Nazarbayev University School of Medicine

Master of Public Health Program

Patient satisfaction with physician-patient communication in outpatient care: A pilot study

Master's Thesis Project

Professional Publication Framework

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Abstract

Background. Measurement of patient satisfaction plays an important role in the health care practice to improve overall health care delivery of health care organizations, to do effective strategic decision making and monitoring of health care performance. There is a shortage of studies conducted about patient satisfaction with health system of former Soviet Union countries, as the range of patient satisfaction studies is limited mainly to countries of the USA and Europe (Footman et.al. 2013). Consequently, there is no standard scale which can be used for studies about patient satisfaction with physician-patient communication.

Aim. 1) to identify the level of patient satisfaction with physician – patient communication in outpatient care; 2) to explore factors associated with patients' satisfaction with physician-patient communication.

Methods. Pilot study with recruitment of 100 patients through consecutive sampling was conducted at the JSC "National center for neurosurgery", Astana, Kazakhstan. Patients were surveyed right after the consultations in the outpatient care units of the clinic. Questionnaire contained scale adopted from the patient satisfaction questionnaire of Royal College of General Practitioners (Family Doctors in UK), along with socio-demographic, health status variables. Results were analysed using binary, multiple logistic regression through the Stata statistical software (StataCorp, LLC).

Results. An overwhelming majority of patients was overall satisfied with the consultation with doctor (90%). Statistically significant association was found between patient satisfaction and patients' ethnicity, region and number of chronic diseases (p-value < 0,1). Patients were especially satisfied with shared-decision making aspect of the consultation (90%), as well as the delivery of information by doctors (87%).

Conclusion. Communication patterns of physicians had big impact on general assessment of provided care by patients. Further validation of the used scale is recommended for its possible introduction into the practice of healthcare organizations.

Introduction

According to the World Health Organization (WHO) standards of care, there are six domains of health care quality which ensure that patient obtain desired health care outcomes. Thus, health care service must be safe, effective, timely, efficient, equitable and people-centered. Not so many times ago, health care had a basis of paternalistic model, where only healthcare professionals managed decisions for patients. Such model was used because of the existed believe that healthcare professionals had enough necessary skills to be experts who should be the only ones who can plan the whole care and treatment (Mazurenko et al 2015). Undoubtedly, physicians are experts in their sphere with clinical background and knowledge they have, but the role of patients shouldn't be underestimated in the decision making. General public is realizing that each patient carries his or her own personal experience and knowledge that may play important role in their plan of medical care. Thus, time when physicians were only the ones who were involved in the decision making had past, and efforts are made on the transition to a model of care where patients are actively involved in planning of their care (Press and Richards 2015). Such changes in the general public's opinion led to the rise of a new model of shared-decision making, which is becoming widely used worldwide (O'Connor et al 2007). The effectiveness of such approach to the delivery of medical care made governments and healthcare organizations to pay attention to this paradigm and follow it. (Meterko et al 2010, Hansson et al 2015). By this way, expectations of patients from the medical care had evolved and now include patients' desire to take part in decision making of their care (Royal College of General Practitioners 2014).

Patient-centered care has several aspects which can be listed as following: recognition of each patient's uniqueness of values, experience, preferences and needs; maintaining emotional and physical support; stimulating a therapeutic relationship between the patient and healthcare professionals; encouraging a contribution of information, power and

responsibility through involvement of patients and their representatives in the care process; managing of the care process to meet the patients' needs and making sure continuity of care (Royal College of General Practitioners 2014, Australian Commission on Safety and Quality in Health Care 2010, Mazurenko et al 2015). Analyzing listed above aspects of patient-centered care, we can state that physician-patient relationship highly depends on a communication between physician and patient. It was identified that physicians who had complaints about their malpractice had also high frequency of complaints about their communication with patients (Hickson, 1994). It is important to note that by malpractice we don't mean lack of especial warmth towards patients or expression of empathy. Instead, by the communication between patient and physician is meant an interaction which helps to reach high quality care for the patient, with consequent positive effect on the health of patient. Studies show the importance of informing, positive attitude and talk, friendly atmosphere in gaining of patients' satisfaction. In addition, it was reported that patients are more satisfied with the communication with doctor, when they are encouraged to ask questions, informed about the possible side effects and generally feel themselves at ease (Walker, Arnold, Miller-Day, & Webb, 2001).

Many studies exist exploring the patient satisfaction, especially such studies which gave extensive attention to the communication patterns between physician and patient (Stewart 1995). Several of them indicate that there are other factors influencing patient satisfaction apart from the physician-patient communication, related to patients' age, health status, sociodemographic characteristics and service expectations (Naidu 2009; Sitzia and Wood 1997). Delivering health care service which corresponds to high patient satisfaction would be key promoter of compliance with treatment, service utilization and loyalty of patients (Prakash 2010). Patients were observed to lack treatment adherence and advice of physicians if they feel dissatisfied with a consultation (Stewart 1995). Some studies indicate

that physician-patient communication can be assessed through derivation of differences between physician and patient. It was identified that after consultations, perceptions of physicians and patients differ referring to the disease level, cause and nature of the problem, along with the content of the consultation (Ahlén and Gunnarsson 2013; Ha and Longnecker 2010). Measurement of patient satisfaction plays an important role in the health care administration and planning to improve overall health care delivery of health care organizations, to do effective strategic decision making and monitoring of health care performance (Rivers and Glover 2008).

There is a lack of studies about patient satisfaction with health system of former Soviet Union countries, as the range of patient satisfaction studies is limited mainly to countries of Europe and the US (Footman et.al. 2013). There is a qualitative study recently conducted on the identification of patients' beliefs about patient-centered care and providers in Kazakhstan, which showed the presence of miscommunication between patients and physicians leading to dissatisfaction with medical care among patients in Kazakhstan (Zhumadilova, Craig & Bobak 2018). Researchers claim that such results are observed because of the health care system managed by the Ministry of Health of Kazakhstan, where policies are concentrated on the punishment of health care organizations for high complaint ratings instead of exploring the problem for possible solutions. More studies are needed to explore patient satisfaction in the outpatient settings in Kazakhstan, focusing on the patient-doctor communication aspects of the care, utilizing quantitative study designs and using standardized measurement tools.

This pilot study's aims: 1) to identify the level of patient satisfaction with physician – patient communication in outpatient care at the JSC "National center for neurosurgery", and 2) to explore factors associated with patients' satisfaction with physician-patient communication.

