something else as well: it made it a Kingdom. The State of Bahrain has become the Kingdom of Bahrain, and Sheikh Hamad has become King Hamad, by his own decree.

The change from Emirate to Kingdom has drawn most of the attention, but the manner of its implementation has also drawn some criticism from those who had previously praised the reforms. The main problem is how they were implemented: by King Decree, now a royal decree. This circumvented a constitutional problem that the whole National Action Charter approach had raised.

Bahrain has a constitution from 1973, following independence from Britain in 1971; and changes in that constitution must be initiated by Parliament. The trouble is, Parliament was "suspended" in 1975 and never restored. In order to create a bicameral system with an elected Lower House, in other words, the constitution has to be amended, but there is no Parliament to amend it, (Mohammed, 2002).

The National Action Charter which was introduced in late 2000 was sharply criticised by Bahrainis on a number of grounds:

- The change of the Emir's title to King appeared to codify the Khalifa family's position as Bahrain's ultimate authority,
- The lower assembly, though elected, would not have any law-making powers,
- The process of preparing the charter did not involve public consultation, it excluded longstanding opposition demands for the legalisation of political parties and labour unions;

- Acceptance of Shiites; the majority of Bahrainis, into sensitive government and security positions;
- The return of deported opposition leaders;
- In addition, the release of all political prisoners, economic justice and the "Islamisation" of public life were not addressed, (Mohammed, 2002).

It is also not entirely clear why King Hamad insisted on taking the title of King and giving the "State" (dawla) of Bahrain the title of Kingdom. Bahrain is smaller than most of the Gulf Co-operation Council countries and poorer than most, yet it is now a Kingdom.

Women have been promised by the King to have full equality in voting and may run for office and an independent Constitutional Court will be established. Bahrain had the second true Parliament in the Gulf Cooperation Council states, after Kuwait, but women still cannot vote in Kuwait. The first of the decrees issued on February 14 carried the title "Royal Order Number One of 2002"; the phrase "Royal Order" instead of "Amiri Order" was explained in the first clause, which declared the official name of the state to be the Kingdom of Bahrain and the official title of the ruler to be the King of Bahrain.

It was signed by His Highness "The King of Bahrain, Hamad bin 'Isa Al Khalifa". Subsequently days it was announced that changes were being made to the flag and the national anthem as well: the flag will add symbols to represent the five pillars of Islam, while the King's royal flag will add a crown.

The idea of changing the state into a Kingdom had been discussed extensively since late 2000; some expected the National Action Charter

announced at that time to make the change. Instead, the Charter merely said that the country would be a hereditary constitutional monarchy and that a constitutional amendment should stipulate the name of the state, (National Charter, 2001).

One question has long been, why? Bahrain is a tiny state, consisting of two main islands and a scattering of reefs and islets, the only other Arabian Peninsula state calling itself a Kingdom is Saudi Arabia. In addition, the change in title distracts attention from the democratisation process and is easy enough to lampoon; not only did it get mentioned in most headlines internationally, but few news stories failed to note how small the new Kingdom is.

His Highness the King himself has never actually spelled out the reasons for the move. Some have argued that the move might be aimed at securing Bahrain's independence in the event of Iran reviving its dormant claim to the islands, but Bahraini independence is not really strengthened by a mere change of name. In 2000, when the move was first discussed, some thought it might have something to do with Bahrain's case in the World Court with Qatar over boundary disputes, but the Court has already settled those disputes.

Others thought it might have something to do with the move toward the principle of popular participation (Ministry of Information, 2001:105), rather than facing the crises between government and people which existed in Bahrain.

> In the year 2001 two Shi'a men reported that the police detained and beat them. Although one of the men admittedly sought the confrontation with the police, the police illegally arrested them without a court-issued warrant .In the past, there were credible reports that prisoners were often tortured and

> subjected to cruel, inhuman, or degrading treatment. Before the annulment of the State Security Act in February 2001, the Government had difficulty in rebutting allegations of torture and of other cruel, inhuman, or degrading practices because it permitted incommunicado and detention without trial. There continued to be credible reports of prisoners being beaten and mishandled (Bureau of Democracy, Human Rights, and Labour, 2003:3).
>
> 'Police earlier clashed with thousands of angry demonstrators in the capital Manama. More than 20 people were hurt, including a Shia opposition activist and member of Manama city council, he received a rubber bullet in the head and is now in hospital undergoing an operation, his brother said. Many women and children fainted from inhaling gas. This is completely unjustified. It was a peaceful rally'. (High Beam Research Center, (1997)
>
> 'Hundreds of Bahraini people demonstrated on Sunday, 2001' (Arabic News, 2002)

In any event and for whatever reason, Bahrain has been declared a Kingdom and its ruler a King. The more important democratisation moves deserve to be understood in their own right, whatever one may think of the country's new and perhaps a bit ambitious self-designation.

The debate over Bahrain's status as a Kingdom has distracted attention from the constitutional reform, which will give Bahrain an elected Lower House. Though the basic outlines had been known for more than a year since the original introduction of the National Action Charter in December of 2000, the constitutional changes provide explanations in much greater detail, (Gulf Daily News, 2002).

The new Parliament is called the National Assembly (Al-Majlis al-Watani). It consists of two houses, an appointed Consultative Council (Majlis al-Shura) and an elected Chamber of Deputies (Majlis al-Nawab).

The original plan as explained in the Charter seemed to imply that the Consultative Council would be identical to the body of the same name, which was established in 1992. But that council has now been dissolved; it consisted of 30 members, while the new Consultative Council, with greater and constitutionally defined powers, will have 40 members. Both houses will have the same number of members, (Bahrain Constitution, 2001).

When they are unable to reach agreement, as will be explained in greater detail later, they will meet jointly as the National Assembly, and votes can be carried by a majority of the whole. The fact that the two are equal in size means that a majority of one house plus a minority of the other could carry a vote when meeting jointly, (Bahrain Constitution, 2001).

Democratisation in Bahrain has formed a rationale for the introduction of administrative public sector management reform. Such a reform has considerable advantages for governments because they will be able to manage their activities more effectively. 'Directives issued by His Excellency the Prime Minister to implement quality performance management programmes in all Ministries', (Ministry of Information, 2002). The King added that there is no recession or set back from the march of comprehensive reforms, the foremost being 'our democratic life provided by the constitution', *(*Arabic News, 2003).

'Since the developments related to the status of political parties have occurred recently in Bahrain, which favours a gradual practice of politics. Bahrain's political societies currently function as de facto parties. In a statement last year, His Highness King Hamad bin Isa Al Khalifa did not

directly reject the idea of legalising political parties, but said that the decision was up to Parliament',(Hawthorn and Choucair, 2004).

For Parliaments, such managerial reforms in theory at least, should help to control government activity because more and better quality information is available. The clients or customers of public services should benefit from a better managed public sector.

Political reforms were also seen as a way to bolster the country's standing internationally. With its small population and meagre resources, Bahrain's influence within the Gulf Cooperation Council (GCC) was limited. His Highness the king Hamad clearly wanted to put Bahrain on an equal footing with its centuries' old rival, perhaps with an eye toward influencing the ruling of the International Court of Justice on Bahrain and Qatar's dispute over the Hawar Islands (which were awarded to Bahrain in March 2001). Improving relations with the Republic of Iran was also an important consideration, (Bahrain Tribune, 2003).

The government hoped that political reform would bolster investor and consumer confidence and thereby boost the economy, because the economic development is a pre condition of new public management. In response to these criticisms, His Highness the King Hamad decided to submit the Charter to a referendum. He also issued an amnesty for most political prisoners, granted permission for the return of people in exile and guaranteed that the Lower House would have full law-making powers.

Following this, the opposition gave the charter its blessing and urged the population to support the referendum. Despite its limitations, many

Bahrainis supported the prospect of change as an alternative to the status However, at the same time, many also feared that the Referendum was a means for the security apparatus to identify discontented elements (this perception was reinforced when voters' passports were stamped - making boycotters readily identifiable in the future). Fearing reprisals, perhaps, 90% of the population went to the polls on February 14-15, 2001, with 98% of voters supporting the Charter, (Ministry of Information, 2001)

The charter nevertheless remained ambiguous. It neither specified the role of the elected assembly, nor the role and powers of the legislature as a whole in relation to the executive. The size of the proposed chambers was not specified, nor was there any indication of how differences between them would be resolved. No target date for elections was specified. Furthermore, the Charter specified that His Highness the king would have the authority to appoint and dismiss the Prime Minister and cabinet.

Most of the reform measures that have been implemented so far are not democratic advances, per se, but human rights advances. The general amnesty for political prisoners and exiles, the reinstatement of dissidents fired from public sector jobs, the lifting of travel bans on political activists, and the abrogation of state security laws have all created more opportunities for political expression, (Ministry of Information, 2001).

However, the bodies set up to suppress the opposition in the mid-1990s (the Special Investigation Service, the Criminal Investigation Directorate, and the Public Security Force) remain intact and under the control of the King's uncle and Prime Minister, His Highness Sheikh Khalifa bin Salman al-Khalifa.

A second important limitation to the reforms is that they have been granted in a patrimonial fashion. Bahrain's reform process commenced as a unilateral royal initiative and continues to be portrayed as a grand gesture from His Highness the King to his people. Most of what passes for economic reforms (e.g., the reduction in university fees, a modest assistance programme to aid the unemployed, exemptions in housing loan instalments, and an extra month's pay for state employees) were announced personally by the King, (Mohammed, 2003).

However, the formal establishment of the monarchy and the undemocratic amendments to the constitution reinforced the belief that the political reform process in Bahrain was to benefit the people. Although the first two articles of the February 2002 Decree changed the name of Bahrain into The Kingdom of Bahrain and the title of Emir into King (with elections being mentioned third) might be hints at the priorities of the reform process and its creator to the King. However, in retrospect, the reforms can be viewed as ad hoc measures responding to a crisis of legitimacy stemming from chronic fiscal difficulties, international democratisation and domestic pressures.

It is open to question whether the regime can withstand the strains that would likely emerge once the political reforms are translated into practice and start affecting the ruling family's privileges. His Highness the King Hamad may soon realise that, as people gain more freedom and voice, the price of continued political stability will exceed ad hoc initiatives and the country will achieve a good standard of economic development.

It is generally accepted that there is some kind of relationship between economic development and democracy and that it can be demonstrated by quantitative empirical evidence (Rueschemeyer et al, 1992:11-39). For

example, Lipcap (1996) claims that there is a strong association between the two and Helliwell (1994) goes further by asserting that they exhibit a positive linear relationship. This relationship suggests that those countries with high levels of economic development tend to be democratic, while less developed countries have never been democratic or have experienced democratic breakdown on one or more occasions.

The 2001 referendum dramatically eased tensions and dissatisfaction among Bahrainis and the public mood has clearly been buoyed by improvement in the human rights' situation and the promises of further reform. Some of this initial euphoria dissipated after the cabinet reshuffle, yet it has a positive impact on the ministries, including Health, and other government organisations.

Healthcare system and human resource development in Bahrain

It is clear that there have been some important political changes in Bahrain. Within this new political environment, attention has been turned to improving organisational performance in the public sector. Human resource development has been targeted as a priority for the government, including healthcare, (Ministry of Information, 2001).

The Government of Bahrain is fully committed to the policy of all residents in the country enjoy the right to access comprehensive healthcare, (Bahrain Health Strategy, 2000). Accessibility is one part of the quality services which the Ministry of Health is trying hard to implement. This implies a determination to provide integrated preventive and curative health services through a network of primary, secondary and tertiary healthcare facilities. The technical and financial responsibility for providing this care lies mainly with the Ministry of Health (MOH) with

the co-ordination of other Ministries, the private sector and the community.

The Minister of Health is a member of the Council of Ministers chaired by the Prime Minister of the State His Highness the king Sheikh Khalifa Bin Salman Al Khalifa. The Undersecretary and four Assistant Undersecretaries assist the Minister of Health. The Assistant Under-Secretaries are administratively responsible for administration and finance, training and planning, hospitals, and primary & public health-care services respectively.

The government is committed to the Al Ma'ata declaration in 1979, a global WHO goal "Health for all". From this perspective, the primary healthcare network includes 19 health centres and 2 clinics, which act as the entry points for the citizens to high quality healthcare services on the island. These units are offering several curative and preventive services which are promoted through medical clinics operated by highly qualified family physicians and skilled general practitioners. Under the umbrella of Maternal and Child Healthcare, various services being offered include, but are not limited to, antenatal and postnatal care, family planning, periodic women screening, premarital counselling, child screening and immunisation, home visits and health education. Additionally, dentists and dental hygienists are offering many curative and preventive dental services, (Bahrain Health Strategy, 2002).

The healthcare in the health centres is provided by medical and allied health services including nursing, pharmacy, clerical and medical record services, laboratory and radiological services. Physiotherapy services have been introduced lately at two Health Centres and soon will be expanded to establish a unit in each region.

The Ministry's strategic plan is to continue improving the quality and quantity of the services. Since the early 1990's, more clinics have been assigned for diabetic patients, as well as clinics for the elderly. In addition, clinics are established for the care of youth and adolescents in an attempt to focus on the problems of this very important age group. Dental services have also expanded to create a child dental care unit that can provide special care to these patients - mainly the preventive aspects, (Bahrain Health Strategy, 2000).

The Salmaniya Medical Complex, five Maternity Hospitals, a Psychiatric Hospital and a Geriatric Hospital provide the Secondary and Tertiary care. The total number of beds available in these hospitals is approximately 1354 Bahrain Health Statistics, (1999), more than sixty thousand patients are admitted annually to different specialised wards and receive the best medical and nursing care. The highly sophisticated Accident and Emergency Department received two hundred thousand patients who were provided with emergency and urgent treatment. Approximately thirty thousand surgical operations were performed including major and complicated ones where laparoscopes had been utilised, (Bahrain Health Statistics, 1999).

The Professional and Diagnostic departments: Radiology, Pathology, Pharmacy and Physiotherapy continued their efforts in supplementing and improving the medical and nursing services at these hospitals. Support Services, Sterilization, Security, Domestic, Medical Records and Communication also focused their efforts in providing the best and friendliest atmosphere in the hospitals.

The environmental and occupational healthcare is the responsibility of the Public Health Directorate. It plays a major role in raising the standard of

sanitation in Bahrain, control and eradication of infectious and communicable diseases through the following sections:

- Communicable Diseases Section
- Communicable Diseases Section/Expanded Programme on Immunisation
- Food and Water Hygiene Section
- Public Health Laboratory
- Nutrition Section
- Occupational Health Section
- Health Education Section
- Epidemiology
- Environmental Health Section, (Strategic Health Plan, 2000)

With industrialisation, an increase in intensity of immigrant workers the Occupational Health Section is expanded and policies are formulated to protect the health of the workers.

There are approximately 6,800 employees working at the Ministry of Health, (Bahrain Health Statistics, 1999). The Ministry is keen on the development and manpower training at all levels of the organisation in order to fulfil the goal of self-sufficiency and Bahrainisation.

The College of Health Sciences was established in April 1976 operated by highly qualified and skilled faculty members. The college is considered as the only institution in Bahrain that provides educational programmes for nursing and allied health professionals, the Ministry employees as well as individuals from local and international healthcare organisations.

Other support services fall under the Ministry of Health responsibilities to facilitate the provision of healthcare services embodied in the Directorate of Finance, Directorate of Personnel, Training Directorate, and Directorate of Material Management. The responsibility for providing the Information Technology services to the Ministry of Health lies with the Health Information Directorate. Hence, to ensure that the Ministry's investments in Information Technology are beneficial and effective, the directorate is engaged in developing a new IT strategy for the coming next four years.

The Ministry is currently facing a number of challenges including the high and escalating cost of health services, the emergence of new and complicated diseases, the increasing awareness and expectations of the population and as well as the demand for top quality care and the evaluation of technology and information. The Ministry of Personnel need to continue their efforts to work hard to ensure the provision of quality health services Continuous Quality Improvement initiatives are accordingly launched in all departments and services.

Reasons for implementing quality management in the Bahraini Health Sector

In the year 2000, His Highness the King of Bahrain began to reform public management, supported by democracy, transparency and equality, including the implementation of quality management.

> What distinguish the move for political development in Bahrain is that they are within the framework of a clear vision and specific philosophy for change which the Bahraini leadership has adopted and is pursuing. Therefore, those moves are harmonious and well integrated, some of them lead to others to achieve the goal proclaimed by His

> Highness the King of Bahrain, namely to bring about comprehensive political, economic, and administrative development, and to take Bahrain to the place it deserves in its regional and international surroundings'.(Ministry of Information,2001:118).

Previously, decision-making was through bureaucratic order. The bureaucracy also influenced and affected Bahraini public opinion and attitudes and inhibited it from participating in political, economic and social development.

The researcher thinks that it is time for the government to establish a system to solve these dilemmas in order to establish a base of quality in the public sector. Quality management is also a key component of NPM (Common 2001: 50). This is because a 'Customer Focus' in the public sector is about, 'refocusing services around the needs of the citizen as a customer of public services, rather than the problems of those who provide the services', (Haddad et al, 1998). However, it is to be expected that changes in the government structure are required to improve the system and to support democratic aspirations. Yet, this is an obstacle faced by the majority of bureaucratic organisations. For example, Libecap (1996:5) argues that:

> Under TQM, bureaucratic personnel rigidities were to be removed and greater communication between rank-and- file employees and management was to be stressed to improve product/service quality, to lower costs, and to advance employee involvement in overall product design and delivery.

Libecap thus supports the argument that having rigid personnel systems in any setting might inhibit the process of quality management. Despite these limitations, quality management was regarded in the 1990's as a key managerial initiative to improve organisational performance. Within this overarching justification for its introduction, this section will explore the major reason for introducing quality management in the Bahraini health sector: increased consumer expectations and as a means to challenge producer power.

Increased consumer expectations

As mentioned earlier, the Bahraini government has an interest in assuring quality services within all Ministries. This is basically a political decision, mainly due to public demands following the political unrest up until the earlier part of this decade. To address economic development and public safety, political problems demanded solutions. Following recent democratisation, Bahrain's pro-Western stance has also been consolidated through membership of the Gulf Co-operation Council (GCC), a six-nation body designed to enhance economic and security co-operation between the Gulf States. Therefore, it could be argued that the introduction of quality management in the public services is in part, a political response to ameliorate public dissatisfaction with the government. Therefore both the public and the government are now looking for a better quality of life in general, including better quality health services.

In general, management reform should persuade the public to trust their governments more and to believe that public sector organisations are accessible, reliable, efficient and sympathetic to their varied needs,

(Pollitt and Bouckaert, 2000). The fact that His Highness Sheikh Khalifa Bin Salman Al Khalifa the Prime Minister issued a Decree to establish a quality performance committee, which is responsible for improving and developing human resources and services, appears to an effort to encourage trust. Trainee doctors, for example, have started to receive a monthly salary based on the Prime Minister's Order for the year 2002 to encourage them to demonstrate quality work within the health region.

A central quality management department has been established recently at the Ministry of Health by the Ministerial Order to assure quality health services. Bahrain is striving to be at the optimum standard level in the health region, based on the Bahrain Health Strategy, (2002: 43): 'Bahrain is one of the healthiest countries in the Gulf region, at the top of the developing world standards and aiming for the first world standard'.

The Ministry of Health has also reviewed the current state of health in Bahrain as the basis on which to create a plan for future development to enable Bahrain to maintain its development standard. Bahrain has made great progress in the last forty years in improving peoples' health. This is demonstrated most vividly by the increase in life expectancy from 51years in the late 1950's to over 72 years in 1996, (Bahrain Strategic Health Plan, 2000).

Therefore the main reasons for the government's interest in implementing quality all over Bahrain generally and in the health sector specifically, is the pressure that has been put upon the government for greater public participation, and quality management administration in Bahrain from both the people who are very well oriented about their rights and striving

to get them similar to other GCC countries, and from the GCC countries of which Bahrain is a member. The government is in the process of implementing democracy and encouraging customers involved in deciding quality. As a result, quality management directorates have been established recently in all the ministries by the King's Order to assure quality services.

The other reason might be the increase in consumer expectations and an increase in consumer awareness and needs. Patients increasingly demand not only more care but also good and efficient care. Based on the researcher's knowledge, more patients in Bahrain are seeking a second opinion which supports this assertion. On the other hand patients in Bahrain want nurses and doctors to attend to them promptly whenever they require them.

According to Press (2002), patient satisfaction is an integral part of healthcare, and oftentimes the key to a successful healthcare organisation. Considering that, satisfied patients often recover faster and better from treatment. This leads to goodwill for the organisation, positive word-of-mouth promotion and more customers at the hospital. When patients are satisfied, it also indicates that the staff is content with their jobs and they perform their jobs well, resulting in decreased turnover and less money spent on finder's fees.

Quality Management as a "challenge" to professional or producer power

Where NPM has been introduced in Western liberal democracies, quality management has often been regarded as a challenge to producer power. This is why it is often linked to cost containment strategies as the

professionals/producers are regarded as rationally over-supplying public services due to the information asymmetry problem. Customers are considered as the health services receivers and the employees are considered as the givers or producers. However, studying customers' opinions and the inclusion of their views is important in the health services.

Sitzia and Wood (1997) suggest several ways of using consumer information to improve quality:

1. Providing feedback to consumer.
2. Providing feedback to health plans for internal quality improvements.
3. Providing feed back to the purchase of the type of insurance.

Using information from consumers to set standards for services and marketing and establishing rules and regulations based on consumers' values.

Alternatively, studying the consumers' opinion from both sides the patient and staff will help in directing the standard of quality care needed in the organisation, especially as such a study has not been conducted previously in the country. These methods help in achieving Bahrain's health plan strategy to reach the top of the developing world countries.

Explaining this dilemma is difficult; who will decide and plan the care for the receiver, the clients themselves as they are more aware of their rights/needs and requirements, or the professionals who are knowledgeable, experienced in the field?. It is difficult to decide on behalf of the clients. The perception of the professionals to the needs and the requirements might differ from that of the patients. Brooker and

Brooker and Dinshaw, (1998) have argued that, the different perceptions on the various aspects of services quality, highlight the danger of taking staff opinion on behalf of the patients. Basically because the patients' opinion is a personal view point which does not necessary match those of the professionals.

Therefore many researchers have considered studying the opinions/ needs and requirements of the consumers before setting the care guidelines as a part of the quality steps (Lauer et al, 1982; Gadow, 1980; Gulino, 1982). Schroeder (1988) explained that, the opinion of clients provides a valuable pointer to the strengths and weaknesses of health service provision. Such views are mainly considered as a guide to quality services. The other benefit from considering consumer opinion is that it is likely to reduce dissatisfaction with the services.

Reiser (1993) supports the participation of the patient in decision making of the treatment and the care; he also has considered the perspectives of the patients in the transformation of the healthcare as the key to changing the healthcare system.

In Bahrain considering the clients' opinions has been shifted to a political issue. The public feel freer to participate in decision making and they are more oriented about their rights due to the new democratic life that they have now. The researcher thinks that the correct time for obtaining the clients' opinions is the current time. The clients might feel that this is the time to ventilate their feelings and views, which was inhibited several years ago, although they might be expected to have views other than their previous expectations, due to recent democracy and transparency in the country.

On the other hand, obtaining the professionals' opinion is potential to assessing the performance of the systems of any agency and helps in planning the care services at the agencies based on Riccio (2000). "The points that might satisfy the clients in healthcare might not satisfy the professionals. Young (1996) has explained that, considering the patients' opinion without that of the professionals might produce gap in the quality of health services".

Professionals might look to the professional aspects or personal aspects such as having an increase in salary or getting better communication among themselves, whereas clients might think about different aspects such as reducing waiting time, or considering their decision in planning the treatment as potential. Therefore studying one part will certainly be a defect in maintaining the quality of healthcare. Since we are now living in a democracy in Bahrain, it is worth to giving the opportunity to every one involved or affected by the health services, who are both the patients and the professionals.

A strong emphasis should be placed by the government on the need for public service providers to become more responsive to the needs and aspirations of customers and citizens. Public service providers need to be more focused on the needs of the public; they need also to consider different perspectives. The provider of a service should consult with citizens to ensure that the policies and priorities adopted by public sector organisations reflect the needs and aspirations of the public. A greater emphasis on the need has to be made on the services, in order to be more responsive to the people who use them and the use of feedback from

customers as a source of information that can be used to improve the way services are delivered.

Finally, such a study will emphasise the increase in public participation and community involvement as an end in itself, which has an important role to play in terms of democratic renewal and the promotion of a more inclusive society. Each of these approaches can be seen as being derived from perspectives. Public Engagement might be considered as a way of informing decision makers by consulting with the public about issues that will affect them as citizens and members of local communities. It might also be considered as a way of seeking to make services more responsive to the needs of customers and it is a way of promoting a more participative approach to decision making and encouraging active citizenship.

In the forthcoming chapters the focus will be on the following:

Chapter 2,
Managing quality in healthcare: perspectives from the literature will be explored as follows:

a. What is quality management and how can it be managed in the public sector, and in the health services?
b. Who is the customer in the health service?
c. What is Performance Management?
d. Managing the quality of both the healthcare process and the physical settings,
e. What are the international perspectives of the patients' satisfaction?
f. What are the global indicators of healthcare quality?
g. This will be followed by the research framework: Donabedian will be introduced.

Chapter 3, methodology will be explored as follows:

a. Selection of the method; the primary research instrument: questionnaire (how it corresponds to the Donabedian frame work), secondary research instrument: qualitative research.
b. Content analysis.

Chapter 4, measuring patient's satisfaction:

a. Presentation of findings
b. Results and analysis will be highlighted.

Chapter 5, the quality of healthcare in Bahrain

a. Interpretation of the results
b. Accuracy and generalisability of the results will be highlighted,

Chapter 6, the researcher will summarise and present the following:

a. To what extent has the researcher's thesis met the original objectives?
b. What contributions to knowledge does the thesis make?
c. What further research on quality management in healthcare can be undertaken?
d. What recommendations does the thesis support?
e. An appreciation of the study relevant to the researcher's own professional practice.

Conclusion

It appears that in Bahrain, the introduction of quality management can be regarded as part of a larger response to popular demands for political reform. The government has also considered that economic development also requires some measure of political reform. Therefore, His Highness the King has achieved many steps forward towards democratisation,

which has found expression in approaches to more open and participative public service delivery:

'The transition in Bahrain which is traditionally feature equality, consultation and communication between leaders and citizens, the strong presence of woman in the Parliamentary elections, and no fear from opinions; no fear from a pen, a writer or a statement. No Silencing of voices, no threats, no terrorising'. (Ministry of Information, 2002)

The human rights situation has also been improved in Bahrain and it has many positive effects on the reform of government departments and Ministries, one of which is the Ministry of Health. Also in this chapter, the way in which the acceptance of quality management by the Bahraini government has affected the management of public services generally and the health sector specifically has been discussed. In addition, this needs to be understood within the wider context of political change within the country, and most specifically for the kind of public service reform analyzed here.

The Chapter has also analysed the development of health services within Bahrain, with special reference to key quality issues in healthcare delivery. The next chapter will examine the key literature relating to quality management in regards to health in general and in health particular public sector management reform in order to understand why quality management in the health service has emerged. From this discussion, the theoretical context will emerge for the empirical research.

Chapter 2

MANAGING QUALITY IN HEALTHCARE: PERSPECTIVES FROM THE LITERATURE

Introduction

This chapter will begin by highlighting quality management in the public sector since it reflects, as mentioned in chapter 1, both the strategy of the government and the Ministry of Health. It is also important to understand what quality management means, and the most effective way of implementing it within the public sector generally and the health sector specifically. The secret of success in any enterprise is the customer, (Deming, 1995), as they are the 'spinal cord' of quality. Therefore it is essential to know who our customers in the health sector are. Are they the recipients of the service or the providers? Are they the patients or the professionals? Are they the government and taxpayers? Answers to such questions will be explored here.

This chapter draws upon the literature to provide a useful definition of quality management and its applicability to health services in particular. In so doing, it addresses two key objectives of the research identified in Chapter One. A theoretical basis for the empirical research requires critical development, and in this chapter the literature on total quality management, in relation to health care delivery is addressed. Only by understanding the debates in the literature will the third objective be attained that will guide further related reforms in the Bahraini health care sector.

- All members must be involved, across all functions and levels.
- There must be an emphasis on measurement to help assess and to meet requirements and objectives.
- A culture of continuous improvement to be established.
- An emphasis to be placed on promoting creativity (Deming, 1985).

Chapmen et al (1998) also believe in implementing continuous improvement within the organisation, an improvement that involves all operations at all levels.

However, a distinction needs to be made between 'goods' and 'services' when attempting to define quality. The public sector mainly produces services, or things that can't easily be specified. With a service: 'the management of the relationship with the customer is crucial' (Norman, 1991) and even more so in the public sector, as users have a right to evaluate the services they receive, Norman, (1991). However, services are more likely to be evaluated in terms of their 'fitness for purpose' rather than conformance since they are difficult to specify and hard to evaluate.

Although some services are capable of being standardized, such as routine operations, many services employ professionals who are granted considerable discretion so that they can vary the service they deliver according to their judgments about a wide range of local and individual circumstances. In such instances, it is difficult to define quality in advance when many of these variables are unknown. As individuals, people who receive services have different reactions to the service they receive (i.e.: a lecture), therefore the user is necessarily involved in the

evaluation of quality, and the impossibility of interpersonal comparisons of utility mean that the measurement of quality is always subjective (Common et al, 1992)

Quality Management in the Public Sector

Quality management as a system cannot be separated from social and political context , However the researcher below primarily focused and studied the literature related to public reform in general and to health quality in specific .

The cross-fertilisation of methods such as TQM into the public sector is often on flimsy grounds, for instance, Morgan and Murgatroyd (1994) note that:

TQM was being advocated almost as something self-evidentially workable to the public sector because of its proven success in certain industries, Morgan and Murgatroyd (1994)

In the private sector, the feedback signal between producer and consumer is much stronger, a producer is constantly reminded of what the customer wants; if sales go down, there is clearly something wrong that demands identification. There is a strong incentive to do this as the producer faces lost revenue and one option will be to improve the quality of what he or she is producing.

Total Quality management, as the name implies, is a generic term for quality management in any organisation. If we look at the basic principles of TQM, as espoused by Deming, it seems feasible for any public sector organisation but conceptual difficulties remain including

changing the culture of traditionally rule driven organisations, strong professional groups, multiple stakeholders, social need, financial restrictions, and a lack of managerial autonomy, (Gaster 1995).

Managing Quality in Health Services

Despite the attention given to quality management in the international public sector management reform agenda, and some of the limitations of the concept when applied to public services highlighted above, quality is still given prominence on the health policy agenda. Clearly, unless it is defined and sensibly used, calls for quality improvement will become merely 'fashion statements'. This is not an easy task. The President's Advisory Committee (PAC) (1998) for example, refers to ensuring the appropriate use of health services, correcting oversupply and undersupply of healthcare resources, and reducing healthcare errors.

Cozens (1997) argues that quality assessment in health services should be based on effectiveness, efficiency and equality. Most observers seem to agree that quality includes effectiveness and economy, which partly explains the attractiveness of quality as a managerialist concept. If health services are about maximizing human health and welfare within the resources available, then if these resources are not used efficiently, quality will be sub-optimal. This involves both allocative efficiency by investing in the types of interventions, which produce the most benefits valued by consumers, and technical efficiency, (Wilson, 1987). Any quality interventions require application in the most technically competent and least wasteful ways. Under the broad concept of quality, care also has to be clinically effective and medically appropriate;

clinicians need to be competent, errors minimized and the systems for delivering care run smoothly and efficiently, (Abramowitz et al, 1987).

In order to provide a theoretical and practical basis for future quality management initiatives within the Bahraini health services, we may need to ensure that consumer focused approaches go beyond mere talk and actually involve patients and professionals, Joss and Kogan, (1996)

Simply increasing appropriateness and access or reducing errors, without reference to the cost of so doing, cannot optimize well being and therefore, cannot constitute quality. However, it is not easy to use the cost effectiveness concept of quality but it does not make it any less important (Batalden and Buchanan, 1989). One might ask why is the movement to improve the quality of health care active at a time when cost containment dominates the health care agenda? . To some degree, improved quality can reduce costs, particularly costs due to overuse and misuse of services. But substantial investment is needed to reduce misuse, and more funds are needed to address under use, Bodenheimer,(1999).

Healthcare purchasers have been demanding, adopting, or developing measures of healthcare performance and in the United States several national organisations such as the National Committee for Quality Assurance (NCQA), the Foundation for Accountability (FACCT) and the Joint Commission on Accreditation of Healthcare Organisations (JACHO), have been developing quality metrics, (Haddad, Fournier, and Potvin 1998).

In the United Kingdom similar developments are occurring, based on the Department of Health report, such as measuring aspects of health improvement, fair access, effective delivery of appropriate care, efficiency, the patient experience, and health outcomes (Hoston, 1995).The quality of care is at the heart of the NHS in the UK (Wilson, 1987). The PAC defined quality as, ensuring appropriate use of health services, correcting miniaturisation of healthcare resources and healthcare errors (Wilson, 1987). Bain et al (1999) argue that patients who have achieved and fulfilled their expectations are more likely to be satisfied. Since the accession of Labour in 1997, the quality focus in the NHS has been addressed under the rubric of 'clinical governance':

The ability of organisations to provide effective, quality healthcare has been the subject of a number of policy and strategy documents within the national health services and independent sectors of healthcare ' clinical governance is seen as one strategy that will enable employers to subject their organisation to scrutiny and develop a competent workforce that meets customer and organisational needs' (Storey, et al, 2002).

> Clinical governance is doing anything and everything required to maximise quality, it is about finding ways to implement care that works in an environment in which clinical effectiveness can flourish by establishing a facilitator culture (Chambers et al, 2000).

Chambers et al, (2000) , also stated that Services are more likely to be appropriate and effective if based on needs identified by together with users.

Users are seeking more openness and accountability. Patients want more information about their health condition, treatment and care Involvement patients in their own care may improve healthcare outcomes and increase patients satisfaction Patients need access to reliable and relevant information to be able to assess clinical effectiveness themselves.

Health professionals are accountable to the general public who are entitled to expect high standards of healthcare the profession- to maintain standard of knowledge and skills of the profession as a whole The government- and employers who expect high standards of healthcare from the workforce.

Therefore clinical governance, professional and self-regulation and lifelong learning are the three elements that the government envisages being cornerstones in achieving high quality healthcare, (Chambers et al, 2000)

Most governance has tendency to market all changes as reform and many ministers wish to be seen to be undertaking new and far-reaching reform projects, rather than consolidating existing schemes. Healthcare, (Sherlock, 2000)

Overseas research also tends to suggest that expectations emerge repeatedly as having a fundamental role in the expression of satisfaction where satisfaction is defined as, the perception of benefits of care and the extent to which these meet the patient's expectations (Abramowitz et al, 1987). Views are considered as opinion or perception, which is judgment, focused, or as opinion or belief about a particular matter, which is not

necessarily based on fact or knowledge. On the other hand, Bodenheiner (1999) defined 'view' as the application of evidence based on either experience or knowledge.

In order to understand how quality is determined, it is necessary to understand the idea of a system within healthcare services. A system is a sequence of actions, or the interaction between functional units that are about the manufacture of a product or the delivery of the service. For example, nursing staff and physicians are functional units. They act and interact to provide health services to patients, (Ingram, and Chung, 1997).

Champen et al (1995, 1998) have defined the quality of healthcare from the customers' perspective as, the degree to which healthcare services meet the needs of the users of care facilities. Others have looked to the quality of healthcare as, how closely the result of the consumer's needs approaches the objectives of prolonging life, relieving distress, restoring function, and preventing disability (Kutner and Mc Alearney, 1998).

Several authors have discussed, applying the features of an industrial model of quality management as a tool for improving the quality of healthcare (Batalden and Buchanan, 1989, Berwick and Knapp, 1987). It entails enlisting an entire organisation to work towards a goal of continuous improvement in quality as defined by the needs and wants of the customer. Deming (1985) believes that the, measurement of quality and the tools to interpret those measures provide the stimulus to guide organisational changes.

Kritchevsky and Simons (1991) suggest certain steps which will be useful in applying continuous quality improvement in inpatient settings such as,

separating external problems from the system, monitoring the system, studying the system to identify how problems arise within the system and evaluating the efficiency of changes to the system. They also recommended establishing a peer review committee, which will be, responsible for the aforementioned steps. A peer review committee can also specify if a certain level of performance or outcome is unacceptable, (Kritchevsky and Simons 1991).

Quality is also determined through rules and procedures, therefore those who set out the rules and procedures are ultimately responsible for the level of quality, (Al Sammak, 2002). The level of quality should be considered before fixing rules and procedures for any organization, therefore customers' opinions or users' involvement should be considered prior to the fixing of those rules, and during implementation of those procedures, (Essen, and Sjoden, 1991). Customers have a broader and more powerful role in healthcare quality, as they are the recipients of a service, (Donabedian, 1988).

For Redfern and Norman (1990: 21), quality has five elements:

1. 'Equality' to make sure that the care is being fairly distributed.
2. 'Accessibility' to make sure that the care is available all the time and any time.
3. 'Efficiency' to make sure that the resource is not being wasted on one person to the detriment of another.
4. 'Effectiveness' making sure that the healthcare is achieving the intended benefit for the individual and the community.

