

Leadership and Patient Satisfaction in a Tertiary Health Care System

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Abstract

Patient satisfaction is one of the best indicators for measuring the success of the services being provided in a health facility. This study investigates the leadership factors that influenced patient satisfaction in the tertiary health care facility of the University of Benin Teaching Hospital, Benin City, Nigeria. This hospital based cross-sectional study was anchored on the social action theory, Talcott Parsons sick role model and concept of bureaucracy. Using a multi-stage sampling technique, 420 in-patients were randomly selected from five different units (Medical, Surgical, Pediatrics, Obstetrics, and Gynecology and Emergency) of the hospital. Data was collected using semi-structured questionnaire and five in-depth interviews (IDIs). Quantitative data were analyzed at univariate and bivariate levels, using descriptive statistics and Chi-square test while qualitative data were content analyzed. Findings revealed that there were good knowledge and level of awareness of the services available. Majority of the patients claimed that they were satisfied and rated the satisfaction experiences as moderate satisfaction with the health care services of the professional doctors and nurses in the hospital. Education ($p < 0.020$) and income ($p < 0.032$) were found to be significant socio-economic factors influencing patient's satisfaction. Answers doctors provided to patients' questions and prescribed drug administration by nurses to the in-patients were derivable from the leadership factors and thus influenced patient's satisfaction with the health care services. Results on answers doctors provided to patients' question ($p < 0.001$) and prescribed drug administration by nurses to the in-patients ($p < 0.0073$) were significant leadership factors. Similarly, from the qualitative data, doctor's communication and interaction greatly influenced patient's satisfaction with leadership ethos of health care providers. Management should organize stakeholder's forum comprising of doctors and nurses' leaders from among the health care providers and in-patients with common health

conditions where subjective needs assessment of patients could be discussed within the hospital.

Keywords: patient satisfaction, tertiary hospital, health care services

Background and Statement of the Problem

The primary goal of a tertiary hospital is to provide the best possible care to patients. Professional health care leaders play significant roles in providing health care services in health facilities that can bring about patient satisfaction. Patients' satisfaction with health care services is regarded as a subjective feeling of contentment expressed by the patients themselves in which he/she feels that their expectations concerning health care are met by the services provided and received (Ware, Snyder and Wright, 1983). Despite the efforts of the federal government at renovating the tertiary hospitals and employing qualified doctors and nurses along with the purchase of modern equipment in hospitals, (FMOH, 2004; Erah, 2009) patients' desires and expectations to receive health care services in a way that gives them satisfaction with the health care services provided by professional health care leaders have received negligible attention. This is worrisome especially as there are indications that services provided at these health facilities are generally perceived as being very poor (Afolabi and Erhun, 2003).

Tertiary hospitals in Nigeria perform various functions that include health care services for the sick, teaching, research and a range of activities with the primary goal of improving health, general well being and social functioning of sick persons seeking help and treatment in these health care facilities (Smith, Sinclair, Raine and Reeves, 2010; Erinosh, 2005). Iiyasu, Abubakar, Abubakar, Lawani and Gajida (2010) in their studies noted that patients face several problems both as in-patients on the wards, as well as out-patients in the different out-patient departments. Such problems include long waiting time, delay in attending to patients, long delays before getting results of investigations, missing or misplaced patients case files, unavailability of drugs and high cost of drugs. Other issues leading to patient's dissatisfaction with health care services in the tertiary hospitals include overcrowding in the admission wards, delays in consultations and lack of proper guidance from health care workers (Skinvasion, 2000; Jawahar, 2007).

Patients' satisfaction with the delivery of care by hospital personnel (doctors and nurses) who are health care professional leaders is very important. According to Cole (2005), leadership is the ability to influence a group towards the achievement of goals. It is essentially a process in which one individual influences the efforts of others towards the achievement, in a given circumstances. Thus, it is a social process and a part of management involving the achievement of defined objectives and goals. Robinson (1988) defines leadership as social process in which one person in a group harnesses the knowledge, skill and motivation of the others in the achievement of the group's goals.