Methods

Study Design

A cross-sectional study design was utilized for this patient satisfaction survey. It was conducted at the outpatient clinics of the JSC "National center for neurosurgery" in Astana, Kazakhstan, a clinic which provides the full range of neurosurgical services, such as diagnosis and rehabilitation of patients using the most up-to-date treatment methods. Study was approved at the Nazarbayev University School of Medicine's Research Ethics Committee, and the Bioethics committee of the JSC "National center for neurosurgery". All the confidentiality and anonymity aspects and associated bioethical issues in non-interventional research were followed. Patients were acquainted with study aim, and verbal informed consent was obtained before the completion of the structured questionnaires. These questionnaires contain 3 sections, with background and health information of the patients and standardized scale assessing the patient satisfaction with physician-patient communication.

Participants

A total number of 125 patients were invited to participate in the study, from which 114 agreed to complete the survey with response rate of 91.2%. Participants of the study were selected by the method of continuous recruitment of patients in the outpatient departments of JSC "National Center for Neurosurgery". Investigator approached consecutive patients right after the consultations or office visit to physicians in the departments of outpatient care, to explain the purpose and procedures of the study and obtain verbal informed consent, then questionnaire respectively, in the waiting room. Each patient was given unique code and number for the purposes of maintaining anonymity and confidentiality.

Measures

Study was based on the questionnaire of patient satisfaction from Royal College of General Practitioners (Family Doctors in UK), consisting of 11 items, rated on a seven-point

scale (from “poor to fair” to “outstanding”), with involvement of additional questions regarding the patient’s sex, age, marital status, educational attainment, ethnic origin, occupational status, average personal income per month, region, health status. Questionnaires were translated to Russian and Kazakh languages. Before the actual study, pre-test was conducted in order to check the validity of the questionnaire.

Data analysis

Some questionnaires contained missing answers, and thus were eliminated from the database. Among 114 patients who filled the answers, data for 100 patients was fully available. Data was missing in different sections, but no any special trends for missing variables were observed.

All answers were recoded as they were ordered in the questions of the questionnaire. New binary variables were generated for the scales’ questions, adopted from Royal College of General Practitioners (Family Doctors in UK) including 11 items, which were taken from the dividing of answers rated on a seven-point scale (from “poor to fair” to “outstanding”) into 2 groups. To be precise, answers from 1 to 3 (out of 7 response options) were categorized to “Unsatisfied”, while answers from 4 to 7 were categorized to “Satisfied”. Another new dichotomous variable was generated through identifying sum of all encoded dichotomous variables from the scale, calculating mean and identifying it’s cut off to be equal 20.19 (the midpoint between “unsatisfied” and “satisfied”), analogically categorizing variables to two groups corresponding to value 1 (“unsatisfied”) and value 2 (“satisfied”).

After conducting descriptive analysis of variables, where percentages of each explanatory variables were identified, the chi-square test was applied for the comparison of differences in proportions of independent variables between unsatisfied and satisfied groups. Bivariate analysis was done using logistic regression between explanatory variables and generated dichotomous variables to identify the characteristics of patients that were

unsatisfied and satisfied, also to assess the strength of association between each independent variable and the dependent variable. Statistically significant variables (p-value < 0.1) were chosen from the binary logistic regression and processed to the multiple logistic regression to measure the strength of associations between the independent variables and the dependent variable. Although, not all categories or ranks of independent variables showed statistical significance, they were further proceeded to the multiple logistic regression for the test of possible relevance to the satisfaction of patients. Additionally, the percentage of unsatisfied patients was identified for each variable of the scale to identify problematic sides of patient-physician communication in that clinic. The whole analysis was done using Stata statistical software (StataCorp, LLC).

Results

Background information about patients

Patients characteristics were described using 11 questions about socio-economic, demographic, health information, the results of which are given in Table 1. Basically, from 100 patients, more females participated in the survey than males (57% and 43%, respectively). The age distribution was quite wide, but with the majority being identified to refer to age groups of 25-34 years and retired (>55 years) patients, 28% and 29%, respectively. Most patients had undergraduate level of education (44%). Vast majority of patients were Kazakhs, others being of Russian, Ukrainian and Ossetian ethnicity (80% and 20%, respectively). The highest percentage of patients was from Astana city (36%), while others gathered from different regions of Kazakhstan, except Almaty city. For the analysis, these regions, except Astana city, were categorized into 5 regions of Kazakhstan, such as Central, North, South, West and East Kazakhstan. Regarding the health status of patients,

59% had chronic diseases, mostly with 1 chronic disease type (22%). Overall, majority of patients were satisfied with their health (57%), but 23% claimed that they have poor health.

Table 1. Background information including socio-demographic, health status characteristics of study participants, N=100 (continued)

Variable	**n**	**%**
Age group		
18-24	5	5
25-34	28	28
35-44	19	19
45-55	19	19
>55	29	29
Sex		
Male	43	43
Female	57	57
Marital status		
Single	20	20
Married	67	67
Divorced or separated	7	7
Widowed	4	4
Cohabiting	2	2
Educational attainment		
Primary school	8	8
Secondary school	21	21
College/diploma	26	26
University/degree	44	44
Postgraduate	1	1
Ethnicity		
Kazakh	80	80
Other	20	20
Occupational status		
Unemployed	10	10
Employed full-time	38	38
Employed part-time	8	8
Retired	25	25
Casual worker	2	2
Not working due to ill health	12	12
Housewife	3	3
Other	2	2

Variable	n	%
Average personal income per month (tenge)		
<50.000	27	27
50.001 – 100.000	32	32
100.001 – 150.000	17	17
150.001 – 200.000	10	10
>200.000	14	14
Region		
Astana city	36	36
Central Kazakhstan	8	8
North Kazakhstan	22	22
South Kazakhstan	16	16
West Kazakhstan	9	9
East Kazakhstan	9	9
Chronic diseases		
Yes	59	59
No	41	41
Number of chronic diseases		
1	22	22
2	16	16
3	6	6
>3	15	15
Health status		
Very good	3	3
Good	17	17
Satisfactory	57	57
Poor	23	23

Patient satisfaction with physician-patient communication

Binary logistic regression analysis was done using comparison of dichotomous dependent variable of patient satisfaction with all explanatory variables from the questionnaire, such as sex, age, marital status, educational attainment, ethnicity, occupational status, average personal income per month, region, presence of chronic disease, quantity of present chronic diseases and how patients overall rates his or her health (Table 2).