5. 'Appropriateness' to make sure that the healthcare is meeting the actual needs of individuals, families and communities.

Redfern and Norman (1990) appear to suggest that for quality to be managed, it must be defined in terms of specific measurable attributes. Although the level of the selected attributes defines the level of quality, Donabedian (1988) has also extensively reviewed a great number of attributes that may be of use in healthcare settings, and it is this framework that will be presented later in the chapter as a framework for the empirical research.

It is also suggested by Donabedian (1988) that patients should be represented and be able to participate in quality management. Abramowitz et al (1987) found that, not only can patients hold different expectations for different aspects of care, but also that expectations and satisfaction with specific aspects of care play independent roles in predicting patient satisfaction. Devitt (1992) contends that patients' satisfaction is a recognised component of quality assurance. The patients' opinion of healthcare will be modelled towards positive aspects if they are satisfied with the services.

Studying patients' opinions, which are a core quality assessment element, will help in identifying opportunities to improve quality. It is also necessary sometimes to have some form of external pressure to make sure that quality is within determined standards, but it is always necessary that the professionals should believe in the quality standards in order to encourage a culture of quality in healthcare, (Al Sammak, 2002). Belief in quality improvement in healthcare is an important factor, which must

be considered in evaluating services (Salisbury, 1997). Pearson et al (1987) and Calnan et al (1998) argue that the evaluation of quality of care should take into account users, professionals and managers.

Who is the customer in the health service?

Earlier in the chapter, the problems associated with defining the customer in public services were briefly discussed. Indeed, the customer focus in much of the generic quality management literature provides a real obstacle to the implementation of quality management in a public services setting. In the health sector, quality implies an organisational culture that aims to address the needs, expectations and behaviour of the public, and then adjusts every aspect of the organisation to align with customer values. This includes the entire delivery chain from policy-making through to front-line services - including strategy, organisational design, business processes, performance measures, information systems and support processes, (Bennett and Tibbitts, 1989).

Public sector bodies typically serve a variety of customers, including staff and business functions within the organisation, other public sector bodies, the general public, businesses and a range of other organisations, (Bassett et al, 1997). Achieving a customer focus across the public sector is one of the fundamental requirements of quality management by making sure that citizens and customers come first. Are we looking for public services that respond to users' needs and are not arranged for the providers' convenience? Or the other way round, do we want services that respond to users' needs (Pearson et al, 1987)?

A customer focus is important because it will lead to major changes in the way in which most public sector organisations are structured, organised,

and co-operate in the delivery of services; it will also change the ways in which the general public perceive, access and benefit from the delivery of public services. But are we considering the patients/clients as the customer of health services or the provider of the care such as the professionals (Calnan et al, 1999)?

Some of the changes are already in hand as a result of the development and progression of democracy in Bahrain, such as giving more freedom to the public as customers of the service to participate in the decision making and many of the requirements of customer focus will need to be realised maybe through the application of the information and communications technology to support new modes of service delivery, especially in the health sector, (Haddad et al, 1998).

In order to have customer-focused organisations, we should understand the customer first by knowing who our customer is and what his requirements and needs are. The move to a customer-focused organisation involves all levels of staff, departments and agencies responsible for delivering services to the public. It will be necessary to put in place a programme to ensure that these services meet the needs of consumers and take account of consumer views at every level in the organisation in the design and delivery of services (Brugha and Zwi, 1998).

Baker et al (1999) appear to believe that a customer focus in the public sector is unproblematic. The organisation's objectives will not specifically include services to stakeholder groups, but the organisation will have working objectives that ensure their interests are considered. In this way customers and suppliers can be identified at all stages of any

process which has clearly defined inputs and outputs e.g. that the approach is 'inclusive', considers the impact on partners in service delivery, on the environment etc. The process also includes a long and changing list of segments, other government departments, agencies, local authorities and other organisations in the delivery 'chain', socio-economic groups and the public of other countries. However, such an analysis is problematic in the health sector, where an example of an 'untargeted customer' might be the public as a whole, not just the patients. Raising awareness of disease, and orienting the public about preventive measures, is a way of addressing the public indirectly. Whether the customer of the service is direct, or indirect, and whether or not we call them a customer, consumer or client, we are all receivers of the service. However, as users of public services funded from general taxation, our stake in the health service is different from a purchaser in the private healthcare market (Calnan et al, 1999).

Clearly, in the health services the patients are the major focus of care, and the starting point for a meaningful quality management system. Changes in the 'customer' will be about related changes in the community and changes in several families may affect the community. In order to identify a patient's individual needs, it is now seen as essential that patients, whenever possible, and their relatives are involved in the decision making process. Indeed it has been stated that participation of the patient in the nursing process is imperative (Steck et al, 1979). Respect for patients needs and wishes are central to a humane healthcare system (Cleary et al, 1991).

In the past, the process of care has been evaluated almost exclusively on the basis of information available in medical records; patient judgments

are not usually included in quality assurance activities. Studies that elicit reports from patients and healthcare providers are viewed increasingly as an important method of assessing hospital care (Cleary et al, 1991). Such studies can be extremely useful for quality assessment and improvement efforts because satisfying patients and providers' expectations is an important component of high-quality care and because both patients and providers can provide information that is not available from other sources.

Performance management

To understand the practicality of implementing quality management in the health service, the issue of performance management needs to be understood as well (Weisman, and Constance, 1985). Performance management is more than just a set of measures; it implies a mode of management, which is correlated with quality. The increasing use of it reflects a growing tendency for society to check and verify or audit activity, (Libercap, 1996).

Although in Bahrain, the highest authority in the country, the King, has initiated the improvement of public sector services, there is a danger that these efforts will not result in the anticipated gains in quality because of the potential conceptual and technical weaknesses in the performance management agenda, unless there is a move towards popular participation in performance management, (Ministry of Information, 2001), The move towards the principle of popular participation places Bahrain ahead of any other Arab Gulf State (Amnesty International Magazine, 2001).

It is, after all, extremely rare to find someone who is opposed to the notion of quality. However, it has lacked a shared understanding, a set of common standards and any explicitly stated common goals which are universally subscribed to, thereby making it difficult to drive forward a meaningful quality agenda without considering performance management, (The Department of Health, 1998)

Sheldon (1998: 46) considered two levels of issues of performance management these are "conceptual and technical" and stated that:

> These provide a foundation for initiatives in quality management seen in the private sector, and increasingly in the public sector, requiring people and organisations to be accountable and that they set down bench marks for legitimacy of organisational action.

Performance management of this type uses regulatory initiatives by government or purchasers to penetrate organisations, to change or reorder internal activities and relations and ensure compliance with rules, while at the same time having less direct control or management responsibility for the running of the service (Power, 1997).

Yet, healthcare quality is an arena that must rely on objectivity and rational measurement. It is essential to make explicit the objectives of, and rationale for, a quality agenda as well as to specify the expected contributions of quality evaluation and improvement, (PAC, 1998).

Therefore the potential impact of applying a set of indicators depends not only on their technical characteristics but also on the degree those

managing, working in and using health organisations support the programme, the existing professional culture and what change in the culture the introduction of performance management may produce, (Sheldon, 1998).

Some of the above indicators have also been stressed by Farnham and Horton, (1993), when they stated that, the concept of quality is based on the assumption that quality improvement activities can contribute to the performance of the healthcare sector, and to the nation at large, in many valuable ways. However, this is largely a reflection of the ideological principles of the Conservative party which underpinned the NHS in the UK in the 1990s, including efficiency, effectiveness, and economy (Carter, 1991).

McKee and Sheldon, (1998) see quality in terms of the three key constituencies to whom quality is delivered: 'individual patients, patient populations, and the system as a whole. Each constituency has its own champions, particular organisations, and conceptions of quality. For instance, individual patients may see quality as unlimited expertise, technology, and resources directed towards their particular problem, although a population may regard it to be the greatest good for the greatest number. The system, it could be argued, can be seen as an instrument for securing quality for the other two constituencies. However, because of the complexity and size of healthcare services, the system itself requires specific quality considerations and initiatives from the users of the service, if it is to function effectively (Jackson, 1995).

We therefore consider the system to be a key constituent in its own right. In another meaning the three constituencies also contribute to quality, for

example, individual patients can affect quality through their choices of lifestyle which subsequently impact on demand for services; patient populations exert influence through collective social conditions and specific demand for services, and the system impacts on quality by the efficiency with which it operates (Sheldon et al 1993).

To conclude, it is clear that any performance management system should be integrated with other quality initiatives at national and local level to promote coordination (McRae, 1985). There is evidence therefore that performance management indicators can have adverse and unintended effects, so any health service embarking on performance management should attempt to establish whether it will produce the desired effects and at what cost, before it is fully implemented (Sheldon, 1998).

Managing the quality of the healthcare process:

Perceptions are often vague, so, in order to study the perceptions of both patients and professionals on the quality of care at the hospital, the research will need to be divided into two main branches, To measure quality, our concepts of what quality consists in must be translated to more concrete representations that are capable of some degree of quantification - at least on an ordinary scale, but one hopes for better. These representations are the criteria and standards of structure, process, and outcome, (Donabedian, 1988:1747). The third branch which is the out come will not be studied here due to the limitation of time. The main branches are:

- The perceptions of the processes of healthcare that have been carried out by the professionals.

- The perceptions of the structure of the hospital or the physical setting.

The physical environment or setting will be discussed in the next section of the chapter. In this section, the process of healthcare will be presented. This is known as, giving and receiving of care by practitioners' activities, which include making diagnoses, recommending and implementing treatment (Donabedian, 1988).

As it is difficult to measure process, Donabedian does not suggest all processes should be evaluated, although the major processes that might affect patients require assessment. In addition, the process of care is considered as responsible for one third of a hospital's overall performance and thus any deficiencies in outcome or structure can be understood (Green, 1997).

Although Donabedian's frame work is to be used for the empirical study, there are many other studies in this area. Some have focused on patient's satisfaction and the quality of communication, for example, Cleary et al (1991) who carried out a national survey which included interviewing 6,455 adult patients recently discharged from the medical and surgical wards of 62 hospitals selected from regions of the United States. The purpose of this study was to examine patients' evaluation of their hospital care.

The results showed that, 44.9% had problems with communication with healthcare providers, such as patients not being told about the daily routine or not being told who to ask for help when needed. 38.7% of the patients had some emotional support deficiencies such as they did not

have a relationship of trust with any hospital staff. 34.5% had discharge preparation problems, such as not being told which food they should or should not eat. In addition, patients were not told about the side effects of the medications (Cleary et al, 1991).

Poor communication continues to be a major source of complaint by patients, (Fitzpatrick, 1991). Nurses, for example are more dissatisfied with their own communication skills. They would like patients to talk freely, but have not learnt how to encourage patients to do so (Altschul, 1983). Therefore, once the patient starts to voice an opinion, many other issues will also be raised. Altschul (1983) also found that effective communication between doctors and patients, nurses and patients, and doctors and nurses is essential in raising patient satisfaction; research has found a strong relationship between the patients' perception of satisfaction and non technical aspects of patient care.

Grary (1953) interviewed patients who had recently changed physicians because of dissatisfaction with their care. These patients perceived that their physician was too busy to talk to them or that the physician did not appear interested in them as people, but they were much less likely to leave their physician because of concerns about the technical quality of the care that they were receiving. Since that time a number of studies have found a significant relationship between satisfaction and the socio-emotional aspects of the staffing behaviour such as the doctors' ability to express care and concern for their patients (Buller and Buller, 1987; Cleary, 1991).

Other research has studied the relationship between professional knowledge, experience, skills and the quality of healthcare. For example,

Young et al (1996) assessed the influence of nurses' experience on practice characteristics. However, their findings were mixed as they found that nurses with more experience reported performing more complex functions than those with less experience.

A study of 117 patient care units in the Chicago area conducted by Marquis et al (1983) examined the quality of care and asked patients to report their satisfaction with several aspects of the care. Patients on units with a higher proportion of baccalaureate prepared registered nurses (RNS) reported more satisfaction with the teaching they had received. Patients on units with more experienced Registered Nurses were less satisfied with the teaching. The effects of nurses' education and experience on other aspects of patient care were not significant.

However, another study carried out in the UK on 583 hospitals reported that, hospitals with higher levels of experienced RNS had lower spending costs in which they were using the medical resources cost effectively (Bloom et al, 1997).

In the United States, a study comparing the death rates of magnet hospitals with those of non-magnet hospitals found that, magnet hospitals had lower death rates and a higher proportion of registered nurses with baccalaureate degrees (Aiken et al, 1994). Belegan et al, (2001) analysed the data collected in two studies of, the relationship between nurses' staffing and the quality of patient care; the quality of care was indicated by lower unit rates of medication errors and patients' falls. They also found that the experienced nurses gave better nursing care, as usual.

In two detailed studies of physicians' non-verbal skills which were conducted by Dineatteo et al (1976), found that, physicians who were more sensitive to body movement and posture uses received higher ratings from their patients on the art of care than physicians who were less sensitive.

Many studies have also shown that, better outcomes for certain procedures are related to the number of such procedures that hospitals and professionals perform (Luft et al, 1990, Kahn et al, 1990). Buller and Buller (1987) studied patients' satisfaction from other aspects. They concluded in their study that, the physician's age, medical specialty, the length of time patients had to wait and the frequency with which they visited a doctor all affected the relationship between communication style and patient perception of satisfaction.

However, Cleary et al (1991) stressed that, the quality of care from the patients' point of view is getting enough information about clinicians and clinical facilities and to provide patients with the kind of information they are most interested in. Studies of consumer opinion have many different measures and have been directed at many different aspects of healthcare. But almost all studies consider one main goal: quality improvement.

Collecting the views of those who are providing services and those who receive them is common practice in quality improvement. As Donabedian, (1988) argues, users of health services are often able to provide useful insight into the processes and outcomes of the services, and the staff who are directly involved in service delivery often have useful insights into the structural aspects of how care organised and prioritised. Seeking out the views of staff can also help them feel

empowered to bring about positive change in service they provide (Brooker and Dinshaw, 1998).

Many suggestions can be raised by both patients and staff, which need to be considered for quality improvement. In the study that has been carried out by Brooker and Dinshaw, (1998) it was noted that, staff suggested many valuable ideas such as changes in timing of meals to fit into the patient's day, increased flexibility in preparing snacks on the ward, ward physically upgraded and the ward establishing visitors' room for privacy. They also recommended that a supervisor provides the staff with patient information to carry out every day work duties, followed by staff opportunities to comment on information presented by management. A further factor that was raised was staff ability to influence and contribute to work place information needed to carry out assigned work duties.

To summarize this section, we may conclude that previous research suggests that patients and staff do not always look on the same areas when they rate quality of care (Arnetz and Arnetz, 1996). Therefore it is beneficial to obtain both patients and staff views in assessing and rating the quality of care. The literature also indicates that, 'the quality of care, at least from a professional perspective, is closely linked to organisational factors (Alken et al, 1994, Arnetz and Arnetz, 1996). Arnetz and Arnetz (1996) also suggest an association between job satisfaction and overall organisational well being in addition to the staff's perception of the quality of care and added that determinants of job satisfaction, such as autonomy, influence over daily decisions, participatory management and skill development, impacts favourably on the perceived quality of care either directly or via job satisfaction. More crucially for this research, there is no evidence published on Bahrain on the effects on managing the

quality of the health care process, and this is an objective for this research.

Managing the quality of the physical settings

As will become apparent from this section, virtually no attention has been given to this aspect of quality in the literature with reference to Bahrain. However, many researchers (for example, Riccio, 2000) in other countries have explored the environmental effects on the quality of care. Structure denotes the attributes of the settings in which care occurs. This includes facilities, equipment and money and of human resources number and qualifications of personnel, Donabedian (1988: 1745). Researchers who have used Donabedian's approach have stressed the following structural elements including:

1. Availability and appropriateness of space, facilities and equipment necessary for healthcare.
2. Human resources (their education, training, experiences and staffing ratio, (Coyle and Battles, 1999).

It is clear that the effect of working conditions on the quality of care is important such as the ability to provide safety, cleanliness and privacy, (Brooker and Dinshaw, 1998). Therefore it is essential to identify, characterise and directly measure the effect of the healthcare environment on the quality of care, including equipment, physical characteristics of the working place, and staffing (Riccio, 2000).

A key challenge for understanding quality management is the evaluation of 'soft' variables. Degling et al (2000) argue that 'a therapeutic

atmosphere has a strong relation with the quality of care. Social atmosphere has been a concept frequently used to describe the social environment of individual units. The Ward Atmosphere Scale (WAS) has been used most frequently for this type of measurement (Moos, 1974). The WAS defines social atmosphere as compressing three dimensions: relationships, treatment programmes and system maintenance. In addition to quantitatively describing the social treatment environment and monitoring the effect of any intervention, the WAS can also contribute greatly to the intervention procedure through its ability to provide structured information (Insel and Moos, 1974).

Koran et al (1983) also note that WAS encourages staff to consider how the unit differs from how they would like it and that their unit has several dimensions rather than one, in addition to the impact the setting as a whole has on the consumer group. It also encourages them to focus on specific elements, reducing confusion and increasing the likelihood of orderly change and to work together with the likely consequences of increasing their environment in the work setting. However, Alexy (1981) found that, staff saw a greater need for change in ward atmosphere than patients. The patient's greatest need was for knowledge about what to expect in the day-to-day routine of the unit. Staff perceived a significantly greater need for change in the amount of support and autonomy given to patients than patients.

Paivi et al (1992) also found that, in the Finnish primary healthcare and hospital system, satisfying the need for sleep and rest was mentioned as a sign of good nursing but the hospital environment was regarded as 'un homely' and uncomfortable. Patients wanted to have pictures, plants and colourful textiles in their rooms and they also wished to have a special

appropriately furnished space to meet their visitors or other patients. In addition they requested interior decoration, leisure activities, efficient ventilation, a spacious room, privacy, and having an opportunity for Peace and quiet.

However, Kahn and White (1989) argue that the development of any environment requires five essential elements; safety, structure, support, socialisation and self – understanding. These elements constitute a hierarchy of needs so that acute patients entering the system would probably require emphasis on a safe environment while recovering patients approaching discharge may desire more emphasis on self-understanding.

There are numerous advantages to clarifying goals and treatment philosophy. For example, Long et al (1992) found that a nurse in charge significantly reduced the levels of behavioural disturbance by placing a greater emphasis on the support and socialisation elements for the patients. Kahn and White, (1989) suggested that both continuous care patients and staff were significantly less actively involved in the day to day social functioning of the ward. This would affect the quality development of the environment, because patients will be less satisfied with the care provided.

Another study carried out by Carroll et al (1980) found the number of incidents of violence, the use of seclusion and restraint, the average dosage of medicine administered and the number of discharges against medical advice were all reduced by introducing a number of ward changes including clarifying the goals of the unit and placing increased emphasis on methodical care and team work. However, Long et al (1992)

argued that, structural change alone could have direct benefits in terms of staff and patients behaviour and in the hospital unit. The quality of the food and cleanliness of the ward may also affect the patient's view of the quality of the hospital. The image of a hospital is important for enhancing the patient's reassurance and relief from possible anxiety (Zeev, 1983).

It is interesting to know that, patients are usually concerned about structure because they wish to know whether there is the potential for providing their care in a way that maximises their chances of a favourable outcome (Applegate et al, 1990). Patients admitted to a hospital, which is reported to achieve better outcomes than those treated in other settings, Mackey et al, (1992) provided that they are adequately staffed (Eddy, 1998).

Green et al, (1997) designated 1631 of the 6581 hospitals in the United States of America as Major Tertiary Medical Centres to find out the 'Best hospitals' in their study. They argued that, although the hospital structure is one of the key indicators of quality, quality of care also depends on the qualifications of the medical staff. However, the physical environment of the hospital settings clearly impacts on both patients and nursing staff, Davies (1983) studied the stress of hospitalization and how both nurses and patients perceive it. Nurses rated most individual stress items higher than their patients did. The analysis of variance showed that stress types differed significantly. There was least discrepancy between nurses' and patients' ratings for the physical aspect of illness such as discomfort, X-rays and treatments equipments physiotherapy and most for stress items concerned with the hospital environment and routine, toileting and privacy. Such results suggest that nurses do not know enough about their

stakeholders in this project were patients, nurses and doctors. To simplify the assessment of their view points, Donabedian's frame work is to be utilised as a basis for the empirical study, therefore the literature on the structure / physical setting has been presented. In this project, the focus is also on the living conditions, hospital environment, sign posting, hospital buildings, parking, quality of food, number of nurses and doctors, cleanliness and ward atmosphere.

International Perspectives of Patients' Satisfaction

Finally, the literature relating to patient satisfaction demands review. Although, international studies of the perceptions of patients and professionals of the quality of healthcare have primarily focused on satisfaction, the literature relating to the Arab Gulf in general and Bahrain in particular, is virtually non-existent. To begin with, Sitza and Wood (1997) review the issues arising from an analysis of over 100 journals published in the field of patients' satisfaction. They found general satisfaction with the care received, which is rather unremarkable and open to challenge.

The published output that appears in the medical literature, which incorporates the term 'patient satisfaction', peaked at over 1000 papers annually in 1994 (Wood (1997). An example of such a study is Lewis and Woodside (1992), who conducted a study of 150 patients who were asked to rate their satisfaction with the health services in the emergency department. There was general satisfaction with the care received, but patients were concerned about the psychological care more than the

clinical competence of staff providing the care. However, the notion of 'patient satisfaction' may well have peaked in the mid-1990s, which points to the somewhat 'faddish' nature of some of quality management literature.

However, considering psychological care as a patient 'need' will affect the health status of patients positively (Cleary et al 1991). In the Netherlands, Verheggen et al (1998) conducted a survey of 135 patients at the University Hospital Maastricht to assess patient satisfaction with health services and to analyse factors determining patients' satisfaction. The questionnaires were divided into three aspects: Medical – Technical aspects, such as satisfaction with medical treatment and satisfaction with extra check-ups on the health condition. The second aspect was assessing patient satisfaction with staff interpersonal relationship and the third aspect was organisational. Satisfaction with medical – technical aspects was high among patients. Most of them felt an improvement in their state of health. Patients were also satisfied with the way they were treated as patients. It was found that the patients were not very satisfied with the organisational aspects, such as physical environment aspects.

The international literature also offers evidence of the growing interest in the consumers and professionals' perceptions or satisfaction in developing countries, (Brooker and Dinshaw, 1998). It follows that when patients are satisfied with the services they receive, the level of quality of care in that hospital might reasonably be expected to be of a good standard, (Reimer et al, 1999).

The measurement of patients' and professionals' perceptions should be coupled with other methods of evaluation of quality, (Dingman et al,

1999). None of the studies that the researcher came across studied patients, professionals' and managers' perceptions with quality of healthcare in an integrated way. None of them investigated managers' perceptions,

> although managers are playing a big role in the quality improvement of health services, and it is their perceptions that dominate quality improvement at the moment (Shaw, 1997)

and it is they who have the authority, responsibility and accountability for managing healthcare services (Kraiksh and Antony, 2001).

In the United States, 25% of hospital deaths from pneumonia, heart attack, and stroke could be prevented by better inpatient hospital quality of care (Khan et al, 1990). Therefore maintaining good quality standard of care is essential through studying in respect of patients' needs and wishes which are supposed to be central to a humane healthcare system, (Al Sammak, 2001).

To meet patients needs better, providers have expressed an increased interest in using patients' evaluations and report to compliment other methods of quality assessment and assurance, such as an American telephone survey which was designed and undertaken, by the Kaiser Family Foundation to 2,006 respondents in 1996 to study the role of quality information to healthcare consumers. This survey revealed that 90% believed that quality of care meant how well a plan cared for members who had health problems. Mainly they wanted an easier, clearer plan for the treatment of their health problems. 88% stated that

ease of receiving relevant answers to their inquiries was 'very important' as measurement of the quality of care. 88% believe that there was a role for the government in the quality of healthcare arena. The majority 52% thought that the government should both monitor health providers to ensure a minimum standard of quality and make sure information about quality was available to the public, (The Kaiser Family Foundation, 1996).

In a rare study within the Gulf region (Kuwait), Al Kandari and Ogundeyin, (1998) also found that, patients' measurement of quality nursing care is based on the personal qualities of the nurse rather than on competence and technical skills. Accountability and responsibility differ from one to another, based on their work experience. Patients were not satisfied with the nurses' planning, implementation and evaluation of the care. However, Kuwait has a different public service culture to that of Bahrain. In Bahrain the government usually makes sure that the minimum standard of quality is available to the public, but we have a deficit provision in quality information. To conclude: the international studies of the perceptions of patients and professionals of the quality of healthcare have focused on considering psychological care, needs and requirements of patients and also to consider professionals' and managers' perceptions in evaluating the quality, (Dingman, et al, 1999).

Introducing the research framework: Donabedian:

The framework guiding this study the structure, process, and outcome is based on Donabedian, (1980). The information from which inferences have been drawn about the quality of care has been divided into two categories: "structure", and "process".

The "outcome" will not be explored in this study, because it needs a long time to assess the outcome of the care provided. It is usually difficult and sometimes impossible to measure the performance, the accurate attribution to the efforts of individuals or teams, particular departments or sometimes even specific therapeutic interventions (operation, treatment, and medication). For example it is difficult to assure that all Caesarean section patients should be discharged the fourth day after surgery. '*The information from which inferences can be drawn about the quality of care can be classified under three categories: structure, process, and outcome,*' (Donabedian, 1980:975-992) the framework, which has been adopted, is as follows:

Structure

The clients and the professionals both evaluated the structure of the Salmaniya Hospital with the focus on the organisational characteristics. Structure denotes the attributes of the settings in which care occurs. This includes the attributes of material resources and organisational structure. Thus the primary research instrument should help the participants to evaluate the structure of the hospital as they are the end user of the services and the building of the hospital.

Therefore seeking their opinion is the objective to maintain quality, such as whether medical facilities are complete and up- to- date, whether the number of nurses and doctors is sufficient or not, whether or not the patients' rooms are clean, comfortable, light, and whether the patients' areas are restful, peaceful and quiet. Other considerations include: whether patients' have privacy, the quality of food overall, the hospital environment; other than the patients' rooms, that signs and directions are clear, the hospital building overall is satisfactory, and there are sufficient parking areas.

Process

Process denotes what is actually done in giving and receiving care. It includes the patients' activities in seeking care and carrying it out as well as the professionals' activities in making a diagnosis and recommending and implementing the treatment, whether the patients have a choice or not, nurses and doctors are flexible in meeting patients' needs, patients are receiving clear and complete explanations, patients' families are kept always informed about the patients' condition and needs, nurses/doctors are willing to answer patients' questions, medicines and intravenous fluids are administered competently, nurses/doctors are communicating effectively, doctors always know about patients' progress, patients trust doctors, patients are always discharge without delay, patients told what to do and what to expect leaving the hospital, hospital policies and procedures are practical.

This two-part approach to quality assessment (the structure and the process) is interrelated, because good structure increases the likelihood of good processes, (Donabedian, 1988). This study focuses on

client/structure, client/process, provider/structure, and provider/process. Both the clients and the providers were asked the same questions to assess their opinion of the setting/structure of the hospital, and seeking their view of the processes that were carried out by the main providers in the health sectors who are the nurses and the doctors. The use of this framework was considered to have several advantages.

The framework of structure and process was relatively simple and well understood. In addition, it facilitated dealing with the work in logical steps. However, Pearson et al, (1987:5) stated that this frame work is difficult and needs to be dynamic. In addition, increasing attention has been focused on quality management in the delivery of health services. This attention has centred on the various relationships between organisational structure, clinical practices, and patient outcomes, with the strong recognition that the practice of healthcare should be evidence based (Fitzpatrick, 1999). Despite the current fashion for evidence-based policy making, the researcher has used this core function framework to conceptualise the practice of healthcare and in the belief that it assesses perceptions of patients and professionals in regard to quality. A scientific basis for the study of quality within the health sector through the perceptions of patients and the professionals is also required so it is necessary to articulate a conceptual framework that explicates the various components of the healthcare system and the relationship between them. As Bushshur (2003: 121) explains:

Donabedian's concern is not with descriptions of particular quality organisations or policy nuances but, rather, the fundamentals of quality, which do not change much over the decades. He does not discuss quality

in office settings, and he pleads unfamiliarity with computerised records as quality tools, but he is not shy about posing some thorny questions. For example, should we intervene when we lack knowledge of the natural history of an illness?

Using Donabedian's framework does have certain limitations, including the focus on only two aspects of categories; the physical structure as well as the processes. The out come was not studied as mentioned earlier. There is also no evidence that either physical structure or process measures are of superior credibility; it is what the recipients themselves believe. It is difficult to even speculate when considering this frame work, whether or not the socio-political situation in Bahrain itself influences the effectiveness of the recipients' perceptions.

Therefore, it was important to understand the context of Bahrain, as outlined in Chapter One. On the other hand, there are few attempts to understand the effects of external forces on the overall health sector or its subsystems or to examine the relationships among the different system components which make the frame work difficult to use. For example, there might be some factors which might be not under neither the physical structure nor the processes which might make it difficult to be studied by using this frame work, for instance, the relationship between mortality and morbidity and the quality of care, because one might ask in which category do these fit? In addition Donabedian's framework is derived from a Western health service context and may be difficult to adapt in Bahraini culture.

Conclusion

This chapter has clearly revealed the almost complete absence of literature that analyses quality management in the Arab Gulf region, let alone the Bahraini health care sector. However, given that many of the principles of quality management are 'generic', it has been possible to identify relevant publications, although the vast majority has been the product of Western settings. Other generic concepts, such as the 'customer' remain problematic. However, the objectives of providing a basis for the empirical research and a critical review of the basis for future quality management initiatives have been established.

Quality in healthcare remains an area that needs to rely on objective and rational measurement because quality improvement activities may contribute not only to the performance of the healthcare sector, but ultimately to the performance of the nation. Therefore, in this chapter the quality management in the public sector generally and in the health sector specifically has been presented, quality management has been defined; the effective way of implementing it has also been highlighted. The main stakeholders in the health sector have also been recognised. In the next chapter the justifications for obtaining the opinions of the stakeholders and their relation to quality management will be explored by conducting a methodology based on Donabedian's framework.

Chapter 3

METHODOLOGY

Introduction:

The previous chapter introduced Donabedian's framework (1980) and provided some detail as to why this was selected as a basis for the empirical study. To restate the overall aim of the study, this is:

> *To improve the quality of healthcare for patients who use Bahrain's secondary health services*

For the overall aim to be achieved, it was necessary to understand the context in which Bahrain's health services were developed, and this was largely done in Chapter One. However, this Chapter now builds on the literature review in the previous chapter by introducing the methodology for the empirical study which also addresses the following objectives:

-To undertake primary empirical research to establish the present quality of healthcare in Bahrain

-To provide a theoretical and practical basis for future quality management initiatives within the Bahraini health services

The results of the study, when critically analysed, will then provide the necessary basis for a critical understanding of the applicability of

future quality management initiatives in the Bahraini health care sector.

By building on Donabedian's framework, this chapter also reflects the selection of a cross-sectional questionnaire survey for this study. The main outcome of the research attempts to measure responses of front line staff (doctors and nurses) as well as the clients. It is crucial to obtain the views of these key groups in terms of structure and processes within the hospital to examine the quality of the services in the Salmaniya Medical Complex Hospital. Permitting both the employees and the clients to ventilate their feelings and suggestions of how to improve the services is considered an additional indicator of the quality of care. Some of the literature was concerned with patient satisfaction, consumer satisfaction, and the quality of healthcare based on information from patients and / or professionals about the structure and the processes of the hospital (Abramowitz and Berry, 1987, Aiken et al, 1994). Both patients and professionals should evaluate the technical and interpersonal features of care (Donabedian, 1988).

The majority of similar studies used closed ended questions and quantitative methods to explore the dimensions of patients' satisfaction with hospital care, such as (Hinshow and Atwood, 1982). Although they provide evidence that patients distinguish among components of care, the studies might have omitted important components and included unimportant ones. Identifying those aspects of hospital care that are important to patients and staff will require a cross sectional, exploratory study.

Selection of the method:

Primary research instrument:

To address the research objectives, page number (71), the data required to develop a quality healthcare strategy comes from a combination of evidence collection sources. The primary sources were the opinions of selected patients, nurses and doctors representing the Salmaniya Medical Complex at the Ministry of Health, through survey questionnaires distributed to selective patients and employees to collect qualitative data during the months of June 2001, to August 2001 (which depended on permission from of the Ministry of Health in Bahrain and approval of the supervisor, at the University of Hull, UK).

A covering letter was distributed together with the questionnaire to the respondents to ensure them of the confidentiality of the collected data and to explain the purpose throughout the research process. Therefore, a questionnaire was selected to focus upon the prerequisites for patient care, which include the physical facilities, the organisation of the Salmaniya Medical Complex and the resources, both human and other. The questionnaire also focuses on the process of care as well as taking into account the intellectual processes and staff behaviour as it relates directly to the quality of care for which they are accountable.

The questionnaire fits with Donabedian's approach, basically because these two approaches cannot be separated. In order to assess quality effectively, information about the resources available (structure) and how they are used (processes) needs to be collected before a judgement of quality can be made.

To select the best methodology for studying patients and staff views of the quality of the hospital services at the Salmaniya Medical Complex in Bahrain, many obstacles and difficulties had to be faced in trying to obtain permission to conduct the research (see Obstacles to Research, page 86). Finally, based on the Ministry of Health officials' order, a research survey was conducted, rather than a focus group study as was originally proposed.

To facilitate access to the system (the organisation and the individuals within the system), an overt approach to the physical access, rather than the covert approach, has been used. This approach was convenient to the researcher who was working within the setting. To avoid ethical problems which might be raised, an overt approach is suitable. Two types of figures are essential to gain access to conduct research: gate keepers and informants (Gummesson, 1991).

It was easy to get access to the informants (patients and professionals), but it was not easy at the beginning to get access from the gatekeeper: officials at the Ministry of Health preferred the use of questionnaires (see page 87). However, as a former member of the professional team at the hospital, the research data could be collected easily. Collecting data and information from public sector clients in Bahrain based on the researcher's own view, is much easier than the private sector where people may seek services as quickly as possible. Therefore, they don't want to spend any extra time completing a questionnaire or discussing any problem further. One of their reasons for using a private hospital might be to avoid any unnecessary waiting time.

On the other hand they might think that they have chosen the concerned private hospital because they think it is the best. Therefore there might be a bias in the study. Mackey (1984) suggested the following selection criteria: the availability of objective evidence to support the chosen method and the acceptance and application of the results obtained from the chosen method. However, acceptability and accessibility must be key facts, not only to individuals, but also to organisations and to management.

A survey was also chosen because it seemed the most suitable approach to explore perceptions. A survey is widely used particularly in exploring perceptions, attitudes and behaviour either through face to face interview or postal questionnaires (Raid, 1993:32). Polit and Hungler (1993:122) also emphasised surveys, as they are the best method of collecting information about people's knowledge, opinions, attitudes and values, particularly in the health sectors. Gilbert (1993:95) added that a survey is one of the best methods not only in exploring individual attitudes and values, but also in exploring personal experiences and behaviour.

This method is also considered relatively inexpensive and the researcher being self-sponsored considered it appropriate. The postal survey is one of the cheapest methods of research and is very suitable for many health topics (Reid, 1993:32). The postal survey's is main advantage is its relative cheapness, (Gilbert, 1993:96). May (1997) also agrees that the main strength of surveys is that they have a lower cost. Other authors have indicated many advantages of survey research. For instance, it can help obtain a large amount of data from a large number of people in a relatively short time, (Mc Neil, 1990, De Vaus, 1996). Other advantages

include filling in questionnaires at a time convenient to respondents, (Gilbert, 1993; Gummesson, 1991).

Although, quality of care can be measured in many different ways, no universal agreement exists on which method should be used. Abramowitz (1987) suggests using a questionnaire as the most common method for measuring the quality of care in hospitals. It is also essential to evaluate the reliability of the method, particularly when considering attitudinal studies. Hall (1974) stressed that there is no particular methodological approach which is the best. Each researcher must therefore select the approach which is suitable for its own country's needs, conditions or situations or cultural needs, and to facilitate the research and overcome obstacles that might inhibit or affect the conduct and the result of the research. Of course, a key problem here is that no research instrument has been developed within the context of the Arab Gulf region, let alone Bahrain.

The research was carried out on two types of categories; patients who are admitted to the hospital, and the providers of healthcare. The main providers are the doctors and nurses. The researcher believes that the most suitable approach is a survey, although it is difficult to decide on a convenient time for all the patients; the time which might be convenient for some might not be the same for others. Therefore, it would be essential to distribute the questionnaire and leave the patients themselves to decide the time convenient to them, particularly when we ask patients about some sensitive issues such as asking them to evaluate their medical team and whether nurses or doctors who are attending them daily are qualified / skilled or have a good attitude with the patients or not.

The Salmaniya Medical Complex has been used in this study, because it is the only general non-profit making, government hospital in Bahrain. The patients in this hospital were thought to participate more easily than in a profit making hospital were the patient might be reluctant to participate and one focus of the project was on supporting programmatic change in non-profit making organisations.