In any organization, leadership is crucial, as an act of influencing the actions, behaviours, beliefs, and goals of one individual in a social system by another actor with the willing cooperation of the one being influenced. Leadership is an ongoing process in which its activities involve individuals with an unequal distribution of power among leaders. The focus of leadership is the accomplishment of goals as outcome. In the health industry, the healthcare team is multidisciplinary with different health care professionals having different goals and skills and also having different kinds of relationships/interactions with patients and clients. The functional headship of the teaching hospital when it comes to the actual individual patient management, are the medical doctor and nurses who are officially designated with this responsibility. According to Asuzu (2012) and Aina (2012), evidence have shown that professional's interaction with their patients can substantially influence patient satisfaction; for example, the importance of good doctor/patient relationship is well documented in literature while poor patient/doctor communication is a major reason for dissatisfaction with health care service (Owumi, 1989).

A survey conducted in Brazil showed that most respondents were satisfied with delivery of care by health personnel. This might be due to the fact that the respondents being of low literacy level might not want to admit that they do not understand the physician's medical jargon (Jaipaul and Rosenthal, 2003). In a similar study conducted in Uganda in a tertiary institution, respondents declared high levels of satisfaction (Kulkami, Dasgupta, Deoke and Nayse, 2011). Studies in Nigeria also reported high levels of satisfaction with delivery of care provided by doctors and nurses (Iliyasu *et. al.*, 2010; Ajayi, 2000; Oyediran, 2005). These reported high satisfaction levels might be due to the nature of healthcare in Nigeria where the physician is often perceived as doing the patient a favour rather than as a service provider. On the contrary, a satisfaction survey conducted in the dental outpatient clinics of the Lagos University Teaching Hospital, Nigeria, however reported that patients expressed dissatisfaction with the practice of allowing unsupervised students to attend to them (Adeniyi and Onajola, 2010). This was also the case in another study that compared public and private institutions. Findings revealed that study participants showed dissatisfaction in the aspects of physician conduct/interaction with the patients (Messina, Scott, Ganey and Zipp, 2009).

In-patients' satisfaction is an increasingly important issue both in evaluation and in the shaping of health care services for any nation. In the past, patients have been viewed as passive recipients of health care services and voiceless, whereas patients' desire is to receive health care services and be treated in a way that gives them satisfaction. Different health service research reports have indicated however that those patients who are satisfied with health care services from health facilities in the developing countries behaved differently from those who are dissatisfied (Reeder, 1972; Wilson, 1980; Linn,

Linn, Stein, 1982; Freidman, 1979). Similarly Owumi (1989) noted that the compatibility of patient's expectation and the physician's performance have important implication for treatment outcome. Alliyu and Oduwole (2005) in their study of patients presenting with STIs and other conditions in the teaching hospital, revealed that patients have certain expectations about the facilities and these expectations become the basis for satisfaction or dissatisfaction. Patients also expect prompt attention which can compromise their satisfaction when lacking.

This study therefore, investigated leadership activities in terms of major interactions in health care service provision between the clients of the teaching hospital (in-patients) who have various expectations and are also recipients of health care services and the professional health providers (doctors and nurses), whose duty it is to provide the desired health care services. A consideration of leadership and patients' satisfaction is not only important to the leaders in the health care industries in terms of addressing the expectations of patients but also an important factor in the continued use of these services by the patients (Dutton, 1978).

Previous studies show that not only do the users of health facilities want full information about the nature of the ailment for which they are admitted; they also want to know about their treatment, the drugs prescribed for them and the administration of the prescribed drugs either by the doctors or the nurses (Alliyu *et. al.*, 2005). The concept of patients' satisfaction is complex and multidimensional, patients' view of some core health care services provided by professional health practitioners (doctors/nurses') in the University of Benin Teaching Hospital Benin City, Nigeria was considered as an outcome measure from the following perspectives:

1. Doctor's communication (clarity of communication between patient and doctor)
 - receive intelligible answers to questions asked.
 - receive adequate information from doctors regarding treatment regimen.
2. Patient/doctor relationship (interaction).
3. Nurses behaviour in providing nursing care services in terms of
 - administration of doctors' prescribed drugs
4. Obedience of patients to health advice and compliance.

The study was designed to address the following objectives, to assess the knowledge of patients about the benefits of the use of health care services in the UBTH; determine the level of patients' satisfaction with the health care rendered by teaching hospital core health professionals (doctors and nurses); and assess the patients' willingness to obey/comply with professional advice in order to continue with the use of the health care services.

Theoretical Framework

This study is anchored on Talcott Parsons' sick role model, social action theory and concept of bureaucracy, as the theoretical framework and effort was made to triangulate the theories.