Categorized Odds ratios, p-value and 95% CI for this analysis are represented in the Table 2. Because of the relatively small sample size, for this study, p-values ≤ 0.1 are accepted as significant. Obtained p-values of variables were generally not statistically significant, but some inside categories of variables like ethnicity, region and variable identifying the quantity of chronic diseases ("How many chronic diseases do you have?") showed some tendency for the statistical significance, with p-values being equal to 0.1 for ethnicity, 0.087 for region and 0.026 for number of chronic diseases. Thus, it was found that the representatives of other ethnicities had 3.63 (95 % CI: 0.78-16.92) times higher odds of being satisfied with patient-physician communication, compared to Kazakh patients. In addition, patients from the East Kazakhstan were less satisfied with physician-patient communication than Astana city residents (OR=0.267, 95% CI: 0.056-1.214). Finally, patients with one type of chronic disease had 10.889 times higher odds of being satisfied with physician-patient communication than patients who didn't have any chronic disease. Interestingly, odds of being satisfied with physician-patient communication were twice as less as in females than in males, although this finding wasn't statistically significant.

Table 2. Bivariate logistic regression of patient satisfaction with physician-patient communication as an outcome with independent, explanatory variables

Variable	**Patient satisfaction/communication (%)**		**Odds ratio**	**p-value**	**95% CI**
Age group	Unsatisfied	Satisfied			
18-24	20	80	ref		
25-34	25	75	0.75	0.811	0.0714-7.883
35-44	36.84	63.16	0.429	0.486	0.04-4.637
45-55	15.79	84.21	1.333	0.823	0.108-16.479
>55	24.14	75.86	0.785	0.841	0.075-8.243
Sex					
Male	18.6	81.4	ref		
Female	29.82	70.18	0.538	0.208	0.207-1.398
Marital status					
Single	25	75	ref		
Married	23.88	76.12	1.063	0.918	0.333-3.38
Divorced or separated	28.57	71.43	0.833	0.853	0.121-5.724
Widowed	25	75	1	1	0.084-11.931
Cohabiting	50	50	0.333	0.466	0.017-6.374

Variable	Patient satisfaction/communication (%)		Odds ratio	p-value	95% CI
Educational attainment					
Primary school	37.5	62.5	ref		
Secondary school	15.38	84.62	3.3	0.26	0.413-26.366
College/diploma	24.14	75.86	1.886	0.455	0.357-9.967
University/degree	26.53	73.47	1.662	0.525	0.347-7.95
Postgraduate		100	1		
Ethnicity*					
Kazakh	28.75	71.25	ref		
Other	10	90	3.63	0.101	0.779-16.923
Occupational status:					
Unemployed	30	70	ref		
Employed full-time	21.05	78.95	1.61	0.551	0.337-7.658
Employed part-time	37.5	62.5	0.714	0.738	0.099-5.118
Retired	24	76	1.357	0.714	0.265-6.958
Casual worker		100	1		
Not working due to ill health	33.33	66.67	0.85	0.867	0.141-5.228
Housewife	33.33	66.67	0.85	0.913	0.055-13.477
Other		100	1		
Average personal income per month (tenge)					
<50.000	37.04	62.96	ref		
50.001 – 100.000	20.69	79.31	2.255	0.181	0.686-7.416
100.001 – 150.000	13.33	86.67	3.824	0.118	0.712-20.539
150.001 – 200.000	20	80	2.353	0.334	0.415-13.341
>200.000	28.57	74.74	1.471	0.589	0.363-5.952
Region*					
Astana city	25	75	ref		
Central Kazakhstan		100	1		
North Kazakhstan	13.64	86.36	2.111	0.307	0.504-8.843
South Kazakhstan	37.5	62.5	0.556	0.361	0.157-1.963
West Kazakhstan	22.22	77.78	1.167	0.862	0.204-6.668
East Kazakhstan	55.56	44.44	0.267	0.087	0.056-1.214
Chronic diseases					
Yes	19.64	80.36	ref		
No	32.56	67.44	0.51	0.146	0.202-1.267
Number of chronic diseases*					
1	4.54	95.55	10.889	0.026	1.324-89.579
2	18.75	81.25	2.247	0.261	0.548-9.218
3	50	50	0.519	0.456	0.092-2.912
>3	26.67	73.33	1.426	0.597	0.383-5.305

Variable	Patient satisfaction/ communication (%)	Odds ratio	p-value		95% CI
Health status					
Very good		100	1		
Good	23.53	76.47	0.903	0.893	0.202-4.029
Satisfactory	28.07	71.93	0.712	0.561	0.226-2.241
Poor	21.74	78.26	1		

*statistically significant values (p-value < 0.1)

Further, multiple logistic regression analysis was conducted for the outcome of patient satisfaction with physician-patient communication including into the model all the statistically significant variables obtained from the bivariate logistic regression analysis (Table 3).

Table 3. Results of multivariate logistic regression of Patient satisfaction with physician-patient communication as an outcome with ethnicity, region and number of chronic diseases in patients

Variable	Odds ratio	p-value	95% CI
Ethnicity	2.694	0.272	0.459-15.781
Region			
Astana city	ref		
Central Kazakhstan	1		
North Kazakhstan	1.687	0.509	0.357-7.979
South Kazakhstan	0.303	0.13	0.064-1.421
West Kazakhstan	0.784	0.805	0.114-5.373
East Kazakhstan	0.083	0.016	0.011-0.628
Number of chronic diseases			
1	26.874	0.007	2.468-292.604
2	3.558	0.116	0.731-17.325
3	0.367	0.298	0.056-2.417
>3	2.759	0.219	0.546-13.943

In this multivariate model, ethnicity lost its statistical significance (p-value > 0.1). Similar trend as in bivariate analysis was observed with patients coming from the East Kazakhstan, with 0.083 times lower odds of being satisfied with physician-patient communication than

patients from Astana city (95% CI: 0.011-0.628). Finally, patients having one type of chronic disease had 26.874 times higher odds of being satisfied with physician-patient communication than patients who didn't have any chronic diseases at all (95% CI: 2.468-292.604).

To identify relatively problematic aspects of the communication between physicians and patients basic descriptive analysis with the percentage of satisfied patients was conducted (Table 4). It was found that, generally, patients were satisfied with the communication they had with their physicians, with 90% of patients indicating that they were satisfied overall (Table 4).

Table 4. Percentage of satisfied patients with each aspect of Royal College of General Practitioners (Family Doctors in UK) scale about physician-patient communication, N=100

№	Question	% (Satisfied)	% (Unsatisfied)
1	Making you feel at ease…	81	19
2	Letting you tell "your" story…	81	19
3	Really listening…	76	24
4	Being interested in you as a whole person…	79	21
5	Fully understanding your concerns…	83	17
6	Showing care and compassion…	83	17
7	Being positive…	84	16
8	Explaining things clearly…	87	17
9	Helping you to take control…	85	15
10	Making a plan of action with you…	90	10
11	Overall, how would you rate your consultation with this doctor today?	90	10

As result, it was identified that mostly patients were not satisfied with the way how physicians were listening to them, so 24% of patients think that physicians were not really listening to them, while 21% of patients think that physicians were not interested in them as a whole person. The next points that made patients stay unsatisfied include making feel patients at ease and letting tell their story, where both were equal to 19%.