The questionnaire:

The questionnaire was developed to meet the cultural needs of the patients, the nurses and doctors in Bahrain. For example, respectful atmosphere question was included to examine the amount of peace and quiet patients have in the hospital. As Bahraini people are very social, they are used to receiving many visitors at once, which is a real problem for the other sick patients, so the researcher included such a question to fit with Bahraini society.

The questionnaire was divided into three sections with the following purposes:

1. To obtain demographic details.
2. To assess respondents' perceptions towards health services.
3. To obtain suggestions to improve the quality of health services in Bahrain.

Questionnaire development:

The researcher developed the questionnaire, which was used in this study, and the approach is similar to Williams (2000). Williams looked at patients' judgments of hospital quality, although patients' opinion only was explored. In the Bahraini study the researcher considered both the patients' and professionals opinion.

The survey questions were designed to consider the cultural needs of the country and focused on specific action taken by the hospital staff. For example, rather than asking patients to rate the general aspects of their care such as "the courtesy and helpfulness of your doctor" we asked questions relating to the doctor's knowledge about the patient's progress. The method and the content of the questionnaire was developed framed to be as specific as possible, to minimise the influence of the confounding factors such as patients' expectations, personal relationships, gratitude, or response tendencies related to gender, or class.

The instrument was developed to examine patients; the care recipients and the professionals; the caregivers. It was also designed to examine their perceptions/ views of health services at the secondary healthcare hospital in Bahrain, from two main aspects the structure and the process. The questionnaire included questions about socio demographic characteristics (age, gender, education, position). In addition, we asked patients whether their admission was an emergency and their health condition during admission. The patient was also asked to rate his or her health as: minor, intermediate, complicated, or emergency.

Selection Criteria:

1. For the patients
   A. All Bahraini patients who are currently admitted to the Salmaniya Medical Complex and those who have a previous admission records of not less than one week in the same hospital.
   B. Those who are fully conscious.
   C. Those who are willing to participate in the study.
   D. Their age between 21 years and above.

2. For the professionals:
   A. All categories of nurses and doctors who are working at the Salmaniya Medical Complex.
   B. Those who are willing to participate in the study.
   C. Those who are available in the hospital during the study period.
   D. Age is between 20-59 years.

Sampling:

A convenient sample of key informants was used. The sampling frame contained 250 doctors, 250 nurses and 500 patients. Those distributed, 193 were received from the nurses, 84 from the doctors and 276 questionnaires received from the patients. Reasons for obtaining a lower participation rate included a lack of both interest and support from the hospital administration. If permission had come from the officials within the hospital, the weight of it might be different and the number of participants might be more.

Secondary research

The secondary sources used in this research were drawn from a content analysis of official documents, as there are a limited number of articles on public management in general in Bahrain. The researcher has used a range of official publications such as: Health Statistics, Bahrain Strategic Health Plan, Bahrain Health Strategy, Salmaniya Medical Records, plus information concerned with the quality of health service plans from the Ministry of Health, journals, and media. Together they have been used to support and help the researcher in understanding, analysing and presenting the primary collected information and evidence. Of course, the lack of a critical literature on government reforms in Bahrain means that a reliance on official publications may present a distorted picture of the extent of various government reforms and initiatives.

Validity and reliability

Reliability as defined by Polit and Hungler (1993:445) as '*The degree of consistency or dependability with which an instrument measures the attribute it is designed to measure'*. This can be tested by the repeated use of the questionnaire that is by testing and re-testing, with the same results. It was not possible in this research, mainly due to the sensitivity of the subject. It is fine to get participants willing to participate in such studies in Bahrain and repetition of the testing might obstruct the respondents from participating in the main study.

The questionnaire was tested using Cronbach's Alpha test. This test is defined by Polit and Hunger (1993: 434) as '*a widely used reliability*

index that estimates the internal consistency or homogeneity of a measure composed of several subparts; also referred to as Coefficient Alpha'.

The questionnaire was tested on a sample of patients who were admitted to the hospital, and nurses and doctors who worked in Bahrain throughout a pilot study which was conducted in June 2001. Validity refers to whether the instrument actually measures what it is supposed to, that is, whether it really does measure the quality of care.

To maximise the validity of the survey the following measures have been taken:

Research Access

It was extremely difficult to obtain permission to conduct the study. Permission had to be obtained from his Excellency, the Minister of Health, personally and Ministry of Health officials in the Kingdom of Bahrain. Letters to the patients, doctors and nurses inviting them to participate in the study were sent through nursing officers, departmental secretaries and the researcher.

Participants were assured that the data would be strictly confidential and informed about the purpose and aims of the study. The letter is included in (the appendix 2, page 221).

The questionnaire content

Based on Donabedian's approach, the questionnaire was based on a validated version that had been designed for the assessment of the view points of the clients and the professionals in regard to the quality of the structure/building and the processes that are carried out by the

professionals within the Salmaniya Hospital; it also included demographic data, (see appendix 2, page 222). The questionnaire was translated into Arabic for the patients because they are Arabic speaking respondents. Response alternatives were typically: strongly disagree, agree, don't know, disagree, and strongly disagree, the last question was on open ended question to give respondents more freedom to express their suggestions, ideas and requirements to improve the quality of care provided.

The doubt is whether the clients' opinions are considered as a measure of quality care, because the clients lack the expert knowledge to accurately assess the technical competence of medical personnel accurately. They are also influenced by non-medical factors such as the interpersonal skills of the providers, reluctance to disclose what they really think because of their sense of dependency or prior failures in patient-physician communication, or they cannot recall aspects of the delivery process (Strasser and Aharony, 1992).

An appropriate physical environment for the respondents was assured. For the professionals they were asked to take the questionnaire back home, fill it in and send it back to the given address. For the patients the time chosen was between 1 and 2 pm when the patients are relaxed have finished their lunch and nursing care.

The pilot questionnaires were conducted to increase both the reliability and the validity of the questionnaire. Based on the piloting, unclear questions that did not meet the purpose of the study were excluded and some other useful questions were included.

The questionnaires were computer coded. The data analysis was performed on a computer to minimize the errors. To maximise the validity of the content analysis, two persons analysed the data, the researcher and the statistician. The internal consistency of the questionnaire was tested using Cronbach's Alpha Test. Characteristics related to the quality of the physical settings, which are the environmental and organisational characteristics and the process of the care which is the performance of professionals in the management of patients and clients in the Salmaniya Medical Complex, were identified from a literature review and tried to fit our Bahraini culture to increase the content validity of the questionnaire.

ETHICAL ISSUES

Polit and Hungler (1993, 356) articulated three essential ethical principles in research. Those are 'beneficence, respect for human dignity and justice. These ethical principles will be highlighted in this study.

1. PRINCIPLE OF BENEFICENCE
   a. Freedom from harm

      The respondents were assured that their participation would not do them any harm either physically or psychologically. The phrasings of questions were considered carefully.

   b. Freedom from exploitation

      The respondents were assured that their participation, or the information that they will provide would not be used against them in any way.

c. Risk / Benefit Ratio

The researcher considered risk / benefit ratio carefully through the research process, and ensured that there are no risks that the participants may be involved with; on the other hand there are benefits, some of which included:

- Comfort in being able to write down their feeling or problems, which are related to quality of care.
- Being part of the study and the satisfaction of desire to find out what it is like to participate in the study.
- Knowledge and information that they will provide, can be used to develop healthcare in Bahrain, improve staff attitudes, beliefs and knowledge they held towards heath- care.

2. PRINCIPLE OF RESPECT FOR HUMAN DIGNITY

a. Right To Self-Determination

The researcher considered the right to self-determination very carefully. The researcher made sure that the participants were not influenced by the researcher's position so in order to maximise absence of 'coercion' did not distribute the questionnaires. Although the researcher mentioned in the covering letter the advantages of participation in this study, it was left for the participants to decide whether to participate or not.

b. Right To Full Disclosure

The researcher fully described to the participants the nature of the study, the researcher's responsibilities and the purpose of the study

before their participation in the study and the researcher is planning to explain the research study findings after the research.

c. Informal Consent

Accurate information was provided to respondents. Consent can be assumed by completion of the questionnaire.

d. Issues Relating To The Principle Of Respect

The participants were fully respected, their right to self-determination and full disclosure was considered. The use of "Deception" in which withholding information about the study or providing participants with false information was not used in this study.

3. PRINCIPLE OF JUSTICE

a. Right To Fair Treatment

This element is not applicable to this study.

b. Right To Privacy

Privacy and confidentiality were maintained throughout the survey process.

Anonymity was assured as no names or any other identification information was required.

Obstacles to Research

The researcher has faced many obstacles during carrying the research; these obstacles will be explored as follows:

Obtaining permission:

The researcher has faced many obstacles to obtain permission to conduct the research. A letter was sent on 11th April, 2001, to the assistant under secretary for the hospitals, and a copy of the same was sent to the chief executive officer (C.E.O) of the Salmaniya Medical Complex, asking for permission to conduct the research (see Appendix 1). Frustratingly, no replies were ever received from him, despite weekly calls and advise 'to wait'! Finally, on 29th April 2001, I called the CEO of the Salmaniya Medical Complex asking if she had a reply to my letter. She stated that she will call for a meeting, but after another month of waiting, and with frequent calls to the CEO's secretary, I was finally called for a meeting with an administrator of diagnostics and professional services. Then, an hour was spent trying to convince me not to go any further with such a study because it might reveal some negative issues about the hospital. It was clear that the hospital did not want to risk its reputation overseas. I tried my best to imply that the research may produce positive findings, or that the hospital could be anonymised, but he strongly disagreed.

In addition, there was ignorance about the focus group study method, and only a readiness to allow a questionnaire survey only. I informed the administrator that I was prepared to change the methodology if this will allow the research, but he remained firm. I also asked for his decision in writing (so I could go to higher authority). I also suggested that I will go

to another hospital, but because I might be questioned by the other hospital officials why I approached them when I am working at the Salmaniya, he totally refused. Then I met the CEO to discuss my project, but she called me for another meeting, which consisted of the following members:

1. Administrator of diagnostic and professional services.
2. Administrator of support services.
3. Administrator of medical services.
4. Chief of nursing services.
5. Chief executive officer.

At the meeting, the CEO was very rough with me, shouting in front of the other members present and knocking on the table, stating that this hospital is her home and she will not allow me to enter her home. I responded that if this is the case then this is the home of all employees. Her response was to shout loudly stating it is her home only from a managerial point of view, adding that she will never agree to the research!

I then asked for a meeting with the under secretary for the Ministry of Health, and told him the whole story. He was very supportive verbally and promised to see this issue through. He was also very happy with the title of the research stating that he is going to establish a quality directorate at the Ministry of Health (which we miss). However, I was then waiting for his action until February 2002, although I was either calling him personally or leaving a message with the secretary, but no reply received except 'wait and see'! Finally, I conceded that I might have to change the method to a questionnaire instead of a focus group,

just to facilitate my work. I issued a letter to the minister, attached with copies of both questionnaires (see attached).Within a week, I received a call from the minister's secretary that the minister replied in writing to the assistant under secretary positively to request that all top managers at the hospital cooperate with me and allow me to do the research (please see attached).

No support received all over the study

a. My work area has changed

My direct supervisor, the chief of nursing services, is not convinced about my study, although I wrote a letter to her before starting the study that I will study at my own expense, out of working hours, and that it will not interfere with my work. Instead of considering this, she has moved me from nursing officer for the oncology unit which has 50 employees to a nursing officer of level 5 (internal medicine department). It is the biggest department in the hospital which has 140 employees, and assigned me in addition to that to carry cardio pulmonary resuscitation C.P.R. bleep to be a member of the C.P.R. team for the entire complex which means that I have to leave my work and run to resuscitate any respiratory arrest patient anywhere in the hospital. I was also given many responsibilities, and the main objective for her is to bar my study. I am one of only three members of the hospital who have master's degrees and only my self is studying for a doctorate in the whole of nursing services (which consists of 2061 nurses) at the Salmaniya

Medical Complex (Ministry of Health; Bahrain health statistics, 2001).

b. No study leave considered

There is a circular from the assistant under secretary for the training that all employee are eligible to have a study leave for one month per year to attend conferences, workshop and to build up employee knowledge.

When I requested for study leave for only a few days (please see attached) it was rejected. When I have approached the training department, the director stated that they cannot do any thing for me except through my supervisor (the chief of nursing services) who refused to refer my letter to the training department.

Despite these obstacles, I remained determined to continue doing the research and to fulfil my study. The Chief Executive Officer for the Salmaniya Medical Complex since retired, and the chief nursing officer for the hospital and her deputy have been moved out from the service by ministerial order. Subsequently, the researcher was promoted to a hospital administrator on October 2002, by under secretarial order.

c. No research supervisor:

No research supervisor was appointed for the researcher by the University for about two years (from 2001 till 2003); she was left alone trying to do her best by concentrating on the literatures.

Conclusion:

This chapter has presented the development, management and limitations of the primary research instrument, the survey. It is hoped that participation in such studies will encourage respondents to think that their opinion and views are important. Furthermore, such a study will encourage the feeling of transparency and democracy developing within the country. Although, this is a dimension that may need to be considered in research in almost all administrations it was thought to be especially important during a transition from autocratic rule to democratic government in Bahrain. Transparency requires a well-developed system for communication not just within the administration but also between it and the public at large, as governments need not only to listen but also to be seen to listen to the people. Officials, when they listen to their employees' view points and suggestions to develop their work place, permit the opportunity to express their feelings and ventilate their ideas. Moreover, such opinions will contribute positively in developing public services, in addition to encouraging a sense of well-being in employees as a part of an increasingly transparent and democratic culture.

In terms of the empirical research, the researcher has adopted Donabedian's quality management framework which provides a useful scheme for developing systems and procedures for dealing with feedback from service users, despite some of the shortcomings discussed in Chapter Two. It also encourages managers and staff to think about the needs of service users when they are implementing changes or making improvements to the way services are delivered. In the forthcoming chapters, the distinct opinions of both patients and staff about many components of hospital care in Bahrain will be explored and analysed and the impact of quality management on health services will be analysed and assessed. This is intended to provide a sound framework on which to address a key objective of this thesis, which is to provide a theoretical and practical basis for future equality management initiatives within the Bahraini health services.

Chapter 4

MEASURING PATIENTS' SATISFACTION: RESULTS AND ANALYSIS

Introduction

This chapter is intended to fulfil one of the main objectives of this research, presented in Chapter One, by establishing the present quality of healthcare in Bahrain.[1] The findings here will also help to reach another objective of the research by providing the theoretical and practical basis for future quality management initiatives within the Bahraini health services. A key assumption of this thesis is that despite recent pressures for democratisation within Bahrain, documented in chapter one, the perceptions of the participants in the study would be largely positive. Although overall dissatisfaction with the government remains, the majority were satisfied with the healthcare provided at the government hospital. Whether or not this level of satisfaction indicates that the reforms in Bahrain have had a positive effect across government, including the Ministry of Health is conditioned by Bahrain's unique social and political context, as outlined earlier.

In sum, this chapter presents the empirical findings, where the demographic data, age, gender, occupation and the patients' level of education, constitute independent variables. The admission of patients, the patient's health condition during admission, sufficiency in the numbers of doctors and nurses, quality of food at the hospital, hospital parking, and the overall perceptions of patients, nurses and doctors of the

[1] The use of 'present' here relates to when the empirical research was conducted, in 2001.

physical settings and to the processes constitute independent variables will also be highlighted only, but will be discussed further in the next chapter.

Presentation of the Findings

The responses to the survey questions were categorised into statistical data by assigned numerical codes. Tables were then utilised to reflect the demographic and descriptive variables in relation to the quality of the physical settings, which is the environmental and organisational characteristics, and the process of the care; which is the performance of professionals in the management of patients and clients in the Salmaniya Medical Complex. After initial tabulations, the main variables, 'structure' physical setting, "process", were then cross tabulated and the results presented in the tables.

The data was entered with a unique code for missing values. The SPSS (Statistical Package for Social Science, 1975) system was used for data analysis. Reid (1993, p66) notes that SPSS is mainly suitable for survey data and it has particular advantages in large scale studies, it is an interactive package, it is also designed for exploratory data analysis and it is simple, couched in ordinary language and short and the accompanying documentation is well expressed and statistically sound. This provides a sound rationale for the use of SPSS in this study.

There were two questionnaires, one for the professionals, and another one for the patients. Data organisation and Chi- Square as the type of statistic were used in both questionnaires for tests of relationship for age, sex, and

occupation, for the professional questionnaire. Chi-square analysis was intended to examine the correlations between the quality of the physical settings and the process of care carried out by the professionals, from both the clients' and the professionals' point of view.

Response rate

Out of the 1000 questionnaires distributed, 553 were received. Reid (1993:32) examines low response rates from questionnaires and suggests that the use of follow up questionnaires will increase the response rate. In this study, missed communications was the main cause although the final number of respondents was more than enough, especially when the difficulties of carrying out such a study in the country prior to the 'transparency and democracy' stage are considered. Good communication between the director or the management personnel of the place where the study is carried out and the respondents who are employees also may raise the response rate. In other words, the expectation is that if the respondents know about the study from their supervisors and had the agreement to participate in such a study the response rate might be better. In this study, the researcher distributed, with Ministry agreement, the questionnaire to the participants, rather than had it circulated by the chief executive officer of the hospital. Thus, the participants did not know about this study from their supervisors and they were not sure whether they were allowed to participate.

The other major effect is from the sensitivity of the subject; the participants might have felt that they were not allowed to participate, both administratively and politically. This is because the study is to explore

their ideas and opinions about the standard of the quality of one of the government hospitals, with democracy a relatively new phenomenon in Bahrain. It might be easier in a democratic country for people to participate in decision-making and to raise their opinions.

The sample was 1000, out of which 500 were distributed to patients, 250 to nurses and 250 to doctors. All were present in the Salmaniya Medical Complex.

Since we are looking for public services that respond to users' needs are arranged for the providers' convenience based on (Pearson et al, 1987), the researcher therefore thought to examine the opinion of both the receiver of care and the giver. 'Such studies can be extremely useful for quality assessment and improvement efforts because satisfying patients and providers' expectations is an important component of high-quality care and because both patients and providers can provide information that is not available from other sources', (Cleary et al, 1991)

Summary of Demographic Data

Of the 553 respondents, the majority were female (62.2%). Most of the respondents were patients (49.9%); most of them were young, aged between 20-30 years (37.4%). Around a third of patients who participated in the study were secondary certificate holders (34.1%), and about half (53.6) were admitted through Accident and Emergency. Around a third of them (32.6%) described their condition as emergency.

Age range:

The age range was as follows:

- Patients: Out of the total 100%, 20.4% from 20-30 years; 11.2% from 31-40 years; 8.5% from 41-50 years; and 9.8% were 51-59 years.
- Nurses: Out of the total 100% 15.2% from 20-30 years, 12.5% were from 31-40 years, 9.2% from 41-50, and 0.2% was from 51-59.
- Doctors: Out of the 100% 1.8% from 20-30 years, 6.5% were from 31-40 years, 4.0% were from 41-50 years and 0.7% was from 51-59 %.

Gender:

The main category of the study participants were female 62.2% out of which 23.7% was patients, 31.8% were nurses and 6.7% were doctors.

37.8% were male, out of which patients were 26.2%, nurses were 5.2% and doctors were 6.3%. , as indicated in table 2.

Table 2

Gender * Subject Cross tabulation

			Subject			Total
			Patient	Nurse	Doctor	
Gender	Male	Count	145	29	82	256
		% Of Total	26.20%	5.20%	6.30%	37.80%
	Female	Count	131	176	37	344
		% Of Total	23.70%	31.80%	6.70%	62.20%
Total		Count	276	205	119	500
		% Of Total	49.90%	37.00%	13.00%	100.00 %

Table 2 demonstrates that the main category of the study participants (62.2%) were female.

Occupation:

12.4% were doctors, out of which 1.5% were consultants. 38.1% were nurses, out of which 0.8% were ward supervisors, 0.8% were nursing officers, 5% of the patients were workers, 5.4% were students, 12% were house wives, 4.3% were un-employed, 4.8% were technical, 0.4% were administrators and 14.5% were professionals, as indicated in table 2.

Table 2.1

Occupation * Subject Cross tabulation

			Subject			Total
			Patient	Nurse	Doctor	
Gender	Professional	Count	75			75
		% of Total	14.50%			14.50%
	Administrator	Count	2			2
		% Of Total	0.40%			0.40%
	Technical	Count	25			25
		% Of Total	4.80%			4.80%
	Un Employed	Count	22			22
		% Of Total	4.30%			4.30%
	House Wife	Count	62			62
		% Of Total	12.00%			12.00%
	Student	Count	28			28
		% of Total	5.40%			5.40%
	Worker	Count	26			26
		% of Total	5.00%			5.00%
	Staff Nurse	Count		197		197
		% of Total		38.10%		38.10%
	Doctor	Count			64	64
		% of Total			12.40%	12.40%

	Ward Supervisor	Count		4		4
		% of Total		0.80%		0.80%
	Nursing Officer	Count		4		4
		% of Total		0.80%		0.80%
	Consultant	Count			8	8
		% of Total			1.50%	1.50%
Total		Count	240	205	72	517
		% of Total	46.40%	39.70%	13.90%	100%

Table 2.1 demonstrates that the main category of the study participants' occupations (38%) were nurses.

Patients and level of education:

2.3% (34) were illiterate, 7.6% (21) can read and write, 5.8% (16) were primary certificate holder, 21.4% (59%) were intermediate certificate holders, 34.1%(94) were secondary certificate holders, and 18.8% (52) were graduates, as indicated in table 2.2

Table 2.2

Patients and level of Education

	Number of Patients	**Percent**
Illiterate	34	12.3
Read and write	21	7.6
Primary certificate	16	5.8
Intermediate certificate	59	21.4
Secondary certificate	94	34.1
Graduate	52	18.8
Total	276	100

Table 2.2 demonstrates that the main category of patient participants were secondary certificate holders.

Admission:

The response to the question what was the type of admission whether through the accident and emergency, private clinic or through previous arrangements were as follows: 53.65% (148) were admitted through Accident and Emergency, 31.9 % (88) through a private clinic, and 14.55% (40) had previous arrangements. , as indicated in table 2.3.

Table 2.3

Patients and Admission through the followings

	Number of Patients	**Percent**
A/E	148	53.6
Private Clinic	88	31.9
Previous Arrangement	40	14.5
Total	276	100

Table 2.3 demonstrates that the main categories of the patient participants were admitted through Accident and Emergency.

Patient's health condition during admission:

32.6 %(90) described their condition as emergency, 31.5% (87) difficult, 28.6 %(79) were moderate and 7.2% (20) % minor, as indicated in table 2.4

Table 2.4

Patients and Health Condition During Admission

	Number of Patients	Percent
Minor	20	7.2
Moderate	79	28.6
Difficult	87	31.5
Emergency	90	32.6
Total	276	100

Table 2.4 demonstrates that the main category describe their health condition during admission (32.6%) as emergency.

Perception Statistics of patients according to gender Summary:

Many researchers (for example, Riccio, 2000) in other countries have explored the environmental effects on the quality of care, therefore the researcher examined it in Bahrain to establish the present quality of healthcare in Bahrain. To measure quality, our concepts of what quality consists in must be translated to more concrete representations that are capable of some degree of quantification - at least on an ordinary scale, but one hopes for better. These representations are the criteria and standards of structure, process, and outcome, (Donabedian, 1988:1747), therefore the researcher examined those (the process and the structure) criteria in Bahrain.

The literature indicates that there is a significant difference between the perceptions of staff and patients in relation to the physical environment. In this study we found that there is no differences in the perceptions of patients and professionals in regards to the physical building of the hospital and the processes , they were satisfied with both , may be due to the above mentioned reasons the results were as follows:

Perception structure average , male were 2.91 median and 2.93 mean, female were 2.92 median and 2.91 mean, perceptions of processes average were male 3.00 median and 3.02 mean and female were 3.00 median and 2.98 mean.

Overall gender: The majority of the males who participated in this study agreed on the structure (27.8%) of the hospital (physical setting), and on the processes carried out (27.1%).See graph 1.2, and 1.3.

There was little difference in the number of females who agreed (25%) and disagreed (26.4%) on the physical setting of the hospital and with regard to the processes, also the range is similar, 22.9% agreed and 27.1% disagreed.

There was no correlation between gender and the perception of the participants in both the structure and the processes.

Nurses perceptions:

Perception statistics of nurses according to gender

Perception structure averages, were:

- For the male, 2.82 were the median and 2.78 were the mean.

- For the female, 2.83 were the median and 2.80 were the mean.

Perception process average, were:

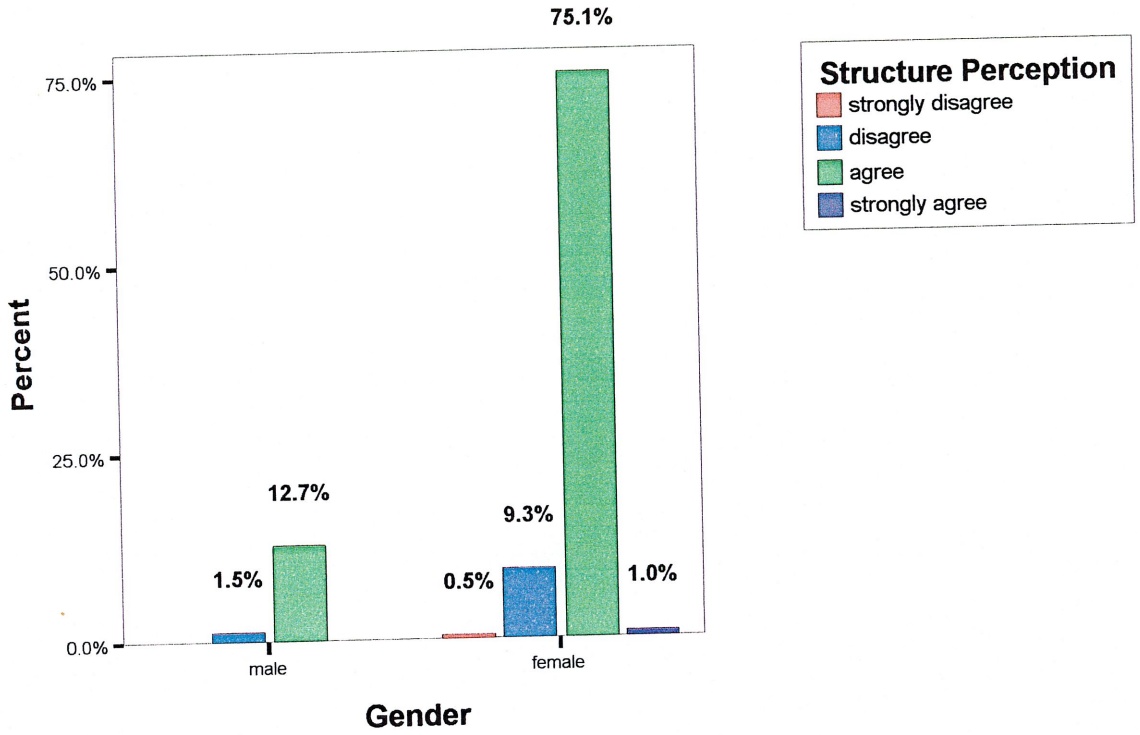
- For the male, 2.80 were the median and 2.74 were the mean.
- For the female, 2.67 were the median and 2.65 were the mean.

Perception nurse averages were:

- For the male, 3.00 were the median and 2.90 were the mean.
- For the female, 3.00 were the median and 3.05 were the mean.

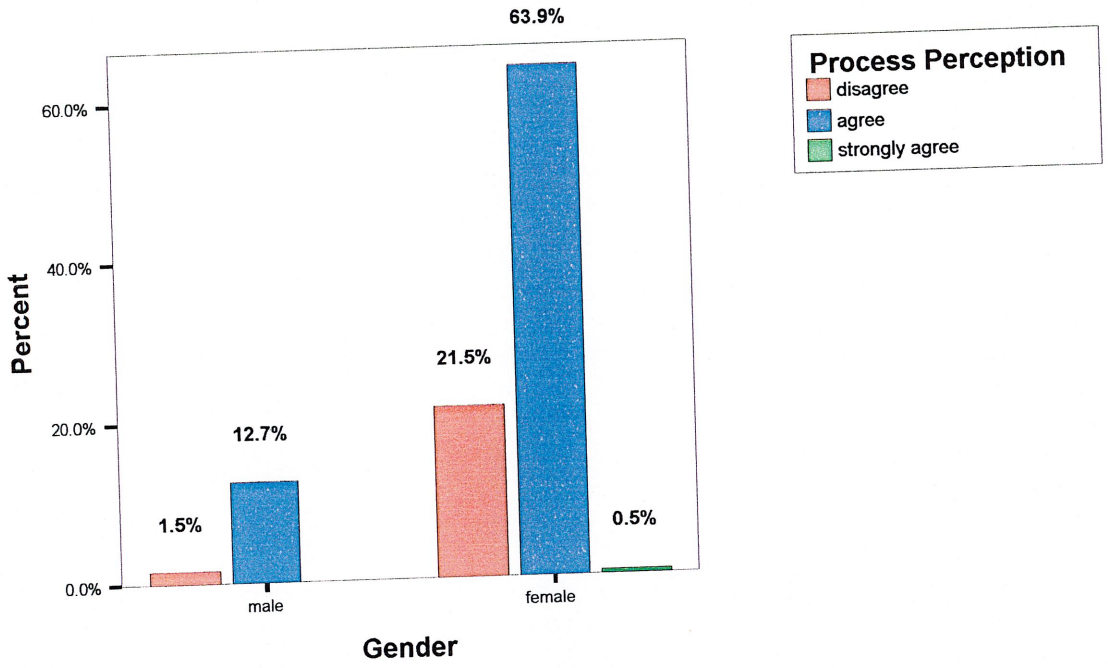
Female nurses agreed more (75.1%) on the physical setting as indicated in graph 1, (page 100)

Nurses' Perception Structure
Graph 1



(63.9%) nurses agreed on the processes, as indicated in graph 1.1, (page 101).

Nurses' Perception Process
1.1



Graphs 1 and 1.1 indicate that female nurses agreed more on the physical settings (75.1%) of the hospital than the processes, (63.9%).

Doctors' perceptions

Perception doctors' average, were:

- For the male, 2.50 were the median and 2.62 were the mean.
- For the female, 2.60 were the median and 2.60 were the mean.

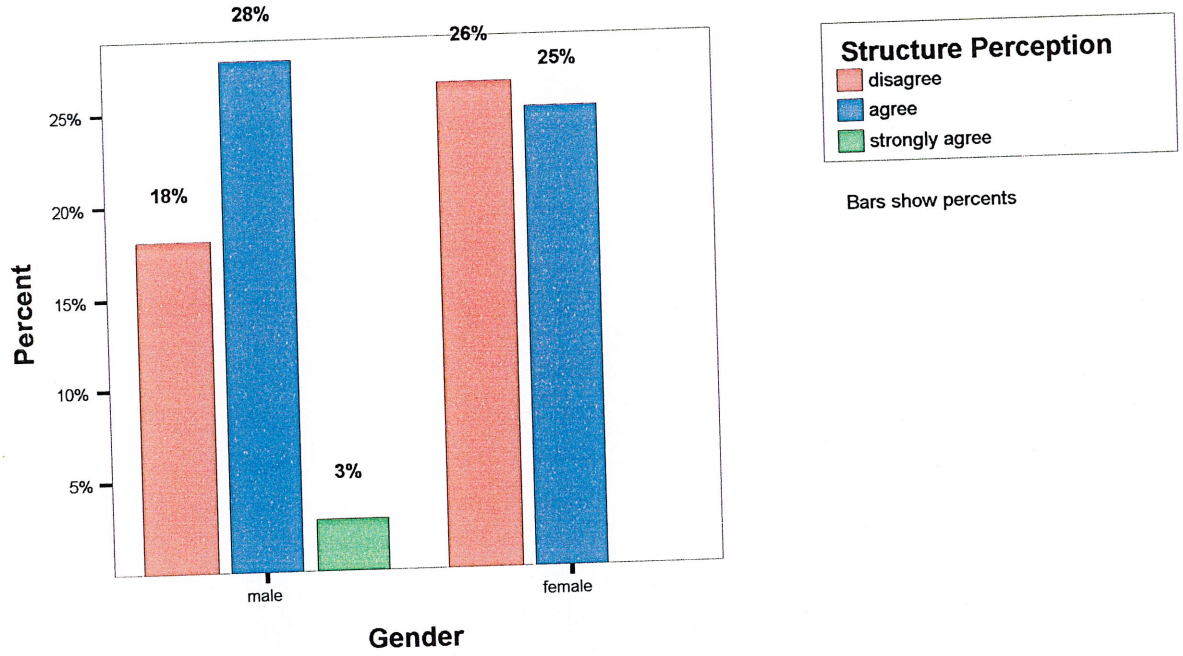
Perception overall averages were:

- For the male, 2.83 were the median and 2.76 were the mean.
- For the female, 2.76 were the median and 2.76 were the mean.

See graphs 1.2, and 1.3.

There was little difference in the number of females who agreed (25%) and disagreed (26%) on the physical setting of the hospital, as indicated in graph 1.2.

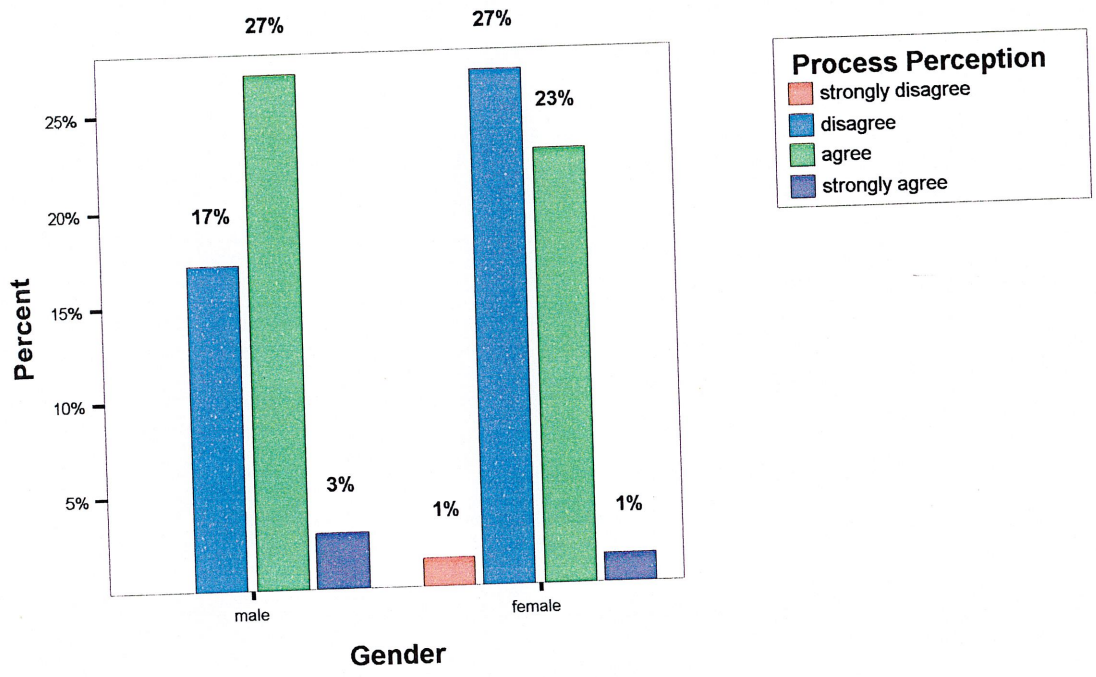
Doctors' Perception Structure
Graph 1.2



Concerning the processes, the range is also similar; 23% agreed and 27.1% disagreed, as indicated in graph 1.3.