Parsons' Sick Role Model

Sick role model was advanced by Talcott Parsons (1951) and emphasizes the social dimension of illness (sick role) and social expectation. The main thrust of the theory is on how social expectations and cultural beliefs and practices surrounding sickness and illness management influence how the sick person behaves within the social context in the therapeutic milieu. To Parson, being sick confers a social role (sick role) with people who are sick acting in different ways according to the culture of the society. Talcott Parsons' sick role model explains patient/physician relationship and patient/nurse relationship during illness management within the framework of social roles and expectations. Talcott Parsons (1951) argues that illness is not purely a biological state but has a social dimension to it.

Thus, the sick role describes the patterns of behaviour that the sick person adopts in order to minimize the disruptive impacts on others. Parsons argues that the patients and doctors, the patient and nurses are acting out roles in a complementary but asymmetrical role relationship. The obligation on the part of the sick to get well involves a further obligation to seek technically competent help usually from a physician (doctor) and the nurse. The sick person is also expected to co-operate with the physicians and nurses in the process of trying to get well.

In applying the theory to the users of health care services and in the role of patients, the sick (patient) enters into a social relationship with the medical and health professionals- the doctors and nurses. According to Parsons, patients, doctor and nurses are acting out prescribed roles. The role of the sick person is deemed to be undesirable; patients are expected to desire better health condition, to voluntarily seek professional health advice and cooperate fully with the doctor and other health care providers (HCPs). The roles of the patients/doctors are also characterized by rights and expectations. Doctors are expected to use their skills and expertise for the benefits of their patients. In the course of their duties they have the right to conduct physical examinations and ask patients question about their physical health and personal circumstances.

A major expectation concerning the sick individual in our society particularly in Nigeria is to seek health care services and advice and also cooperate with the professionals. This behaviour is predicated upon the assumption made by Parson that being sick is an undesirable state and the sick person desires a healthy state. By engaging in illness management, with the behaviour of acceptance and co-operation in using the health care services he/she becomes involved with the role of the professional doctor/nurse in a

complementary but asymmetrical role relationship as one of obedience to expected norms and medical directive thus and health care services become a mechanism by which a social system seeks to control the illness of the sick persons by returning them to the normal state of functioning as possible. Health care services (Hospital Services) are oriented towards a supportive/creative notion of patient welfare.

The sick or injured persons, following admission into the wards are organized into various patient units, namely emergency, medical, surgery, ophthalmic, haematology, neurology, orthopaedics, urology, paediatrics, maternity/obstetrics and gynaecology and psychiatric. Thus, this organization reflects the medical staff definition of their illnesses. Part of the orientation in the wards includes giving information about visiting regulations and instruction on type of food to eat. The visiting regulation does not only control when patients are allowed to have visitors, but also who is allowed to visit and the duration. In addition, the nurse supervises the diet/food served, decides the general conduct and social life in the hospital.

Social Action Theory

Social action theory examines the cause and effect relationship in human relationship within a specified social context. It explains the subjective meaning patients attach to social behaviour in the therapeutic milieu as they receive health care services (Haralambos and Holborn, 2008; Olutayo and Akanle, 2013). According to Enaikele (2013) social action is that which individuals are acting with others in mind. For Weber it is only when the subjective meaning behind an action is understood that an action could be regarded as social. This implies that a patient will take health related action such as acceptance of health related instructions in interactions with health professionals who are also viewed as leaders (doctors), involvement in undressing for physical examination, acceptance of drugs/treatment administration and the serving of food in the context of present analysis, when the patient understands the action of the health professionals by interpreting the action provision of care services) and attaching meaning.

Their interpretation, subjective meaning and understanding of action produce a willingness to continue to use or discontinue with patronage at the hospital as outcome of their subjective evaluation. The patient/care givers ascribe meaning to the different activities of care provisions by the medical and health care professionals which are oriented to bring about better health in the patient's life who is admitted into the hospital. This is the most consistent individualized approach to understanding the intentions/motive of individual actors (the in-patients) who are ill and receiving healthcare in a given social context is relevant in explaining the subjective meanings attached to behaviour that are associated with use of health care services among in-patients in the tertiary hospital (with regards to satisfaction with healthcare services). It provides an individualized approach to understanding the motives or intentions of individual actors within the health institution. Applied to this study, the

theory provides a basis for understanding the subjective interpretation of the outcome of interaction between the patients and health care professional leaders within the therapeutic milieu.

