

A Qualitative Study of Patient satisfaction in Oncology Wards Setting in Saudi Arabia

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Research Article

ABSTRACT

Background: The incidence of cancer in the Kingdom of Saudi Arabia (KSA) is increasing. Whilst meeting the growing demand for health care services in oncology, organisations must ensure they provide high quality care. Despite patient satisfaction being an important metric in assessing quality of care, there is a dearth of literature in this field in the KSA, particularly in oncology hospital wards. The aim of this study was to examine how interpersonal aspects of care and socio-cultural communication impact upon patient satisfaction in an oncology ward setting in the Saudi Regional Cancer Centre (SRCC), in Riyadh.

Methods: A sequential, explanatory, mixed methods design was employed. This paper presents the findings of the qualitative phase of the research, when semi-structured telephone and face-to-face interviews were conducted with 22 adult oncology inpatients admitted to the SRCC in Riyadh.

Findings: Three primary themes emerged from the interview data: doctor-patient relationship, nurse-patient relationship, and contextual factors of cancer in the KSA. The findings indicated that patient satisfaction levels were significantly influenced by the interpersonal aspects of care. Doctor-patient and nurse-patient relationships were deemed core to patients' experiences, with person-centered, interpersonal skills being especially important. In addition, socio-cultural issues such as language barriers and non-disclosure negatively impacted on levels of satisfaction. Attention to such factors is necessary to improve quality of care in oncology ward settings in the Kingdom. Improvements in care arising from enhanced interpersonal skills of staff, contextualised against a backdrop of social and cultural factors, would positively influence patient satisfaction in the KSA.

Conclusion: This study has provided new evidence supporting the need for stronger interpersonal relations and a more patient-centred approach in the oncology health system in the KSA. This research will assist policy makers and hospital management teams wanting to improve patient satisfaction in oncology wards in the KSA.

Keywords: Patient satisfaction, Patient experience, Clinical effectiveness, Oncology, Saudi Arabia, Hospital wards settings

INTRODUCTION

Promoting quality in healthcare represents a strategic responsibility for healthcare providers globally. Within the Kingdom of Saudi Arabia (KSA), the need to take appropriate steps to achieve improvements in quality of care is a key policy requirement of the KSA development plan (2009-2014) [1].

It was established by Professor Donabedian over 25 years ago, that as consumers of healthcare services, patients can significantly contribute to quality assurance [2]. Respect for patients' needs and wishes has emerged as increasingly important and nowadays, patient satisfaction is a major indicator of quality of healthcare delivery across the globe [3-6].

Even in Arab countries, where patient autonomy and opinion has historically been neglected for several reasons, particularly cultural influences and the region's inherent hierarchical structure, patient satisfaction is now being recognised as an integral part of evaluating care by health care authorities [7,8]. This is evidenced by the KSA's Joint Commission International (JCI) accreditation, where patient satisfaction surveys by health care authorities are gaining increasing traction [9]. Healthcare managers and policy makers are thus using patient opinions to formulate effective and strategic quality improvement plans and initiatives [10]. Notably, there is now a shifting dynamic in the KSA, with researchers noting the importance of good interpersonal relationships and communication between medical staff and patients as part of high quality care.

The growing demand for quality healthcare in the KSA is especially evident in oncology, with the rate of cancer diagnoses having risen in the Kingdom in recent years and with researchers predicting that cancer incidence is set to continue to rise [11,12]. This will inevitably increase the pressure on oncology wards in the KSA, raising concerns regarding the Kingdom's ability to provide sustained, high-quality cancer care, whilst meeting the anticipated increased demand in the future.

There is a paucity of published evidence focusing on the quality of hospital-care in the KSA. No prospective empirical research investigating satisfaction of oncology inpatients has been performed in the KSA. However, a retrospective study by Akhtar and Nadrah [13] into the quality of cancer care specifically assessed the quality of breast cancer care in a health care institution in the Kingdom. Similarly, Alaloola and Albedaiwi [14] performed a follow up assessment of patient satisfaction in a tertiary care centre in the KSA. Other researchers interested in the quality and standards of healthcare in the Kingdom have also provided some insight into factors that might adversely affect patient satisfaction, citing problems with access to care and treatments, service coordination and communication issues [8,13,15-19]. The dearth of research into patients' views on their experiences of inpatient care in the Kingdom KSA was further demonstrated in two reviews which investigated the general quality of health care. Findings from the review by Al Mutairi and Moussa [20] showed various issues affected patient satisfaction. Areas of concern related to skills of healthcare workers and included the need for enhanced empathy as well as a need for them to better understand patients' problems and cultural beliefs. In a similar manner, the review of patient care in university hospitals in the KSA by Aljuaid et al. [21] highlighted a need to improve the quality of healthcare delivery. The areas of greatest concern were patient safety, clinical effectiveness and patient-centeredness.