Discussion

Study derived high overall patient satisfaction with physician-patient communication. Although, some independent variables like age, sex, education level had theoretical importance and were illustrated as potential confounders in previous studies, they didn't show statistically significant values and any associations related to patient satisfaction in our study. Instead, we found that ethnicity, region and number of chronic diseases showed some trends for statistically significant association with patient satisfaction with physician-patient communication. It was found that the odds of being satisfied with the physician-patient communication is 3,63 times higher in representatives of other ethnicity rather than Kazakhs. This was an interesting observation, as despite the fact that majority of patients were Kazakhs (80%), remaining 20% were from other ethnicity such as Russian, Ukrainian and Ossetian, their ratings of the consultations with doctors were significantly high. This observation may rise the presence of the cultural differences in the perception of communication between doctor and patient and needs further exploration. Previous studies differ in their findings, where the association between nationality of patients and their satisfaction with primary health care was explored. On the one hand, there are studies which show that non-nationals had higher satisfaction with provided primary care, rather than nationals (Majeed Alhashem, Alquraini, and Chowdhury 2011). On the other hand, other studies were found showing no significant difference between Saudi and non-Saudi patients satisfaction with provided primary care (Mansour and Al-Osimy, 1993; Al-Doghaither and Saeed, 2000).

Analyzing different regions of Kazakhstan, generally, patients from all listed regions, except for East Kazakhstan, were mostly satisfied. No any relevant studies, exploring the patient satisfaction with physician-patient communication were found for the East Kazakhstan region. However, there was found only one study which explored the satisfaction of mothers with the quality of hospital services in East Kazakhstan. Still, study revealed

substandard quality of hospital services in the institutions of the East Kazakhstan, with 51.8% of female patients responding that they were satisfied with delivered medical care quality, while other percentages of respondents indicated that current quality of care needs substantial improvements (Dauletyarova et al. 2016). In addition, study revealed a need in psychological counseling for mothers in all maternity facilities of the East Kazakhstan. Thus, we can further test our findings in patients coming especially from that region of Kazakhstan to do some assumptions, such as association with poor quality of life or other confounding factors, that could present explanation for the observed tendency.

Furthermore, the multivariate analysis showed that less number of chronic diseases lead to more patient satisfaction with provided doctor's consultation, compared to having multiple chronic diseases, except the case when patients had 3 types of chronic diseases. There are several studies exploring the association between patients' chronic illnesses and patient satisfaction with consultation (Little et al. 1999; Udonwa and Ogbonna 2012). One of them shows that patient satisfaction influenced a duration of patient disease (Little et al. 1999). Other study shows that because of the fact that patients with chronic illnesses know more about their health status than patients with acute disease, they need more psychological support and attention. Also, authors assume that chronic illness might become a psychologic burden to a physician and may influence quality of the physician consultation. Interestingly, we identified in our study that patients with 1 type of chronic diseases were much more satisfied than patients who didn't have any chronic disease. Although such tendency can be explained with our findings. To be more precise, as we obtained high overall satisfaction of patients with the physician-patient communication and as previous studies show that patients with chronic illnesses look for mostly psychological support from physicians, patients with 1 type of chronic disease seem to get enough psychological support from the physicians during their communication. While patients who didn't have chronic disease, might have an acute

case, which influenced much on their answer as they might want to get immediate remedy for their disease, without paying any attention on the process of communication with physician and being diagnosed from the very first consultation is not always reached. Further studies are needed to justify the relationship between the presence of chronic diseases, comorbidities and patient satisfaction with physician-patient communication in ambulatory care.

Scale on Patient satisfaction with physician-patient communication adopted from Royal College of General Practitioners (Family Doctors in UK) was tested for the reliability using Cronbach's alpha test, where it was equal to 0.983, with average interitem covariance equal to 2.148. So, scale has an excellent internal consistency, with questions constructed in a manner which would give us consistent and meaningful results about the patient satisfaction with physician-patient communication. Scale showed that patients were mostly satisfied with the communication behaviors of doctors, which was analyzed through usage of 11 items. Basically, patients were significantly satisfied with the information giving and discussing options abilities of doctors. Thus, doctors seem to explain things clearly, exploring with patients what they can do to improve patients health themselves, encouraging rather than "lecturing" them. Patients were highly satisfied with shared-decision making process, rating a making plan of action item of the scale as the leading one. Thus, doctors were found to discuss the options, involving patients in decision making as much as patients wanted to be involved, without being ignored during the consultation. Another point to mention is the way how doctors encouraged patients to ask questions, through fully answering patients' questions, explaining clearly, giving them adequate information, not being vague. Not so highly, but still patients were also satisfied with positive attitude of doctors towards them, being honest, but not negative about patients' problems. All these results are consistent with previous findings, where significant association was found between patient satisfaction with provided care and communication characteristics of doctors, such as respect towards patients'

thoughts and preferences, involvement of patients in decision making (Jenkinson et al. 2002;Joffe et al. 2003;Gesell, Clark, and Williams 2004).

At the same time, patients were relatively not satisfied with some aspects of the consultations that they had with physicians. More precisely, some patients (24%) think that doctors were not really listening to patients. There is a possibility that physicians couldn't pay close attention to what patients were saying, because of being disturbed by other external factors like calls, quick visits of members of medical personnel to sign some documents, or taking and looking at notes, computer during talking with patients. Such situations might lead to loss of the link between the patients' explaining their health status and formation of possible diagnosis, as a result of which physicians had to ask patients to start telling everything again. Definitely, such situations don't occur intentionally, but doctors should think about the possible ways of minimizing or elimination of such factors which affect the quality of consultations with patients. Next aspect refers to the item of being interested in patient as a whole person. So, patients want to be treated as an individual who needs consistent attention to his or her unique situation. Thus, doctors should consider this aspect and work on their style of communication with patients through asking relevant details about patients' life, their situation, not treating them as "just a number". Next relatively weak aspect of communication with patients refer to making patients feel at ease. During the limited time of the consultation, especially if it is a first acquaintance with patient, it is quite a challenging mission to gain the trust of patient, but for the purposes of providing effective care, doctors should try to be more friendly, open and warm towards patients, treating them with respect, avoiding being cold or abrupt. In this regard, communication trainings for physicians and health care providers can be recommended, to develop a patient-centered approach in medical care. Although, we should note that treatment process depends not only on the physician, but

also on patient. That is why trainings should also include patients to rise their education about the patient-centered care.