Max Weber Concept of Bureaucracy

Max Weber concept of bureaucracy which emphasizes strict adherence to strict rules and regulations governing organizational activities was also adopted. Black and Gruen (2009) observed that the concept of bureaucracy is summarizable in the following ideas; hierarchy, continuity, impersonality and expertise.

Hierarchy- In the teaching hospital for example people engage in narrowly defined tasks and work under rules. Among the doctors for example, power is distributed according to defined area of competence in the discipline. Authority and responsibility are clearly defined for each one, following the hierarchy. Doctors work in hierarchies with other doctors while providing treatment and health care to patients. In the provision of treatment, the Consultant is the most senior in the hierarchy who gives instructions that should be followed, and next in the hierarchy is the senior registrar which is closely followed by the registrar and house officer, who does the write up of prescription on paper and the running around for the seniors in the profession.

Similarly, nursing leaders have their own hierarchy of leadership starting with the deputy director of nursing services. However in the administration of the wards, the Ward Managers give directives to other nurses. Members of different professional roles are oriented to different tasks. Thus the administration of drugs prescribed by doctors to the patient is carried out by the nurse on duty. This important leadership role of nurse is not done haphazardly but follows laid down rules. Therefore the administration of drugs prescribed by doctors to the patient by the nurse leader is an outcome of complexity of division of labour. The physician who is the medical expert in the field does the prescription which can be at different levels. The drugs prescribed by doctors are carefully looked at and then administered by the nurse in a manner that will be acceptable to the patient. The patient has his/her right to accept and show compliance or reject. While this flow is significant, acceptance however reflects assessment of leadership of the different professional leaders.

In Weber's view, bureaucracy is a consequence of increasing complexity of division of labour. It is in the light of Weber's approach to organizational structure, that the tertiary hospital is seen as a tightly structured organization that functions in accordance with strict bureaucratic rules and regulations. The teaching hospital by its size and complexity develops the characteristics of bureaucracy. Thus, the teaching hospital houses in one place medical experts of various specialties with a great deal of division of labour and delegation of authority between the various hierarchies of medical officers which spreads from (1) the consultant through the senior registrar to the registrar and the

house officer and the various functional units. Amongst this professional group, there is a distinct and clear division of integrated activities which are regarded as duties inherent in the office. These types of hierarchies that exist can negatively or positively affect the interaction between the patients and the health professionals (doctors/nurses) and invariably the outcome of health care provided and received.

Methodology

Study Area

The study was carried out at the University of Benin Teaching Hospital (UBTH) which is located on a large expanse of land (a 150-acre site) in Benin City, along the Benin-Lagos Highway in Edo State. It shares boundary with the main campus of the University of Benin, Benin City to the West, to the east, its other boundary is with the Federal Government Girls College road, Benin City. The University of Benin (former Institute of Technology) was founded on Sunday, 23 November, 1970. The University of Benin Teaching Hospital is an integral part of the University of Benin which was established by law in the Edict No. 3 of 1975 Midwestern State of Nigeria. Since 1973, the University of Benin Teaching Hospital as a training institution provides effective practical medical training for medical/dental undergraduate students of the University of Benin, Benin City.

The structural organization of the hospital shows that in a simple form, the departments are located and grouped into functional complex. They are made up of the Consultant Outpatient clinic (COPD), the Physiotherapy Department, the Special Investigation Unit, Ophthalmic Complex, Male medical ward A1, Female medical ward A3, Male and Female stoke ward 5, Male Surgical ward B4, Male Surgical Orthopaedic Ward B2, Gynaecological Ward A2, Renal Unit, Intensive care Unit, Male and Female Neurological ward, Labour ward and Paediatric ward P. New Accident ward1, Emergency ward, Maternity wards (Prof. T.B. Osagie Maternity ward) and Prof. P.N. Ajobor Maternity ward.

This study location was purposively selected because it is a Federal Tertiary Teaching Hospital with highly qualified professional health team members and state-of-the-art facilities provided by the federal government.

Study Design

The study design was a hospital based cross-sectional design. The study collected primary data using several research methods including a survey and in-depth interviews (IDIs).

Study Population

The Study population for the quantitative data comprised patients admitted into the hospital wards in the five different units/departments which include; Medical, Surgical, Obstetric and Gynaecological, Paediatric and Emergency units.

