AFRICAN JOURNAL OF MEDICINE and medical sciences

VOLUME 34 NUMBER 2 JUNE 2005

ISSN 1116—4077

Afr J Med med Sci (2005) 34, 133-140

Patient satisfaction with the services provided at a general outpatients' clinic, Ibadan, Oyo State, Nigeria

IO Ajayi[1], EA Olumide[2], and O Oyediran[3]
Department of General Outpatients' Clinic[1], University College Hospital and Departments of Community Medicine[2] and Human Nutrition[3], College of Medicine, University of Ibadan, Ibadan, Nigeria

Summary
Patient-based assessments of medical care are increasingly being used to measure the quality of health care. A variety of methods – qualitative and quantitative - are available. However, patient satisfaction surveys are frequently used. Triangulation of methods increases both the validity and reliability of data. This study assessed patients' perception of care provided at an outpatient clinic using triangulation of methods. No evaluation of care provided at this clinic has been carried out since established. Four hundred and seven adult patients selected by systematic sampling technique were interviewed, 10 focus group discussion sessions (FGD) were held and observations were made at the record clerks' desk, nurses' desk and waiting hall. Also, 35 consultations were observed. Generally, all methods revealed high level of satisfaction with the different aspects of care assessed. However, assessment of satisfaction using survey method concealed a variety of negative experiences reported at FGD and observation. These discrepancies were related to satisfaction with the organization of the clinic, attitude of record clerks' and consultation process. The study provided valuable information to assist in improving the quality of care at the clinic; specifically, the long waiting time, attitude of the record clerks, the dearth of basic amenities, deficient patient-doctor communication skills and health promotion services.

Keywords: *Patient satisfaction, triangulation method, measurement, outpatient clinic*

Résumé
Des évaluations des soins médicaux sont incéssament utilisés pour mésurer la qualité des soins de santé. Des variétés de méthodes-qualitative et quantitative sont disponible , cependant les surveillances de la satisfaction des patients sont fréqement utilisées. La triangulation des méthodes augmente la validité et l'acceptabilité des données. Cette étude évaluait la perception du patient des soins approvisionnés en clinique génerale par les méthodes de triangulation. 407 adultes étaient sélectionnés au harzard pour l'interview, 10 groupes focal de discussions (GFD) et des observations au hazard étaient faite a l'unité d 'enregistrement, la table d'infirmérie et la chambre d'attente. Trente-cinq consultations étaient observés. Toutes ces méthodes révelain et un niveau de satisfaction élévé avec different aspects des soins évalués. L'évaluation de la satisfaction utilisant la méthode de surveillance réfutait les expériences négatives observés dans les groupes de discussions. Ces problémes observés étaient liés à l'organisation, l'attitude des employés et la procédure du consultation. Cette étude apporte des informations valables pour améliorer la qualité des soins en clinique et la promotion des services de santé spécialement a l'attente , l'attitude des employés et déplore la rareté des nécessités de base et le déficie de communication entre le médecin et le patient.

Introduction

The quality of health care has become a topical issue in recent years and pressure is on the increase for change in the health care delivery system in many countries [1]. The introduction of quality assurance and medical audit that constitute some of the tools for the change is now an important development in General Practice [1]. Patient-based assessments of medical care are increasingly being used to measure health care quality. Several forces have converged to promote patient perceptions as a measure of health care quality. These include: increasing competition in health care, the emergence of managed care, concerns about potential adverse effects of cost containment policies on access and quality of care, application to health care of industry-based models of continuous quality improvement, attention paid to the doctor-patient relationship and increasing patient's expectations and needs [2].

Patients' satisfaction with care, a patient-based assessment, is strongly associated with perceived problems in the delivery of important aspects of care [3]. Patients' satisfaction assessment can be done using qualitative (case studies, focus group discussion (FGD)) and/or quantitative (survey) methods [4]. Patient satisfaction survey appears to be most favoured and used. While survey method is a more objective method of assessment, it has been frequently criticized [5,6]. Distribution of patients' perception associated with many current instruments is often skewed towards the highest response categories [7,8,9] and the quasi–official atmosphere of interview could make response to be restricted. It has been shown that for studies that require consumer perceptions, an interview may not be sufficient to elicit their candid opinion especially where negative criticism is suggestive. Qualitative

Correspondence: Dr. I.O. Ajayi, Department General Out-patiens', UIniversity College Hospital, Ibadan, Nigeria.

method will provide in-depth information and explanation for responses provided in such interview [10]. The concurrent use of both qualitative and survey methods would provide a more comprehensive and valid picture of consumer's opinion.