Limitations

This study was conducted among patients who came to consult with specialists in the offices of JSC "National Center for Neurosurgery", where medical services are provided at the expense of personal funds of citizens. It is also known that the National Center of Neurosurgery is one of the leading clinics in Central Asia, providing a full range of neurosurgical services, from diagnosis to rehabilitation of patients using the most modern methods of treatment. Thus, the results of this study may differ significantly from the situation, which is observed in public primary care outpatient clinics. Due to this potential selection bias, our study sample may not be representative of the population of the whole city or country. It leads to the problems of generalizing any conclusions on the aspect of physician-patient communication to other city hospitals and polyclinics.

The main scale that was used which is patient satisfaction questionnaire from Royal College of General Practitioners (Family Doctors in UK) was not widely validated in previous researches which may compromise the validity of the current study. However, we found a high reliability score of the scale in our sample and further validation of the scale in local languages is recommended in future studies.

Finally, our study had a sample size consisting of 100 patients, which could be one of the most potential causes of the frequent presence of statistically insignificant values in the results. Further studies with more sample size are needed to increase the validity of the study outcomes, that should be held in city hospitals and polyclinics where citizens get free medical care from the state budget. Also, other independent variables can be added to derive another possible predictors or factors influencing patient satisfaction with physician-patient communication in outpatient care, such as frequency of patient’s visits to particular

physician, time spent on the consultation, coverage of the visit by health care insurance if service is not free.

Conclusion

Patient satisfaction measurement is an important tool in providing an effective, high quality medical care which coincide with expectation of patients. In this regard, physician-patient communication plays an important role in patient satisfaction with provided consultations in the outpatient care. This pilot study adopted and introduced a validated tool for the measurement of patient satisfaction with physician-patient communication. Generally, patients were satisfied with physician-patient communication provided in outpatient care of one of the clinics of Astana city, Kazakhstan. In addition, possible factors of patient satisfaction with physician-patient communication were derived. Possible factors influencing the rating of patients on satisfaction with physician-patient communication included ethnicity, region, and number of chronic diseases. Communication behaviors of physicians had a great contribution on general assessment of provided care. Further validation of the used scale is recommended for the possible introduction into the practice of healthcare organizations.

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APPENDIX 1a.

Research topic: Patient satisfaction with physician-patient communication in outpatient care: Pilot study

/___ /___ /2018 /__ __ __

Background information

Q1. Sex:
1. male
2. female

Q2. Age:
1. 18-24
2. 25-34
3. 35-44
4. 45-55
5. over 55

Q3. Marital status:
1. single
2. married
3. divorced or separated
4. widowed
5. cohabiting

Q4. Educational attainment:
1. primary school
2. secondary school
3. college/diploma
4. university/degree
5. postgraduate

Q5. Ethnic origin:
1. Kazakh
2. Russian
3. Other (specify): _____

Q6. Occupational status:
1. Unemployed
2. Employed full-time
3. Employed part-time
4. Retired
5. Casual worker
6. Not working due to ill health
7. Housewife
8. Other (specify): _____

Q7. Average personal income per month:
1. Less than 50,000 tenge
2. 50,001 - 100,000
3. 100,001 - 150,000
4. 150, 001 – 200, 000
5. More than 200,000

Q8. Region:
1. Almaty city
2. Astana city
3. Akmola Region
4. Aktobe Region
5. Almaty Region
6. Atyrau Region
7. Karaganda Region
8. Kostanay Region
9. Kyzylorda Region
10. Mangistau Region
11) Pavlodar Region
12) North Kazakhstan Region
13) East Kazakhstan Region
14) South Kazakhstan Region
15) West Kazakhstan Region
16) Zhambyl Region

APPENDIX 1a (Continue).

Information about health

Q9. Do you have a chronic disease?

1. yes
2. no

Q10. If yes, how many chronic diseases do you have?

1. 1
2. 2
3. 3
4. More than 3

Q11. How would you rate your overall health?

1. Very good
2. Good
3. Satisfactory
4. Poor
5. Very poor

Patient satisfaction with physician-patient communication

Please rate the doctor at:

Q12a. Making you feel at ease… (being friendly and warm towards you, treating you with respect; not cold or abrupt)

1. Poor to Fair
2. Fair
3. Fair to Good
4. Good
5. Very Good
6. Excellent
7. Outstanding

Q12b. Letting you tell "your" story… (giving you time to fully describe your illness in your own words; not interrupting or diverting you)

1. Poor to Fair
2. Fair
3. Fair to Good
4. Good
5. Very Good
6. Excellent
7. Outstanding

Q12c. Really listening… (paying close attention to what you were saying; not looking at the notes or computer as you were talking)

1. Poor to Fair
2. Fair
3. Fair to Good
4. Good
5. Very Good
6. Excellent
7. Outstanding

APPENDIX 1a (Continue).

Q12d. Being interested in you as a whole person… (asking/knowing relevant details about your life, your situation; not treating you as "just a number")

1. Poor to Fair
2. Fair
3. Fair to Good
4. Good
5. Very Good
6. Excellent
7. Outstanding

Q12e. Fully understanding your concerns… (communicating that he/she had accurately understood your concerns; not overlooking or dismissing anything)

1. Poor to Fair
2. Fair
3. Fair to Good
4. Good
5. Very Good
6. Excellent
7. Outstanding

Q12f. Showing care and compassion… (seeming genuinely concerned, connecting with you on a human level; not being indifferent or "detached")

1. Poor to Fair
2. Fair
3. Fair to Good
4. Good
5. Very Good
6. Excellent
7. Outstanding

Q12g. Being positive… (having a positive approach and a positive attitude; being honest but not negative about your problems)

1. Poor to Fair
2. Fair
3. Fair to Good
4. Good
5. Very Good
6. Excellent
7. Outstanding

Q12h. Explaining things clearly… (fully answering your questions, explaining clearly, giving you adequate information; not being vague)

1. Poor to Fair
2. Fair
3. Fair to Good
4. Good
5. Very Good
6. Excellent
7. Outstanding

Q12i. Helping you to take control… (exploring with you what you can do to improve your health yourself; encouraging rather than "lecturing" you)

1. Poor to Fair
2. Fair
3. Fair to Good
4. Good
5. Very Good
6. Excellent
7. Outstanding

Q12j. Making a plan of action with you… (discussing the options, involving you in decisions as much as you want to be involved; not ignoring your views)

1. Poor to Fair
2. Fair
3. Fair to Good
4. Good
5. Very Good
6. Excellent
7. Outstanding

Q12k. Overall, how would you rate your consultation with this doctor today?