Inclusion criteria were: 1. In-patients who have been admitted into the wards for not less than forty-eight hours 2. In-patients, who are conscious, well oriented to time, place and person. 3. In-patients with good mental status. 4. Patients who give their consent 5. Significant others/care givers who stood proxy in the paediatric unit and under-age.

Exclusion Criteria

Patients who are unconscious, patients admitted into the wards that have had health care for less than forty-eight hours, and patients who refuse to give their consent to participate in the study were excluded.

Sample Size

The sample size was calculated from the confidence interval for the population mean using the formula below:

Sampling Methodology

A multi-stage sampling technique was adopted in the selection of samples from the five different units/departments of the hospital. The first stage involved the purposive selection of the 5 units/categories of the hospital units providing medical care, surgical care including orthopaedics, neurosurgical and ophthalmology, obstetric and gynaecological care and ante-natal care, paediatrics care and emergency care. This was followed in the second stage, by proportionate allocation of respondents in the different units (86, 86, 89, 87, and 74, respectively to each unit). The final stage involved simple random selection using balloting.

Data Collection

Some crucial steps were taken to ensure that reliable and relevant data were collected. These included the selection and training of research assistants, negotiating access to the respondents, the administration of the instrument and the conduct of interviews and qualitative sessions. Four research assistants were recruited and trained on the focus, objectives and various themes to be addressed. The data collection was undertaken in six weeks.

The structured questionnaire schedule contained both close and open-ended questions, which were pre-coded. The questionnaire was pre-tested among 20 in-patients in a teaching hospital before the final copies were produced, following the necessary exclusions and inclusions. In-depth interviews (IDIs) were conducted among the patients/significant others by the researcher and discussions were tape recorded along with note taking during the interview sessions.

Data Analysis

The pre-coded quantitative data were sorted and cleaned and analyzed with the Statistical Package for Social Science (SPSS). Data analysis was carried out at two levels: the univariate and bivariate levels in line with the objectives of the study. At the univariate levels, descriptive analysis of data was done using percentages and frequency distribution of variables while at the bivariate levels, cross tabulations that identify important associations between variables were done. Associations between the variables were defined by the chi-square test that had probability values (P-values) of less than 0.05.

Qualitative data analysis from the IDIs involved translation and transcription of tape recorded discussions and interviews. The data gathered were read, coded and organized thematically to enable ease of comparison of similarities and differences between various groups of respondents. Useful quotes were thereafter used to elucidate and support quantitative data. The resulting data were analyzed using manual content analysis. Information gathered along with the insight generated was imported into the different aspects of the study findings based on their relevance to the study discourse.

Ethical Consideration

In compliance with ethical standards on research work involving human subjects, the researchers obtained the approval of all relevant authorities. Ethical approval was obtained from the University of Ibadan Institutional Review Committee (UI/IRC) and the University of Benin Teaching Hospital Ethical Committee. During the entire period of the field work, ethical considerations were emphasized. The participation of the respondents was based on informed and voluntary consent. Confidentiality was assured and the respondents were also assured that they were at liberty to withdraw from participating at any time if they so desire at any time and will not be used against them.

Results

Socio-demographic characteristics

The socio-demographic profile of the respondents for the study revealed that 62% were females while the remaining 38.3% were males. This indicates that there were more females than males in the sample. This may be due to the fact that women undertake caring responsibilities not only for themselves but for other members of the family. This current study reveals a larger proportion of female than the male respondents. This finding confirms the views of Erinoshio (2005) and Jegede (2013) that women do not only undertake more caring responsibilities, not only for them but are saddled with the responsibilities of caring for their spouses and other members of the family.

From the sample, the age of respondents ranged from 20 to 70 years and above. More than half (70.0%) of the respondents were married. Regarding professed religion, majority (96.0%) of the respondents were Christians, with less than 2.0% who are Muslims, while the remaining about 3.0% belong to the

African Traditional religion. This is not surprising because the study area is predominantly inhabited by Christians. Majority of the respondents with secondary education constituted the highest cluster, representing 42.0% of the total population.