Doctors' Perception Process

Graph 1.3



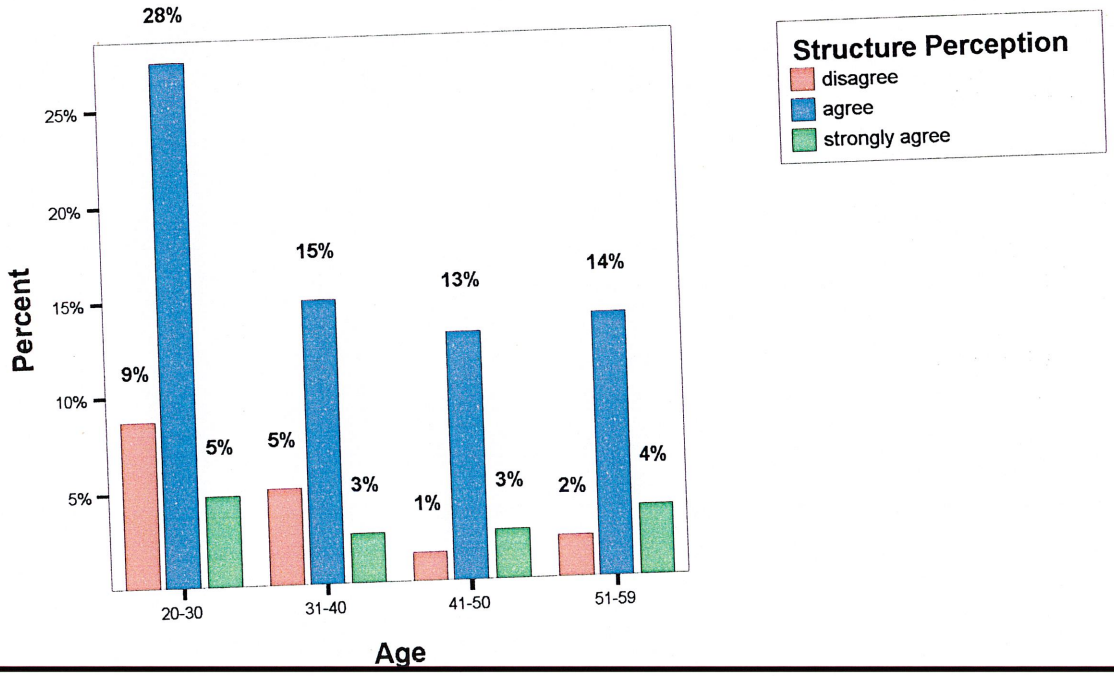
Perception statistics of patients according to age

Summary:

Perceptions structure averages were:

- For the ages from 20-30 years, the averages were 2.83 for the median and 2.87 for the mean.
- For the age from 31-40 years, 2.87 were the median and 2.85 for the mean.
- For the ages from 41-50 years, 3.00 were the median and 3.00 were the mean.
- For the ages from 51-59 years, 3.09 were the median and 3.05 were the mean, as indicated in graph 1.4

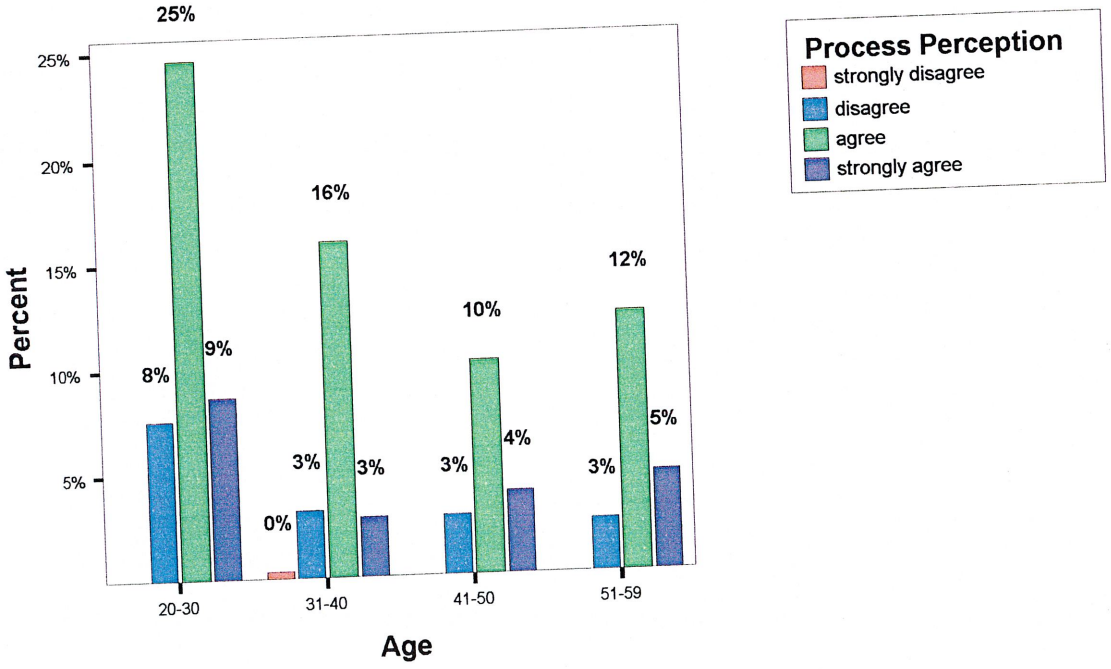
Patients' Perception Structure
1.4



Perceptions processes average, were:

- For the ages from 20-30 years, the averages were 3.00 for the median and 2.98 for the mean.
- For the ages from 31-40 years, 3.00 were the median and 2.91 for the mean.
- For the ages from 41-50 years, 3.00 were the median and 3.09 were the mean.
- For the ages from 51-59 years, 3.00 were the median and 3.06 were the mean, as indicated in graph 1.5.

Patients' Perception Process
1.5



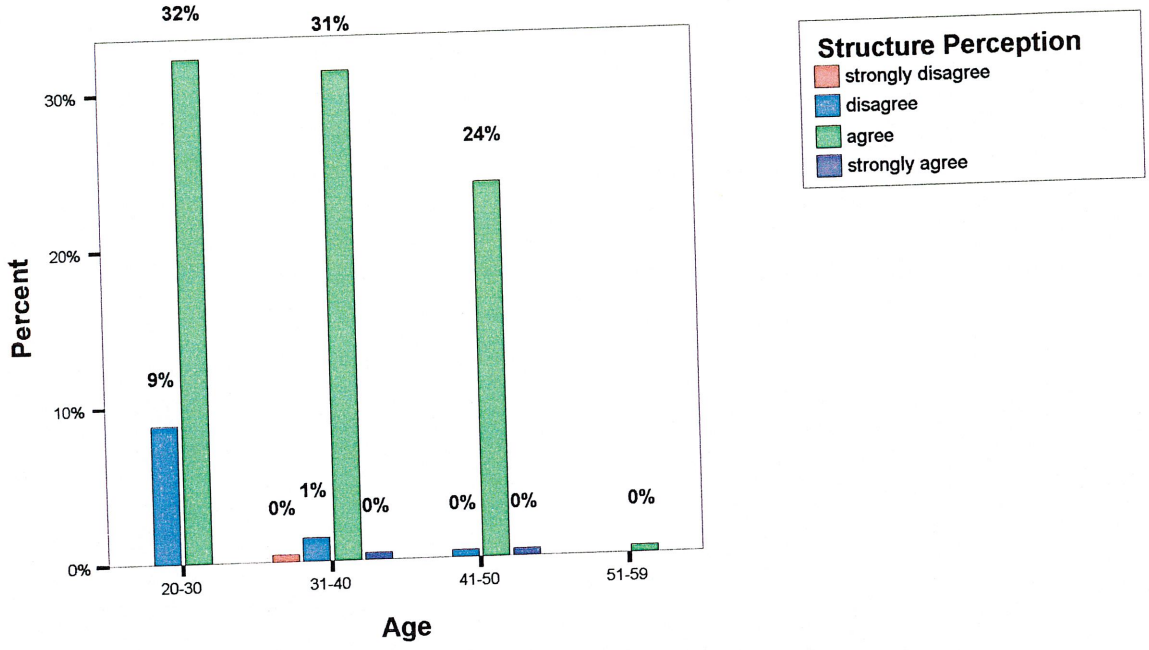
Perception nurses' averages were:

Summary:

- For the ages from 20-30 years, the averages were 3.33 for the median and 3.35 for the mean.
- For the ages from 31-40 years, 3.00 were the median and 3.23 for the mean.
- For the ages from 41-50 years, 3.33 were the median and 3.34 were the mean.
- For the ages from 51-59 years, 3.33 were the median and 3.27 were the mean.

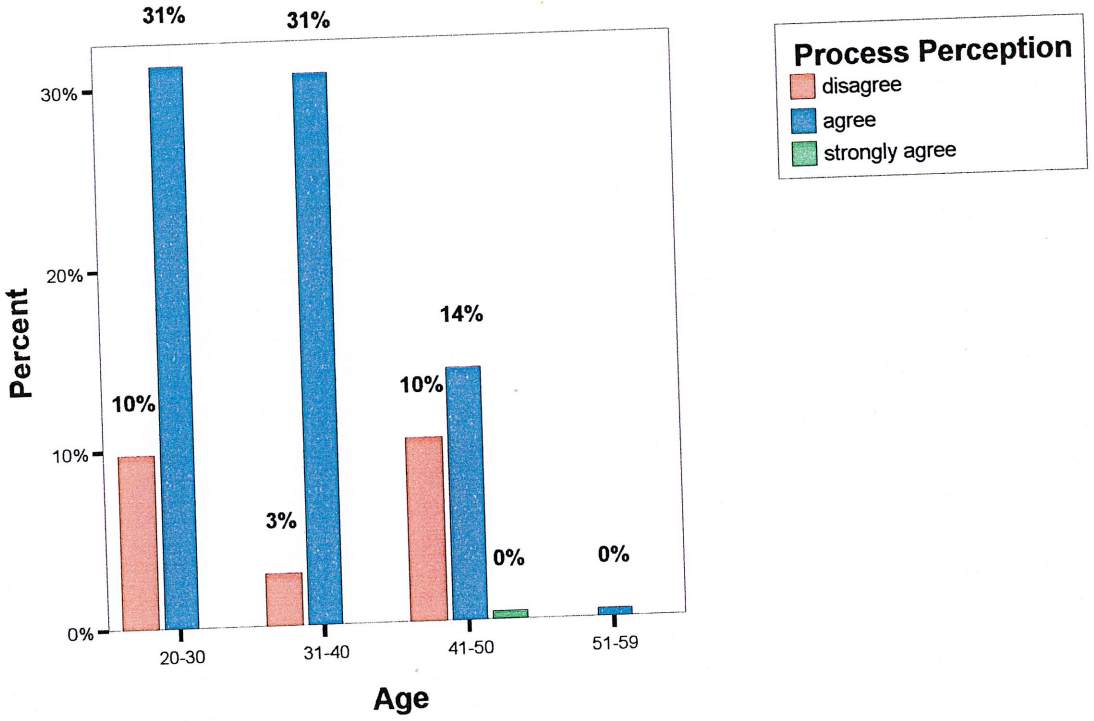
Young nurses (20-40 years) agreed more on the structure of the hospital more than any other categories of ages, as indicated in graph 1.6.

Nurses' Perception Structure
Graph 1.6



Young nurses also agreed more on the processes of the hospital than in the other age categories, as indicated in graph 1.7.

Nurses' Perception Process
Graph 1.7

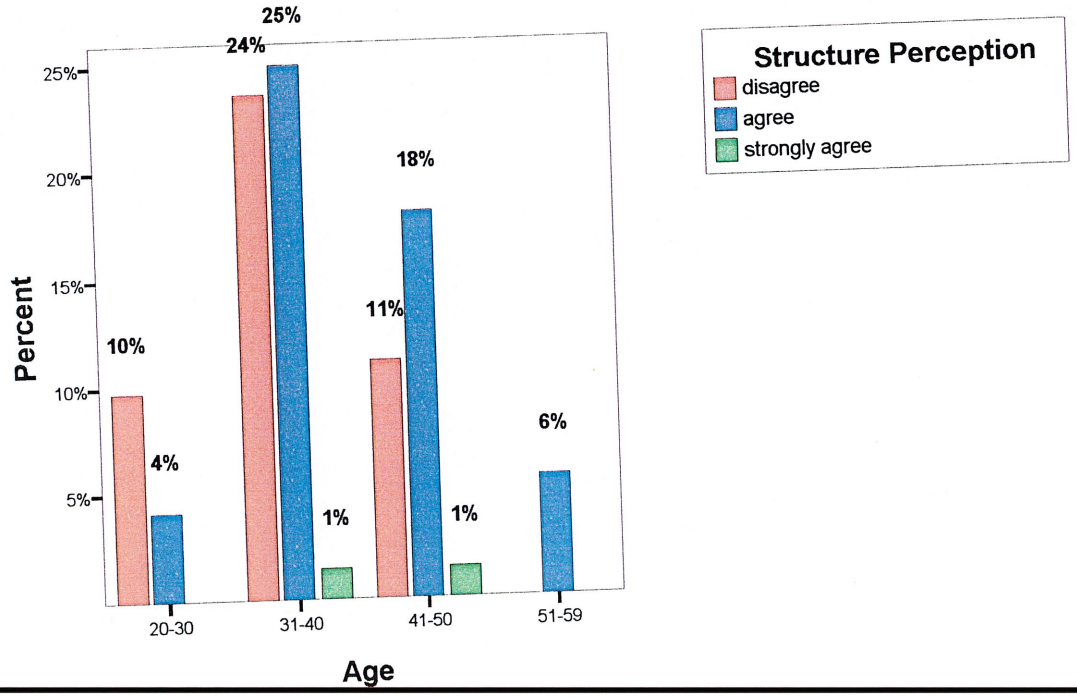


For the doctors, the averages were:

- For the ages from 20-30 years, the averages were 3.00 for the median and 3.04 for the mean.
- For the ages from 31-40 years, 3.00 were the median and 3.02 for the mean.
- For the ages from 41-50 years, 3.00 were the median and 3.16 were the mean.
- For the ages from 51-59 years, 3.20 were the median and 3.15 were the mean.

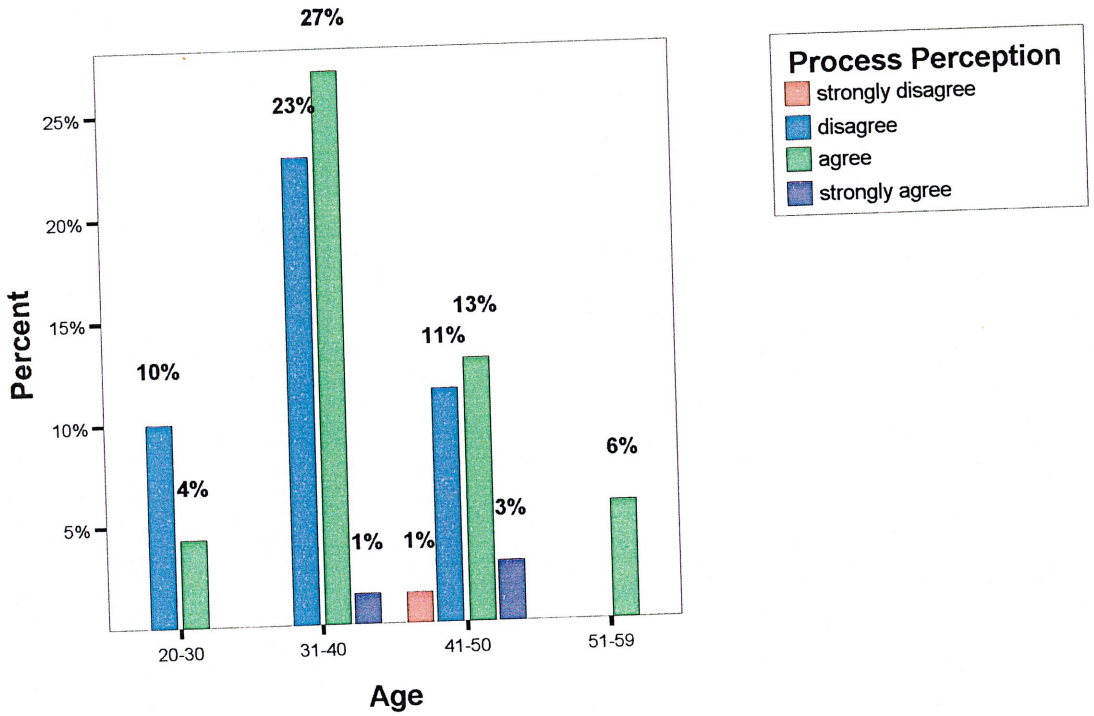
Doctors with ages from 31-40 years were the most agreed most with the structure of the hospital as indicated in graph 1.8

Doctors' Perception Structure
Graph 1.8



Doctors in the age group from (31-40 years) were more agreed on the processes than the other age categories, as indicated in graph 1.9.

Doctors' perception process
Graph 1.9



Perception overall averages were:

- For the ages from 20-30 years, the averages were 2.96 for the median and 2.98 for the mean.
- For the ages from 31-40 years, 3.00 were the median and 2.95 for the mean.
- For the ages from 41-50 years, 3.00 were the median and 3.09 were the mean.
- For the ages from 51-59 years, 3.08 were the median and 3.10 were the mean.

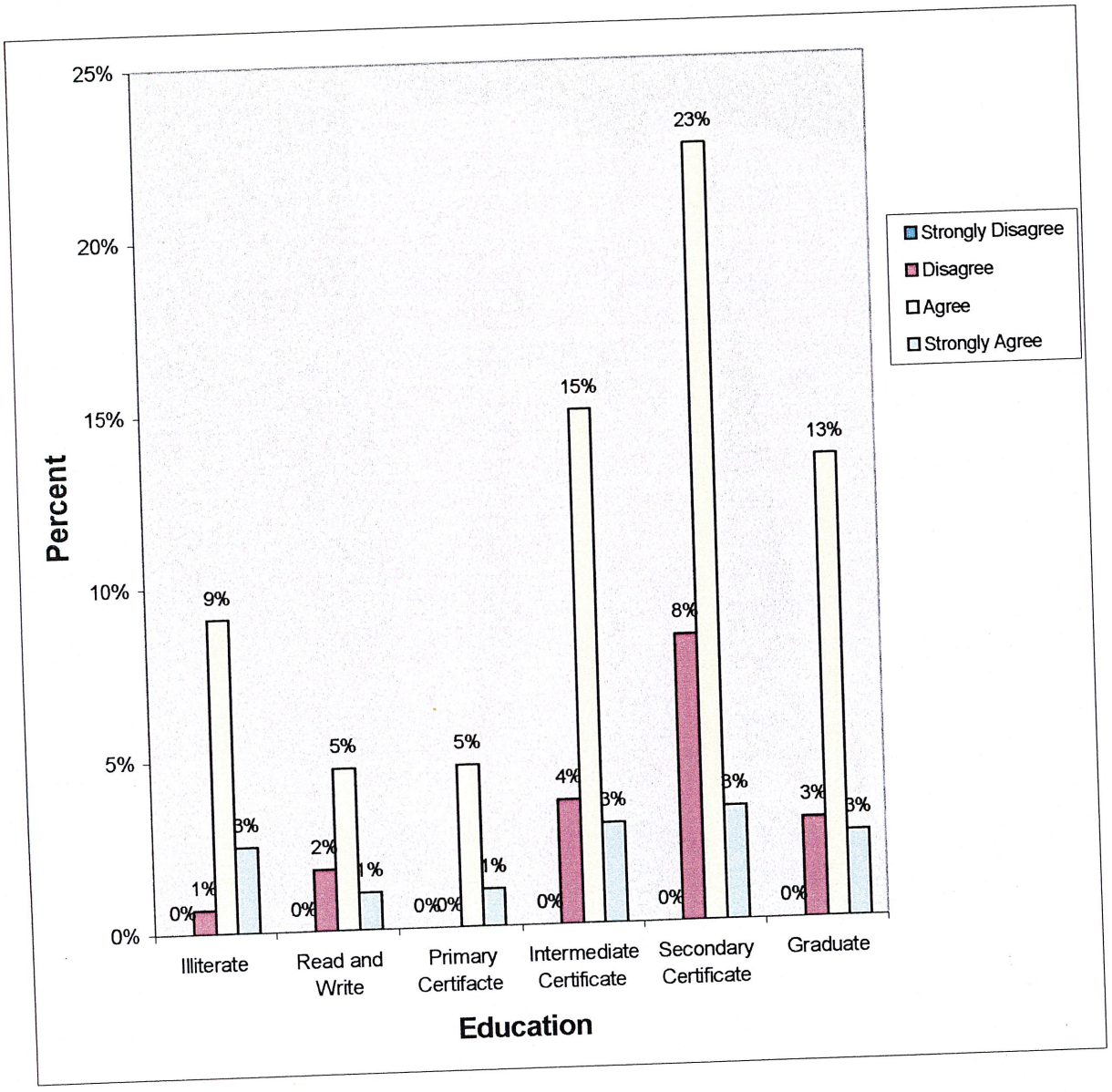
The previous graphs indicate that the young age group (between 20-31years) in all categories of participants was more satisfied with the physical setting of the hospital than the processes.

Perception statistics of patients according to level of education

Although some studies found that there is relation between the level of education and the satisfaction of respondents to the quality standard of both the physical building and the processes that carried out by the staff such as that of Marquis et al (1983)and Aiken et al, (1994) , but in this study perception structure averages, were: as indicated in graph 2, that the patients who hold secondary certificates were the most satisfied with the physical setting of the hospital, as follows:

- For the patients who were illiterate, 3.13 were the median and 3.09 were the mean.
- For the patients who were able to read and write, 2.77 were the median and 2.87 were the mean.
- For the patients who hold primary certificates, 2.96 were the median and 3.11 were the mean.
- For the patients who hold intermediate certificates, 3.00 were the median and 2.94 were the mean.
- For the patients who hold secondary certificates, 2.80 were the median, and 2.83 were the mean.
- For the patients who were graduates, 2.90 were the median, and 2.93 were the mean.

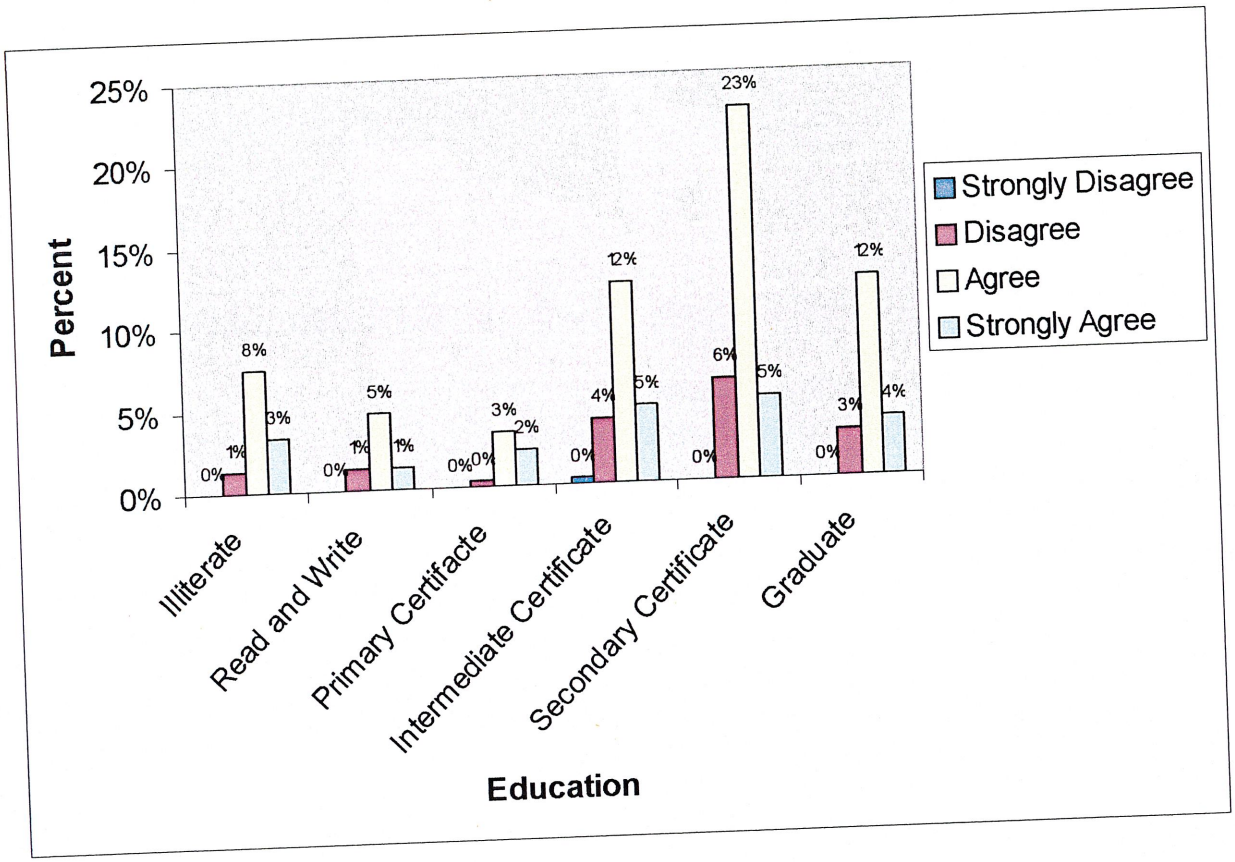
Patients' Perception Structure
Graph 2



Perception process averages, were:

- For the patients who were illiterate, 3.00 were the median and 3.09 were the mean.
- For the patients who were able to read and write, 3.17 were the median and 3.03 were the mean.
- For the patients who hold primary certificates, 3.08 were the median and 3.16 were the mean.
- For the patients who hold intermediate certificates, 3.00 were the median and 2.97 were the mean.
- For the patients who hold secondary certificates, 2.80 were the median, and 2.83 were the mean.
- For the patients who were graduates, 3.00 were the median, and 2.99were the mean, as indicated in graph 2.1.

Patients' Perception Process
2.1

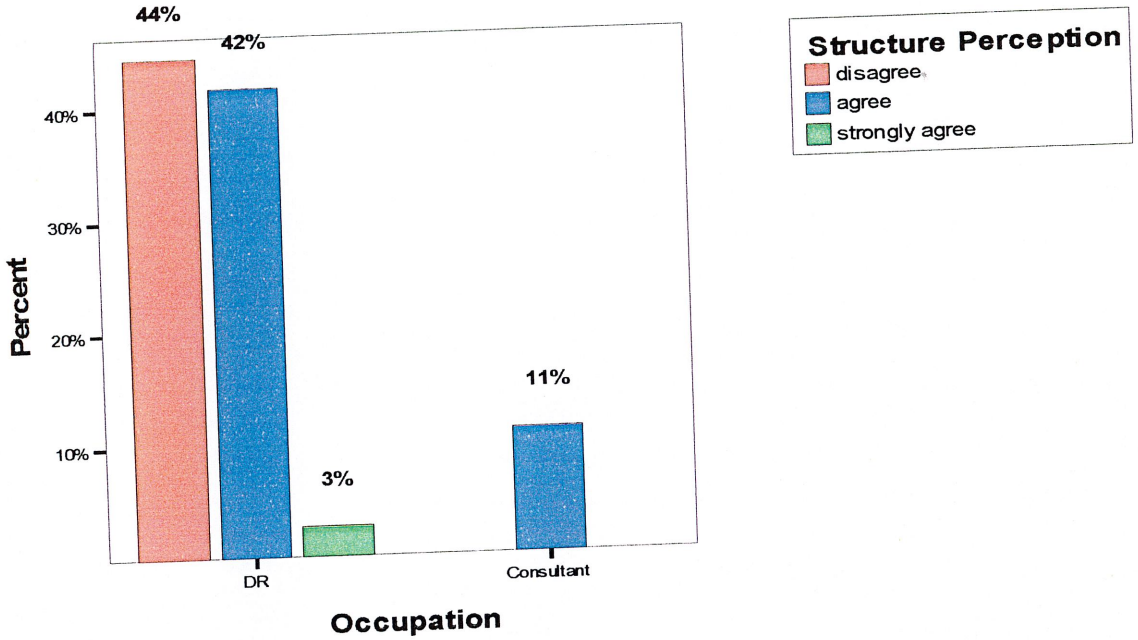


Occupation:

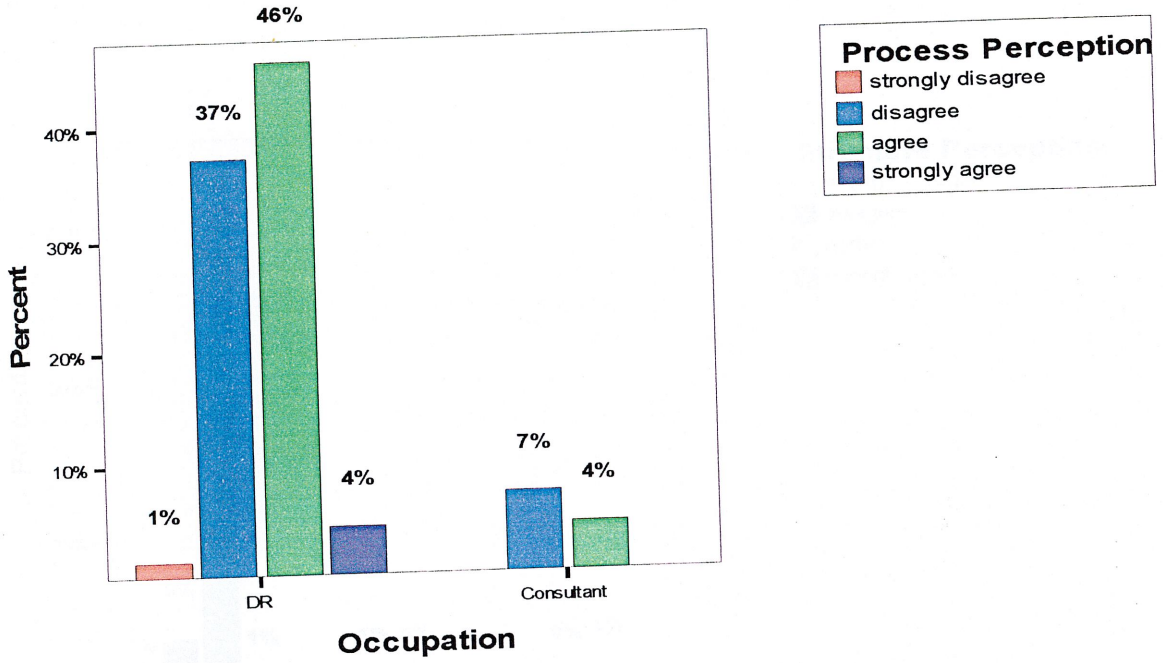
The relationship between occupation of participants towards physical settings and the processes that were carried out in the hospital were as follows:

Doctors were not satisfied (44%) with the physical settings of the hospital as indicated in graph 2.2

Doctors' Perception Structure
Graph 2.2

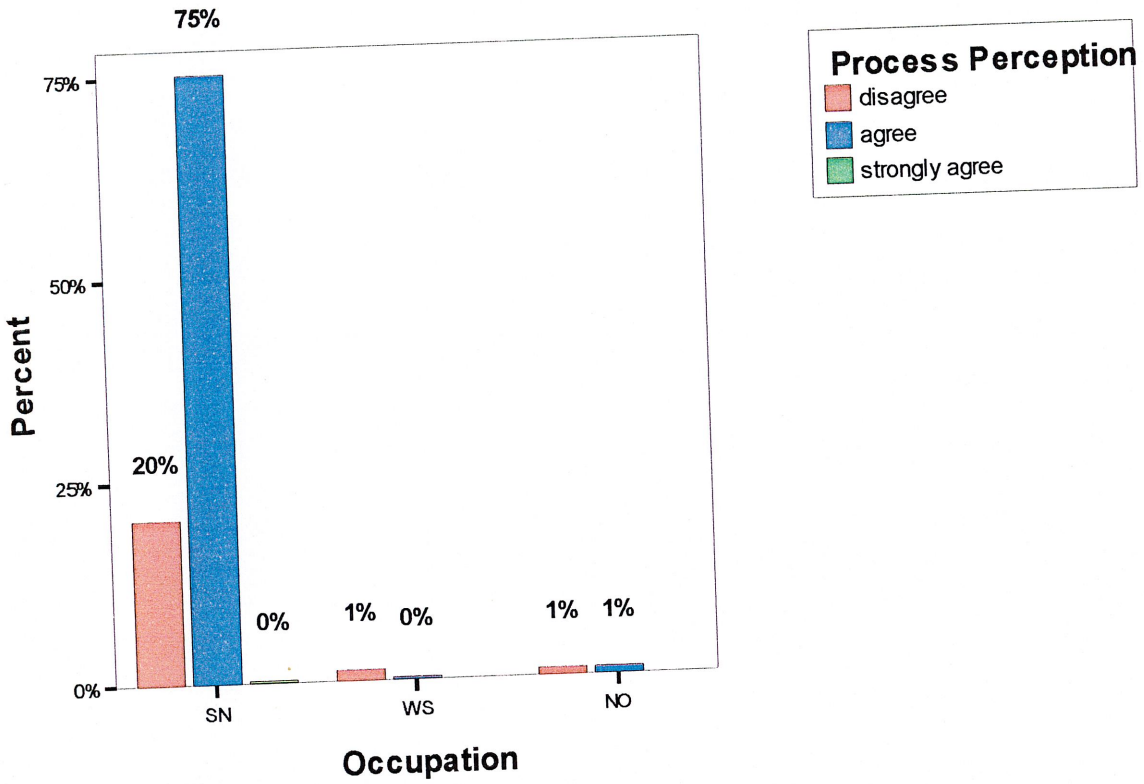


Doctors' Perception Process
Graph 2.3



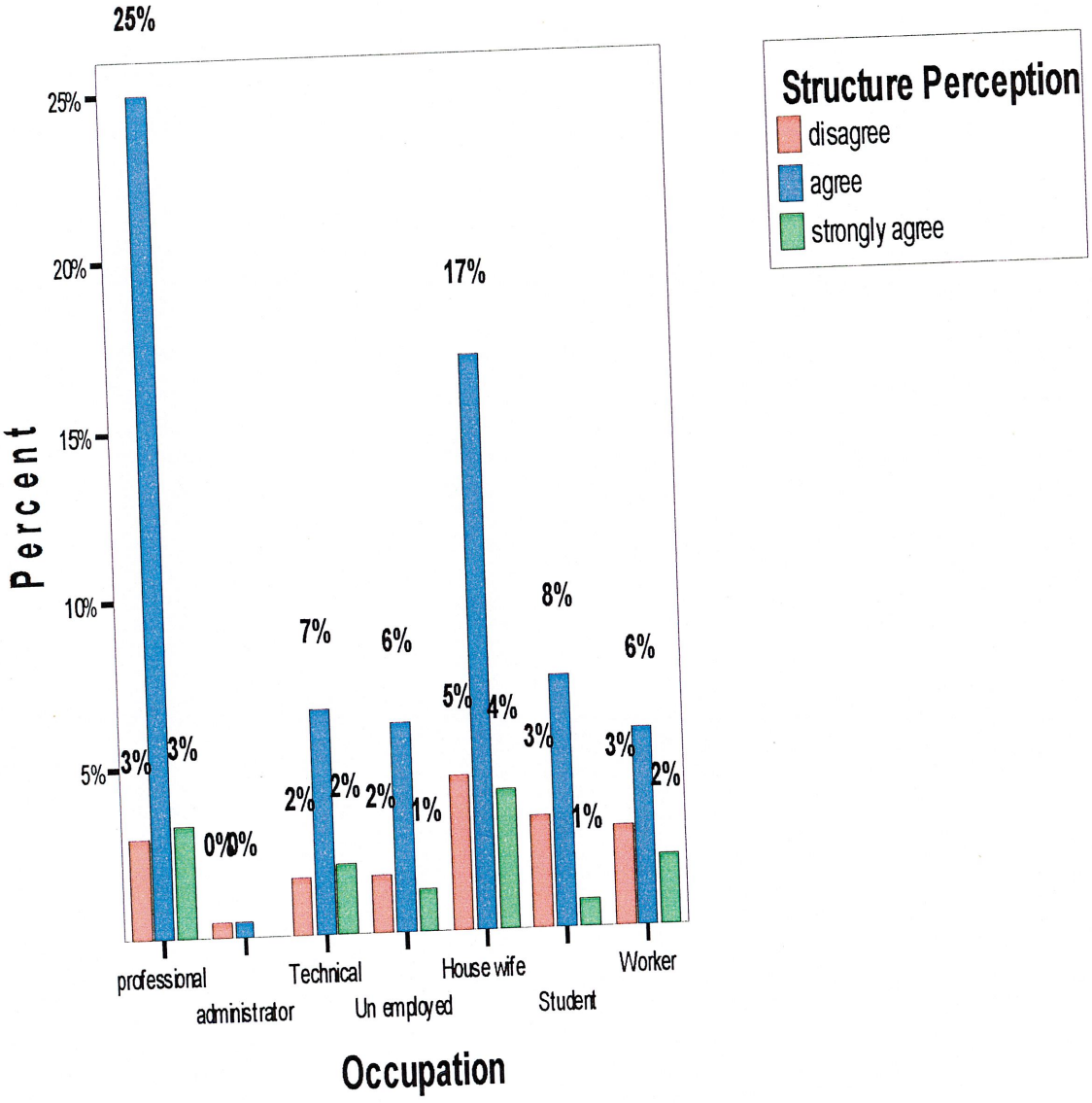
As indicated in graph 2.3, the main categories of the doctors (46%) were satisfied with the processes that are carried out in the hospital.

Nurses' Perception Process
Graph 2.5



The majority of nurses (75%) also agreed on the processes that are carried out in the hospital, as indicated in graph 2.5.