Patient satisfaction can be evaluated using qualitative research, quantitative research or mixed methods, which utilise both approaches. This paper reports the qualitative aspects of a sequential, explanatory mixed methods study, using Donabedian quality framework [22] and Patient Experience Model by Reimann and Stretch to assess patient satisfaction with quality of care. The study aimed to assess factors that contribute to or hinder patient satisfaction with care in oncology ward settings at the Saudi Regional Cancer Centre (SRCC) in Riyadh, Saudi Arabia. The quantitative results are published separately. The patient experience model shown in **Figure1**.

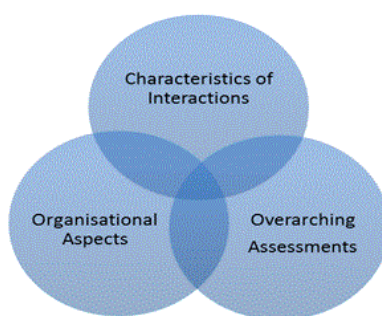


Figure 1. Core components of patient experience.

RESEARCH AIM AND QUESTIONS

The study sought to answer the following questions:

- How do interpersonal aspects of care influence adult oncology inpatients' satisfaction with care at the SRCC in Riyadh?
- How do socio-cultural communication factors influence adult oncology inpatients' satisfaction with care at the SRCC in Riyadh?

METHODS

Design

This exploratory study is the first of its kind. It uses a qualitative approach with semi-structured interviews to elucidate the views of adult oncology patients on the quality of their care and their experiences during their hospital stay. The Donabedian quality framework ^[22] and Patient Experience Model by Reimann and Stretch were integrated to provide a conceptual framework that would allow patients' perceptions of health care needs, experiences and expectations to be embedded within the concept of patient satisfaction with the quality of care they had received. There was particular focus on exploration of interpersonal aspects of care and socio-cultural communication factors, areas deemed important from previous published evidence. Questions were formulated to allow detailed exploration of patients' opinions on the healthcare delivered to them in relation to these factors, and how the care received impacted upon their levels of satisfaction.

Setting

The setting of this study was adult male and female oncology wards in the Saudi Regional Cancer Center (SRCC), one of the main KSA regional referral cancer centers in Riyadh. This setting was deemed appropriate, as the center admits adult male and female patients with varying types of cancer. In addition, geographically Riyadh is known to have the highest rates of cancer prevalence in the KSA ^[23]. Further, the city and its surrounding regions include a diverse population from which potential participants of various ages, socio-demographic and cultural backgrounds could be sampled.

Participants

The population of interest was adult male and female inpatients admitted to the SRCC in Riyadh. Limitations were placed upon the research in terms of timings since the sponsors of the research required completion of the clinical aspects of the research within a three-month timeframe. This meant that recruitment and the ultimate sample size was largely dictated by patient through-put, rate of diagnosis, oncology ward-size and bed occupancy.

All participants were required to have a confirmed diagnosis of cancer, be aged 18 years or older, be hospitalised for at least three days, be mentally fit to answer questions and be aware of their medical condition. Recruitment and consent took place on the ward through direct contact with patients by oncology nurse educators at the SRCC. Patients were given an information sheet about the study and invited to participate. They were then given time to consider whether they wished to participate and to discuss the study with their relatives. Those interested in participating were provided with a questionnaire to complete as part of the quantitative phase and informed of the opportunity to be selected for a follow-up interview for the qualitative phase of the study.