In terms of ethnic composition, the majority of the respondents are Binis, represented by 57.0% and followed by respondents from Yoruba (8%), Igbo 12.0%, Hausa 1.0%, while respondents from "other" ethnic groups constituted 22.0%. The occupational distribution shows that 44.0% of the respondents were self employed, 20.5% had no jobs at all, only 16.0% were civil servants, 9.0% said they are teachers, while 9.0% are full-time housewives. More than half of the respondents 55.0% earn less than N20,000 monthly.

Table 1: Respondents assessment of satisfaction with doctor's communication with in-patients by sex

Gender	Doctor's communication with in-patients on illness type			Total
	Low satisfaction	Moderate satisfaction	High satisfaction	
Male	5.0%	20.0%	13.6%	38.6%
Female	2.9%	31.4%	27.1%	61.4%
Total	7.9%	51.4%	40.7%	100%

Chi-square= 10.739, df=2, P-Value= 0.004

Table 2 is a cross tabulation of the outcome of interaction during illness management with the professional health care leadership by sex which shows a relationship at 0.005 significant level. Chi-square analysis showed that there is a statistically significant difference between the levels of satisfaction with doctor's communication with the team of doctors headed by the consultant on ward rounds by sex. Table 2 also shows that 40.7 percent of the entire 420 respondents experienced high level of satisfaction with reference to doctors communication with patients while 5.0 percent of the male reported their satisfaction as low satisfaction as against 2.9 percent of the female respondents who reported their experience of satisfaction as low satisfaction. The result shows the statistically significant relationship. Those with less knowledge of health care services are less likely to be satisfied.

Also, respondents with tertiary education are more likely to have knowledge of health care services provided. This finding on low satisfaction shows that the respondents know about doctors authority to lead. It can be explained as the respondents non-realization of their expectations concerning doctors' communication and interaction during illness management. The question that measured satisfaction with doctors' communication with the in-patients was cross-tabulated by sex to see whether satisfaction with the doctor's communication with the in-patients (an expectation of leadership of the doctor in the facility) was depended on their sex reveals that this depended

on their sex. What this means is that low level of satisfaction with reference to doctors' communication reflects the basis of the acceptance of authority to lead by the health professionals.

This finding supports the views of Alliyu *et. al.* (2005) who observed that men differed significantly from women on knowledge of available health care services and how health care professionals should provide health care services. The low level of satisfaction with reference to doctors communication have obvious implications for patients compliance prescribed drugs by doctors and prescribed drugs administration by nurses. It is probable that the authorities to lead in these areas are really not fully accepted and require "other categories" of health care providers.

Another possible explanation for this differentials with satisfaction derived may be in terms of expectations from the availability of the drugs in the hospital, an experience of which considerations are not given to. Patients want the drugs prescribed to be available in the hospital, as quality outside the hospital cannot be guaranteed, particularly with the pluralistic nature of health care delivery in Nigeria. The chi-square values of both sexes Chi-square= 10.739, df =2, P-Value= 0.004 attest to the fact that the level of satisfaction is statistically related to gender of respondents and reflects the overall pattern of satisfaction with the doctors' communication about the type of illness. The females were less satisfied with communication issues than the males.

Findings from the qualitative data revealed that the general perception of the male respondents and interviews regarding level of satisfaction with doctors' communication were similar as emphasized by a male participant in the IDI thus:

The doctors come in large numbers and gather round my bed, but when they start to talk, they do not say anything to me about the reason why I am on admission. Different doctors, one by one take their turn to examine me and they only talk to Oga among them. (IDI Male, February 2014)

Table 2: Respondents perception of physicians' responses to patients' questions

Gender	Doctors responses to patients' questions			Total
	Low satisfaction	Moderate satisfaction	High satisfaction	
Male	5.5%	19.5%	13.6%	38.6%
Female	3.8%	31.4%	26.2%	61.4%
Total	9.3%	51.0%	39.8%	100%

Chi-square= 8.247 df=2 P-Value= 0.01

In our quest to find out the level of satisfaction of patients with the physician, the respondents were asked to assess the responses of the doctors to the questions requested from them, to provide answers. About 9.3 percent of the respondents reported the satisfaction experiences achieved as low satisfaction

with answers provided by the doctors to the questions they asked. There was also statistically significant difference between the levels of satisfaction with health care services with respect to physicians' responses to patients' questions by sex ($P < 0.05$). What this means is that levels of satisfaction with health care services with respect to physicians' responses to patients' questions is not contingent on sex. About 3.8 percent of the female indicated low satisfaction with the physicians' responses to patients' questions in the facility (Table 3).