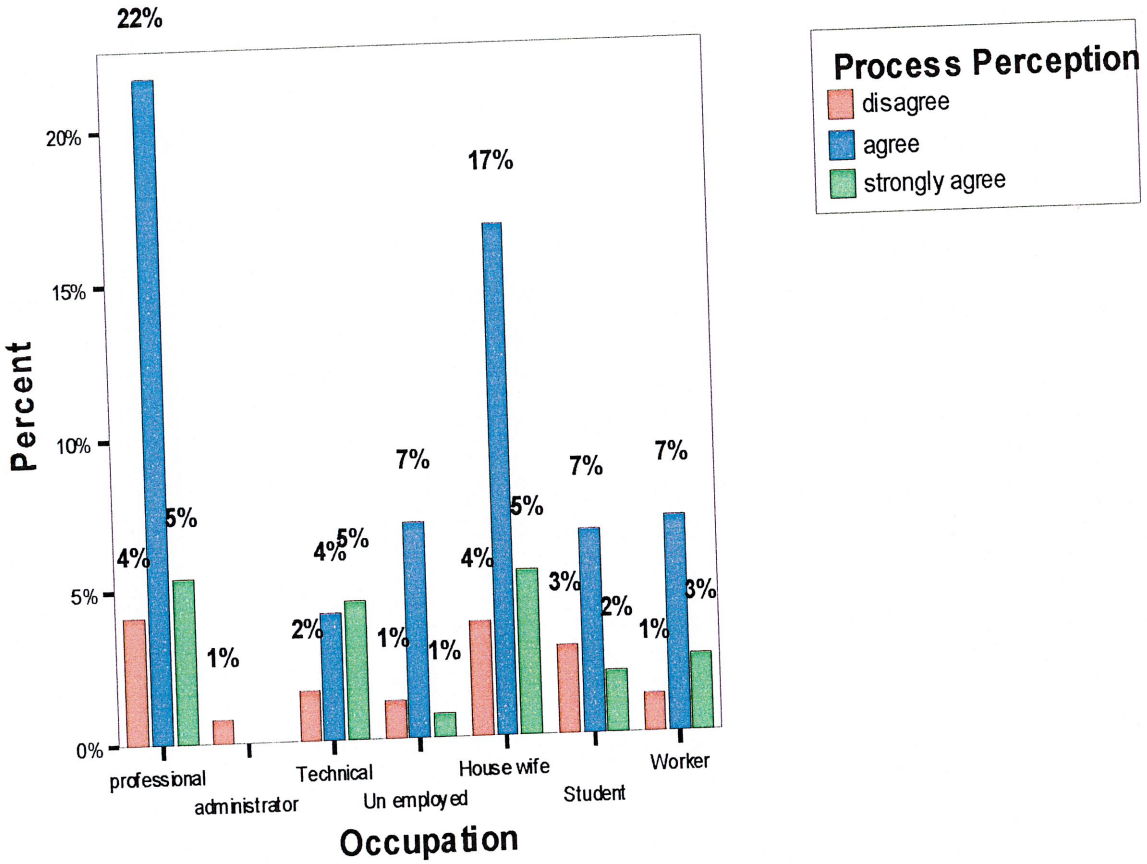
Patients' Perception Structure
Graph 2.6



As indicated in graph 2.6, the main category of patients who agreed on the physical settings of the hospital was professionals, then house wives (17%).

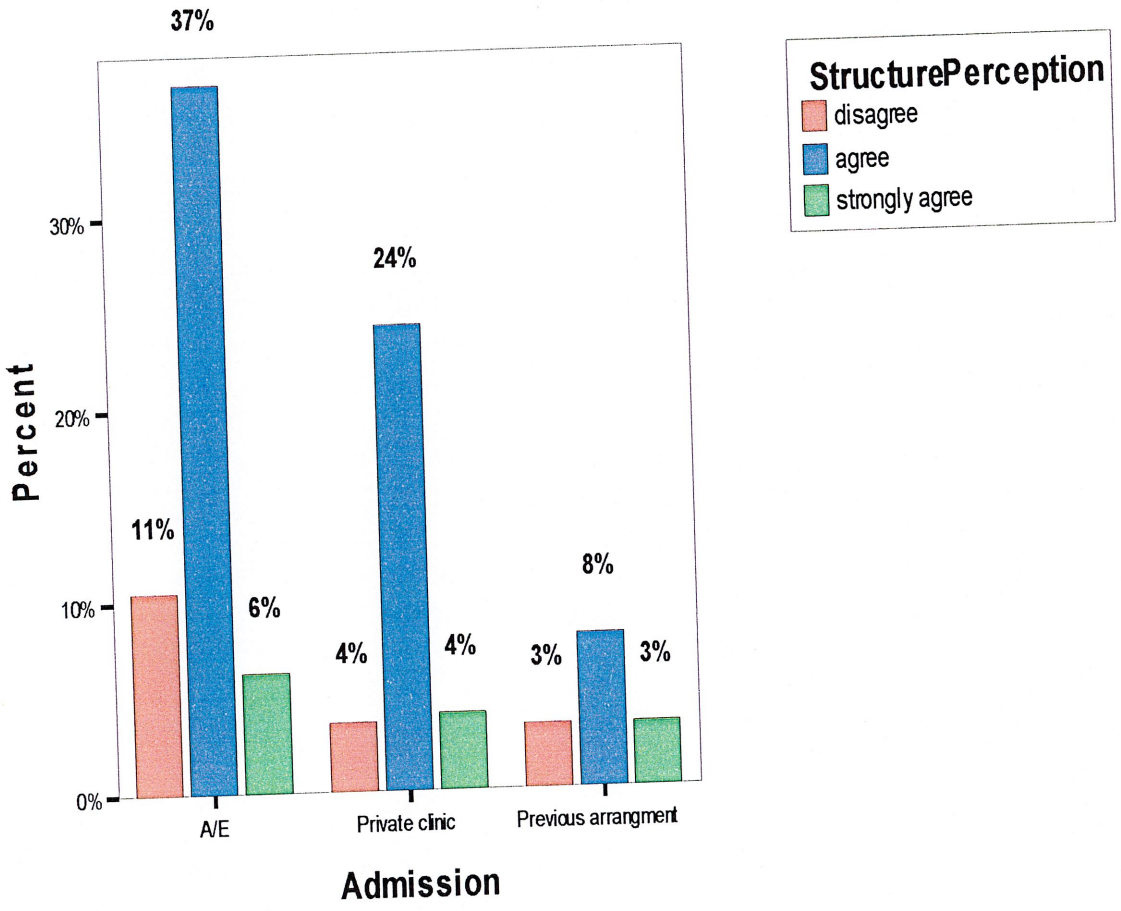
Patients' Perception Process

Graph 2.7



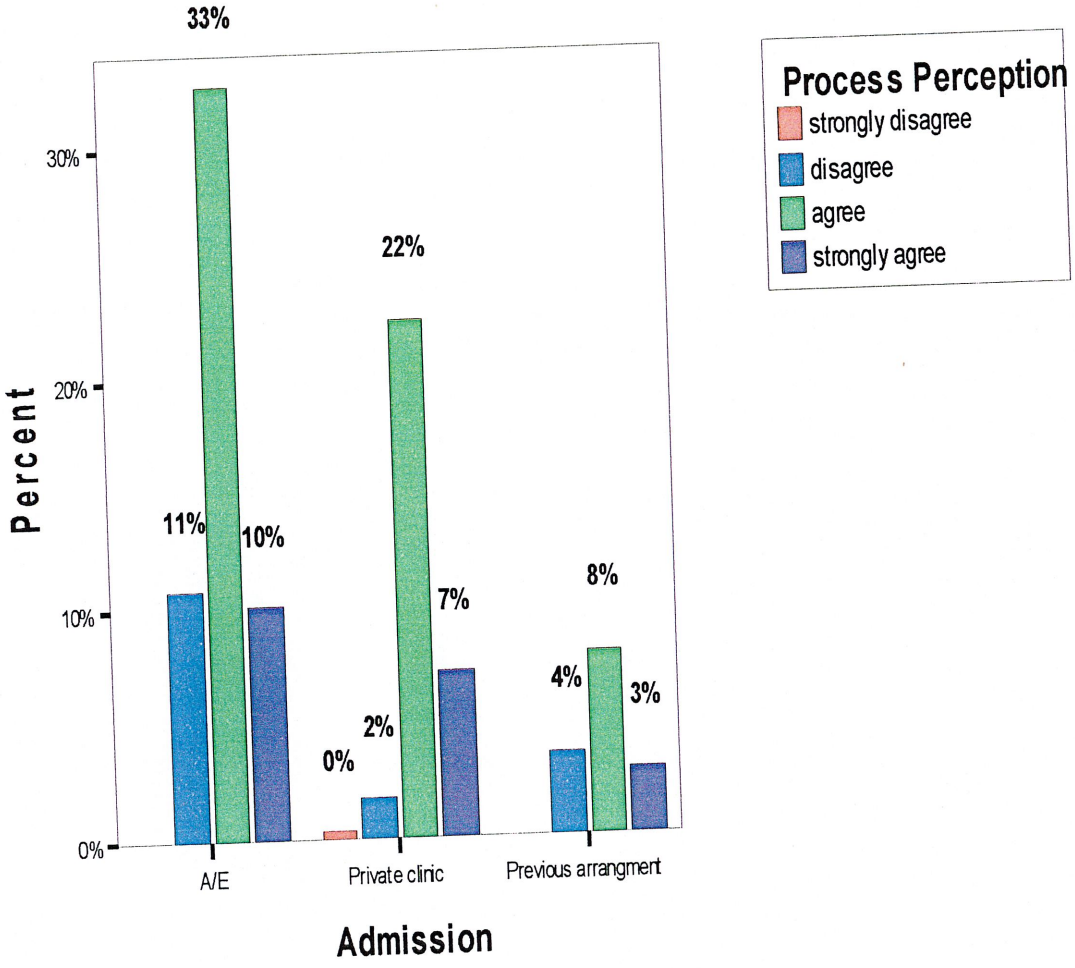
As indicated in graph 2.7, the professionally employed patients (22%) and homemakers (17%) were still the main category who agreed on the processes.

Patients' Perception Structure
Graph 2.8



Patients who were admitted through Accident and Emergency (37%) and through private clinics (24%) were the most satisfied with the physical settings of the hospital, as indicated in graph 2.8.

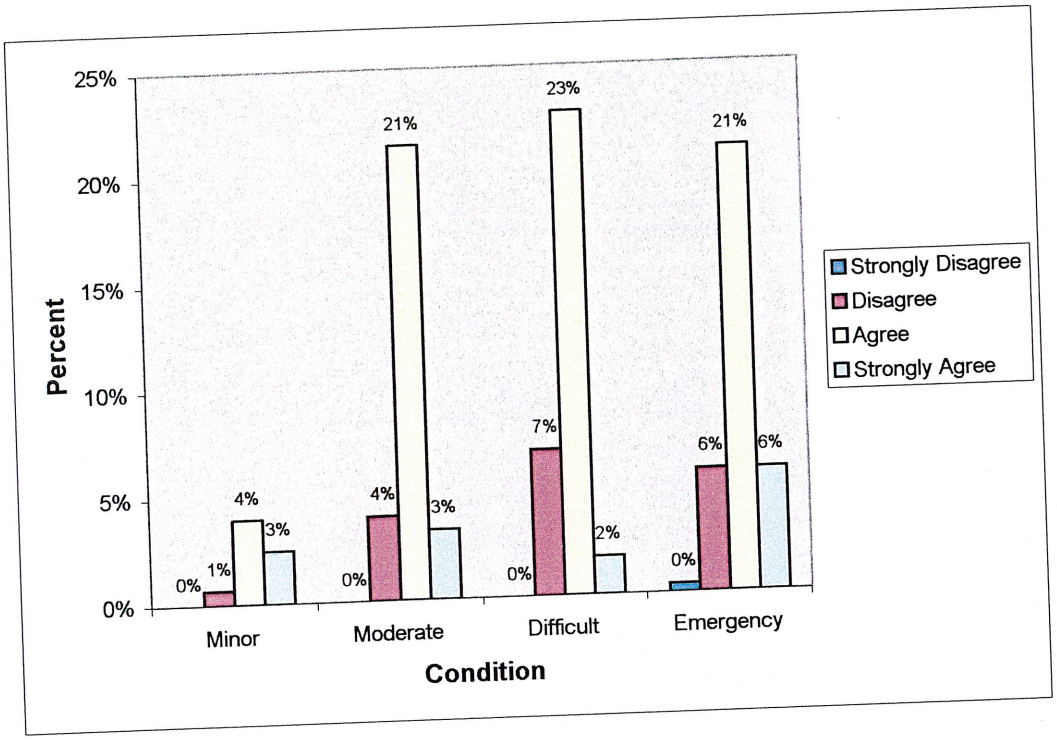
Patients' Perception Process
Graph 2.9



Patients who were admitted through the Accident and Emergency department (33%) and through private clinics (22%) were still the main category who agreed on the processes, as indicated in graph 2.9.

Patients' Perception Structure:

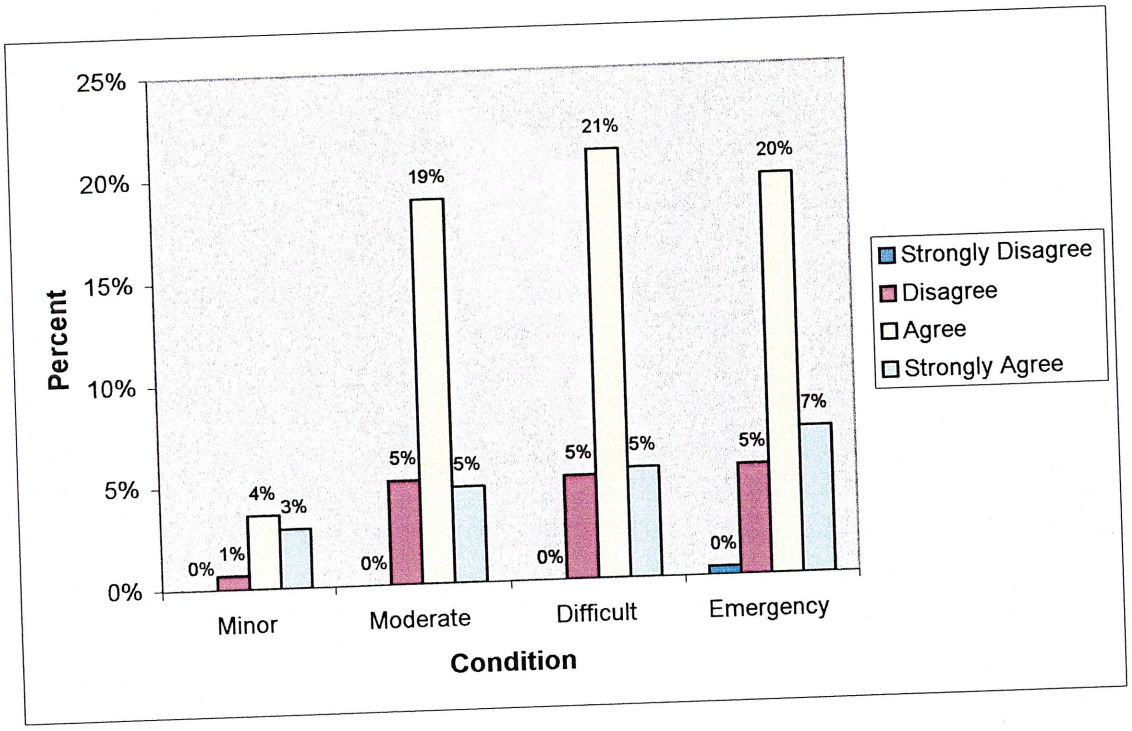
Graph 3



Patients who see their health condition as difficult, (23%), moderate (21%), and emergency (21%), were the most satisfied with the physical settings, as indicated in graph 3.

Patients Perception Process:

Graph 3.1



Patients who see their health conditions as difficult, (21%), moderate (19%), and emergency (20%) were still the most satisfied with the physical settings, as indicated in graph 3.1.

Participants' characteristics

Overall perception

The majority of all the participants who agreed on both the processes and the structure of the hospital were as follows: 69.2% of the patients, 87.8% of the nurses and 52.8% of the doctors agreed on the structure of the hospital. 63% of the patients, 76.6% of the nurses and 50% of the doctors agreed on the processes within the hospital, as indicated in tables 2.5, 2.6, and 2.7.

TABLE 2.5 (Overall perception)

Subject :(Overall perception)						
Doctor		**Nurse**		**Patient**		
Perception Process Average	Perception Structure Average	Perception Process Average	Perception Structure Average	Perception Process Average	Perception Structure Average	
%	%	%	%	%	%	
1.4%	.0%	.0%	.5%	.4%	.0%	Strongly disagree
44.3%	44.4%	22.9%	10.7%	16.3%	17.4%	Disagree
50.0%	52.8%	76.6%	87.8%	63.0%	69.2%	Agree
4.3%	2.8%	.5%	1.0%	20.3%	13.4%	Strongly agree

Structure Items

TABLE 2.6: perception of participants towards the physical setting of the hospital

			strongly disagree	disagree	agree	strongly agree
Subject	Patient	hospital makes patients feel comfortable	2.7%	11.2%	62.5%	23.6%
		medical facilities are complete	2.1%	3.8%	60.0%	34.2%
		number of nurses is sufficient	23.9%	23.9%	33.8%	18.3%
		number of doctors is sufficient	10.0%	24.7%	42.0%	23.3%
		patient's room is clean comfort and	6.3%	13.0%	50.9%	29.7%
		patients' areas are restful peace and	5.8%	13.6%	53.3%	27.2%
		patients have privacy	2.6%	6.3%	58.2%	32.8%
		quality of food overall is good	17.6%	31.0%	38.8%	12.7%
		hospital environment other than	3.1%	15.1%	60.9%	20.9%
		signs and directions are clear	.0%	4.0%	51.4%	44.7%
		hospital building overall is excellent	2.0%	8.4%	59.2%	30.4%
		there is always parking space	34.6%	35.4%	23.2%	6.8%
		Hospital policies and procedures are	2.6%	10.8%	60.3%	26.3%
	Nurse	hospital makes patients feel comf	3.5%	16.9%	72.7%	7.0%
		medical facilities are complete	2.3%	18.7%	68.4%	10.5%
		number of nurses is sufficient	17.1%	45.2%	34.7%	3.0%
		number of doctors is sufficient	16.4%	19.7%	49.3%	14.5%
		patient's room is clean comfort and	6.0%	13.7%	67.3%	13.1%
		patients' areas are restful peace and	1.5%	5.9%	72.3%	20.3%
		patients have privacy	9.3%	32.2%	55.1%	3.4%
		quality of food overall is good	6.5%	30.0%	48.5%	15.0%
		hospital environment other than	3.5%	21.8%	59.9%	14.9%
		signs and directions are clear	3.0%	8.9%	60.4%	27.7%
		hospital building overall is excellent	5.0%	6.5%	76.0%	12.5%
		there is always parking space	4.5%	11.2%	68.7%	15.6%
		Hospital policies and procedures are	7.0%	29.0%	46.5%	17.5%
	Doctor	hospital makes patients feel comf	1.5%	31.8%	57.6%	9.1%
		medical facilities are complete	4.2%	29.6%	57.7%	8.5%
		number of nurses is sufficient	22.6%	59.7%	11.3%	6.5%
		number of doctors is sufficient	6.3%	39.7%	49.2%	4.8%
		patient's room is clean comfort and	7.1%	39.3%	48.2%	5.4%
		patients' areas are restful peace and	5.8%	27.5%	59.4%	7.2%
		patients have privacy	8.8%	27.9%	58.8%	4.4%
		quality of food overall is good	9.0%	40.3%	41.8%	9.0%
		hospital environment other than	18.0%	42.6%	32.8%	6.6%
		signs and directions are clear	7.4%	39.7%	47.1%	5.9%
		hospital building overall is excellent	1.5%	35.8%	56.7%	6.0%
		there is always parking space	10.8%	29.2%	47.7%	12.3%
		Hospital policies and procedures are	6.3%	41.3%	47.6%	4.8%

Process Items: Perception of participants towards the processes of the hospital

TABLE 2.7

			strongly disagree	disagree	agree	strongly agree
Subject	Patient	patients have choice	8.9%	18.8%	52.1%	20.2%
		patients are receiving	5.7%	15.9%	55.7%	22.8%
		patients family were kept	4.0%	11.6%	56.3%	28.1%
		medicines and ivs are	1.2%	6.5%	55.7%	36.6%
		patients are always	10.7%	19.9%	54.4%	15.0%
		patients were told what	3.0%	10.0%	64.8%	22.2%
	Nurse	patients have choice	4.5%	14.2%	71.0%	10.2%
		patients are receiving	3.2%	36.9%	41.2%	18.7%
		patients family were kept	2.1%	32.3%	49.7%	15.9%
		medicines and ivs are	6.5%	18.4%	52.2%	22.9%
		patients are always	24.5%	45.1%	28.8%	1.6%
		patients were told what	14.9%	31.5%	45.3%	8.3%
	Doctor	patients have choice	3.3%	24.6%	54.1%	18.0%
		patients are receiving	10.8%	40.0%	40.0%	9.2%
		patients family were kept	3.1%	42.2%	48.4%	6.3%
		medicines and ivs are	4.9%	34.4%	54.1%	6.6%
		patients are always	25.0%	45.3%	26.6%	3.1%
		patients were told what	14.1%	53.1%	29.7%	3.1%

Overall perception:

Perceptions of the doctors (averages) were:

The general doctors were more agreed (42%) on the structure and the processes than the consultants (11%).See graphs 2.2, and 2.3.

The staff nurses were more agreed (85%), than the ward supervisors (1%), and the nursing officers (1%).See graphs 2.4, and 2.5.

The professional patients were more agreed (25%), than other occupations, such as homemakers (17%), students (8%), technical (7%), and workers (6%). See graph 2.6, and 2.7.

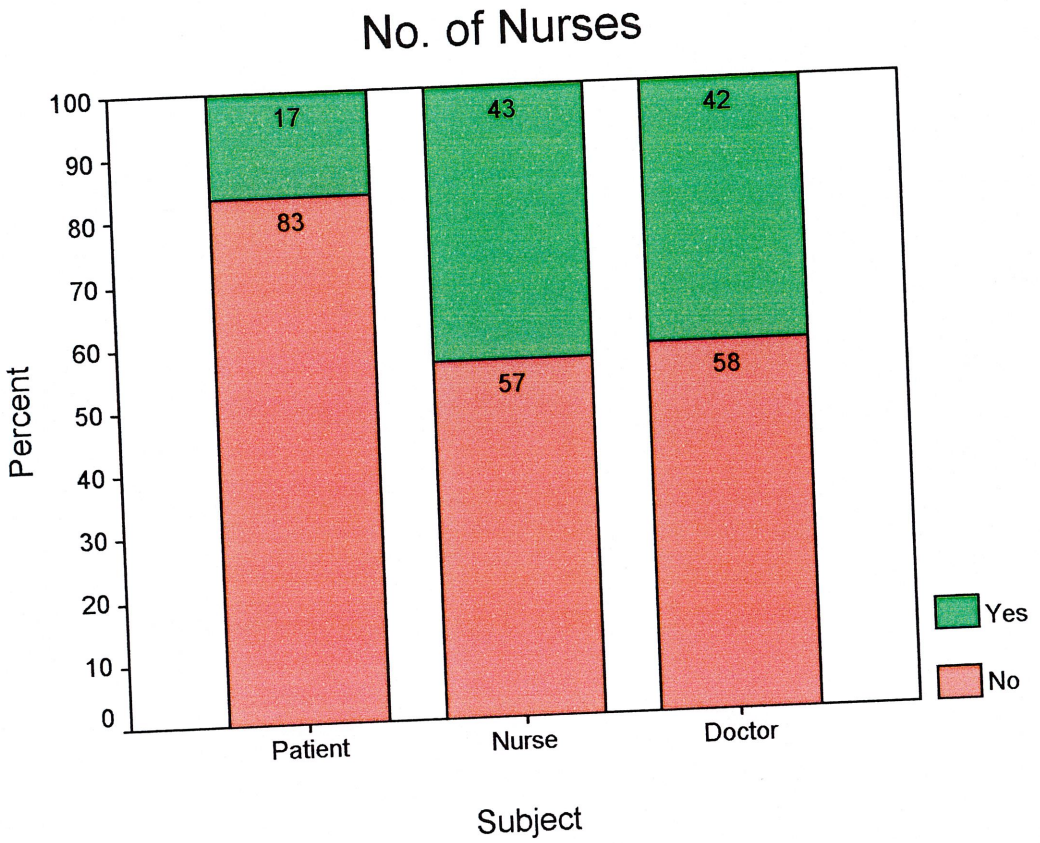
There is no relation between the level of patients' education and their perception of the physical setting and the processes. The secondary certificates holders were the most satisfied with the care (22%), and then the graduates (13%), literates were (9%). Both the intermediates and primaries were (5%).

Patients, who see their health condition as difficult, were more satisfied with the care (23%), those who see their conditions as moderates and emergency, were also satisfied (21%). Those who see their conditions as minor were the least satisfied (4%).

Suggestions of participants to improve the quality of health services in the Kingdom of Bahrain

Sufficient number of nurses

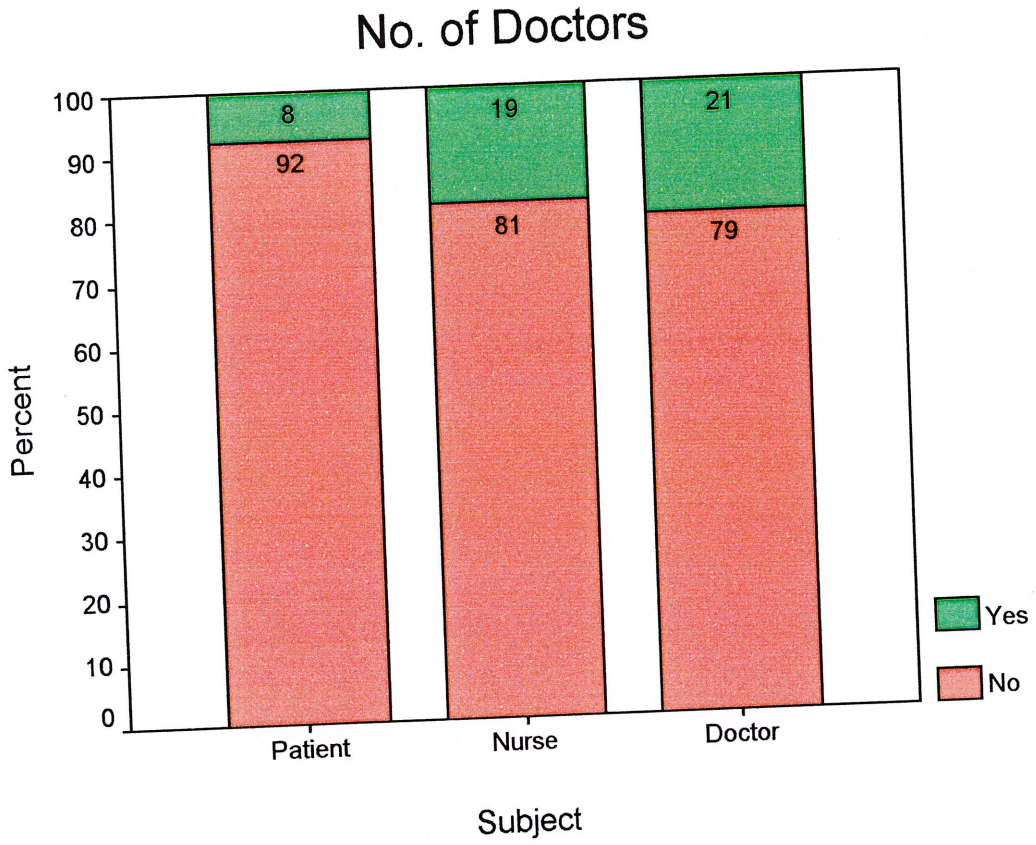
Graph 3.2



The answers to the question are the number of nurses and doctors sufficient were as follows:

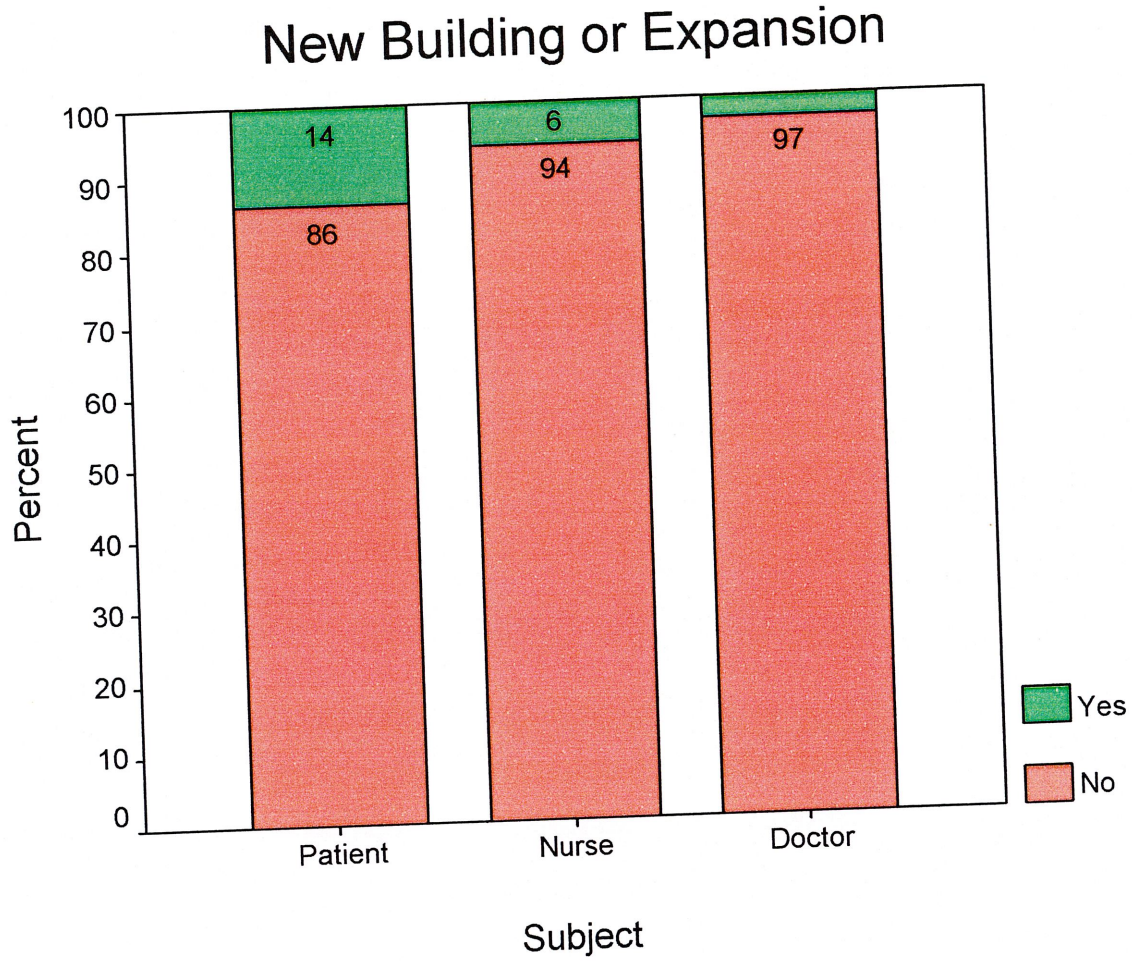
17% of patients, 43% of nurses, and 42% of doctors stated no to the suggestion of increasing the number of nurses, as indicated in graph 3.2.

Sufficient number of doctors
Graph 3.3



8% of patients, 19% of nurses, and 21% of doctors only responded positively to the suggestion of increasing the number of doctors, as indicated in graph 3.3.

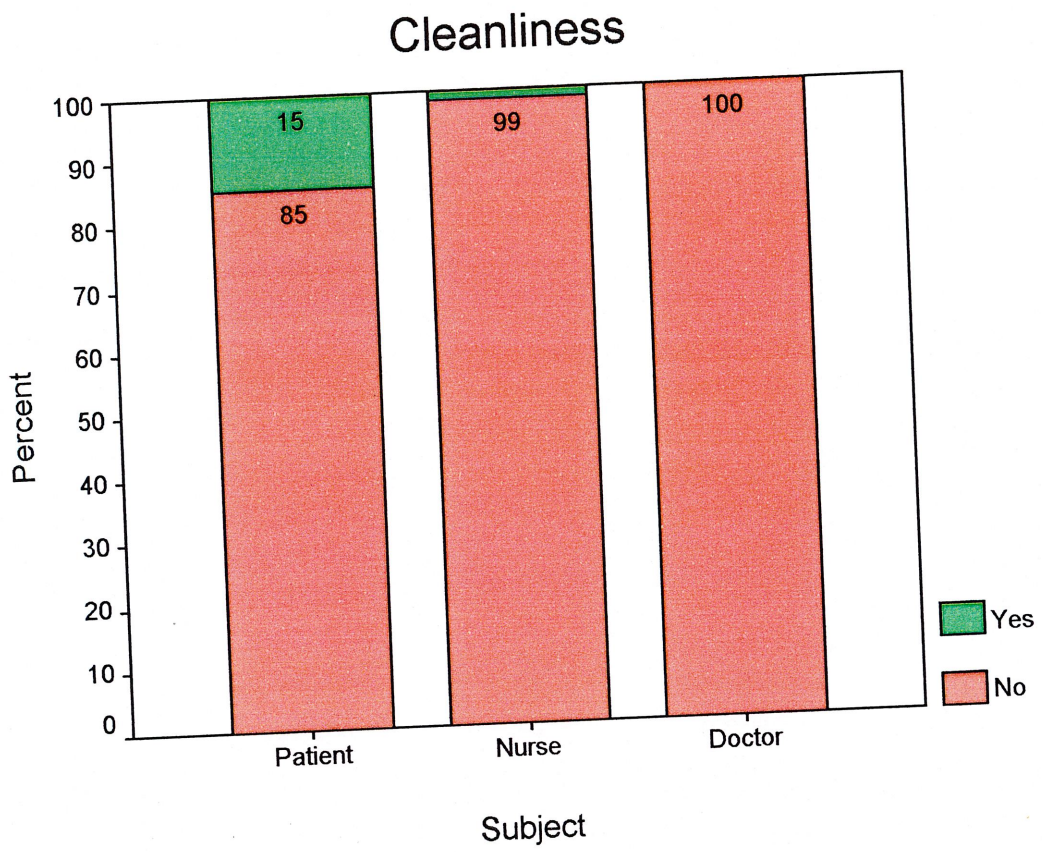
Suggestion to have either a new building or to have an expansion to The existing building: Graph 3.4



14% of patients, 6% of nurses, and none of the doctors responded positively to the suggestion to have a new building or to have an expansion to the existing building, as indicated in graph 3.4

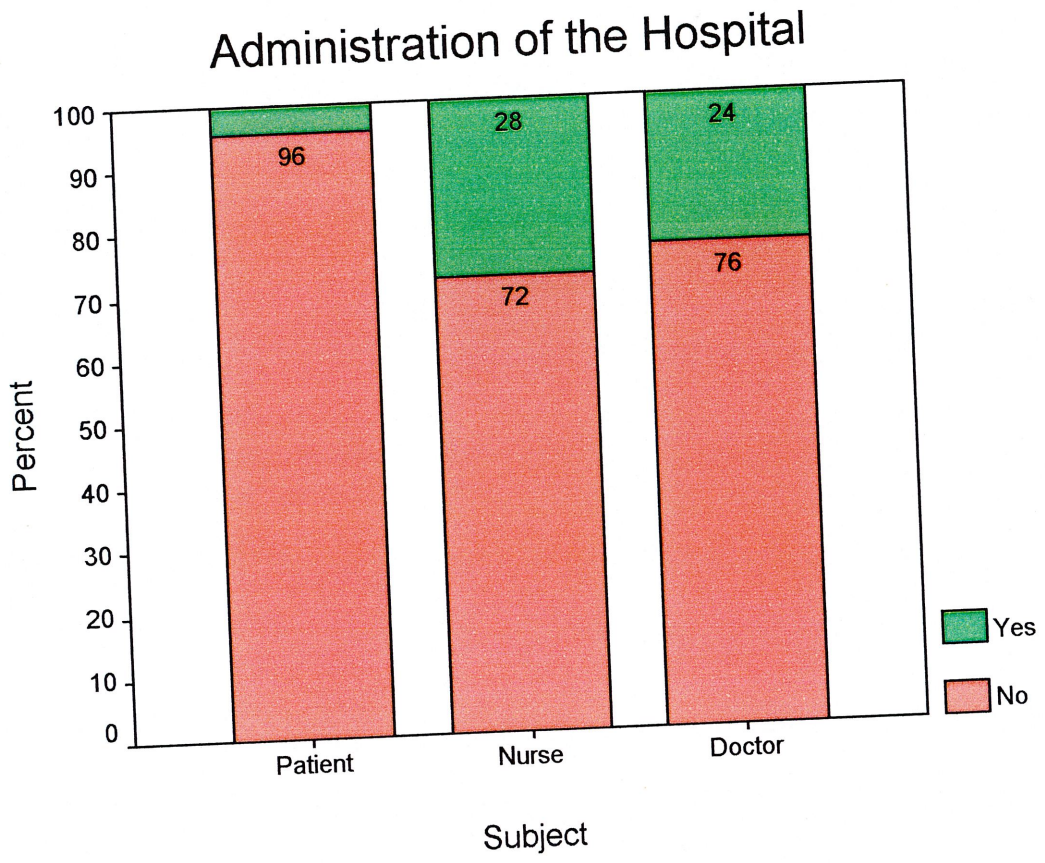
Out of the 553 respondents who completed the suggestion form, only 15 suggested that the hospital needed better cleanliness; the remainder had no suggestions to this particular question. Others, such as nurses and doctors also did not have any suggestions. See graph 3.5