No assessment of the quality of care has been carried out in the General Outpatients' (GOP) Clinic, University College Hospital (UCH), Ibadan. The current trend in patient care globally and emphasis on audit [11] requires that the GOP clinic audit the practice in order to give optimal care and ensure patients' satisfaction. This study was carried out to assess patients' perception of the quality of care received at the clinic, identify the aspects of care patients are satisfied with and those they would like improvement upon using both qualitative and quantitative methods. These will provide information that would assist with planning and re-organization of health care delivery at the clinic.

Study setting

Nigeria has 3 levels of health care delivery - primary, secondary and tertiary. The primary level of care is designed to be the most accessible to the people especially in the rural areas. The secondary level care is provided through general hospitals. Many patients make this level their first point of contact with health care while others are referred from the primary level. The tertiary level provides specialized services through the teaching and specialist hospitals. Patients are referred from level one and two to this level of care. However, some patients still go there as their first point of contact with medical care. Such patients are catered for by GOP Clinics that are established by the hospitals for both service and to have patients for teaching and research. This study center is one of such centers. The GOP clinic was established over 3 decades ago as a service center and in 1980 became one of the General Medical Practice/Family Medicine residency training centers in Nigeria. It attends to more than 15,000 patients from Ibadan city and its environs annually [12]. Ibadan is in the south-western part of Nigeria and the major ethnic group is the Yorubas.

Operation of the clinic

Clinics are held daily from Monday through Friday between 8.00am and 4.00pm and on Saturdays till 1.00pm. In the mornings of the clinic days, new patients are assembled in a sorting hall and sorted by senior doctors according to the nature of their illness. Patients selected for registration are directed to the medical records desk for proper registration while others are treated accordingly or referred to appropriate specialist. The records' clerks take the case cards to the nurses' desks from where patients are called to the doctors' consultation cubicles. Patients are seated in the waiting hall while waiting to be called to see their doctors. While waiting, the adult patients get their blood pressure measured and urinalysis done; and the paediatric patients get their weights and temperature measured by the nurses. Patients on follow-up visits also drop their cards at the records clerks' desk for pulling. Thereafter, they go to sit in the waiting hall till they are called to see the doctor.

At the time of the study, there were 5 doctors, 4 nurses, 3 medical aids, 3 medical records clerks, 3 porters and 1 lavatory attendant providing services in the clinic. On the average, a doctor would attend to 30-40 patients per day.

Method

Sample

Questionnaire survey:

A sample of 415 adult follow-up patients who had attended the clinic 3 or more times were selected using systematic sampling technique. Two trained interviewers conducted interview after consultation in the last cubicle on the way out of the clinic from 9.00am till 4.00pm daily (exit interview). The collection of data was from January to March 1998.

FGD: Patients not selected for the interview were selected purposely according to age and sex for the FGD. Ten groups of patients representing adolescents (10-19 years); young adults (20-40 years); adults (41-60 years) and the elderly (>60 years) participated. Each group consisted of 6-8 participants. Three trained assistants facilitated the sessions. Each session lasted approximately an hour.

Observation: Eight observations of activities were made at the medical records' desk and nine at the waiting hall and nurses' desk using checklist. Thirty-five doctor-patient consultations with adult patients were also observed. Three trained observers made these on specified days of the week over a period of 2 months. The personnel and the consultations to observe were selected randomly by balloting while ensuring that each of the personnel was observed on equal or near equal number of times. The inter-observer agreement score of the trained interviewers was 85%.

Ethical approval for this study was obtained from the Joint Ethical Committee of the University of Ibadan/ University College Hospital, Ibadan.

Instruments

Survey:- The questionnaire was developed using questions borrowed from a past study's questionnaire [13,14] and those formed by the investigator based on the culture and local environment of the study site. The developed questionnaire was face-validated by 3 family physicians at the GOP clinic who read through it for clarity, ambiguity and appropriateness to the objectives of the study before pre-testing among 10 English speaking patients attending the clinic. Thereafter, it was translated into the local language (Yoruba) of the intended subjects by an experienced field interviewer and back translated into English by the

health educationist. The Yoruba version was pre-tested among 15 Yoruba speaking patients attending the clinic. Some of the questions from the borrowed questionnaire were dropped after the pre-test based on poor understanding and influence of culture on response rather than objectivity. Also, to avoid responses that are skewed some questions that were "Yes" or "No" questions were made to be in the Likert scale form. Thereafter, another pre-test was carried out before the final questionnaire used for the study was printed out.