The findings show that the patients are in a better position to indicate physicians' professional authority as they are also better placed to assess physicians' response to patients' questions, hence the reporting of their satisfaction experiences. Furthermore, the physicians who are able to meet with the expectations of the patients in terms of responses to patients' questions earn the patients respect which gives the indication of whether physicians have professional authority which patients look out for or not. This invariably reflects in the reporting of levels of their satisfaction achieved. This supports the findings by Iiyasu *et. al.* (2010) that physician's failure in meeting patient expectation is associated with low satisfaction.

Finding was supported with interviews from the IDIs with participants. A female participant reported thus:

It is going to three weeks that I have been on admission, and both the doctors and nurses are trying. In fact I feel better. The doctors and nurses are trying for me every time. Many doctors come to see me. When I ask them questions about my health, they use big, big grammar. I do not know when and what the doctor is suppose to use to explain to me about my health condition. (IDI Female, February, 2014)

In order to document the level of satisfaction of patients regarding communication by health care provider leadership, respondents were asked how satisfied they were with different communications by these health care leaders with in-patients. Half (51.0 percent) of the respondents reported experiencing moderate satisfaction, while 40 percent claimed they had high satisfaction, while only 9.3 percent experienced low satisfaction with doctors providing answers to patient's questions during the period of hospitalization on wards. More (26.2 percent) females reported high satisfaction than males (13.6 percent) with doctors' answers provided to patients' questions. Appropriate communication of health issues have been revealed to influence satisfaction obtained by users of alternative medicine in a study conducted in Okpe local government area of Delta State (Owumi, 1989).

Table 3: Respondents satisfaction with the leadership health care service and sex

Gender	Prescribed drug administration by nurse to the in-patients			Total
	Low satisfaction	Moderate satisfaction	High satisfaction	
Male	2.4%	18.3%	17.9%	38.6%
Female	3.1%	31.2%	27.1%	61.4%
Total	7.9%	51.4%	45.0%	100%

Chi-square=.544 df=2 P-Value= .0073

Table 3 shows respondents' satisfaction with nurses' administration of prescribed drugs to patients being leadership activity. Respondents were asked to rate how satisfied they were with administration of drugs by nurses to in-patients. Findings revealed that slightly above half 51.4 percent of the respondents were moderately satisfied, while 45 percent reported experiencing high satisfaction with prescribed drug administration by the nurses to the in-patients while only 8 percent reported low satisfaction with drug administration by nurses to the in-patients.

Table 4 also shows the distribution of the patients by how they reported their experience of satisfaction with service provision with respect to prescribed drug administration by the nurse as a leader to the in-patients. Table 4 shows that 31.2 percent of the females relative to 18.3 percent males reported satisfaction that is rated as moderate satisfaction level with the prescribed drug administration by the nurse to them. While 27.1 percent of the female relative to 17.9 percent male reported satisfaction experience that is expressed as high satisfaction. The fact that the chi-square value ($p < 0.0073$) is significant, attest to the fact that this is statistically related to level of satisfaction with the sex having the doctors prescribed drugs administered by the nurse to the respondents. This may also be explained by the fact that the expectation of what to benefit from the health care activity of the nurse is greatly valued by the different sexes. Although this is a weak association, however it calls for attention considering the fact that the feeling of satisfaction is closely linked with identified expectations from specified health care services and health care providers.

Discussion

In examining the knowledge and awareness of the participants about the health care services, the findings from the study showed that there is a relatively high level of knowledge and awareness of the health care services that the health care professional leaders in the teaching hospital render. Over 80% claimed to have knowledge of the health care services that professional leaders in the teaching hospital are supposed to render. This buttresses the findings of Iliyasu *et. al.* (2010) in a study of in-patients and expected roles and duties of professional leaders conducted in a teaching hospital in the Northern Nigeria

that most of the in-patient users of the tertiary hospital in Nigeria are well educated as majority have knowledge of the health care services provided by the professional health care leaders in teaching hospital.

This current study reveals a larger proportion of females than the male respondents in the sample. This differentials in the sex proportion may have been due to the fact that women undertake both complex and major family responsibilities of childrearing and in fact family reproduction which entails the responsibility of being saddled with caring activities not only for their spouses during illness management but for their own children as some other studies have found (Erinosho, 2005; Jegede, 2013). Another possible explanation for this gender differentials with satisfaction derived may be in terms of expectations from the clinical ward experience of events and emotional problems which considerations are not given to. The implication on emotional health is devastating on marital status.