Cleanliness of the hospital
Graph 3.5



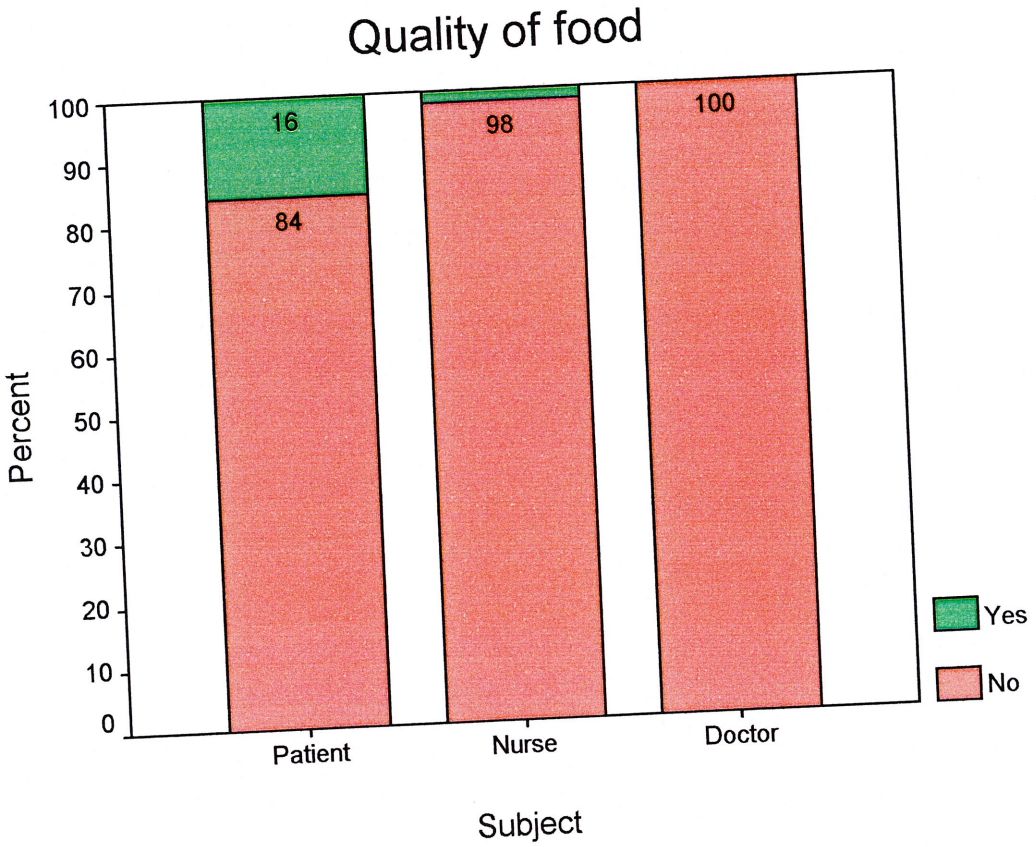
Patients made no suggestions regarding the administration of the hospital, although some nurses (28%) and doctors (24%) suggested some improvement was required. See graph 3.6

Suggestion to improve the administration of the hospital
Graph 3.6



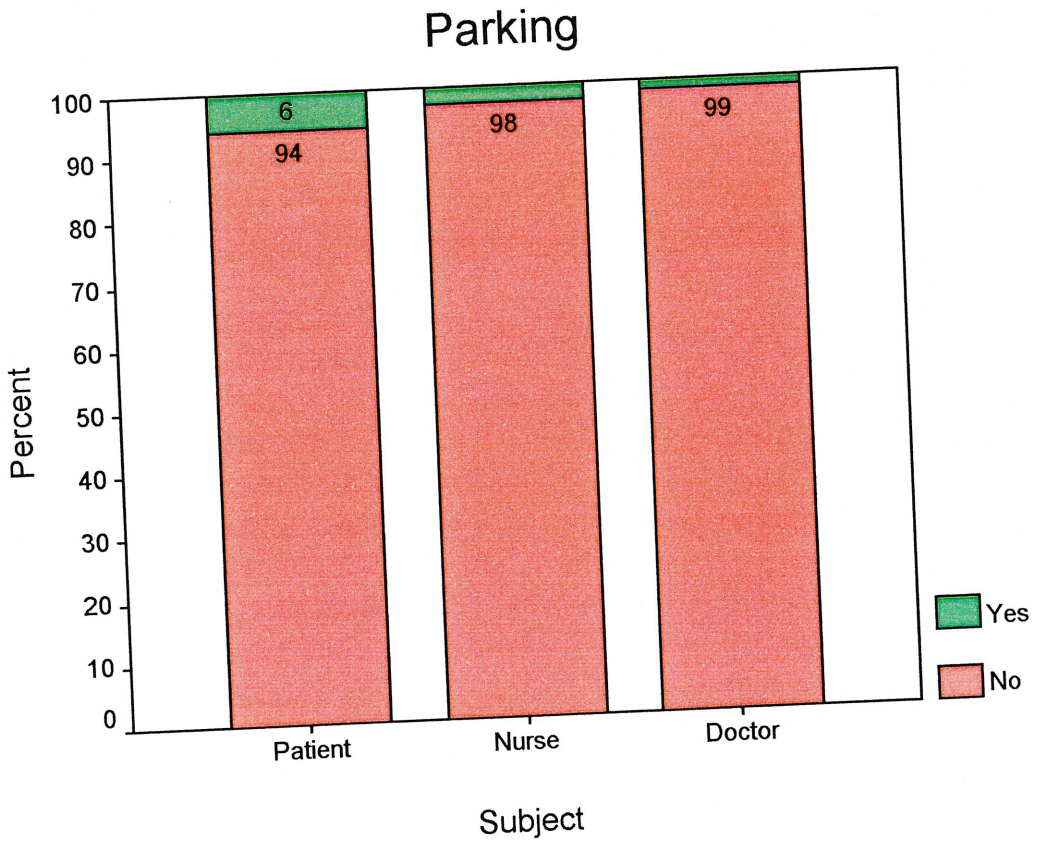
The researcher has examined the quality of food at a Bahraini hospital from the respondents own view as the quality of the food may also affect the patient's view of the quality of the hospital. The image of a hospital is important for enhancing the patient's reassurance and relief from possible anxiety (Zeev, 1983). The researcher found that Very few patients said 'Yes the hospital food needs to be looked at' (15), Nurses and doctors had no suggestions, as indicated in graph 3.7.

Quality of food
Graph 3.7



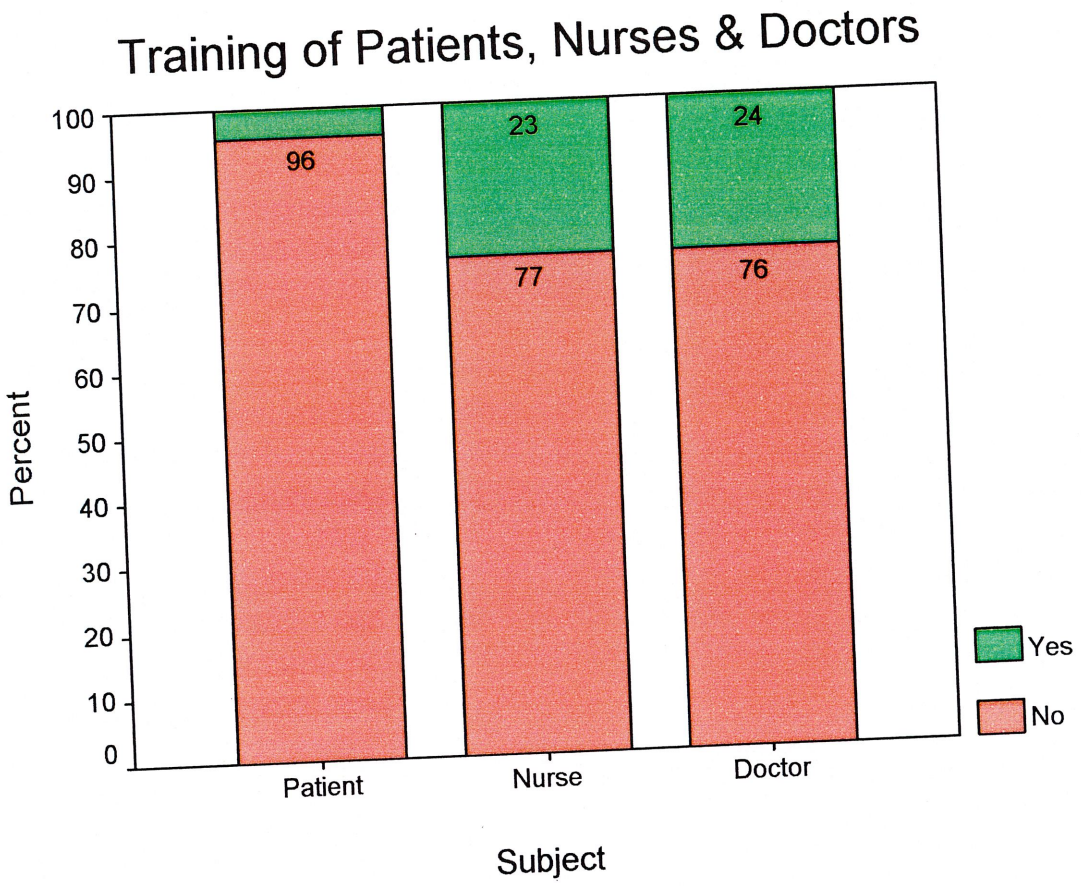
Almost non of the participants made suggestions regarding the parking space, although they were not satisfied with it .See graph 3.8

Parking space at the hospital
Graph 3.8



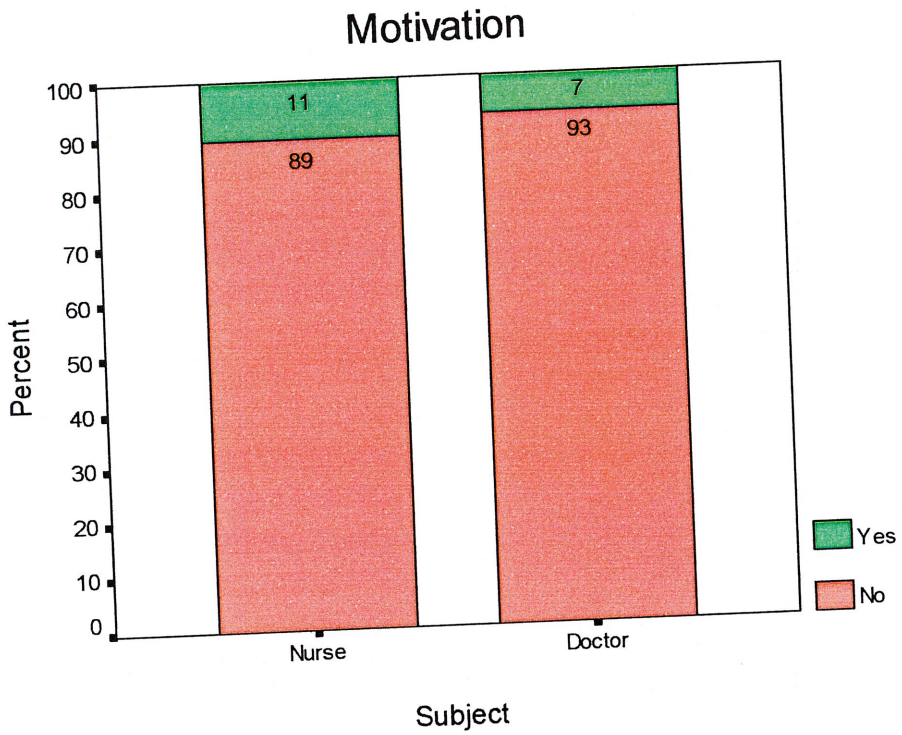
Training of patients, nurses and doctors

Graph 3.9



24% of doctors and 23% of nurses suggested better training was required, without stating what training they required. See graph 3.9

Motivation of nurses and doctors to improve their productivity
Graph 4



11% of nurses and 7% of doctors felt that they required more motivation to increase their productivity, as indicated in graph 4.

Conclusion

The main findings of this research understand the nature of the context of health services in Bahrain. The researcher also provided theoretical and practical basis for quality management initiatives within the Bahraini health services. ,Overall, the results reveal that the socio cultural and political issues has an impact on the perceptions of the respondents the participants were generally satisfied with the quality of the physical settings and the processes of care within the Salmaniya Medical Complex in Bahrain.

The government by the political reform had bolster investor and consumer confidence, (Arabic News, 2003) but the study was conducted in year 2000 were the democracy not yet been congested by the people in general and by the respondents in this research in specific.

However, we have to be cautious given the political and social context within which the survey took place. However, the survey raised a number of suggestions, such as increasing the number of nurses and doctors, and improving the administration and management of the hospital. Clearly, such suggestions demand interventions from the government for any meaningful implementation of quality management in the health service. Furthermore, one might inquire as to why if the participants were satisfied with the quality of heath- care; they still feel the need for improvement. Self evidentially, as this study was conducted in 2001, democracy was in its infancy in Bahrain and such findings might be considered as an indicator of a perception of threat that prevented the respondents from freely raising their opinions, which ultimately contradicts principles of quality management.

However, a key aspect of quality management is that improvement is continuous. Therefore, this level of satisfaction reported in the survey may also indicate that reforms in Bahrain have not been fully digested by the public, as mentioned earlier. Participants might have felt that they were not allowed to participate, both politically and administratively. Indeed, they may have thought that it is safer to make suggestions rather than disagree with the quality of care provided by the Ministry of Health. This argument will be further explored in the next chapter.

Chapter 5

INTERPRETING THE RESULTS: AN ASSESSMENT OF THE QUALITY OF HEALTHCARE IN BAHRAIN

Introduction

A major objective of this research was to explore the opinions of patients and professionals (nurses and doctors) with regard to the quality of health services in Bahrain. This was also seen as part of the preparation to incorporate the needs of patients, nurses and doctors as future users of the planned new general hospital in Bahrain. Based on the research findings presented in the previous chapter, it is now possible to identify their needs and to make suggestions to improve the quality of healthcare in the health sector in Bahrain. Overall, the participants in the survey appeared satisfied with the care provided, but this finding alone does not necessarily lead us to conclude that they are experiencing high quality care.

The dissertation has already explored this assumption. This chapter begins with an interpretation of the results, which points to the importance of education when explaining levels of satisfaction with the quality of care. The chapter also considers the accuracy and generalisability of the research findings and highlights the limitations of the study. Finally, a theoretical model is presented, based on the research findings, to assist in understanding the context of quality management in Bahrain.

1. Interpretation of the results

An interpretation of the results involves exploring the meaning of the results, importance of the results, and accuracy of the results and generalisability of the results (Polite and Hungler 1993:377). This section will be guided by this approach.

I: Meaning and importance of the results

The majority of the participants were satisfied with the quality of care provided. Although this seems an obvious point to make, satisfied patients are less likely to reject health plans and resort to litigation and are more likely to return to a physician or hospital (Ware and Hays, 1988; Weiss and Senf, 1990; Steiber and Krowinski, 1990). The kind of medical care those patients find satisfying also tends to make them more compliant with their treatment regimes and thereby produce better clinical outcomes (Greenfield et al, 1985). Satisfied patients also tend to improve the quality of the work experience for providers, reducing staff turnover and burnout.

When the study was conducted, it was possible that respondents were unsure as to whether or not they were allowed to express their opinions freely with regard to a government provided service. Therefore, results may be biased towards expressing satisfaction, simply because respondents thought it would be politically 'safer'. This is despite the apparent freedoms of the new Constitution which:

> '*...provides for the right to express and publish opinions under the rules and conditions laid down by law, provided that the fundamental beliefs of Islamic doctrine are not infringed, the unity of the people is not prejudiced and discord*

or sectarianism is not aroused, in practice, the Government limited this right, particularly in the media' (Bureau of Democracy, Human Rights, and Labour, 2003:2).

In this study, the patients appeared to be more concerned about the structure of the hospital and its physical settings rather than the quality of care. This is similar to the study carried out by Essen and Sjoden (1991) in which they found, that patients were more discriminating than nurses in the importance attached to various caring behaviour. While nurses viewed emotional needs as most problematic, patients were more concerned with physical needs.

On the other hand, professionals tended to concentrate on aspects of care. It might be because patients may feel less able to form opinions about aspects of care or the procedures carried out by the professionals, or it might be that the procedures were of a sufficiently high standard, that the impact on the variation in patients' satisfaction seen in this study was minimal.

It is also more likely that patients in this study based their opinions about their hospital on the structure rather than the procedures, because they may regard the structure as more personally meaningful than the processes. Previous research also suggests that patients and staff do not always focus on the same areas when they rate quality of care, (Arnetz and Arnetz, 1996). This data also suggests that even though patients, from their vantage point, might be satisfied with the care provided, professionals typically express a great need for further improvements.

In this study, the socio-demographic categories have demonstrated no consistent relationships with service satisfaction. Typically, increased service satisfaction was found to be significantly and positively associated with being older, (Pascoe, 1983), and being female, (Pascoe, 1983; Taylor et al 1981, Strasser et al, 1992). However, in this study, it appears to be different; males aged between 20-40 years are more satisfied with the quality of care in Bahrain than the elderly or very young females. It might be because the majority of our population is of this age: out of a total population of 650,604, 358,789 are aged between 20-49 years, (Bahrain Health Statistics, 2001). Out of the total population in the country, only 2.5% are 65+ years.

Generally, older people are more satisfied with medical care (Gray, 1980, Dimatteo and Hays, 1980). This is probably due to greater continuity of doctor-patient relationships and their lower expectations about patient involvement in care. The fact that younger people tended to participate in this study rather than the elderly (see chapter 4, page 93) is a reflection of the age profile of Bahrain as a whole (Bahrain Health Statistics, 2002:1-3).

Because the main category of the study participants were female (62.2%), the overall perception was that females were more satisfied with the physical settings and the care provided in the hospital. The reason for less male participants might be due to the fact that males were more affected by the political situation in Bahrain than females, because they suffered more as a group during the period from 1990 to 2000. Therefore they may think it is better not to participate in such studies, due to perceptions about the political situation in Bahrain at the time of collecting the data (see chapter 1, page 23).

Out of the 276 patients who participated in this study, 14.5% who call themselves 'professional' were satisfied with the care provided, although 34.1% of them are secondary certificate holders. The next more satisfied group of patients were house wives, 12%. This indicates that the relationship between education and satisfaction is rather weak, (see pages 114 and 115).

Although some studies carried out in Western countries found that poor people have poorer health, get poorer healthcare, have less continuous relations with doctors, and have harder times getting appointments, they are also treated differently from privately insured patients to some degree. Consequently, they tend to be less satisfied (Patrick et al, 1983; Chaska, 1980, and Calnan, 1988). However, from the research we found that there is a weak relationship between occupation and the satisfaction of the respondent to the quality of the health sector in Bahrain as was mentioned earlier, this might be again due to the socio political reasons were the respondents afraid fully express their opinions.

Over a quarter of the population in Bahrain are secondary certificates holders (26.4%). Out of the total population in Bahrain (672,123),only 0.3% hold doctoral degrees, 1.1% are masters' degree graduates, 2% have a bachelor's degree, 26.4% are secondary certificate holders, 15.9% have preparatory certificates, 11.1% have primary certificates, 10.6% can read and write, and 13.5% are illiterate (Health Statistics, 2002:2-6). Therefore, it is logical to assume that most of our participants are from this level of education (secondary certificate holders' level). The researcher thinks that this demonstrates the phenomena of promotion and placement of candidates in high positions in Bahrain without appropriate academic qualifications. They are considered to be professionals; although over a quarter (34.1%) are only secondary certificate holders.

The researcher also thinks that democracy in Bahrain may still need time to overcome the bureaucratic inflexibility of career managers in the public sector, although most of them only held secondary certificates or lower. Most of the low-level educated managers whom are very bureaucratic those who work within the public sectors in Bahrain will need time to be replaced with the highly educated personnel that are why democracy in Bahrain may still need time to overcome the bureaucracy.

The researcher also thinks that it is difficult to expect those kinds of managers who consider qualifications in their departments or sectors, whenever vacancies occur, as a compulsory requirement for promotion to high positions when they themselves had been successful with minimal qualifications (see chapter 1, page 9). People tend to exaggerate their status to researchers, especially those with high qualifications or the other extreme; when unemployed or with a low category of work position.

This indicates that the people in Bahrain are placed in positions not based on their personal merits and qualifications although the highly qualified personnel are very few in the country and the researcher think that in a democracy culture country, such personnel need to be considered and their knowledge need to be utilized in building up the country .

The majority of patients were satisfied with the physical setting of the hospital and the processes. Many who participated in this study were admitted through the Accident and Emergency department. Because critical cases are treated first, there is less waiting time, which leads to an increase in their satisfaction. People do not like to wait for an appointment and they don not like to wait in the waiting room when they come for an appointment (Dolinsky and Caputo, 1990).

Over a third of patients (38.8%), less than half of nurses (48.5%) and doctors (41.8%) (See table 2.6, 2.7 pages 120,121), agreed on the quality of food provided for the patients. With regard to their suggestions, and in respect of the quality of food, only 16% of patients suggested having a menu for a better choice, and recommended that the food should be hot. None of the nurses or doctors believed that there was a great need to enhance further the quality of care offered by the healthcare system in general, (see graph 3.7, page 135).

It is surprising to have the majority of the respondents satisfied with the quality of food. Within the context of health services, people in Bahrain are quite different from other nationalities. As the data was collected in 2001, democratic change was relatively new. Therefore, respondents may have thought that raising any negative issue in regard to the hospital might affect the quality of the treatment they would receive from the hospital staff, in addition to worries about the political effects on them personally.

The government is now in the process of privatising the hospital food services, most probably by the next year 2006. The government now are discussing the issue with private companies and evaluating the quality of services in some of the gulf countries those who implemented the privatization of food such as Saudi Arabia and United Arab Emirates before actual implementation of this services by the next year . This may be a positive step because this action might result in an improvement of efficiency and patient satisfaction and it might also help to focus on the core function of the hospital, which is patient care. Privatisation may give more freedom to management, in addition to providing options/choices of menu for the beneficiaries. Or it might be the other

way round Although privatisation can improve quality and increase the amount of transition (Alexander, 1997) and may also lead to an improvement in performance and an increase operating efficiency (Mier et al, 2002), or it might be the other way round there are still negative consequences. In particular, the migration of staff from the public to the private sector may damage the quality of service. To offset this, the Ministry of Health has proposed a plan, based on research, which proposes the early retirement of staff along with a good financial package. The government also need to consider that privatization in some countries has damaged the quality of care such as that of ancillary services in NHS in the UK.

About a third of the patients and a third of the doctors were not satisfied about parking space. On the other hand, only 11.2% of the nurses were not satisfied. It is necessary to have more space for parking, because it is the only general government hospital in the country. Patients like to be able to park close to the facility, walk in through a safe neighbourhood, and then find the appropriate room easily (Lochman, 1983).

About half of the nurses, more than half of the doctors, and around a third of the patients were not satisfied with the number of nurses and doctors provided in the hospital. However, the shortage of professionals in the healthcare sector is a global issue. For instance, in the United States, Lagerquist, (2003), the president and founder of a global medical placement company, stated that, a well-documented severe shortage of healthcare workers exists in the US and will only worsen over the next decade. The Professor of Nursing and Professor-in-Charge of Research at the Penn State School of Nursing also stated that nursing shortages still appear periodically in many hospitals, which have trouble in filling and

keeping their nursing staff. Staff turnover not only incurs large costs of hiring and training new employees, but also adversely affects the quality of patient care. There is also a major nursing shortage in the United Kingdom (Sullivan Havens, 2003), which is being addressed by importing foreign nursing staff.

A: Privacy and Cleanliness

Regarding the privacy of the patients in the hospital, 27.9% of the doctors, 32.2% of the nurses, and only 6.3% of the patients were not satisfied. Patients recommended that they should be specified and divided according to age. They felt that their privacy is diminished when all age category patients are allocated to the same cubicle, but otherwise the survey indicated that patients were satisfied with levels of privacy.

With respect to the environment of the hospital other than the patient's room, 42.6% of the doctors, 21.8% of nurses, and 15.1% of the patients disagreed that the environment in the hospital is quiet, comfortable and clean. With regard to cleanliness, standards set by the Ministry of Health are reviewed by the Infection Control Committee. It might be worth combining cleanliness issues within the hospital between the hospital administration and the Infection Control Committee. Using the standards will therefore provide a more complete picture of the cleanliness of the hospital. Patients expect certain things of the Ministry of Health. When they are in hospital they rightly want to know that the fundamentals of care are there. They expect high quality care in hospitals that are clean, tidy, quiet and welcoming. Patients and professionals apart from the doctors are satisfied with this aspect.

However, it is not unusual that patients and professionals suggested having privacy in the hospital, because during visiting hours the hospital usually looks like a central market rather than a hospital. There are no rules and regulations for the visitors in general wards and Bahrainis are very social, so that each patient might get minimum of six visitors every visiting time, therefore the hospital during visiting hours is too crowded. Patients generally, based on the researcher findings, like their relatives and friends to have easy access to them and to communicate with physicians and staff about the care of the patient.

People also like the doctors to talk to them as equals, based on the researcher findings, to be able to listen, to ask many questions, to answer many questions, to explain things in a simple way that the patient can understand, and to allow patients to make decisions about their care (Lochman, 1983). Lengthening consultation time is the easiest and most direct variable shown to improve the interpersonal communication of providers and patients. With nurses and staff, promptness and friendliness are the main determinants of patient satisfaction (Abramowitz, 1987).

It was found that, People also like good food and clean, attractive rooms without other annoying patients in them. When dealing with Admissions, Discharge and Billing Staff, patients like to be treated courteously and promptly on admission, discharge and when they have questions about billing. They like physicians, nurses and staff to wear clean, "gender-appropriate" clothing. If they have to wait for a room they like to know why and how long it will take. When they are being discharged they like their doctor or other staff to explain what they should do to facilitate their recovery and to assist them in overcoming homecare difficulties. In the

emergency room, they like being attended to promptly and having staff frequently explain how long they still need to wait (Hughes, 1991).

In another study, Arnetz and Arnetz (1996) reported that, departments receiving high scores from patients also receive high scores from personnel, both in terms of quality of care as well as perceived ward atmosphere. However, in this study, the doctors appear to rate the overall quality lower than do patients and nurses. Thus the doctors' view of the quality of care provided appears to be a relevant factor in determining total quality of care independently of other outcome measures. Because organisational change impacts on factors such as job satisfaction and psychological climate. It is relevant to study possible effects on staff, specifically doctor -rated quality of care.

II: Accuracy and generalisability of the results

The main weakness of an exploratory descriptive survey is that response rates tend to be low (Reid 1993: 32), yet the response rate is good in this study. However, a limitation of this study is that the accuracy of some of the answers reported by respondents may be an additional problem because democratization is relatively very young in Bahrain. People might be not sure of their freedom to ventilate their feelings and they may still be afraid to state the facts when the bureaucracy might influence their replies. For example, the majority suggested an increase in the number of nurses and doctors to improve the quality of care at the hospital, but they were overall satisfied with the ratio of nurses /doctors to the number of patients. It is reasonable to believe that fewer staff will result in greater

workload, which will negatively affect staff production and satisfaction. Ultimately, the research presented here represents a potential input into the policy process in making the case for more staff resources in the health sector.

In addition, participants may be motivated to suggest rather than mention staffing as a negative issue within a government institute which, in turn, might create a negative impression on the managers and administrators of the hospital. To reiterate, respondents may also worry that a negative response might affect the way they are treated or may have political consequences for them personally. Apart from the changing political context, there are other factors that may have influenced the findings of this research.

Quality Issues and Societal Change

The levels of satisfaction were significantly related to secondary certificate holder participants, who were more satisfied with the care than the higher or lower educated participants (see above). In addition, due to advances in technology and a general desire for a higher and higher quality of life, means that there will always be more demand for healthcare than the country can afford. As healthcare systems expand to cover more demand, there might be pressures applied on the managers to reduce expenditure. The end product is a growing emphasis on cost reduction, possibly it was argued, to the detriment of the quality of service. In addition, it was found that new technologies required a more and more highly skilled person, which increases the complexity of the management of healthcare. Bahrain is not unique in this respect.

Healthcare is always in high public demand – it is not only the means to good health and long life, it is a symbol of democratic rights and citizenship, particularly for countries like Bahrain. No one should be denied the right to health or to a good quality of life. In addition, this may be the meaning of access to services that the Ministry of Health strives to implement. However, interestingly, this is a relatively new concern. The democratic situation should emphasise the need for a comprehensive health service. Another aspect of access is ensuring that everyone who needs healthcare gets the right services.

This requires that special services should be provided to meet the needs of particular groups in society. In addition, a third aspect of access has also become important. One of the major changes in our thinking about quality of healthcare came from an understanding that people's willingness to use healthcare depends upon their relationship with the healthcare system. Donabedian (1988:1748) also included accessibility as a highly subjective attribute. "Accessibility of care, the doctor/patient relationship and the "amenities of care" will greatly influence acceptability, legitimacy and equity".

Therefore, when thinking about equity and fairness, we need to consider what is acceptable to people in terms of their personal value systems and their personal desires as well as what might be considered, in objective terms, good for them. We have moved to an understanding of quality as a set of judgments made about the various aspects of care and we have a number of different tools available to assist with this.

Based on Donabedian's categorisations of quality; the elements of a system, inputs, processes and outputs, require different approaches. The first concentrates on examining the characteristics of the physical settings in which the care is provided (structure); this is an indirect assessment of care, (which is quality assurance) that uses standards laid down for the appropriate structures of a healthcare organisation. This is frequently conducted through what is termed accreditation in which teams of reviewers or surveyors examine an organisation for its level of compliance with published standards or inspection processes using the skilled judgments of independent reviewers, (Donabedian, 1990).

The second examines the attributes of the processes of care and may use inspectors or internal mechanisms for ensuring that the care of patients conforms to agreed-upon processes such as care pathways or other treatment schedules. Maybe it is necessary to understand some of the assumptions made by thinkers about quality some two decades ago. A distinction was drawn between what have become called technical quality and functional quality (Gronroos, 1984).

Functional quality is how the patient receives a service. For example, the quality of nurse/patient interaction and the condition of the environment might produce functional quality. Measures of patient satisfaction with hospital care have focused on the quality of food and the condition of the surroundings. However, although these are important in terms of providing patient comfort, they do not address the issue of the content of the clinical care provided – the technical aspects of the quality of healthcare delivery. The issue of the best use of resources and outcome is a major consideration in healthcare. If the spending of healthcare money is not simply a technical exercise, it becomes necessary to ensure that

healthcare reflects the preferences and wishes of the community served by the healthcare system.

To enable individuals to achieve their full health potential, we have to move to a more relevant set of assumptions about the role of the patient in considering the quality of healthcare, through the search for the appropriate and relevant judgments which consumers of services can and do use to assess quality (Donabedian, 1990). After all, they experience the whole process. There is a valuable role for patients as observers and receivers of the care. We need to listen to what they say about their experience in order to learn and to improve and to ensure that their views are taken into account.

Donabedian (1980) proposed the approach to the assessment of quality over two decades ago. The purpose of assessment is to pass judgments on the quality of healthcare, regardless of whether the care was provided by practitioners or institutions, implemented by patients or used by the community. The interesting thing with Donabedian's approach is the assessment of patients' and professionals' opinions and considering their in building up the quality in health sectors. Quality in the health sector is considered by him "Measurement in the classical sense – implying precision in quantification – cannot reasonably be expected for such a complex and abstract object as quality. What is needed is a set of reasonable and valid judgments" (Donabedian, 1988:1748).

Rather than seeing views of quality of healthcare just as something we can measure, we now need to talk about quality as something more akin to an attitude made up of many different influences on our perceptions. This is important in that attitudes to healthcare and healthcare providers

can have a strong impact upon our overall health behaviours. Compliance with healthcare requirements such as taking prescribed drugs when required is something, which patients do not readily do. We have learnt to recognize the need to ensure that the health system empowers patients and professionals to achieve their full health potential and satisfaction. We have also asked patients and professionals about what their expectations were in terms of good service. Did the patients get what they were led to expect? For example, was the service provided in a comfortable and respectful manner?

These ways of thinking about quality in healthcare are central to what is needed to ensure that the healthcare system can be considered fair and can be trusted. Finding ways of ensuring that professionals recognise and understand the need for continuous reflection upon the quality of the care provided and learning from practice and mistakes is needed to improve continually the services they are providing (Scally, 1998; Halligan, 2001). This includes ensuring that the patient is safe and ensuring that doctors are well trained in clinical procedures and knowledge. In turn, this involves having systems in place to check they have done things properly, that they understand their roles and responsibilities in the system for providing healthcare and they monitor their own performance in order to assess where they need help to improve.

The key to the change in attitude has been the understanding that no clinician, doctor, nurse or other healthcare professional, operates in isolation. They are part of a complex system involving many different people, such as patients and their families and many different actions but they can each individually prevent the system from operating effectively if they do not themselves operate effectively and efficiently.

Donabedian (1980) not only drew our attention to systems in healthcare and the importance of thinking about healthcare as a system with structure, process and outcome. This way of thinking helped to broaden our understanding of quality as I have explained above. Nevertheless, it also changed thinking in two other ways. First, it enabled us to think about healthcare as something provided by a number of interlocking channels. We began to realise that we could not think just in terms of independent channels, such as the hospital's physical structure, but about the ways in which patients pass through a number of different channels and processes. Second, it began the much more difficult process of thinking about the management of change in an industry which is subject to continuous and rapid change.

Any change will have consequences for a system – therefore in an industry, which is constantly changing through innovation, new technologies and new drugs, there is a need to review continuously the impact of changes. Those working as parts of the system need to be aware of "things going wrong" or "not achieving what is required". In addition, it is impossible to ignore the fact that healthcare is a dangerous business. Medical errors are now considered to be unacceptable and have only recently been the subject of public and policy attention. Patients too are being actively encouraged to participate in healthcare, and not to simply assume that they will receive appropriate and safe care.

However, there is another consideration, which is to remove bureaucracy and concentrate on processes. Patients might be given the chance to raise their suggestions, concerns and discuss their ideas with their doctors and nurses. Berwick (1989) claimed that

> Real improvement in quality depends, according to the theory of continuous improvement on understanding and revising the production processes on the basis of data about the processes themselves. The focus is on continuous improvement through constant effort to reduce waste, rework and complexity.

In short, we need to keep analysing what we do to understand the impact of the whole system of healthcare.

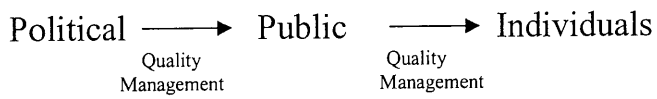
The emphasis on systems has gelled with the new ideas of continuous quality improvement and with the idea of not apportioning blame when errors occur, but looking for where the process went wrong. Healthcare institutions must organise themselves to cope with quality improvement. Flexible project teams must be created within the Ministry of Health, and this is where the dimension of personal accountability becomes very important in the quest for quality. Understanding who is responsible for the provision of care, who is responsible for identifying when changes create risk in the system and who is responsible for addressing those risks is fundamental to improving quality in healthcare. Part of the new approach to management is recognising that people have to understand their contribution to the whole system of care and to value their place within the system.

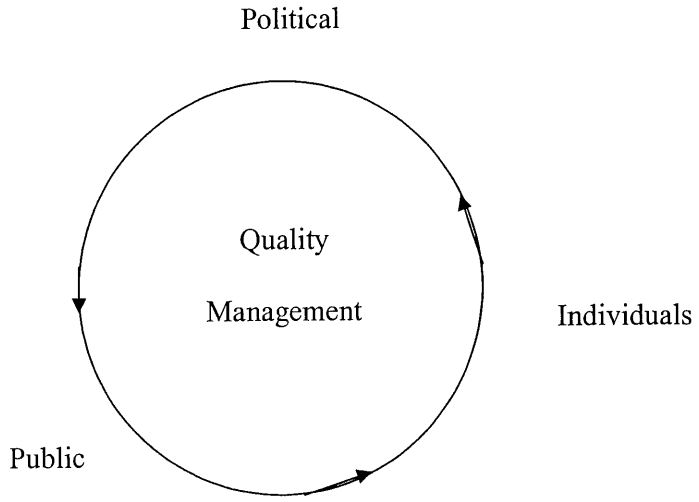
Recognising the centrality of the patient in determining healthcare, the vision for the new health service may place such emphasis upon listening to patients. We need to understand that, healthcare systems improvement requires the capability to see care through the eyes of the patients who are served.

However, it also becomes clear that part of what we are demanding of our healthcare systems is more than just better individual care. We are seeking a reassurance that our healthcare institutions are worthy of an advanced Bahraini democratic society and can reflect our concerns about what we value in our day-to-day life. For this reason satisfaction with healthcare services is seen as an important indicator of how well a healthcare system serves its population.