The questionnaire items were divided into categories: – accessibility (5 items), organization (25 items), doctor-patient consultation process (29 items), perception of technical competence (5 items), nurses' and medical record clerks' attitude (11 items), general satisfaction and barriers to further use of the clinic (4 items).

The level of satisfaction with various aspects of care provided in the clinic was evaluated using ratings from 3-5 point Likert scale [15]. Each item was scored on response ranging from strongly agree to strongly disagree. Scores for negatively worded items were reversed. Higher scores indicated greater satisfaction. The scores were ranked into "very good" "good" "fair" and poor based on the distribution of the scores and the average score for each of the variables.

Focus group discussion:- A guide was prepared and used to facilitate discussions. The discussions were recorded using audiotapes and note taking.

Observation:- Observation checklist was prepared to guide the observers.

Data analysis

Data analysis was done using Epi-Info version 6.2 and Statistical Package for the Social Sciences (SPSS). Appropriate statistical tests such as Chi square test and t-test were used to test the significance of associations between categorical variables and differences in mean values respectively. The level of significance was at 5%.

The FGD interview tape recordings were transcribed. The text, the field notes and observation notes were analyzed by content analysis (i.e. identifying, coding and categorizing into themes).

Results

The results are presented according to the various aspects of care assessed. For the survey, 407 patients out of the 415 selected responded giving, a response rate of 98%. The non-respondents were too small to detect any significant difference between them and the respondents. The demographic characteristics of the respondents are shown in Table 1. The characteristics of the patients used for the FGD were not different from those interviewed.

Table 1: Demographic characteristics of the respondents

Variables	Number	%
Age group (in years)		
<30 years	87	21.4
31-40	63	15.5
41-50	69	17.0
51-60	111	27.3
61-70	49	12.0
>70 years	28	6.9
Mean age = 47±17 years		
Sex		
Male	154	37.8
Female	253	62.2
Level of education		
Never attended school	178	43.7
Primary school	93	22.8
Secondary	85	20.9
Post secondary	51	12.5
Occupation		
Trading	200	49.1
Schooling	38	9.3
Artisan	35	8.6
Unemployed	34	8.4
Farming	27	6.6
Teachers	16	3.9
Civil servants	15	3.7
Professionals	12	2.9
Others e.g.clergyman, cleaner	30	7.7
Marital Status		
Never married	69	17.0
Married	280	68.8
Separated/Divorce	14	3.4
Widowed	44	10.8

Accessibility

Accessibility was measured by asking questions about opinions on ease of getting transport to and from the clinic, the consultation fee charged and the waiting time.

Survey:- Seventy-five percent of the respondents found it easy to get transport to the clinic. The cost of transportation in 81% of the respondents was less than N20.00 (30 cents). Fifty-one percent of the patients indicated that they have other health facilities near their homes. However, 27.4% of them would not patronize them because of dissatisfaction with the treatment offered, 18.7% preferred UCH because of the good quality treatment available, 17.8% would just not go there and 13.5% would not because they are privately owned.

The mean waiting time was 169 (SD=81 minutes). This was found to be too long by 213 (52.3%) of the patients. A mean waiting time of 67 (SD=39 minutes) was deemed reasonable. It was found that those with higher education waited for shorter period ($X^2 = 17.8$; df = 9 ; p =

0.04) and were more likely to perceive the waiting time as too long ($X^2 = 11.3$; df = 3; p= 0.01).

waiting hall arrangement and the experience in getting tests done. The survey showed that 85-90% of the respondents

Table 2: Summary table of ratings of the various aspects of organisation of the clinic using the rated composite score of respective variables