1. Poor to Fair
2. Fair
3. Fair to Good
4. Good
5. Very Good
6. Excellent
7. Outstanding

APPENDIX 1b.

Зерттеудің атауы: Амбулаторлық-емханалық көмектегі пациенттердің дәрігер мен пациенттің коммуникациясымен қанағаттануы: Пилоттық зерттеу

/___ /__ _ /2018/__ __ __

Жалпылама ақпарат

Q1. Сіздің жынысыңыз қандай?
1. Еркек
2. Әйел

Q2. Сіздің жасыңыз:
1. 18-24
2. 25-34
3. 35-44
4. 45-55
5. 55-тен астам

Q3. Отбасы жағдайыңыз:
1. Некеде емес (басы бос)
2. Үйленген
3. Ажырасқан
4. Жесір
5. Азаматтық некеде

Q4. Білім деңгейіңыз:
1. Бастауыш мектеп
2. Колледж / диплом
3. Университет / дәреже
4. Докторлық

Q5. Сіздің ұлтыңыз?
1. Қазақ
2. Орыс
3. Басқа (анықтаңыз)_____

Q6. Кәсіби жағдайыңыз:
1. Жұмыссыз
2. Толық жұмыс күні
3. Толық емес жұмыс күні
4. Зейнеткер
5. Тұрақсыз жұмыста
6. Денсаулығының нашарлығынан жұмыс істемеймын
7. Үй шаруасындағы әйел
8. Басқа (анықтаңыз) _____

Q7. Бір айдағы орташа табысыңыз:
1. 50 000 теңгеден аз
2. 50,001 - 100,000
3. 100 001 - 150 000
4. 150, 001 - 200 000
5. 200 000-нан астам

Q8. Сіз қай аймақтансыз?
1. Алматы қаласы
2. Астана қаласы
3. Ақмола облысы
4. Ақтөбе облысы
5. Алматы облысы
6. Атырау облысы
7. Қарағанды облысы
8. Қостанай облысы
9. Қызылорда облысы
10. Маңғыстау облысы
11. Павлодар облысы
12. Солтүстік Қазақстан облысы
13. Шығыс Қазақстан облысы
14. Оңтүстік Қазақстан облысы
15. Батыс Қазақстан облысы
16. Жамбыл облысы

APPENDIX 1b (Continue).

Денсаулық жайлы ақпарат

Q9. Сізде созылмалы ауру бар ма?

1. иә
2. жоқ

Q10. Егер солай болса, қанша созылмалы аурулар бар?

1. 1
2. 2
3. 3
4. 3-тен артық

Q11. Жалпылама денсаулығыңызды қалай бағалайсыз?

1. Өте жақсы
2. Жақсы
3. Қанағаттанарлық
4. Нашар
5. Өте нашар

Пациенттің дәрігер мен пациенттің коммуникациясымен қанағаттануы

Төмендегі критерийлер бойынша дәрігерге баға беріңіз:

Q12a. Сіз өзіңізді емін-еркін сезіндіңіз (дәрігер сізбен достық қарым-қатынаспен тілдесті, құрметпен қарады, суық немесе дөрекі емес)

1. Қанағаттанарлықтай дерлік
2. Қанағаттанарлық
3. Көңіл толарлық
4. Жақсы
5. Өте жақсы
6. Керемет
7. Тамаша

12b. Сізге өзіңіздің тарихыңызды айту мүмкіндігін берді (шағымыңызды егжей-тегжейлі сипаттау үшін уақыт берді)

1. Қанағаттанарлықтай дерлік
2. Қанағаттанарлық
3. Көңіл толарлық
4. Жақсы
5. Өте жақсы
6. Керемет
7. Тамаша

Q12c. Мұқият тыңдаңды (сіз өзіңіз туралы айтқан кезде, дәрігер компьютерде жазбаны сақтауға назарын бөлмей, айтқандарыңызға ерекше назар аударды)

1. Қанағаттанарлықтай дерлік
2. Қанағаттанарлық
3. Көңіл толарлық
4. Жақсы

APPENDIX 1b (Continue).

5. Өте жақсы
6. Керемет
7. Тамаша

Q12d. Сіз дәрігерді адам ретінде қызықтырдыңыз (сіздің өміріңіз туралы, сіздің жағдайыңыз туралы қызықты, жай ғана сан ретінде қарамады).

1. Қанағаттанарлықтай дерлік
2. Қанағаттанарлық
3. Көңіл толарлық
4. Жақсы
5. Өте жақсы
6. Керемет
7. Тамаша

Q12e. Сіздің алаңдаушылықтарыңызды толығымен түсінді (пікірін білдіріп, алаңдаушылықтарыңызды сезінді, елемеуден бас тартты)

1. Қанағаттанарлықтай дерлік
2. Қанағаттанарлық
3. Көңіл толарлық
4. Жақсы
5. Өте жақсы
6. Керемет
7. Тамаша

Q12f. Сізге қамқорлық пен жанашырлық танытты (шын мәнінде алаңдаушылық білдіртті, сізбен тұлға ретінде қатынасып, бейқам болмады)

1. Қанағаттанарлықтай дерлік
2. Қанағаттанарлық
3. Көңіл толарлық
4. Жақсы
5. Өте жақсы
6. Керемет
7. Тамаша

Q12g. Оң болды (дәрігер тарапынан оң көзқарас байқалды, сіздің проблемаларыңызғды тыңдаудан, түсінуден теріс айналмады)

1. Қанағаттанарлықтай дерлік
2. Қанағаттанарлық
3. Көңіл толарлық
4. Жақсы
5. Өте жақсы
6. Керемет
7. Тамаша

Q12h. Ақпарат анық түсіндірілді (сауалдарға толық жауап берді, барабар ақпаратпен қамтамасыз етті, мүмкіндігінше айқын болды)

1. Қанағаттанарлықтай дерлік
2. Қанағаттанарлық
3. Көңіл толарлық
4. Жақсы
5. Өте жақсы
6. Керемет
7. Тамаша

Q12i. Жағдайды бақылауға көмектесті (сізге қандай ем-шараларды қабылдауға болатынын жайлы баяндады, жай лекция оқу арқылы ғана емес, сізді ынталандыру арқылы)

1. Қанағаттанарлықтай дерлік
2. Қанағаттанарлық
3. Көңіл толарлық
4. Жақсы
5. Өте жақсы
6. Керемет
7. Тамаша

Q12j. Сізбен бірге емдеу жоспарын дайындады (сіздің пікіріңізге құлақ асты, ал шешім қабылдауда ең алдымен сіздің ойыңыз ескерілді)

1. Қанағаттанарлықтай дерлік

APPENDIX 1b (Continue).