For the qualitative phase described here, a convenience sample was obtained from those participants who had completed the quantitative phase. All 100 participants who completed the quantitative phase were invited to provide their telephone number at the end of the questionnaire, so that the researcher could contact them directly to discuss participation in follow-up interviews. The primary researcher's contact number was also provided so that potential participants or someone acting on their behalf, could contact her for further information. A total of 38 participants indicated that they were willing and interested to participate in interviews, however of these, only 26 had provided full and correct contact details. The researcher contacted all 26 patients to agree a mutually convenient interview method, either via telephone or face-to-face, arrange a time for the interview and obtain verbal consent. Ultimately, a total of 22 patients were interviewed, 20 by telephone and 2 by face-to-face interviews. The key socio-demographic details of these participants are presented in **Table 1**. There were three male participants spanning a wide age range and 19 female participants most between 36 and 45 years old and of varying marital status and education level.

Table 1. Socio-demographic characteristics of participants.

| Participant | Age | Gender | Education | Marital status |
|-------------|-------------|--------|-------------|----------------|
| 1 | 36-45 years | Female | High school | Married |
| 2 | 46-55 years | Female | Primary | Married |
| 3 | 36-45 years | Female | High school | Married |
| 4 | 26-35 years | Female | University | Married |
| 5 | 36-45 years | Female | High School | Divorced |

| | | | | |
|---------------------------------------------------|----------------|--------|--------------|---------|
| 6 | 36-45 years | Male | Intermediate | Married |
| 7 | 18-25 years | Female | Intermediate | Single |
| 8 | 26-35 years | Female | High School | Married |
| 9 | 36-45 years | Female | Illiterate | Married |
| 10 | 36-45 years | Female | High School | Married |
| 11 | 66-75 years | Male | Primary | Married |
| 12 | 46-55 years | Female | Primary | Widowed |
| 13 | 46-55 years | Female | University | Married |
| 14 | 56-65 years | Female | Intermediate | Widowed |
| 15* | 46-55 years | Male | Intermediate | Married |
| 16 | 46-55 years | Female | Intermediate | Married |
| 17 | 46-55 years | Female | University | Married |
| 18 | 36-45 years | Female | University | Married |
| 19 | 26-35 years | Female | High school | Single |
| 20 | Above 76 years | Female | Primary | Married |
| 21* | 18-25 years | Female | High school | Single |
| 22 | 36-45 years | Female | University | Married |
| *Participants who received face-to-face interview | | | | |

Ethical Considerations

Ethical approval was obtained from the University of Stirling, School of Health Sciences' Ethics Committee, and from the Saudi Regional Cancer Centre (SRCC) Ethics Committee.

Data Collection

The primary researcher conducted the interviews in Arabic between March and April 2014. Most of the interviews (n=20) were conducted over the telephone at a mutually convenient time. This made sense logistically due to potential difficulties of travelling to Riyadh. Although telephone interviews precluded the researcher from recording non-verbal cues such as body-language, this was considered an acceptable compromise. Indeed, these participants appeared more relaxed, reflective and able to freely discuss sensitive topics compared to those who had face-to-face interviews. Thus, telephone interviews appeared to suit the cultural context of this study. The two face-to-face interviews were conducted with participants 15 and 21 within the oncology ward.

Participants were interviewed between discharge from hospital and their follow-up hospital appointments, which occurred six to eight weeks post-discharge. Thus interviews took place on average 4 weeks after discharge. This short interval was chosen in order to maximise patients' recollections of their care. The initial plan to record interviews was abandoned due to insurmountable logistical issues arising from conditions imposed by the ethical committee of the SRCC in Riyadh. The researcher therefore ensured she was well prepared in effective note taking to accurately capture all participants' responses and relevant details [24].

The interviews were guided by an interview schedule, which was piloted by the primary researcher with her Arabic speaking university colleagues. The interview guide was organised in order to capture responses in certain key areas of interest arising from the quantitative phase of the study and other published research evidence. Accordingly, there were questions which explored interpersonal aspects of doctor and nurses skills and exchange of information and socio-cultural communication issues. Examples of the interview questions are presented in **Table 2**. Sometimes the researcher would ask the participants additional questions to clarify meaning and elicit a better understanding of their opinions. Interviews lasted on 30 min.