	Very good n (%)	Good n (%)	Fair n (%)	Poor n (%)
Sorting process N=406	93 (22.9)	291 (71.7)	22 (5.4)	0 (0.0)
Registration N=407	261 (64.1)	126 (31.0)	19 (4.7)	1 (0.2)
Arrangement for getting test done N=298	202 (67.8)	85 (28.5)	11 (3.7)	0 (0.0)
Waiting hall arrangement N=407	145 (35.6)	254 (62.4)	8 (2.0)	0 (0.0)
Assigning patients to doctors N=407	36 (8.9)	312 (76.8)	59 (14.3)	0 (0.0)
Overall N=407	125 (30.7)	264 (64.9)	18 (4.4)	0 (0.0)

Table 3: Respondents responses to some items related to the consultation (n=407)

The doctor...	Strongly agree n(%)	Agree n(%)	Neutral n(%)	Disagree n(%)	Strongly disagree n(%)
was difficult to understand	1 (0.2)	16 (3.9)	0 (0.0)	179 (44.0)	211 (51.8)
gave you full attention	89 (21.9)	315 (77.4)	2 (0.5)	1 (0.2)	0 (0.0)
gave you chance to say what was in your mind	112 (27.5)	289 (71.1)	2 (0.5)	3 (0.7)	1 (0.2)
said/did anything which has helped to reduce your worries	42 (10.3)	258 (63.4)	8 (2.0)	90 (22.1)	9 (2.2)
explained what he understood your problem to be	47 (11.5)	271 (66.6)	8 (2.0)	77 (18.9)	4 (1.0)
explained the treatment of the problem	51 (12.5)	263 (64.6)	7 (1.8)	80 (19.7)	6 (1.5)
taught you how to prevent this sickness	39 (9.6)	207 (50.9)	12 (2.9)	137 (33.7)	12 (2.9)
taught you how to prevent other illness or accident	3 (0.7)	68 (16.7)	15 (3.7)	265 (65.1)	56 (13.8)
You felt understood by the doctor	71 (17.4)	322 (79.1)	13 (3.2)	1 (0.2)	0 (0.0)
The time spent with the doctor was a bit short	68 (16.7)	212 (52.1)	102 (25.1)	17 (4.2)	8 (2.0)
You are satisfied with the present care provided by your doctor	168 (41.3)	218 (53.6)	18 (4.4)	1 (0.2)	2 (0.4)

FGD: Accessibility was expressed to be good and only few had difficulty seeing their doctor when they come on days other than their appointment dates. The most important and emphasized issue at discussion was the patients' dissatisfaction with the long waiting time. Majority of the discussants would like a time specific appointment put in place.

Organization of the clinic

The organization of the clinic was assessed in general and by individual aspects of the organisation which included the registration process, assigning of patients to doctors, assessed the over all and individual aspects of the organization of the clinic to be good (Table 2). The FGD revealed that many of the participants were not aware of how patients were assigned to doctors. Majority of them had the opinion they were being assigned to a doctor who is a specialist in their ailment.

An interesting finding was the discrepancy between the high percentage (98%) of interviewee that perceived the waiting hall to be good and conducive at the survey and the negative findings at FGD and observation. At FGD, the general response is that the waiting hall was not conducive. This was compounded by the long waiting

time. The complaints included uncomfortable benches, stuffiness and poor ventilation, non-provision of electric fans and overcrowding. Many of the discussants were of the opinion that diseases can be contracted from other patients and suggested a bench should be made for maximum of 4 persons or separate seats be provided for each patient to minimize this possibility. Below are some quotes to support the findings: "a very busy person will be embittered about the time he would be wasting while waiting to see the doctor" (a 46 year old patient who claimed she has lost economic time) "this place is stuffy and can contribute to one's illness. It would have been better if spacious place with adequate seats can be provided". During observation at the waiting hall, resentment of patients at the long waiting time, the discomforts with the benches and patients' helplessness in the situation were corroborated.

Consultation

The responses to some of the items used to assess the consultation process are shown in Table 3. The analysis of the composite score used to rate the consultation process was opined to be good by 238 (58.5%), very good by 160 (39.4%) and fair by 9 (2.2%) of the patients. None of the patients judged the process to be poor. A high proportion [390 (95.8%)] of the patients were satisfied with their doctors. However, 4 (0.9%) would like to change their doctor while 394 (97%) expressed willingness to recommend their doctor to a friend. The outcome of care was positive in 338 (83%) respondents. They reported their illness improved after visit and use of recommended treatment.