2. Қанағаттанарлық
3. Көңіл толарлық
4. Жақсы
5. Өте жақсы
6. Керемет
7. Тамаша

Q12k. Жалпы, осы дәрігермен өткен консультацияны қалай бағалайсыз?

1. Қанағаттанарлықтай дерлік
2. Қанағаттанарлық
3. Көңіл толарлық
4. Жақсы
5. Өте жақсы
6. Керемет
7. Тамаша

APPENDIX 1c.

Наименование исследования: Удовлетворенность пациентов коммуникацией врача и пациента в амбулаторной помощи: Пилотное исследование

/___ /__ _ /2018/__ __ __

Общая информация

Q1. Укажите свой пол
1. Мужской
2. Женский

Q2. Ваш возраст:
1. 18-24
2. 25-34
3. 35-44
4. 45-55
5. Более 55

Q3. Семейное положение:
1. Не замужем/не женат
2. Замужем/женат
3. Разведен/(-а)
4. Вдов(-а)/(-ец)
5. Сожительство/Гражданский брак

Q4. Образование:
1. Начальная школа
2. Средняя школа
3. Колледж / диплом
4. Университет / степень
5. Докторантура

Q5. Ваша национальность?
1. Казах (казашка)
2. Русский (русская)
3. Другое_____

Q6. Профессиональный статус:
1. Безработный
2. Полный рабочий день
3. Не полный рабочий день
4. Пенсионер
5. Непостоянный работник
6. Не работает из-за плохого состояния здоровья
7. Домохозяйка
8. Другое, укажите _____

Q7. Средний личный доход в месяц:
1. Менее 50 000 тенге
2. 50 001 - 100 000
3. 100 001 - 150 000
4. 150, 001 - 200 000
5. Более 200 000

Q8. С какого Вы региона?
1. г. Алматы
2. г. Астана
3. Акмолинская область
4. Актюбинская область
5. Алматинская область
6. Атырауская область
7. Карагандинская область
8. Костанайская область
9. Кызылординская область
10. Мангистауская область
11. Павлодарская область
12. Северо-Казахстанская область
13. Восточно-Казахстанская область
14. Южно-Казахстанская область
15. Западно-Казахстанская область
16. Жамбылская область

APPENDIX 1c (Continue).

Информация о здоровье

Q9. У вас есть хроническая болезнь?

1. да
2. нет

Q10. Если да, то сколько у вас хронических болезней?

1. 1
2. 2
3. 3
4. более 3

Q11. Как вы оцениваете свое общее состояние здоровья?

1. Очень хорошо
2. Хорошо
3. Удовлетворительно
4. Плохо
5. Очень плохо

Удовлетворенность пациентов коммуникацией врача и пациента

Пожалуйста, оцените врача по следующим критериям:

Q12a. Вы чувствовали себя непринужденно (врач был дружелюбен с Вами, относился с уважением, не был холодным или грубым)

1. Почти удовлетворительно
2. Удовлетворительно
3. Почти хорошо
4. Хорошо
5. Очень хорошо
6. Отлично
7. Превосходно

Q12b. Дал Вам возможность рассказать свою историю (выделил Вам время, чтобы Вы подробно описали Ваши жалобы)

1. Почти удовлетворительно
2. Удовлетворительно
3. Почти хорошо
4. Хорошо
5. Очень хорошо
6. Отлично
7. Превосходно

Q12c. Внимательно слушал (уделял особое внимание тому, что Вы говорили, не отвлекаясь на ведение записей, на компьютер, пока вы рассказывали о себе)

1. Почти удовлетворительно
2. Удовлетворительно
3. Почти хорошо
4. Хорошо
5. Очень хорошо
6. Отлично
7. Превосходно

Q12d. Был заинтересован в Вас как в личности (спрашивая/узнавая детали касательно Вашей жизни, Вашей ситуации; избегая отношения как к «простому числу»)

1. Почти удовлетворительно
2. Удовлетворительно
3. Почти хорошо
4. Хорошо
5. Очень хорошо
6. Отлично
7. Превосходно

APPENDIX 1c (Continue).

Q12e. Полностью понимал Ваши беспокойства (выражая свое мнение, чувства по поводу ваших беспокойств, избегая игнорирования)

1. Почти удовлетворительно
2. Удовлетворительно
3. Почти хорошо
4. Хорошо
5. Очень хорошо
6. Отлично
7. Превосходно

Q12f. Проявлял заботу и сочувствие (показался искренне обеспокоенным, контактируя с Вами как с личностью, не был безразличен)

1. Почти удовлетворительно
2. Удовлетворительно
3. Почти хорошо
4. Хорошо
5. Очень хорошо
6. Отлично
7. Превосходно

Q12g. Был позитивным (наблюдалось позитивное отношение и позитивный подход со стороны врача, будучи честным, но не негативным к Вашим проблемам)

1. Почти удовлетворительно
2. Удовлетворительно
3. Почти хорошо
4. Хорошо
5. Очень хорошо
6. Отлично
7. Превосходно

Q12h. Понятно объяснял вещи (полностью отвечая на Ваши вопросы, предоставил адекватную информацию, будучи как можно конкретным)

1. Почти удовлетворительно
2. Удовлетворительно
3. Почти хорошо
4. Хорошо
5. Очень хорошо
6. Отлично
7. Превосходно

Q12i. Помогая контролировать ситуацию (изучая с Вами какие меры можно предпринять, мотивируя Вас, не просто читая Вам лекцию)

1. Почти удовлетворительно
2. Удовлетворительно
3. Почти хорошо
4. Хорошо
5. Очень хорошо
6. Отлично
7. Превосходно

Q12j. Составлял план действии с Вами (обсуждал варианты лечения, максимально включая вас в принятии решения, не игнорируя Ваши взгляды)

1. Почти удовлетворительно
2. Удовлетворительно
3. Почти хорошо
4. Хорошо
5. Очень хорошо
6. Отлично
7. Превосходно

Q12k. В целом, как бы Вы оценили консультацию с этим врачом?

1. Почти удовлетворительно
2. Удовлетворительно
3. Почти хорошо
4. Хорошо
5. Очень хорошо
6. Отлично
7. Превосходно

APPENDIX 2a.

NAZARBAYEV UNIVERSITY

Verbal Informed Consent

Study Title: Patient satisfaction with physician-patient communication in outpatient care: Pilot study

Investigators: Dr. Raushan Alibekova, Dr. Alessandra Clementi, Aigerim Tursynkhan

This study will identify the association between the patient satisfaction and doctor's communication in outpatient care. Before we begin, let me describe what this study involves. I am conducting a survey among patients to determine the patient satisfaction with physician – patient communication in outpatient care at the JSC "National center for neurosurgery" and to identify factors associated with patients' satisfaction with provided care. Such study is important for improvement of physician-patient communication which will then enhance patient involvement and adherence to treatment, will influence patient satisfaction, health care utilization, and improve the health care quality of JSC "National center for neurosurgery" and other medical institutions in the future.