Towards a theoretical model

The final objective of this research was to provide a theoretical and practical basis for future quality management initiatives within the Bahraini health services, based on the empirical study. Below is a model developed by the researcher as a product of this analysis and based on her thorough understanding of the quality management which will be introduced and discussed as follows:





Quality Management Model

It is clear that the quality management that Bahrain is experiencing is being generated politically and implemented by public services and experienced by individual users of public services. For instance, Chapter One discussed the interest of His highness King Hamad in implementing reform and quality management within the country. Chapter One also discussed the new constitution for the country which extends equal rights to all citizens, regardless of nationality or religion. The constitutional reform process was an important watershed in the maturation of Bahrain democracy that had repercussions for quality management and public sector reform. It is therefore natural that reform gravitates to the subject of how the public sector is managed. Therefore the professionalism and performance of public sector employees in Bahrain appears to be

positively affected. Thus, quality management is depicted cyclically. In other words, genuine implementation of quality management provides an important feedback mechanism to the political executive, who uses this information to further embed quality initiatives to achieve long-range public service improvement.

Conclusion

The findings of this study suggest that higher levels of satisfaction with the quality of healthcare in Bahrain depend on both provider and organisational characteristics which result in more "personal" care and better communication. Therefore, quality healthcare improvement in Bahrain seems to demand the effective utilisation of staff. Although such a conclusion seems unremarkable and could be generalised to any service sector, the Ministry of Health needs to change the traditional way of calculating and distributing the staff to a scientific way (see chapter 1, page 4, 5). It was also found in the study that the majority of patients and more than half the nurses and doctors suggested increasing the number of nurses and doctors which might also indicate that nurses and doctors were not effectively distributed on the wards and departments within the hospital.

Continuity and quality of care is also important. People need to stay with "their" doctors, and having a continuous doctor-patient relationship is a strong predictor of overall satisfaction with healthcare. Patients also need to be treated more courteously and promptly on admission, discharge and when they have questions. Patients also demand a quiet and clean environment. When they are discharged they need their doctor or other staff to explain what they should do to facilitate their recovery and to

assist them in overcoming homecare difficulties. In the emergency room, they need to be attended to promptly, and have staff frequently explain how long they still need to wait. Other suggestions raised by the participants as requirements for quality healthcare included: convenient parking, location in a safe neighbourhood, and ease of access.

A key objective of this thesis was to provide a theoretical and practical basis for future quality management initiatives within the Bahraini health services. With the latter, although the researcher has many other recommendations for practice other than the ones recommended by the participants, these will be explored in the next chapter along with the conclusions of the research. In terms of a theoretical basis, it is clear that there is a lag between the promulgation of political reforms and the extent to which these reforms become embedded in public service reforms. It is clear that the empirical study, conducted in 2001 while political reform was in its infancy in Bahrain, reflects caution on the part of the participants.

Chapter 6

CONCLUSIONS AND RECOMMENDATIONS

Improving the quality of healthcare in Bahrain cannot be divorced from wider political and administrative change. The Bahraini government has begun to promote democratisation processes, supported by greater transparency and equality, freedom of speech, the press, association, and the rule of law. The government is also keen to ensure that political competition and participation in decision making are meaningful, and with the latter, this has included the implementation of quality management since 2000. Previously, decisions were implemented through bureaucratic order without input from the public. In turn, the bureaucracy also influenced and affected Bahraini public opinion and attitudes and inhibited it from participating in political and economic development.

Earlier in the thesis, the transition to democracy in Bahrain that resulted from revolutionary arguments between people and government against bureaucracy was analysed. This process was part of the wider political debate in the country:

> There has been political unrest in Bahrain for years, a port where the U.S. Navy stations its Fifth Fleet. The Shiite majority wants democracy and jobs and equality and Bahrain is troubled by social unrest. While contained for now, problems in the Arabian Gulf nation could erupt, destabilising other countries in the region and

threatening American interests (High Beam Research Centre, 1997).

Thus, the king of Bahrain had to respond to the demands of society to exercise political rights in the forthcoming Parliamentary elections in 2006. Essentially, Bahrain is experiencing a transitional phase until Parliament agrees on the organisation of political action in Bahrain (Al Rubi, cited in Ministry of Information, Bahrain, 2003).

Clearly, democratisation will take time; it needs to be fully understood by the people, otherwise their expectations will not be fully met and they might not be completely satisfied because they do not know their rights and or are unable to articulate their needs. Democratisation might be perceived by Bahrainis as a fundamental transformation of the whole society, and the rebuilding of relations between people and government. As part of the process, improving the quality of public management is crucial. Only by ensuring citizens' participation in and satisfaction with the decision-making processes will the management of the country generally and healthcare specifically be improved. This is reflected in the survey responses when the majority agreed on the quality of the hospital and at the same time, suggestions to improve the standard of quality were raised. As discussed in the previous chapter, this indicates the uncertain relations between the government and the people in Bahrain at the time the empirical research was conducted.

Therefore, in this thesis, the researcher has brought together the current political situation in Bahrain, quality management in the public sector generally and in the health sector specifically and related these together to

form a new view of quality management. In the course of this, the diversity of stakeholder perceptions of quality management in healthcare in Bahrain has been highlighted, quality management defined, and the context of quality management in healthcare within wider political and administrative change has been focused upon. In terms of the healthcare system and quality management, healthcare quality has been analysed and reviewed and several recommendations made accordingly.

This chapter will summarise:

1. To what extent this thesis has met the original objectives which were stated at the beginning?
2. What contributions to knowledge has the thesis made?
3. What further research on quality management in healthcare can be undertaken?
4. What recommendations does the thesis support?
5. An appreciation of the study relevant to the researcher's own professional practice.

1. The original Aim of research

To improve the quality of healthcare for patients who use Bahrain's secondary health services

The original motivation, as outlined in Chapter One, was based on my own professional experiences, particularly when I was a nurse manager. To achieve this aim, the following objectives were set:

-To understand and critically analyse the context of health services in Bahrain

-To undertake primary empirical research to establish the present quality of healthcare in Bahrain

-To provide a theoretical and practical basis for future quality management initiatives within the Bahraini health services

In terms of the context of Bahrain's health services, the introduction of quality management appeared to accompany the political changes that began in 2000. This provided a window of opportunity: the researcher was convinced that by arguing for quality and criticising the obvious failures around her were acted upon the interests of her patients. The researcher needed a system to identify those comments and to consult patients, doctors and nurses, so that their views could be taken into account.

The researcher's personal objective changed from the search for an ultimate and universal scientific quality system to research for a way of bringing together diverse factors because the problem was more complex than first appreciated. Consequently, the healthcare quality problem was not directly related to a particular shortage of nurses /doctors, or to the use of any particular system to overcome such problems. Rather the understanding of quality in healthcare is that it is problematic because of the dilemmas arising out of quality management with the public generally and with healthcare specifically.

These contributions to knowledge will be discussed more fully:

2. Contributions to knowledge the thesis makes

An increased understanding of quality management in general and in health services in Bahrain in particular

The objective of an increased understanding of a theoretical and practical basis for future quality management initiatives within the Bahraini health sector has been achieved in several ways. First, political and social stability of the country will contribute to embedding quality management within the public sector and this will be moved to individuals in terms of quality performance. However, the implementation of quality management to public organizations may be interpreted narrowly as mechanism to manage the performance of employees. The meaning of the term performance management changed recently in Bahrain. Up to year 2002 it was often taken to mean rating employees using a trait-based instrument – one looking at factors such as this style of performance appraisal only is no longer considered good practice.

Quality management in Bahrain has been introduced within the country as a key component of administrative reform, for example, Bahrain has started to have developmental performance management. On July 2004, a new set of rules and regulations were issued by the Civil Service Bureau with regards to, for example, a suggestions allowance where the employee can claim up to 500 Bahraini Dinars which is about $ 1250 US Dollars per suggestion, (Civil Service Bureau , 2004). More importantly, another development is the activation 'of civil institutions and encouraging the media to express all views' (Ministry of Information, Bahrain, 2001).

Secondly, users have a broader and more powerful role in healthcare quality, as they are the recipients of a service. It is suggested that patients should be represented and participate in quality management. The most important factor in any quality focused organisation is not finance- it is the customer or service user.

Third, by expanding the researcher's knowledge of quality aspects, it was found that it is essential for quality in healthcare specifically or in any business management field generally, to be viewed from two main aspects. These might termed based on the researcher 'spinal cords of quality judgments', which are the physical settings and the processes which comprise how high standard achievements or services are attained. It is believed that quality components, just like a human being, contribute to excellence. The reverse is also similar; any one with undesirable characteristics cannot be accepted as a good quality person. Both aspects need to be considered together; the physical settings and the characteristics of persons or processes that are carried out are central to any service. An example of this argument is that there will be an attractive display in a jeweller's shop to attract customers and the salespeople will usually deal with them in a charming way, with good inter-personal skills. Customer relations have now become a science within itself.

b. A new understanding of reforms related to quality management in Bahrain.

Bureaucracy has an effect on the critical thinking of the managers who work under bureaucratic government and will affect vice versa the staff who work under such managers, the central and /or the local bureaucracy. Since any government is bureaucratic due to the demands of policy

implementation and resource allocation, the effect of the bureaucracy has reflected on the mind of managers and officials who are usually assigned by the government, in managing their organisations.

The general orientation of society towards management and interpersonal authority in formal organisations will also affect the behaviour of public officials (Peters, 2001). An example of the bureaucratic manager is the previous chief executive officer of the hospital who was found to be very difficult (see Obstacles to Research, page 83). Therefore, staff of any bureaucratic organisation delivering front-line services ('street-level bureaucracy') may have difficulties in raising their own opinions without permission from the managers of such organisations, Lipsky, (1980). Furthermore, when people of any country experience restrictions on the ability to participate in decision making, by extension it may also inhibit their participation in surveys and studies. However, this did not appear to be the case with this research where the participation rate was high, it might be because people were likely to be more confident in year 2001 about participating.

The majority of participants were positive about the physical settings and the processes that were carried out at the Salmaniya Hospital, but at the same time they suggested development of the quality of both aspects. It appears that participants still felt inhibited from criticising a government organisation, in this case a hospital, so they felt more comfortable about making suggestions rather than criticisms. Of course, there are many other factors which might affect the patient's perception of quality such as unemployment, age of the patient, fear and beliefs (Maddox and Douglass, 1973). Socio-political factors, such as unemployment,

dissatisfaction with one's life circumstances and bureaucracy, are associated with less favourable perceptions.

3. Opportunities for further research on quality management in healthcare

It is clear that the introduction of meaningful quality management is pivotal to the political and economic development of Bahrain. Democratisation implies a new relationship between the government and its citizens and improving public service delivery is a part of that process. However, democracy in Bahrain is relatively young. It is also clear that old administrative paradigms will not change overnight. Public sector reforms that threaten the status and power of senior bureaucrats may encounter resistance, particularly if the reforms are not built upon solid, independent research evidence. Therefore, further research in this area should help develop a constructive three way exchange between policy makers, practitioners and the users of public services with regard to the following initiatives as assisting in this process.

Although the objective to undertake primary empirical research to establish the present quality of healthcare in Bahrain has been achieved, but further research is required to repeat the research study to measure the relation between post democratisation on the perception of patients, nurses and doctors to the healthcare settings. This will help ensure effective evaluation of quality perception during democratisation. Socio-psychological factors might also affect perceptions such as the respondents' ability to express their opinion and concerns (Buller and Buller 1987).

Future quantitative studies should be designed with a larger sample size which represents all in-patients, nurses and doctors working in Bahrain. Qualitative studies using interviews could be designed to explore values and beliefs. Studies that explore the nature of the causal relationship between professional attitudes about their jobs and the potential impact of these attitudes on patient satisfaction attitudes should be performed.

Further research is required to repeat the research study by involving administrators and managers within the Ministry of Health as it was mentioned earlier in chapter 2, that quality is also determined through rules and procedures, therefore those who set out the rules and procedures are ultimately responsible for the level of quality (Al Sammak, 2002).

Short courses, conferences, symposia and workshops related to the meaning of democratisation and its implications in Bahrain also need to be designed and conducted. Research of this nature could be employed to inform management development and training for Ministry of Health officials and government officials generally. In particular, lessons can be drawn from other countries (both developed and developing) in terms of the effectiveness of quality management systems and their potential drawbacks. Any development or training course packages will need to be tailored to suit Bahrain's own cultural and political needs.

Self-study programmes using distance-learning materials in regard to democratisation in Bahrain need to be developed. The oriented people who understand the meaning of democratisation will participate more effectively in any study that leads to the development of the governments' organisations.

If a quality management system can work in healthcare it should work in other public services and in commerce and industries also. In practice this can work if the private sector is able to produce the quality physical settings of the work and manage the quality of the workers' characteristics. It has already been suggested that this can be achieved by focusing on both the physical settings of any work environment and the people who will work within this environment. On the other hand, democracy should be effectively implemented first in order to have good quality management both in the public and private sectors.

4. Recommendations which the thesis supports

The finding from this research that revealed a shortage of healthcare professionals might indicate that the distribution of both nurses and doctors to patients was not calculated properly. It is time for the hospital administration to calculate the nurses and doctors rate based on the patients' dependency. However, to reduce the number of staff might lead to extra work being imposed on staff in being expected to work faster, being responsible for more patients, covering for absent staff more frequently and performing procedures that are more complex.

The recognition that staffing has a major constraint on the development of healthcare led to an increased accent on personnel management. Without the appropriate staff, improvement in care and achievement of health Plan targets might not happen. There should be a human resource planning office within the Ministry of Health to study human resources requirements, considering the dependency level of each patient and following a review of the existing system these would lead to human

resource planning for all disciplines, commissioning training programmers, such as universities and encouraging recruitment. The number of nurses and doctors who graduate annually might not be enough. An adequate strategy for human resources within the Ministry of Health Plan is required.

The Ministry of Health might also need to set targets for increasing staff numbers. All staff working at the Ministry of Health might also need to work under agreed protocols. Identifying the number of patients that each staff will take care of, and the calculation of the ratio between numbers of staff to the number of nurses would be better made on a scientific basis. The suggested human resources office might ensure that protocol based care takes hold throughout the Ministry of Health. The Ministry of Health might need to work on this protocol with patients, clinicians and managers to develop clear protocols that make the best use of all the talents of Ministry of Health staff and which are flexible enough to take account of patients ' individual needs.

The new approach will shatter the old system of distributing nurses and doctors blindly to take care of patients which might have held back staff and slowed down care. Ministry of Health employers will be required to empower appropriately qualified nurses, and therapists to undertake a wider range of clinical tasks including the right to make and receive referrals, admit, and discharge patients, order investigations and diagnostic tests, run clinics, and prescribe drugs. The extended role of nurses will certainly to overcome the shortage in the number of doctors.

As part of this suggested approach, nurses will have the right to prescribe a limited range of medicines. Which means that we will then extend both

the range of medicines, which can be prescribed, and the role of nurses who can do so? The protocols that the researcher suggested enable nurses and other professionals to supply medicines to patients according to protocols authorised by a doctor and a pharmacist. The majority of nurses should be able to prescribe. In our study, it was found that the patients, nurses and doctors all suggested increasing the number of professionals. In the researcher's opinion, it may also be necessary to focus on developing the managers' skills.

To help manage the complex system, for example the managers need to now how to distribute the professionals in a scientific way according to the dependency of the patients, not to have to fix a policy for all the patients. Some wards may need more professionals than others, although the number of patients is similar, the type of patients in the wards differs from one ward to another.

Hospitals with hundreds of beds may need to employ thousands of people, to make sure those patients are well cared for. These range from doctors and nurses and other clinically skilled personnel highly trained and specialised in using the sophisticated equipment available, catering staff to make sure food is provided properly to help healing and health, cleaners to ensure a clean environment, general services supervisors to keep the buildings and equipment in proper order and many others. Therefore, it is essential to have the right number of staff on duty every day and to make sure that it is the same number every day; in turn this demands professional management to contribute to the improvement of quality healthcare.

Radical reform is required in staff education and training to reshape care around the patient and these staff will play a key part in raising standards of the fundamentals of patient care. The reforms in education and training will give everyone working in the Ministry of Health the skills and knowledge to respond effectively to the individual needs of patients. There should be training across the professions in communication to enable individuals to demonstrate competence in communicating with patients. The Ministry of Health is committed to giving staff the support they need in order to make the most of their contribution to patient-centred care.

In respect to the environment of the hospital, there should be standards of cleanliness in the Ministry of Health, which are revised by the Infection Control Committee; the revision takes account of a broader range of cleanliness issues within the hospitals. Using these standards will therefore provide a more complete picture of the cleanliness of hospitals.

The researcher believes that the Ministry of Health plan should emphasise the importance of providing patient care within hospitals that are clean, safe and quiet. The Ministry of health might think of establishing visiting rooms for those patients who want many visitors, so they can be moved to those rooms to meet their relatives, rather than receive all the visitors in patients' cubicles, where other patients might be very sick and striving for quietness. The researcher suggests that there should be an office within the Ministry of Health responsible for standards of cleanliness. This might be the role of the Infection Control Committee, rather than depending on the hospital administration.

We need to ensure that healthcare systems are capable of delivery; we may not be able to know all the answers to what makes successful healthcare. We do indeed need evidence based medicine but we also need to have efficient and effective institutions. We need to have organisations, either within the Ministry of Health or other public organisations, which can demonstrate not only good utilisations of public resources, but also the need for better decision-making. The researcher thinks that it might be worth carrying out an audit to determine the current position of patients care. Suggestions can be raised accordingly by the auditors for improve inpatient care services. It is important that patients also receive the best possible care and this means that services must be continually evaluated and improvements made where necessary to deliver high-quality, cost-effective care.

5. An appreciation of the study relevant to the researcher's own professional practice

Based on the researcher's understanding of the theory of quality management which was obtained from this research and being a hospital administrator, many changes have been implemented accordingly within the hospital structure (physical building) and the processes being carried out within the hospital.

Below, the researcher will highlight some of the achievements of the years 2002 to 2004 which demonstrate effective understanding and practical demonstration of the theoretical aspects of quality management. Since she joined the hospital as an administrator in October 2002, based on the Under Secretary's Administrative Order Number (22), (see

appendix 5 page 235-2) much was achieved by the researcher. Only some of these achievements will be explored as examples as follows:

5.1 Work Achievements from 2002 to 2004

The researcher implemented what had been learned in order to have quality structure and processes within the hospital. The hospital physical structure and the processes that were carried out by the professionals were investigated and evaluated. Below, is a selection of these examples

5.1 A. *Cubical curtains to all non acute psychiatric patients*

It was noticed from the research findings that 66.4% of the respondents disagreed of with the privacy at the Salmaniya Medical Complex, (see table 2.6, page number 127) follows 6.3% of patients, 32.2% of nurses and 27.9% of doctors were generally not satisfied with the privacy. It was also found that the psychiatric hospital did not have any cubical curtains and all the patients slept beside each other without privacy. The case for greater privacy was put before the hospital management committee, but some members disagreed due to their fear that the patients might attempt suicide behind these curtains. The majority agreed they could be fixed on the non-acute wards and both patients and staff are very satisfied with the privacy offered. (See appendix 6 page 235-4).

5.1 B. *Telephone calls at the hospital*

The hospital has no direct telephone lines. All the departments and sections, within the hospital have extensions with just four digit numbers. The normal numbers within the country have six digit numbers. The telecommunications at the hospital are controlled by the telephone operator of the Salmaniya Medical Complex. The rationale behind that is based on the officials at the Directorate of Engineering and Maintenance at the Ministry of Health who have found it would be costly to have a separate telephone operator, but on the other hand, the Psychiatric Hospital is a small building with only 2001 beds.

There was wide dissatisfaction among the staff due to the wrong transfer of calls by the telephone operator to their extensions and among patients' relatives who could not call patients or the relevant doctors directly. It is necessary to call the Salmaniya telephone operator to transfer the line to the Psychiatric Hospital. Therefore, a request was made to the telecommunications section at the Ministry to have a direct line to all the departments and sections within the hospital. It was suggested that a one digit number should be omitted from each current extension within the hospital and the number 279 put at the beginning. For example, if the extension for administration is 3301, but this is not known by callers, callers have to request the Salmaniya telephone operator to transfer the line and so there is always the risk of misplaced calls. The number therefore would be (279301) which is a direct line and can be reached by any one directly with no interference from the Salmaniya Medical Complex. This was achieved and all extensions have been changed to direct lines in this way.

Public awareness has also been raised by the researcher, by establishing a telephone card which is given to the patients during the first visit to the Psychiatric Hospital, (see appendix 8, and appendix 8-1 page235-6). This process has raised satisfaction among staff, patients, and relatives; it has facilitated their calls to their patient's doctors, nurses and to any other member of staff within the hospital.

C. *The hospital garden*

It is believed that the Psychiatric Hospital decoration and garden are very important to increase patients' satisfaction. From the research it was found that 15% of patients, 21.8% of nurses and 42.6% of doctors were not satisfied with the environment of the hospital. Although these finding were in a different hospital, it was in one of the healthcare sectors. The researcher has improved the garden of the hospital by placing new plants, purchased new garden chairs, overcome the shortage of water for the garden by placing new water drums in the hospital. Se the purchase request for the garden furniture that has been issued in (appendix 9, and appendix 10-2, page 235-9-10)

5.1. D. *A dietician*

The hospital does not have a dietician. At the beginning of every year the hospital food services department will prepare a menu which will be used for one year. This menu is sent to the head of food services at the Salmaniya Medical Complex for their review and approval. In case it was found that some patients were a diabetic or had high blood pressure, advice would be taken from the dietician at the mentioned hospital in

regard to the quantity and quality of food to be given to such patients. No food assessment is carried out to all patients although there are some geriatric patients may need more dietetic care. A request to have a dietician at the hospital has been made by the researcher to the Ministry of Health (see appendix10-2, page, 235-11).

5.1. E. *Alarm bells*

There were frequent problems at the out patient clinics regarding of aggression or assault of nurses and doctors, by the patients. By the time the security guards heard the noise, the staff would already have been assaulted. Therefore, the researcher has had alarm bells fixed inside the doctors' clinics; if a doctor or an accompanied nurse experiences any aggression from a patient, the bell can be rung and the security guards rush to their assistance. This was done for the safety of the hospital staff (See appendix 11, page 235-12).

5.1. F. *Hospital administration policies*

The researcher has played an important role as co-ordinator of the periphery hospitals' policy development. In order to implement quality management in any setting, there should be a standard to measure the work against. Since policies have not been developed for the Psychiatric Hospital or for the periphery hospitals, the researcher took the initiative to develop policies for all the periphery hospitals. A committee was formed

consisting of the administrators of the periphery hospitals, plus some other concerned members who worked hard to have these policies developed. This was officially appreciated by his Excellency the Under Secretary of the Ministry of Health Dr A. Aziz Hamza. The researcher and the group members with whom she worked in developing the policies received a special award, (see appendix 11-1, 235-13).

5.1. G. *Donations to the hospital*

The researcher has stopped some malpractice and re-engineered many processes within the hospital; one example is the donation system that occurred regularly before the researcher joined the hospital. Foodstuff was donated annually to be distributed to the patients' poor relatives, (see appendix 11-2, page 235-14). The process of donations has been organised through a committee which consists of members of the finance and public relations directorates at the Ministry of Health.

5.1. H. *Personal computers*

The psychiatric hospital has limited computers assigned to the secretaries of the departments and to the department heads only. There are no computers inside the wards and none of the consultants has a computer. Some of them are very old with limited functions. The researcher believes that the computer is one of the basic requirements in any setting generally and in the health sector specifically in order to have good

quality performance of doctors and nurses. For example, patients' blood results must be collected manually from Salmaniya Medical Complex laboratory because there is not one within the Psychiatric Hospital, a process which consumes time and effort. Therefore the researcher requested computers for all the consultants, and the wards, (see appendix 11-3, page number 235-15), so the nurse can obtain the results through the electronic system.

5.1. I. *Support from the Ministry of Health*

Many other achievements during the last two years have been made possible with the assistance of officials within the Ministry of Heath (See budget requirements for the year 2005 and 2006, appendix 10-1, page 253-16), which indicates that the researcher has brought to attention all the required equipment and human resources to the officials within the Ministry of Health. In addition, the research has helped to demonstrate her effective understanding and practical demonstration of the theoretical aspects of quality management, because the researcher learned that "patients who have achieved and fulfilled their expectations are more likely to be satisfied" (Bain et al, 1999). Yet, wider attempts to managerialise health services provide a dilemma in the quest for efficiency. However, this research supports the view that at the core of quality in health care, in addition to efficiency, is reliability and empathy,. Foster, S (2001)

In addition, the relationship between quality and performance management is more than just a set of measures; it implies a mode of management, which is correlated with quality. The increasing use of it reflects a growing tendency for society to check and verify or audit

activity, (Libercap, 1996). However, Sheldon (1998: 46) considered two levels of issues of performance management; "conceptual and technical".

Being a hospital administrator, and as a direct result of this research, the researcher has attempted to implement quality management in the health service while showing awareness of its conceptual limitations within the context of Bahrain. This chapter has also served to highlight how ultimately, the researcher has gained the support to develop and implement the tools of quality management, some of which have had a direct or potential impact on her work situation or local working environment. The demonstration of the researcher's ideas to officials at the Ministry of Health has also been pursued and most of these ideas, documented above, have been implemented with full support.

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Appendix 1

The Kingdom of Bahrain

The Kingdom of Bahrain comprises a group of some 36 Island; the capital is Manama. It lies 22 kilometres off the eastern coast of Saudi Arabia, to which a causeway, and 28 kilometres from the coast of Qatar connect it. The total land area is about 710.90 square kilometres.

The Kingdom of Bahrain declared independence in 1971. Since then the country has made rapid economic progress under the leadership of his highness sheikh Essa Bin Salman Al Khalifa and the present King his highness Shaikh Hamad Bin Salman Al Khalifa who established the national charter for the kingdom on 2000, looking forward to regulating, guiding, protecting, maintaining, restoring and improving the social, economical, health of people of Bahrain depending on fairness, transparency, justice and low implementation.

The national economy is centred on oil production; Bahrain was the first in Gulf region in production of oil, which was on June 2nd 1932. The economy also depends on industrialisation such as petrol refining, aluminium smelting, petrol- chemical industry development, agriculture, Banking and tourism.

Bahrain centralised in location within the Gulf region and has excellent port and airport services, which makes it an attractive local tourist resort and also important business center.

The significant aspects of the general climate are hot form, June to September, with the average temperature of 32 0C and the average humidity for the summer is 55%. The most comfortable whether is between October and May when the average temperature is 17oC with sparse rainfall. The official religion in Bahrain is Islam, and Arabic is the official language of the Kingdom. English is considered as the second language.

History of healthcare services in Bahrain:

In 1901 an American Mission hospital was established in the Kingdom. In 1925 the government of Bahrain has established a first primary healthcare clinic in Muharraq Island. In 1925 the Government of Bahrain has established another seven health clinics across the kingdom. Health manpower was appointed to work in those clinics. In 1942 The Naime health general hospital was opened which was the first Government hospital. In 1959 the Salmaniya Medical Complex and Muharraq maternity hospitals both were opened.

The Salmaniya Medical Complex has undergone several expansions since it opened, because it is the only general Government hospital in the kingdom. It is consist from 1000 beds. The researcher has conducted the project in this main secondary and tertiary hospital in the kingdom.

The hospital has a total number of 185,785 visits to out patient clinics in year (2000), and a number of 234,306 patients were triaged by Accident and Emergency doctors. A total number of doctors working at the hospital are 288 doctors out of which 199 Bahraini, and 89 are non-Bahraini. A total number of nurses are 1,384 working at the hospital, out

of which 71% are Bahrainis (Health statistics, 2000). In 1975 Bahrain Defense force hospital was opened which is mainly serves the ministry personnel.

Bahrain is considered as one of the healthiest countries in the region. Based on the health statistics (2000) there has been a considerable decrease in infant mortality rate, which reached 8.6 in 2000. Children born today will live on average to 72.9 years, more than 40% longer, when compared with 1950s. Nutrition and housing conditions have improved and supply of drinking water and safe disposal of sewage has been guaranteed. The Government has made all of these improvements and overcome the problems of communicable diseases such as malaria, tuberculosis and typhoid, which were widely spread during 1950s.

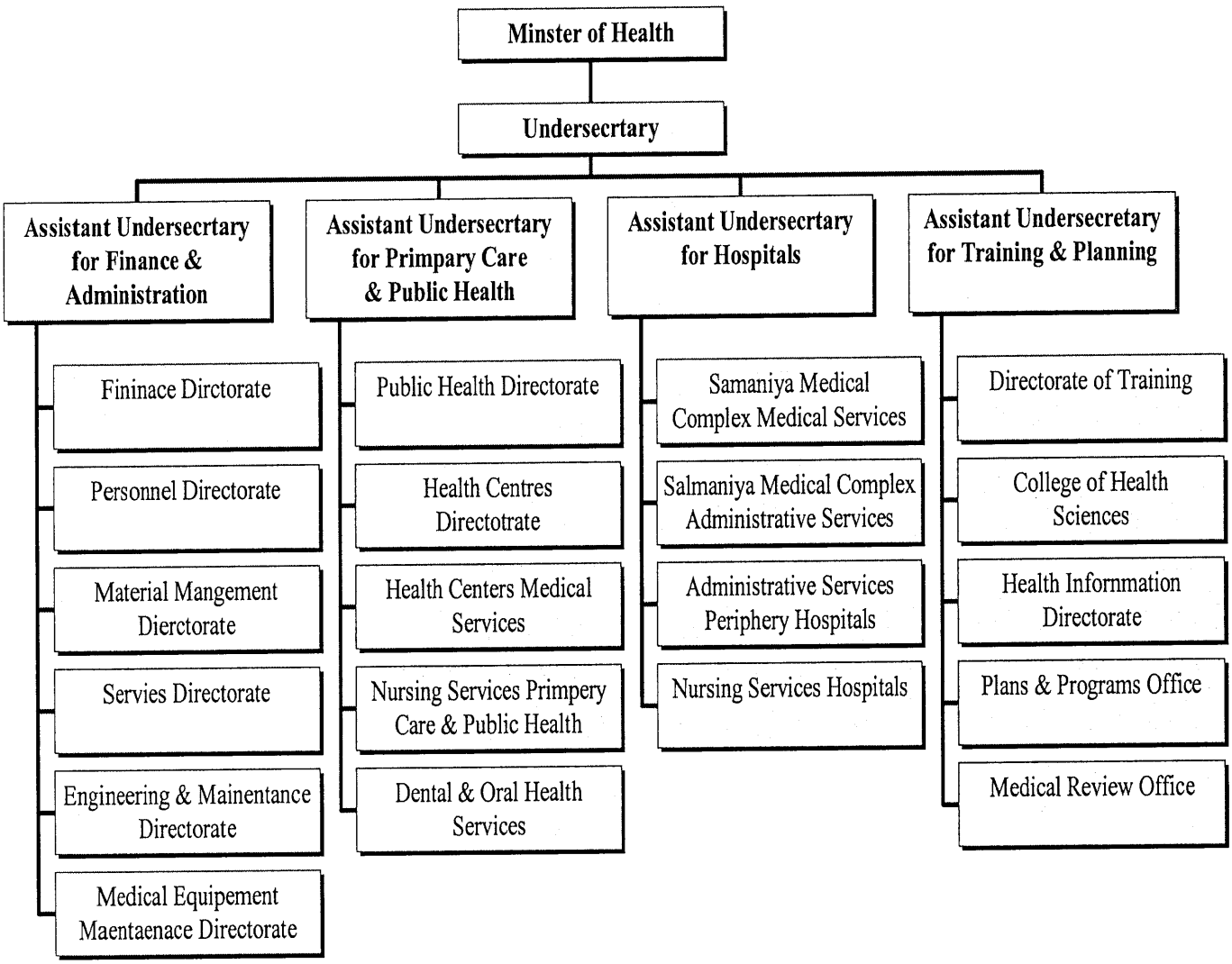
Ministry of health organisational structure:

The Ministry of Health is managed centrally through the minister of health who is appointed by the king. The minister is a member of the cabinet of ministers headed by the Prime Minister. The undersecretaries for support the minister:

* Hospitals;
* Primary care and public health;
* Training and planning; Finance and administration

Please find attached Ministry of Health Structure

Ministry of Health Organisational Structure



Ministry of Health Vision:

The Ministry of Health works in partnership with stakeholders to improve the health of the population of Bahrain and ensure that every one has access to a high quality, responsive health service throughout their lifetime (Bahrain Health Strategy, 2002). The vision of the Ministry of Health is reflecting my aim for the study, which is to improve the quality of health services.

Ministry of Health mission:

The Ministry of Health aims to ensure the provision of accessible, preventive, curative and palliative health services to the community of Bahrain.

Ministry of Health philosophy:

The Ministry of Health's philosophy is the vision of a more responsive, efficient and effective health system achieved through creation of a fully integrated seamless system of service, offering eligible beneficiaries direct access to a full continuum of care regardless of their point of entry (Ministry of Health direction, 2002).

Bahrain has been selected by World health organisation (WHO), as one of the countries that has Global health indicators; these are some of them as follows:

1. Bahrain committed to health for all since 1979.
2. Provided free health for nationals, available within 1 hour's walk or travel.

3. Bahrain contributes to and benefits from WHO membership- it receive no aid as such.
4. 100% Safe water in the home with reasonable access and adequate excreta-disposal facilities available.
5. 98% attendance by trained personnel for pregnancy and childbirth, and care for children up to at least one year of age, Health Statistics, (2000).

Bahrain Government has the following ministries and organisations:

Government Ministries

- Ministry of foreign Affairs
- Ministry of Justice And Islamic Affairs
- Ministry of Cabinet Affairs
- Ministry of Information
- Directorate of Legal Affairs
- Central Statistics Organisation
- Civil Service Bureau
- Ministry of Oil
- Ministry of State for Consultative Council Affairs
- Ministry of State
- Ministry of Education
  1. University of Bahrain
- Ministry of Interior
- Ministry of Health
- Ministry of Transportation
  1. Civil Aviation Affairs
- Ministry of Finance and National Economy
  1. Central Stores Directorate

2. Pension Fund Commission

- Ministry of Housing and Agriculture
- Ministry of State for Municipalities and Environment Affairs
- Ministry of Works
- Ministry of Electricity and Water
- Ministry of Commerce and Industry
- Ministry of Labour and Social Affairs

  1. General Organisation for Social Insurance

- Ministry of Defence

  1. National Guard Headquarter
  2. Consultative Council

Government Organisations

- The Supreme Council for Youth and Sports
- Bahrain Monetary Agency
- Bahrain Stock Exchange
- Bahrain Centre for Studies and Research
- Economic Development Board
- Equestrian and Horse Racing Club
- National Commission for Wildlife Protection.

The Total public Expenditure for year 2002 is 996,600 Bahraini Dinners, were Ministry of Health expenditure for the same year is 71,139 (Health Statistics, Ministry of Health). It looks from the figure that the Ministry of Health expenditure is around 7% of the public expenditure which is high number if we considered that the Ministry of Health is only one beside many other Ministries and Organisations that are located under the Government umbrella, in the other hand Ministry of Health is the spinal

cord of the people in any country, One may get rid or live without Civil Service Bureau, or Central Statistics Organisations, but it is impossible to live without protection from diseases or treating illnesses. It has also a direct effect on the people's health.

Democracy and health services in Bahrain

The national charter has been established on year 2000, by his highness the king of Bahrain Sheikh Hamad Bin Essa Al Khalifa, since then the democracy, equality, Transparency all are objectives had been taken by the government in order to be achieved.

The democracy verbal or documental had been supported to all individuals, which is one of the topics that has been raised clearly at the national charter, were every citizen has the right to express and ventilate his or her feeling.

Therefore the democracy has played a role in giving chance people to participate in decision-making. The researcher thinks it is usual at this stage that people complain about the service mainly and not about the hospital professionals. They might complain about hospital food parking waiting time. People might feel that they have been encouraged by the open community to express their feeling and raise their opinion freely without any resection.

The researcher also thinks that this study has been carried out at the correct time, were the people will not feel obstacle to express their feeling. Were if this study has been carried out 5 years ago, people might feel afraid to ventilate their feeling.

In the other hand the democracy might also be used the other way round, were people might talk about any things, even the nonsense. Therefore it is acceptable to have complains at this stage.

The ministers under the direction of the Government also have initiated the democracy in all the ministries. At the Ministry of Health and in order to implement the Democracy, many targets needs to be revised and changed accordingly, one of which is the organisational structure within the Ministry as it is hierarchy and bureaucracy structure.

"Clear lines of accountability and communication need to be developed and the services need to be managed through a flatter structure", Bahrain health strategy, (2000).

The other targets also might need to be focus on as follows:

1. To strive to achieve equality of access to health services for all.
2. To be open in the decision made about priorities for health gain and the development of health services and communicate the reasons to staff and the wider community.
3. To improve the local community decisions about health improvement and provision of healthcare.
4. Such study might contribute in fulfilment of the ministry of health targets, by involvement of patients and professionals in evaluating the service and raising their recommendations and suggestions to improve the care provided.