The mean (SD) consultation time was 7.5 (±4.5) minutes. There was no statistically significant variation in consultation time and the demographic variables ($P>0.05$). However, the trend suggested that the educated and younger patients spent less time at consultation. The consultation time significantly influenced the assessment of the consultation, $X^2 = 8.2$; df = 3; p = 0.02. More of those seen for more than 5 minutes rated the consultation to be very good compared with those seen for shorter period. Further analysis to determine the association between responses to items on consultation and the consultation time showed significant association only between doctor being warm and friendly and the consultation rated as good, $X^2 = 14.6$; df = 2; $P = 0.05$.

FGD: The general reaction to the consultation was that the doctors attended to them and treated them well. Majority of the participants commented their conditions improved following their visit to the doctor. The drugs the doctors prescribed usually help to alleviate their problems. The attention given by the doctors was said to be encouraging and gives them confidence that there ailment would be ameliorated. To support these findings is this quote:

> *"the doctors here are very educated, they also investigate all that is wrong and bring out the cause of disease unlike the "quack" doctors. They are very distinct and competent".*

Many of the discussants were satisfied with seeing the same doctor on each visit. They believed this allows for continuity of care and better relationship with their doctors. Some dissatisfaction was expressed and these bothered on privacy and interruption of doctors during consultation. They expressed concern about how doctors discuss their problems with medical students to the hearing of other patients. The arrangement of the sitting in the consultation area was faulted and as some patients put it:

> *"the location of benches they ask us to sit on is not good enough because when a patient is talking to the doctor, other patients will be listening"*
> *"I have much to discuss with the doctor but these are very private matters which I found difficult to share in the presence of other patients. I would have been more 'open' if privacy was provided".*

Other comments include:

> *"anytime doctors are attending to patient, those nurses come around to interrupt which is not good".*
> *"They leave us on the seat to attend meetings".*

The little or non-provision of health promotion and disease prevention services was also mentioned as an aspect of dissatisfaction.

Observation: The observers' comments on the consultations further corroborated the findings at interview and FGD. Only 8 (22.9%) consultations were observed to have included health promotion advice and information on the use of prescribed drugs. Consultation interviews were conducted mostly by using close-ended questions and the doctors did not seek the patients' opinion concerning their illnesses nor did they provide much explanation about the illness the patients present with.

The observation revealed some attitudinal deficiencies. It was only in 14 (40.0%) of the consultations that doctors were observed to have good rapport, listened patiently to the patient and put patients at ease. In 15 (42.9%) consultations, patients expressed gratitude to their doctors after consultation. In most consultations involving adolescents accompanied by their parents, doctors directed their questions mostly to accompany persons rather than to the patients. Interruptions during consultation were reported in 25 (71.1%) of the consultations.

It was observed in 10 (28.6%) consultations that patients were blamed for their actions or behaviours regarding the approach to seeking care. Also, in 2 (5.7%) consultations, the doctors disregarded the expressed opinions of patients on their illness.

Attitudes of the doctors, nurses and records staff
Overall, 80%-90% of the respondents perceived the attitudes of the doctors, nurses and record staff to be good. However, going by individual items 4 (1%), 13 (3.2%) and 23 (5.8%) of the respondents mentioned the doctors, nurses and records clerks, respectively, upset them by the way they spoke to them. The nurses and records clerks did not provide information to assist respondents in 79 (20%) of the cases, respectively.

Similar to findings at the interview, majority of the discussants at FGD expressed their relationship with doctors and nurses as cordial. They also found them to be caring and provided necessary information. They found the medical records staff to be competent.

However, FGD and observations were found to be superior to the survey interview in that they provided in-depth information on the attitudes of the staff and negative criticism were expressed with no inhibition. Many of the respondents expressed that the records clerks were hostile to them.

During observation, while some clerks were found to be impolite to patients on some days; and some patients were also noticed to be rude to the clerks and this precipitated or aggravated the unfriendly behaviour of the clerks. Only on few instances were some of the nurses found to be impolite and only a doctor was mentioned to be "harsh" in one of the observations

Overall assessment of the Clinic
Three hundred and sixty-one (88.9%) patients assessed the overall performance of the clinic to be very good while 46 (11.3%) rated it as good. However, 126 (31%) expressed some other form of dissatisfaction such as lack or shortage of diagnostic equipments, doctors, social amenities like water, electricity supply and toilets.