As regards in-patients' satisfaction with health care services provided by the doctors and nurses, the results showed that majority of the female and male patients claimed and reported in-patients' satisfaction as moderate and low satisfaction respectively with professional leadership health care services received at the health facility. This has implications for follow-up treatment and compliance with take home prescribed drugs and also advice from doctors relating to continuity with the use of health care services. This finding agrees with the previous studies by Owumi (1989) that compliance with prescribed treatment and advice from doctors is dependent on patients' satisfaction and they are also more unlikely to return for additional care when necessary, more willing to recommend the facility to others (Sun, Adams, Oravs, Rucker, Brennan and Burtin, 2009).

With respect to getting their prescribed drugs administered to them by the nurse is much expected and the proportion of the respondents (49.5 percent) who rated the health care services received as moderate satisfaction with respect to getting their prescribed drugs administered to them by the nurse is much expected from the category of professional health care leaders in an institution that has been in existence for over forty years. However close to 50 percent of the males and 40 percent of the females claimed and rated the satisfaction with having the prescribed drugs administered by the nurse as low satisfaction. The reason for this may be the belief in cultural values attached to the provision of western medication when the need to change care provider arises. Slightly more than half (50.2 percent) rated the services received as moderate satisfaction with doctors communication about the illness condition.

Overall, the males are more satisfied than females in the sample with respect to in-patients' subjective level of satisfaction with the professional health care leaders activities following the use of the tertiary health care facility of the University of Benin Teaching Hospital, were rated by the majority as

moderate satisfaction. This also has an implication for the future use of the health care institution by the public in general.

This study argues that the critical role of leadership activities of core professional health care providers in enhancing patients' satisfaction with healthcare services during illness management cannot be overemphasized. For the most part, it concretizes the extent of the social interactions in the doctor-patient in the therapeutic milieu. This supports the views of Erinoshio (2005) on the roles and importance of socio-cultural factors in the ways in which illness management is interpreted in relation to gender.

Conclusion

The study has provided data that reveals link between the different ratings of patient satisfaction with the expectations from the leadership of professional health care providers (doctors and nurses) activities that stem from the self-rated assessment in the University of Benin. Leadership and patient satisfaction was investigated by examining in-patients knowledge of the benefits to be derived from the health care activities of the doctors and nurses and in-patient satisfaction with professional health care activities of the doctors and nurses. It is evident that the achievement and attainment of satisfaction rated as moderate satisfaction by the respondents reflects the overall pattern of satisfaction with having the doctors' prescribed drugs administered by nurses to them. This feeling and behaviour may not be unconnected with the commitment to duty. This research drew insight from the views of in-patients who are recipients of health care services in order to have a clear understanding of the factors that contribute to in-patients' satisfaction with leadership activities of core health care providers.

Findings from this study have also shown that not all of the respondents using the health care services of the teaching hospital have their expectations realized from the health care services rendered and received. It is pertinent to note that the desire of the in-patients and significant others concerning communication and interaction have significant implications for appropriate intervention by the core professional health care leaders.

Recommendations

In order to enhance the therapeutic interactive processes between the professional health care practitioners who are leaders in the health care system and the people (as patients) who are the recipients of the different health care services, the following recommendations are suggested:

- (1) Assessment of patient satisfaction profile with different health care service activities in the different departments of the hospital should be initiated and this must be on a continuous basis so that necessary change that can lead to improvement in the health care service delivery can be made.
- (2) Very importantly, specific policies that aim at abolishing the existing ambiguities and gaps in the roles of the leaders as professional health care

providers, especially bringing to the fore those which relate to the rights of the patients to treatment during hospitalization particularly disclosure and communication of health information should be made.

- (3) Relevant supervisory authorities such as medical monitory/audit and nursing monitory/audit should be put in place to monitor the performance of medical doctors and nurses, in the achievement of set goals, and also to help relieve the associated stress that patients go through during hospitalization.
- (4) The role and place of research cannot be underrated. There is great need for a survey to be conducted at the national level on leadership factor that will improve outcome of health care received from the perspective of the patients and their subjective expectations in the hospital, to enable the Federal Ministry of Health formulate policies that will address the social complaints of different manifestations in the therapeutic milieu.

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