Appendix Two

The questionnaire

Dear our patient: This is a doctorate study from which we would like to know your opinion in regards to the healthcare provided at Salmaniya Medical complex. Please answer the following questions. Your answers will be kept strictly confidential

Please tick next to the proper answer

Please tick next to the proper answer

1. Age
   - 20-30 _____
   - 31-40 _____
   - 41-50 _____
   - 51-60 _____
   - 61-70 _____

2. Sex
   - Male _____
   - Female _____

3. Occupation _____

4. Level of Education
   - Literacy _____
   - Read and write _____
   - Primary _____
   - Intermediate _____
   - Secondary _____
   - Graduate _____

5. Your Admission was through :

Accident and Emergency Department _____

Private Clinic _____

Scheduled in Advance _____

6. How serious was your condition when you were first admitted to the hospital?

Minor _____

Moderate _____

Serious _____

Critical or emergency _____

7. During your hospital stay, how much assistance did you need from the hospital staff with every day activities (eating, bathing, dressing etc?)

A lot of help _____

Quite bit of help _____

Some help _____

A little help _____

No help at all _____

8. During your hospital stay did you experience?

A lot of pain _____

Quite bit of pain _____

Some pain _____

No pain at all _____

9. Do you think that time spent in the hospital was about right, or do you think it was too short a time, or too long a time

About right _____

Too short _____

Too long _____

Not sure _____

Now we would like you to rate some things about your hospital stay in terms of whether they were excellent, very good, good, fair or poor. Please check only one rating for each statement.

	Excellent	Very good	Good	Fair	Poor	Don't know
10. Preparation for admission: How clear the information Was about how to prepare for Your stay in the hospital and What to expect once you got there?	☐	☐	☐	☐	☐	☐
11. Efficiency of the admitting Procedure: easy of getting Admitted, including the Amount of time it took	☐	☐	☐	☐	☐	☐
12. Attention of admitting staff To your individual needs The flexibility in handling your Personal needs and wants	☐	☐	☐	☐	☐	☐

	Excellent	Very good	Good	Fair	Poor	Don't know
13. Medical facilities: How Complete and up to date the Medical equipment was	☐	☐	☐	☐	☐	☐
14. Recognition of your opinions: Asking you what you think is Important and giving you Choices	☐	☐	☐	☐	☐	☐
15. Consideration of your needs Willing to be flexible in meeting Your needs	☐	☐	☐	☐	☐	☐
16. Information you were given, How clear and complete Were the explanations about Tests, treatments and what to expect	☐	☐	☐	☐	☐	☐
17.Informing family, how will They were kept informed About your condition and Needs	☐	☐	☐	☐	☐	☐
18. Ease of getting information, Willingness of nurse/Doctors, To answer your questions	☐	☐	☐	☐	☐	☐

	Excellent	Very good	Good	Fair	Poor	Don't know
19. Specialists and special Therapy: Availability of Getting the specialized tests, Medicines or drugs and Treatments you needed	☐	☐	☐	☐	☐	☐
20. Helpfulness: ability of Nurses/Doctors to make You comfortable and reassured	☐	☐	☐	☐	☐	☐
21. Safety and Security: the Provisions for your safety And security of your belongings	☐	☐	☐	☐	☐	☐

You're Nurses:

	Excellent	Very good	Good	Fair	Poor	Don't know
22. Skill and Competence of Nurses: How will things Were done like giving Medicine and handling I.V.S	☐	☐	☐	☐	☐	☐
23. Number of nurses available	☐	☐	☐	☐	☐	☐
24. Nursing staff response to Your calls: How quick they Were to help	☐	☐	☐	☐	☐	☐

	Excellent	Very good	Good	Fair	Poor	Don't know
25.Concern and caring by Nurses: Courtesy and respect You were given friendliness, And kindness	☐	☐	☐	☐	☐	☐
26.Information given by nurses: How well nurses communicated With patients, families and doctors	☐	☐	☐	☐	☐	☐

Your Doctors

27.Attention of Doctor to your Condition: How often doctors Checked on you and how Well they kept track of how You were doing.	☐	☐	☐	☐	☐	☐
28.Availability of Doctor: How Easy it was to get you doctor When needed	☐	☐	☐	☐	☐	☐
29.Respect for you: How well The doctor listened to what You had to say, how well The doctor understood what You thought was important	☐	☐	☐	☐	☐	☐

Living arrangements

	Excellent	Very good	Good	Fair	Poor	Don't know
30.Condition of your room Cleanliness, comfort, lighting,	☐	☐	☐	☐	☐	☐
31.Respectful atmosphere: Amount of peace and quiet	☐	☐	☐	☐	☐	☐
32.Hospital environment: Other than your room how Comfortable, quiet and Pleasant it was	☐	☐	☐	☐	☐	☐
33.Signs and directions: Ease Of finding your way around The hospital	☐	☐	☐	☐	☐	☐
34.Hospital building: How you Would rate the hospital Buildings overall	☐	☐	☐	☐	☐	☐
35.Parking : Number of space Available .convenience of location	☐	☐	☐	☐	☐	☐
36. Number of beds available	☐	☐	☐	☐	☐	☐

37.Privacy: Provisions for ☐ ☐ ☐ ☐ ☐ ☐

Your privacy

Excellent Very good Good Fair Poor Don't know

38.Quality of food, overall, ☐ ☐ ☐ ☐ ☐ ☐

How well it tasted, serving

Temperature and variety available

39. Provisions for family and ☐ ☐ ☐ ☐ ☐ ☐

Friends: adequacy of visiting

Hours and facilities for them,

Visitors treated like welcome

Guests

39.Discharge procedures: time ☐ ☐ ☐ ☐ ☐ ☐

It took to be discharged from

The hospital and how efficiently

It was handled

40.Discharge instructions: ☐ ☐ ☐ ☐ ☐ ☐

How clearly and completely

You were told what to do

And what to expect when

You left the hospital.

41. Your health: How well your ☐ ☐ ☐ ☐ ☐ ☐

Health or condition improved

By your stay in the hospital

Please answer this question:-

42. What are your suggestions to improve the quality of care provided at the hospital?

_____

_____

_____

_____

Thank you

Dear professional: This is a doctorate study from which we would like to know your opinion in regards to the healthcare provided at Salmaniya Medical Complex. Please answer the following questions. Your answers will be kept strictly confidential

Please tick next to the proper answer

Please tick next to the proper answer

1. Age
   - 20-30 _____
   - 31-40 _____
   - 41-50 _____
   - 51-59 _____

2. Sex
   - Male _____
   - Female _____

3. Occupation _____

Now we would like you to rate some things about your hospital stay in terms of whether they were excellent, very good, fair, or poor. Please check only one rating for each statement

	Excellent	Very good	Good	Fair	Poor	Don't know
1. Helpfulness :Ability of Nurses/doctors to make patient Comfortable and reassured	☐	☐	☐	☐	☐	☐

	Excellent	Very good	Good	Fair	Poor	Don't know
2. Medical facilities : How Complete and up to date Do you think the medical? Equipment was	☐	☐	☐	☐	☐	☐
3. Recognition of patient Opinions are you asking Patient what is important to? Him/her and giving him/her choice	☐	☐	☐	☐	☐	☐
4. Consideration of patients Needs, willingness to be Flexible in meeting patients needs	☐	☐	☐	☐	☐	☐
5. Information you were given To the patients were clear And complete such as the Explanations about tests, Treatments and what to expect	☐	☐	☐	☐	☐	☐
6. Informing patients family: How well they were kept Always informed about Patient's condition and needs	☐	☐	☐	☐	☐	☐
7. Willingness of Nurses/Doctors to answer Patient's questions	☐	☐	☐	☐	☐	☐

	Excellent	Very good	Good	Fair	Poor	Don't know
8. The provisions for patients Safety and the security Of /her belongings	☐	☐	☐	☐	☐	☐
9. Skills and competence of Nurses: How well things Were done like giving medicine And handling I.V.S	☐	☐	☐	☐	☐	☐
10. Number of nurses available	☐	☐	☐	☐	☐	☐
11. Information given by nurses How well nurses communicated With patients, families/and doctors	☐	☐	☐	☐	☐	☐
12. Attention, of doctors to Patients condition, how often Doctors checked on patients And how well they kept track Of how patients were doing	☐	☐	☐	☐	☐	☐
13. Number of doctors available	☐	☐	☐	☐	☐	☐

Living arrangements

	Excellent	Very good	Good	Fair	Poor	Don't know
14. Condition of Patient room, Cleanliness, comfort, Lighting and temperature	☐	☐	☐	☐	☐	☐
15. Restful atmosphere: Amount of peace and quiet	☐	☐	☐	☐	☐	☐
16. Privacy: Provision for Patient's privacy	☐	☐	☐	☐	☐	☐
17. Quality of food , overall, Serving temperature and Verity available	☐	☐	☐	☐	☐	☐
18. Hospital environment : Other than patient room, How comfortable, quite And pleasant was	☐	☐	☐	☐	☐	☐
19. Sign and directions: Ease Of finding patients way Around the hospital	☐	☐	☐	☐	☐	☐
20. Hospital building how you Would rate the hospital Building overall	☐	☐	☐	☐	☐	☐

	Excellent	Very good	Good	Fair	Poor	Don't know
21. Parking : Number of space Available for patients parking	☐	☐	☐	☐	☐	☐
22. Discharge procedure: Time It took for patients to be Discharged from the hospital	☐	☐	☐	☐	☐	☐
23. Discharge instructions :How Clearly and completely Patients were told what to do And what to expect when He/ she left the hospital	☐	☐	☐	☐	☐	☐
24. How well nurses / doctors Following hospital policies And procedures	☐	☐	☐	☐	☐	☐

25. What are your suggestions to improve the quality of care provided at the hospital?

_____

_____

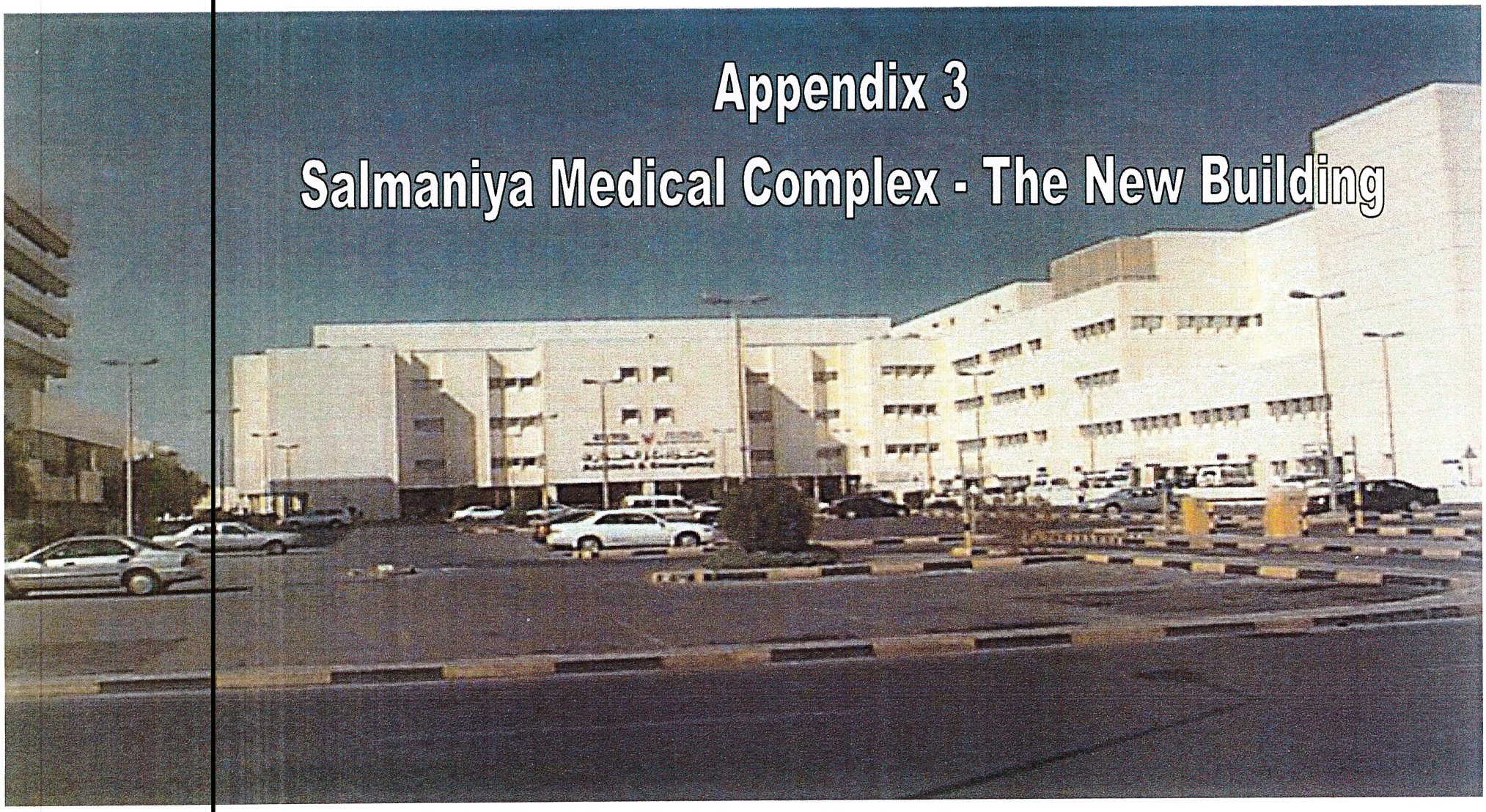
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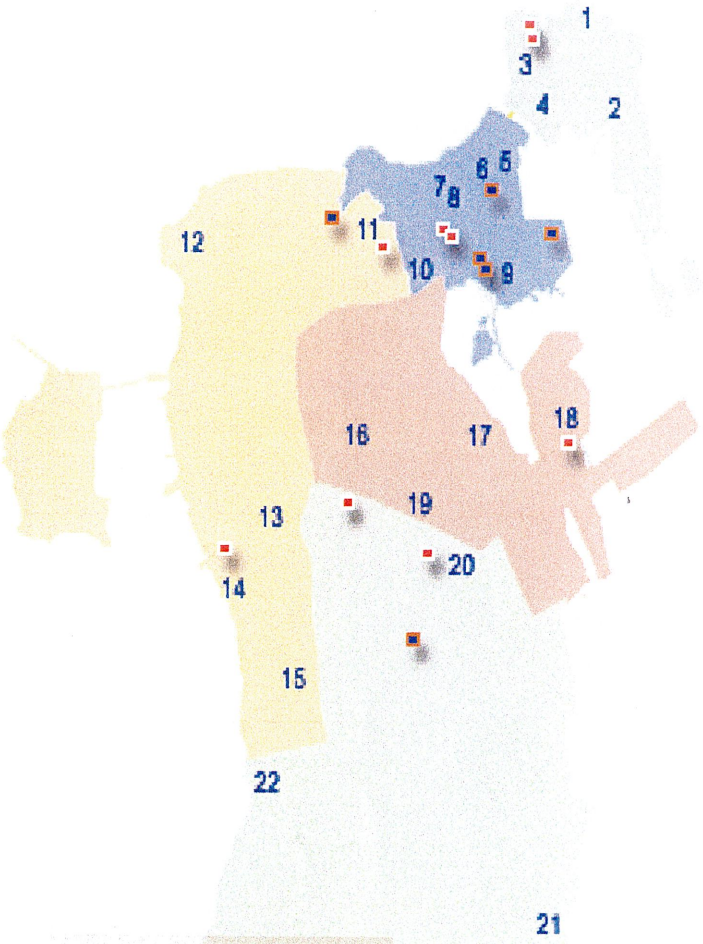
Thank you

Appendix 3

Salmaniya Medical Complex - The New Building



Appendix 4
(Map of Health Institutions)



Government Health Centers
Ministry of Health

1- Al Dair
2- National Bank of Bahrain
3- Muharraq
4- Sh.Salman

5- Hoora
6- Ibn Sinna
7- Al-Razi (Workers H.C.)
8- Naim
9- Sh. Sabah Al-Salem
10 - Bilad Al-Kadeem

11- Jidhafs
12- Budaiya
13- Hamad Town
14- Kuwait
15- Mohammed bin Jassim Kanoo

16- A'Ali
17- Isa Town
18- Sitra
19- Hamad Kanoo

20- East Riffa
21- Jaw & Asker Clinic
22- Zallaq Clinic

Government Hospitals

Geriatric Hospital
Muharraq Maternity H.

Salmaniya Medical Complex
Psychiatric Hospital

Jidhafs Maternity Hspital
West Region Maternity H.

Sitra Maternity Hospital

Bahrain Defence Force H.
Riffa Maternity Hospital

Private Hospitals

APPENDIX 5

STATE OF BAHRAIN
MINISTRY OF HEALTH
UNDERSECRETARY'S OFFICE

دولة البحريـــــن
وزارة الصحـــة
مكتـــب الوكيـــل

No. .....
Date .....

الرقم ..... ٧٨ ـ ٢٣ ـ ٠٢
التاريخ ..... ٥ أكتوبر ٢٠٠٢م

قرار إداري رقم (٢٢) لسنة ٢٠٠٢م

ـ مـــادة ـ ٤ ـ

تنقل السيدة جميلة السماك مسئولة تمريض بمجمع السلمانية الطبي وتكلف بعمل إداري مستشفي الطب النفسي .

Transfer Mrs. Jameela Al-Sammak, The Nursing Officer at Salmaniya Medical Complex to Psychiatric and effected as the hospital administrator.

ـ مـــادة ـ ٨ ـ

على جميع المسئولين بالوزارة تنفيذ هذا القرار ويعمل به اعتبارا من تاريخ صدوره ولمدة ستة شهور، تجدد تلقائيا لمدد مماثلة ما لم يصدر قرار آخر من وكيل الوزارة بإلغائه أو تعديله .

الدكتور عبدالعزيز حمزة
وكيل وزارة الصحة

هاتـــف : ٢٥٢٧٥٥ ـ تليفاكـــس : ٢٧٠٠٤٤ ـ تلكـــس : ٨٥١١ صحـــة بي إن ـ ص . ب : ١٢ المنامـــة
Phone : 252755 - Telefax : 270044 - Telex : 8511 HEALTH BN - P. O. Box : 12 Manama

APPENDIX 6

Kingdom of Bahrain
Ministry of Health
Periphery Hospitals
Psychiatric Hospital

No. : Psy./JM/2002/ 219
Date : 4/1/2003

To : Mr. Najeeb Al-Mansoor
(General Engineer)

From: Mrs. Jameela Al-Sammak
Psychiatric Hospital Administrator

Subject: Cubical Curtains for all Building at Psychiatric Hospital.

Kindly Arrange to fix cubical rails as follows:

- Al -Gazali 1 (1 Cubic with 4 beds)
- Al -Gazali 2 (1 Cubic with 2 beds)
- Al -Gazali 3 (1 ***Cubic*** with ***4*** beds)
- Al -Gazali 4 (1 Cubic with 6 beds)
- Ibn Al-Nafees 2 (1 Cubic with 4 beds)
- Ibn Al-Nafees 3 (Rails for 22 beds) 4=2+2
- Ibn Al-Nafees 4 (Rails for 10 beds) 6=1+5
- Ibn Al -Farabi (Rails for 9 beds)

Your co-operation to get patients privacy is highly appreciated.
Yours
Jameela Al-Sammak
C.c. - Dr. Hassan Al-Jaroodi - Periphery Hospital Administrator (For Information)
- Dr. Ahmed Al-Ansari - Medical Chairman
- Mrs. Fatima A1-Ansari- Sr. Nursing Officer

APPENDIX 7

Telephone Card

The Psychiatric Hospital

Clinic	Open Days	Ext.
Geriatric Clinic	*Monday*	17279378 17279368
Anxiety Clinic	Sunday – Tuesday	17279370
Child Clinic	Saturday – Sunday – Tuesday	17279342
		General Clinic
Room No. 1	Saturday – Sunday – Tuesday – Wednesday	17279373
Room No. 2	Saturday – Sunday – Tuesday – Wednesday	17279372
Room No. 3	Saturday – Sunday – Tuesday – Wednesday	17279371
Room No. 4	Saturday – Wednesday	17279370
Room No. 7	Saturday – Sunday – Tuesday – Wednesday	17279335
Room No. 115	Saturday – Sunday – Tuesday – Wednesday	17279368
Room No. 10	Saturday – Sunday – Tuesday – Wednesday	17279378
Room No. 11	Saturday – Sunday – Tuesday – Wednesday	17279376
Drug Alcoholic Clinic		
Room No. 6	Saturday - Monday	17279382
Room No. 5	Saturday - Monday	17279375
Room No. 11	Saturday - Monday	17279350
Appointment Section		**17279311**

Hospital Department & Wards

			Departments
Medical Section	17279300	Pharmacy	17279348
Hosp.	17279301	Food Services	17279338
Administration	17279307	Social Worker	17279328
Nursing Section	17279310	Psychologist	17279314
Support Services	17279308	Occupational	17279340
Security	17279311	Therapy	17279337
Medical Record		Day care Unit	

Wards

Child Unit
17279343

Al Farabi Unit
17279341

Al Moayyed Unit
17279325

Ibn Al Nafees

17279353	3	17279351	1
17279354	4	17279352	2

Al Ghazali

17279323	3	17279321	1
17279324	4	17279322	2

APPENDIX 8-1

Telephone Calls at the Psychiatric Hospital

STATE OF BAHRAIN — MINISTRY OF HEALTH

TELEPHONE INSTALLATION REQUISITION

Tel.

No

Type of Facility Requested: New [ ] Modify [✓] Shift [ ]

Directorate/Department: Psychiatric Hospital

Contact Person: Jaffar Al Ghanmi Tel. No. 279310

Existing Telephone Installation:

Pabx No. 255555 Del/Extn No. Same Location: O.P.D. and Admayad (Um

Used By: Doctors Extn's:

Service Now Requested:

Service Requested: To change these following Extensions to D.D.I: 3110, 3111, 3112, 3113, 3108, 3148, 3206, 3502, 3505, 350

Used By: Doctors

Del/Extn Affected: —

Reasons for Change/New Installation: To improve the patients services, quick and ease for the patients to get the Doctors, and Reduce the another pressure

Requested By

Date: 2nd Feb 11

Jameela M. Al Sammak
Pay. Hospital Administration

Approved By
DIRECTOR

Date:

FOR USE BY DIRECTORATE OF SERVICES

Cost Implications	Existing Cost B.D.	Future Cost B.D.	Additional Cost B.D.
Installation			
Rental Per Annum			
Annual Running Cost			

Service Recommended for Approval:

Chief Engineer

Director of Services

Budget Approval

APPENDIX 9

STATE OF BAHRAIN
MINISTRY OF HEALTH
DIRECTORATE OF MATERIALS MANAGEMENT

دولة البحرين
وزارة الصحة
مديرية التجهيزات

طلب شراء للمواد غير المخزنة
PURCHASE REQUEST FOR NON-STOCK ITEMS

DOCUMENT CONTROL NUMBER رقم الرقابة على المستند		
تاريخ اعداد الطلب DATE REQUEST INITIATED	رمز الزبون CUSTOMER CODE	الرقم المتسلسل SERIAL NUMBER
06/04/03	981	306958

ACCOUNT CODE	مركز التكلفة COST CENTRE

تاريخ طلب المواد Date Materials Required .....

ITEM No.	رقم الصنف مخزون NON. STOCK NUMBER (LEAVE BLANK)	DESCRIPTION البيـــان	الوحدة UNIT	QUANTITY الكمية REQUESTED المطلوب	QUANTITY الكمية APPROVED الموافقة	سعر الوحدة UNIT COST	السعر الاجمالي TOTAL COST	ملاحظات REMARKS
		Singing Bench, Covered edge	Each	6				صور مرفقة
		Cast Iron, Heat & water						Photo
		Resistance, Color Unchangable	Each	5				
		with radio						
		Tables & Chairs, a Set &	Each	15				حرب
		6 Chairs, Washable, recycl						Superton
		able, Resistance to Staining						Photo
		Heat resistance and sunlight						Attache
		resistance - Colored green						

مبررات الشراء JUSTIFICATION ارجو شراء المذكور أعلاه لاستخدامه في دفنة المستشفى طوارئ بالرفاع
وأفاكم علما بأنه من المستعجل - ارجو مراعاة الرفع

GRAND TOTAL

SUGGESTED SOURCE OF SUPPLY :
Address :
Telephone :

Requested By طلب الطلب	Authorised By صرح الطلب	Purchase Approved by صرح لطلب الشراء	Financial Approval by :
Name الاسم	Name الاسم	Signature التوقيع	Signature
Designation الوظيفة	Designation الوظيفة	Designation الوظيفة	Designation :
Signature التوقيع	Signature التوقيع	Action الاجراء المطلوب	Amount : BD :
Telephone No. رقم الهاتف	Telephone No. رقم الهاتف	Date تاريخ	Date
	Jameela M. Al Sammak Dy. Hospital Administrator	L. P. O. No. ..... Date	

S. No. 4540 2125

الأصلية : مدير اللوازم Original copy : DMM

الصورة الخضراء : المشتري Green copy : Re

APPENDIX 10-1

BUDGET REQUIRED FOR THE YEARS 2005 AND 2006

S.N.	PARTICULARS	RESPONSE
1	Name and brief description of the program	Recruiting Dietician
2	Supervising Department	Catering Department
3	Objectives alike Project/program	Provide dietician services for Per Hospitals patients (Psychiatric Hc Jidhafs Maternity Hospital, Mu Maternity Hospital, Geriatric Unit)
4	Proposed date commencement	
5	Expected date of completion	
6	Planned source of funding	❑ Realignment ❑Additior
7	Are the Project / Program dependent on approval of any other program? If yes, please provide details	No
8	Has the manpower for the program been approved by CSB?	Yes
9	Priority (A, B. C or B) (A indicates highest Priority)	A

		Amount for 2005	Amount for
10	**Project Budget required for:** Construction / Building, Medical and other Equipment, Furniture etc.		
	TOTAL PROJECT BUDGET		

1	**Budget Required for Manpower:** If you required additional manpower, please attached a separate sheet showing the following information for each additional employee: Position Title: Dietician Specialization: Clinical Section: Food Services Grade: P3 Shift/Regular: (R) No. Of Staff: 2		
12	**Budget Required for Services:** Electricity & Water Telecommunications		
	Cleaning Contracts Others		
13	**Budget Required for Consumables:**		

	Drugs and Medicines Surgical Dressings & Disposables Laboratory and Other Chemicals X-Ray Materials Other Materials		
14	**Budget Required for Assets: (Replacement Only):** Medical Equipment Computer Equipment Furniture Other Assets (Please Specify)		
15	**Budget Required for Maintenance:** (Please Specify)		
TOTAL RECURRENT BUDGET			

APPENDIX 10-2

BUDGET REQUIRED FOR THE VEARS 2005 AND 2006

S.N.	PARTICULARS	RESPONSE
1	Name and brief description of the program	Land Escaping for Hospital Garden
2	Supervising Department	
3	Objectives alike Project/program	It is a Part of the treatment for the psyc patients.
4	Proposed date commencement	March 2004
5	Expected date of completion	
6	Planned source of funding	❑ Realignment ❑Additional
7	Are the Project / Program dependent on approval of any other program? If yes, please provide details	No
8	Has the manpower for the program been approved by CSB?	
9	Priority (A, B. C or B) (A indicates highest Priority)	A

		Amount for 2005	Amount for
10	**Project Budget required for**: Construction / Building, Medical and other Equipment, Furniture etc.		
	TOTAL PROJECT BUDGET		

1	**Budget Required for Manpower:** If you required additional manpower, please attached a separate sheet showing the following information for each additional employee: Position Title, Specialization, Section, Grade, Shift/ Regular, No. Of Staff.		

12	**Budget Required for Services:** Electricity & Water Telecommunications Cleaning Contracts Others		
13	**Budget Required for Consumables:** Drugs and Medicines Surgical Dressings & Disposables Laboratory and Other Chemicals X-Ray Materials Other Materials*******	**Required for:** Sand, Plants, Decorations	
14	**Budget Required for Assets:** **(Replacement Only):** Medical Equipment Computer Equipment Furniture Other Assets (Please Specify)		
15	**Budget Required for Maintenance:** (Please Specify)		
TOTAL RECURRENT BUDGET			

KINGDOM OF BAHRAIN
MINISTRY OF HEALTH
OFFICE OF THE UNDERSECRETARY

مملكة البحرين
وزارة الصحة
مكتب الوكيل

Date: Wednesday, 05 November 2003

To: Dr. Hassan Jaroodi
Periphery Hospitals

From: Dr. A. Aziz Hamza
HE the Undersecretary

RE: *Health Policy Project Appreciation*

Dear Dr. Hassan,

This letter is to thank you. I now fully understand that the success of the '*Health Policy Project*' has only been possible because of the excellent efforts of all our staff. I am genuinely proud of you and your department's dedication. Your hard work did not go unnoticed.

For this reason, I ask that you identify, in priority order, the Policy Development Coordinators (PDCs), and/or Subcommittee Members who deserve rightful recognition in developing your department's DPPs.

Due to limited availability of awards (approximately 150), it is important you rank individuals according to involvement. It is your responsibility to assure the information is accurate, realistic, and comprehensive. Please do not include staff that has already received a Quality Step/Incentive for this project. For *each* individual, copy and complete the attached form (Supplementary Form for Incentive Awards). All forms must be submitted to Project Manager, **Elizabeth A. Dubois in the Office of Planning and Policy** *no later than* **November 26, 2003.** All correspondence received will be logged and dated. Forms submitted after this date will not be accepted.

Again, thank you all. The Policy initiative represents a significant accomplishment for the Ministry as we approach a true crossroads for how we will provide health services. You should feel proud to be a part of it.

Yours sincerely,

Dr. A. Aziz Hamza
Undersecretary

CC: Office of H.E. The Minister
Mr. Sayed Najeeb
Mr. Mahmood Buqer
PAF Team
All Policy Development Coordinators (PDCs) and Subcommittee Members

Tel: 252755 - Fax: 270044 - P.O. Box: 12 - Manama - Kingdom of Bahrain هاتف: ٢٥٢٧٥٥-فاكس: ٢٧٠٠٤٤-ص.ب: ١٢ - المنامة - مملكة البحرين
E-mail: ahamza@health.gov.bh

Kingdom Of Bahrain
Ministry of Health
Psychiatric Hospital

No : PH/HJ/MS/174/2003
Date : 15/11/2003

To : Ms. Elizabeth A. Dubois
Project Manger

Sub: Health Policy Project Appreciation

In reference to the letter dated 5th November 2003, received from Dr. A. Aziz Hamza, the undersecretary, in regards to the above mentioned subject. Kindly find attached prioritized selected candidates as follows:

No.	Name	CPR	Pre. Hospitals
1	Jameela Mansoor Al Sammak	630059144	Psychiatric Hospital
2	Hiatham Ali Jahrami	791207412	Psychiatric Hospital
3	Ali Saleh Ashoor	670114332	Jidhafs Maternity Hospital
4	Amal A. Rasool Al Safar	750103809	Muharraq Maternity & Geriatric Unit
5	Adel A. Nabi Sarhan	630040532	Psychiatric Hospital
6	Ali Hameed Ali	710804709	Muharraq Maternity & Geriatric Unit
7	Naeema Omran Yousif	590102583	Jidhafs Maternity Hospital

Your Cooperation in facilitating this process is highly appreciated.

Yours,

Dr. Hassan Abdulla Al Jaroodi
Periphery Hospitals Administrator

APPENDIX 11-2

Donations to the Psychiatric Hospital

Ministry of Health

Psychiatric Hospital

No : PSY/JS/MS/66/2004
Date: 16/5/2004

To: Dr. Hassan Abdulla Al Jaroodi - Periphery Hospitals Mm

From: Jameela Mansoor Al Sammak - Psychiatric Hospital Administrator

Sub: Donation during Month of Ramadan

It has been raised to my attention that the psychiatric hospital community nurses and the social worker are receiving food stuff annually during month of Ramadan donated by some of business men for out patients' families.
Based on my own opinion, this function is out of the hospital services, we are not a Social or Red Crescent society. But because this functions last, for around 15 years, staffs were not convinced to stop this matter. Therefore, kindly communicate with Mr. Hassan Ali Jabber, Director of Finance to have an official written letter in regards to this subject.

Your Cooperation in this matter is highly appreciated.

You're sincerely,

Jameela Mansoor Al Sammak

Copy To:
Psychiatric Hospital Chairman

APPENDIX 11-3

MINISTRY OF HEALTH

Health Information Directorate (HID)
Tel: 289810/289818 Fax: 246245
E-mail: hid@health.gov.bh
www.health.gov.bh

مملكة البحرين وزارة الصحة
22 NOV 2003
وصل مكتب إداري استشفي

Jameela Al-Samak
22/11/03

MEMORANDUM

18th November 2003

To: Mrs. Jameela Al-Sammak AdministratorPsych. Hospital

From: Ebrahim Al-Nawakda HID

Subject: Re: Equipments requirements of Psychiatric Hospital

Regarding the above subject and reference to our previous communications, we would like to update you of the status of your requests for PC equipments.

HID has floated a leasing tender for the required PC equipments for year 2004. The evaluation is under process and the expected time for the equipments to be received is February 2004.

Please Note that first priority is to replace the existing old PCs on approval of MoFNE we will be contacting you with respect to the distribution plan.

Thanking you for your continuous cooperation.

Regards,

Ebrahim Al-Nawakda 18.03
Head TSU, HID

Appendix 12

استمارة ديوان الخدمة المدنية رقم 0

CSB Form No. 10
1 May, 2004

استمارة ترشيح لمكافأة نوعية العمل
أو مكافأة العمل الخاص
نظام الخدمة المدنية 430

NOMINATION FOR QUALITY STEP INCREMENT OR AWARD FOR SPECIAL ACT
CSR 430

Ministry: Ministry of Health
Directorate: Periphery Hospitals
Employee Name & CPR No.: Jameela Mansoor Al 630059144
Position Title: Psychiatric Hospital Administrator
Grade & Salary: G10

Nomination For:

- **Quality Step Increment**
- **Special Act** *********

Recommended amount BD:

Date of Previous Awards:
More than one year in services: YES / NO
More than one year in grade: YES / NO

If (NO) to either question,
Employee is not eligible for QSI

Name of Initiating Supervisor: Dr. Hassan Abdulla Al Ja
Position & Grade: Periphery Hospitals Administrator
Signature:

Directorate of Personnel Affairs:
Signature & Grade:

Ministry's Approval:
Name & Position:

الوزارة:
الإدارة:
أسم الموظف ورقمه الشخصي:
الوظيفة:
الدرجة والراتب:
المكافأة المقترحة:

- نوعية العمل
- العمل الخاص

مقدار المكافأة:

تاريخ المكافأة التشجيعية السابقة:
أكثر من سنة بالخدمة: نعم / لا
أكثر من سنة بالدرجة: نعم / لا

إذا كان الجواب لا فأن الموظف غير م
لمكافأة نوعية العمل

أسم المشرف المباشر:
الوظيفة والدرجة:
التوقيع:

مدير شئون الموظفين:
التوقيع والتاريخ:

تصديق الوزارة:
الاسم والوظيفة:

FOR CSB USE:

لاستعمال ديوان الخدمة المدنية:

Reviewed by: **Date:**	روجع من قبل: التـــاريـــخ:
3 copies of this form to be send	ترسل 3 نسخ من هذه الاستمارة

STANDARDS FOR QSI AWARDS	1 of 2معايير لمبررات منح علاوة نوعية العمل
1. justifications must focus on the quality of	1. تركيز المبررات على نوعية العمل.
2. quality performance that reflects deve	2. الأداء النوعي الذي يعكس تطوير أساليب الع
work performance	3. الأداء النوعي بتقديم الاقتراحات البناءة.
3. quality performance by submitting constr	4. الأداء النوعي المرتبط بتوفير الوقت والتكلفة
4. quality performance that saves time & co	5. الأداء النوعي الدقيق وبأقل قدر من الأشراف
5. quality performance learns of accura	6. القيام بمسئوليات إضافية في الحالات الطارئ
supervision	7. تقديم الخدمات للجمهور دون شكاوي أو تأخي
6. performance of extra duties during emerg	8. تقدير أداء ممتاز.
7. provide service to the public without c	
delay	
8. outstanding performance	

Standard for sp. Act awards	معايير لمبررات منح مكافأة العمل الخاص
. Nomination must be submitted within six n	
ıe act whether or not it is duty related.	1. تقديم الترشيحات خلال ستة أشهر من الإن
. Performance of a heroic act such as saving o	مرتبطاً بوظيفة الموظف أو بغير.
r protecting public property	2. القيام بإنقاذ الأفراد أو حماية الممتلكات العامة
. Achievements involving substantial ad	3. الإنجازات المرتبطة بالتحسينات الإدارية
nprovement.	4. تقديم الدراسات والاقتراحات لتحسين ال
. Presentation of project studies and suggestio	ولتوفير المال أو المواد أو الوقت أو القوى العاملة
ı tangible saving in money, time, efforts, m	5. قبول أوراق علمية من قبل منظمات تخصصي
′orkforce.	6. القيام بأعمال تطوعية بارزة لمصلحة الدولة.
. Acceptance of scientific and technical	
rofessional organizations.	
. Performance of a tangible voluntary work for	
f the country.	

justification for Nomination	مبررات الترشيح:

Participations in Forming policies for all the departments under the administrations of the periphery hospitals	
Initiating Supervisor: Dr. Hassan Abdulla Al Jaroodi	المشرف المباشر
Position and Grade: Periphery Hospitals Administrator	الوظيفة والدرجة:

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