The FGD also revealed that all the participants were satisfied with the care received at the clinic. There was some recognition that accurate diagnosis; efficient treatment of illness, cordial attitude of staff and the presence of specialists motivated the continued patronage by the patient. Comments include:

> *"there is no sickness that is hard or big for them (UCH) to treat";*
> *"if there is any illness which is brought by a patient to this practice and they are unable to tackle it, I doubt if there is any other place which can cure it because their work here is good and unique"*

General
Suggestions made by respondents to improve the quality of service provided in the clinic include:

> *"attending to patients on time",*
> *"employ more doctors and nurses"*
> *"provide more equipments",*
> *"make drugs less expensive and ensure availability of drugs all the time",*
> *"provide conducive sitting area and provide necessary amenities including clean toilets and "train staff especially record staff" on public relations.*

Discussion

One important way to strengthen a study design is through triangulation, the combination of methods in the study of the same phenomenon or program. Triangulation of methods will most often revolve around comparing data collected through quantitative methods with that collected through qualitative methods [16].

The use of triangulation in this study corroborated the superiority of the approach compared to the single-method approach to evaluation of a program. The weakness of one method was compensated for by another method. The use of both qualitative (FGD and observation) and quantitative (survey interview) research methods in this study provided a comprehensive and broad view of patients' perception of the organization of the clinic and the process of providing medical care to the patients. The study revealed a high level of satisfaction with most of the different aspects of services provided at the GOP clinic especially from the survey interview. The aspects of care where qualitative methods were found to be most complementary to quantitative methods are in the evaluation of the organization of the clinic, personnel attitudes and some aspects of the consultation.

The observation that assessing satisfaction with health services using quantitative methods commonly produced skewed responses toward the highest response categories was corroborated in this study [7]. The overwhelming positive response to most questions on various aspects of the consultation could be adduced to the fact that the doctors where found to be caring and showed some concerns on patients' illness. Also, the high regard and esteem enjoyed by the medical profession worldwide may well produce in patients a reluctance to criticize their doctor [17]. The survey data were obtained by interview rather than by a self-reported questionnaire. Furthermore, the questionnaire used in this study was adopted from studies done outside of this country. It is unknown how much these factors influenced the response of the patients. There is a need to develop instruments that are sensitive to local needs as culture and the country-specific health care system may have significant influence on both the way the questions are asked and the type of responses [18].

The qualitative method provided better information on the organization of the clinic and attitudes of staff than the quantitative approach. Most of the negative criticisms of the care provided were obtained from the qualitative approach (FGD and observation). This is in support of the suggestion that for studies that require patient perceptions, an interview may not to be sufficient to elicit

respondents' candid opinion especially where negative criticism is suggested. Qualitative methods will provide in-depth information and explanations for responses provided in such interviews [10].

The technical competence of the providers was found satisfactory and less criticism was on this aspect of care. This may agree with the finding that patients may be unable or less willing to criticize the technical competence and skill of providers because of the dearth in their own knowledge concerning their illness and health generally [19]. The high level of satisfaction expressed in this study is of course not necessarily synonymous with a high standard of clinical care [17]. This may be possible because the patients had nothing better to compare with hence were satisfied with the one they know.

The aspects of service patients in this study were dissatisfied with which include organization of the clinic; attitudes of the personnel and the inadequate prevention services corroborate findings in the literature. Practice characteristics associated with falls in patient satisfaction include absence of a personal list system, long waiting time, large practice and practice being a teaching practice [20]. Information delivery and staff expressive quality have also been positively associated with overall satisfaction by patients [21]. The patients' perception of the nurse and doctors as being caring may have contributed to the high level of satisfaction with care in this study as suggested in past studies [22,23]. The inadequate health promotion and disease prevention services provided in this practice need to be improved upon as a positive association has been demonstrated between being advised to have a preventive service and reporting satisfaction with care [24]. Improvements in the ways patients are addressed and treated as well as the clinic environment are needed to enhance patient satisfaction in this practice.

The findings in this study apply to one practice only and may not be representative of attitudes of health care providers and the quality of care provided in other clinics in Nigeria. However, the findings give further support to the importance of patients' assessment of quality of care in a general practice setting. General practitioners need to review the organization of their practice to ensure an acceptable balance between the requirements of modern clinical care and the wishes of patients. Future studies should take account of the many variables that can influence patient satisfaction.