Participation should take about 10 minutes. Participation is voluntary. You will be asked to fill out the questionnaire with 24 questions. There are no risks expected that are greater than you would normally encounter in your daily life. Your participation will benefit my study. I will use this information obtained from you only for the purpose of the research. Your individual data will not be associated with your name in any way and will be kept confidential.

You will not be penalized in any way for deciding to stop participation at any time. If at any time you would like to stop participating, please tell me. We can take a break, stop and continue at a later date, or stop altogether.

You will not receive any financial rewards for participating. However, you will make a great contribution for this research by participating in it.

Do you have any questions? If you have questions later, you may contact the investigator, Master of Public Health student at the School of Medicine of Nazarbayev University.

Are you interested in participating in this study?

YES [ ]
NO [ ]

Participants Identification Code (not name):

Date:
Time:

Investigator: Aigerim Tursynkhan
Contact Information: 8-701-847-33-19, atursynkhan@nu.edu.kz

APPENDIX 2b.

Ауызша негізделген келісім

Зерттеудің атауы: Амбулаторлық-емханалық көмектегі пациенттердің дәрігер мен пациенттің коммуникациясымен қанағаттануы: Пилоттық зерттеу

Зерттеушілер: Айгерім Турсынхан, Раушан Әлібекова, Алессандра Клементи

Осы пилоттық зерттеуде дәрігер мен амбулаториялық-емханалық көмекке байланысты науқастардың қанағаттануы қарастырылады. Сауалнаманы бастамас бұрын, осы зерттеудің қысқаша сипаттамасын берейін. Сипаттама бергеннен кейін, сіз осы зерттеуге қатысу туралы шешім қабылдай аласыз. Зерттеудің мақсаты - «Нейрохирургияның Ұлттық Орталығы» АҚ амбулаторлық-емханалық көмекке дәрігер мен науқастың хабарлауымен пациенттердің қанағаттану деңгейін анықтау болып табылады. Сонымен қатар, сауалнаманың келесі мақсаты пациенттің дәрігер мен науқас арасындағы қарым-қатынасқа қанағаттануына әсер ететін факторларды зерттеу болып табылады. Осы зерттеу арқылы біз «Нейрохирургияның Ұлттық Орталығы» АҚ-ның медициналық қызмет көрсету сапасын дамыту салаларын анықтауға көмектеседі деген үміттеміз. Осы тақырыпқа қатысты Сіздің пікіріңіз біз үшін өте маңызды. Сіз осы зерттеуге қатысу үшін кездейсоқ іріктеу әдісімен таңдалдыңыз. Осы сауалнаманы толтыруыңызды сұраймын. Толық құпиялылық және анонимдік сақталатынына кепілдік беремін, Сіздің жауаптарыңыз тек зерттеу мақсаттарында жалпыланған түрінде пайдаланылатын болады. Сауалнамада 24 сұрақ бар және оның ұзақтығы 10 минуттан аспайды.
Сіздің аты-жөнінің анықталмайды және барлық ақпарат жасырын түрде қалады. Сізден атыңызды жазуыңыз немесе құжатқа қол қоюыңыз сұралмайды.
Бұл жоба сізге минималды тәуекел туғызады. Егер, қандай да бір сұраққа жауап беру ыңғайсыздық туғызса, оған жауап бермей, келесі сұраққа көшуге немесе сауалнамаға қатысудан бас тартуға болады.

Сіз осы зерттеуге қатысуға келісіміңізді бересіз бе?

ИӘ
ЖОҚ

Қатысушылардың сәйкестендіру коды (аты емес):
Күні:
Уақыты:

Зерттеуші: Айгерім Турсынхан
Байланыс телефоны және эл.адрес: 8-701-847-33-19, atursynkhan@nu.edu.kz

APPENDIX 2c.

Устное информированное согласие

Название исследования: **Удовлетворенность пациентов коммуникацией врача и пациента в амбулаторной помощи: Пилотное исследование**

ФИО исследователей: Раушан Алибекова, Алессандра Клементи, Айгерим Турсынхан

В данном пилотном исследовании будет рассмотрена проблема удовлетворённости пациентов коммуникацией врача и пациента в амбулаторной помощи. Прежде чем мы начнем, позвольте мне описать, что включает в себя это исследование. После того, как я расскажу вам об этом исследовании, вы можете решить, хотите ли вы принять в нем участие или нет.

Я провожу опрос, чтобы определить уровень удовлетворенности пациентов коммуникацией врача и пациента в амбулаторной помощи АО «Национального центра нейрохирургии». Кроме того, целью этого опросника является исследование факторов, влияющих на удовлетворенность пациентов коммуникацией врача и пациента. Я намереваюсь провести этот опрос среди пациентов, которые будут проходить консультацию у врачей амбулаторной помощи. Это исследование имеет важное значение, поскольку оно позволит узнать текущее состояние удовлетворенности пациентов амбулаторной помощью в АО «Национального центра нейрохирургии» и поможет определить пути улучшения уровня оказываемой медицинской помощи.

Ваше участие в опросе займет не более 10 минут. Участие является добровольным. Вас попросят заполнить анкету с 24 вопросами. Нет никаких ожидаемых рисков, которые бы были выше тех, с которыми вы сталкиваетесь в своей повседневной жизни. Ваше участие принесет пользу данному исследованию. Информация, полученная от вас, будет использоваться только для целей исследования. Ваши личные данные никоим образом не будут связаны с вашим именем и будут сохранены в конфиденциальности.

Если Вы примете решения о прекращении участия в опросе, это не повлечет за собой никаких последствий. Если в любое время вы захотите прекратить свое участие, пожалуйста, дайте мне знать. Мы сможем сделать перерыв, приостановить и продолжить позже, либо полностью прекратить опрос.

Ваше участие не будет компенсироваться финансовым вознаграждением. Тем не менее, вы внесете большой вклад в это исследование, участвуя в нем. Если у Вас возникнут вопросы позже, вы можете обратиться к исследователю, студенту магистратуры по общественному здравоохранению в Медицинской школе Назарбаев Университета, Айгерим Турсынхан по телефону: 8-701-847-33-19, или электронной почте: atursynkhan@nu.edu.kz

Вы заинтересованы участвовать в этом исследовании?
ДА [ ]
НЕТ [ ]
Идентификационный код участников (не имя):
Дата:_____
Время:_____