Conclusion

The use of FGD and observations has been complementary to the survey in this study. There is suggestion that FGD and observation could be used to conduct patients satisfaction assessment in the absence of a survey instrument, for rapid assessment and especially when there are limited funds for triangulation of methods. This study provided valuable information to assist in improving the quality of care at the GOP clinic.

References

1. Grol R and Wensing M. Implementation of quality assurance and medical audit: general practitioners' perceived obstacles and requirements. Br J. Gen Pract 1995; 45(399): 548-552.
2. Khayat K and Salter B. Patient satisfaction surveys as a market research tool for general practices. Br J Gen Pract 1994; 44(382): 215-219
3. Cleary PD, Levitan SE, McMullen W and Delbanco T.L. The relationship between reported problems and patient summary evaluation of hospital care. Qual Rev Bull. 1992; 18:53
4. Wilkin D, Hallam L and Dogget M. Patient satisfaction and measure of patient satisfaction. Oxford University Press, Oxford. 1992; Chapter 9:231-260,
5. Williams B, Coyle J and Healy D. The meaning of patient satisfaction: an explanation of high reported levels. Soc Sci Med 1998; 47(9):1351-1359.
6. Ross CK, Steward CA and Sinacore JM. A comparative study of seven measures of patient satisfaction. Med. Care 1995; 33: 392.
7. Nelson EC, Hays RD, Larson C and Batalden PB. The patient judgement system: reliability and validity. Qual Rev Bull 1989; 15:184.
8. Rashid A, Forman W, Jagger C and Mavin R. Consultations in general practice: A comparison of patients and doctors satisfaction. BMJ 1989; 299:1015-1016.
9. Leimkuhler AM and Muller U. Patient satisfaction – artefact or social reality? Nervenarzi 1996; 67(9): 765-73.
10. Locker D and Dunt, D. Theoretical and methodological issues in sociological studies of consumer satisfaction with medical care. Soc Sci and Med. 1978; 12: 283-292.
11. Maher D. Clinical audit in a developing country. Tropical Medicine and International Health 1996; 1(4):409-413
12. Ajayi IO. 5 -year trend of patients population in GOP Clinic, UCH, Ibadan. Analysis of GOP Clinic Medical Records 1994-1998. UCH Medical Records. In: Patients satisfaction with the quality of services in the General Outpatients' Department of the University College Hospital, Ibadan. A dissertation submitted in part fulfillment of the requirements for the Master Degree of Public Health (MPH), University of Ibadan. 1999.
13. Howie JGR, Porter AMD, Heaney DJ and Hopton JL. Long to short consultation ratio: a proxy measure of quality of care for general practice. Br J of Gen Pract 1991; 41:48-54
14. Howie JGR, Heaney DJ and Maxwell M Measuring quality in general practice. Br J Gen Pract 1997. Occasional Paper 75. Publisher:The Royal College of General Practitioners

15. Hulley SB and Cummings SR (eds). Designing Clinical Research. Williams and Wilkins. USA, 1988.
16. Denzin, NK The research act in sociology. London: Butterworth. 1970; 313.
17. Kaim-Caudle PR and Marsh GN. Patient satisfaction survey in general practice. BMJ 1975; 1:262-264.
18. Baider L, Ever-Hadanu P and De-Nour AK. The impact of culture on perceptions of patient-physician satisfaction. Israel J of Med Sci 1995; 33(2-3): 179-85
19. Calnan M. Towards a conceptual framework of lay evaluation of health care. Soc. Sci. Med. 1988; 27: 927-933.
20. Baker R. Characteristics of practices, general practitioners and patients related to levels of patients' satisfaction with consultations. Br J Gen Pract 1996; 46(411): 601-605
21. Thompson DA, Yarnold PR, Williams DR and Adams SL. Effects of actual waiting time, perceived waiting time, information delivery and expressive quality of patient satisfaction in the emergency department. Ann Emerg Med 1996; 28(6): 657-665
22. William SA. The relationship of patients' perception of holistic nurse caring to satisfaction with nursing care. J Nurs Care Qual 1997; 11(5): 15-29
23. Flocke SA. Measuring attributes of primary care: development of a new instrument. J Fam Med 1997; 45(1): 64-74
24. Morris NM. Respect: its meaning and measurement as an element of patient care. J Pub Hlth Pol 1997; 18(2): 133-154

Received: 02/07/04
Accepted: 09/02/05