Table 2. Examples of interview questions.

| Interview guide | Interview question |
|-------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Doctor skills | How would you describe the doctors' communication regarding illness? Could you say more about your relationship with doctors during your hospital stay? Why is it important to you? |
| Nurses skills | What were the nurse's attitudes like when dealing with you? Could you say more about that? Where the nurses accurate about indicated treatment? What do you think was important to you regarding technical skills of nurses? |
| Exchange of information | Can you describe your opinions on the exchange of information as you perceived it in hospital? How do you think information exchange should be? |

Data Analysis

The primary researcher translated her transcripts and notes of the interview responses from Arabic to English. Literal translation was used wherever possible but with elements of 'free' translation, which required some word changes and minor modifications to improve grammar and enhance the readability and understanding of the meaning in English [25]. It should be noted the extracts drawn from patients' interview narratives and presented in results should not be regarded as verbatim translations. Analysis involved a combination of inductive and deductive thematic analysis using coding. This was performed by the primary researcher in collaboration with the other researchers, thereby enhancing the reliability of the results.

Analysis of the translated notes was facilitated by importation of the textual data from Microsoft Word into NVIVO 10 software. This latter is a widely used and validated electronic package for qualitative research. Thematic analysis followed the six stages identified by Fereday and Muir-Cochrane [26]. Firstly, the coding manual was developed, which was informed by the research questions and findings of the quantitative phase of the study. The codes were further identified as those factors that were influential in determining a patient's level of satisfaction with their care based upon the Donabedian [22] quality of care model. The coding was checked with the other authors. Overall, agreement of coding was high, and the few minor issues arising were discussed and resolved before proceeding to the actual analysis. Next, the primary researcher identified the preliminary themes which emerged from the data and summarised the findings. Analysis also involved inductive coding from annotated extracts, this helped identified new themes. For example, the concept of power dynamics of doctors affecting patient satisfaction emerged from the data during the coding of doctor skills as part of clinical effectiveness. The coded themes were corroborated and legitimized as being representative of the original data by revisiting the text from the original interview extracts [26]. Thereafter, definitive core themes that captured the phenomena of patient satisfaction in an oncology ward setting in the KSA were identified.

RESULTS

Table 3 presents the three core themes identified, along with their associated subthemes. The first two themes "doctor-patient relationship" and "nurse-patient relationship" are relevant to the first research question which aimed to explore the impact of interpersonal aspects of care on patient satisfaction. The second theme "contextual factors of cancer" related to the second research question of the impact of socio-cultural communication on patient satisfaction.

Table 3. Key themes from qualitative research.

| Themes | Subthemes |
|-----------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------|
| Doctor-Patient Relationship | Non-disclosure, listening skills, information provision, motivation, care and compassion |
| Nurse-Patient Relationship | Clinical effectiveness and technical competence, interpersonal skills, care and compassion, availability |
| Contextual factors of Cancer in the KSA | Patients' perception of cancer, doctor-patient power dynamics, influence of religion, influence of family, impact of multi-cultural environment |

Doctor-Patient Relationship

Fourteen of the twenty-two research participants in the study were positive about their experiences of the doctor-patient relationship. They expressed appreciation and gratitude for their doctors' personal qualities and interpersonal

skills, which had clearly contributed to satisfaction with their hospital stay. However, as the interviews proceeded, a number of issues relating to their experiences emerged, in particular information provision, care and compassion.

One emergent issue of note, and one that infiltrates into quite a few other sub-themes, is non-disclosure. Non-disclosure of patient information to the patient themselves is not uncommon in the KSA setting, being influenced by cultural norms, religious beliefs and attitudes of the doctors^[8,27]. For example, information relating to a female patient's diagnosis may be disclosed to her male guardian, who may then take responsibility for making decisions regarding her healthcare. In this study, the issue of non-disclosure appeared to impact on the experiences of several peoples' care. In eight cases, five where information had not been disclosed appropriately to patients and they had not been involved in decision-making, this translated into concerns over interpersonal skills of the doctor. Notably, however, it is conceivable that the patient's family may have insisted that the doctor restricted disclosure of the patient's health status. This is an emotive area and one which could not be explored retrospectively. It is an issue which is frequently alluded to in the discussions that follow:

Information provision

Another concern pertains to the sharing of information between doctors and patients, although this is complicated by the potential for a prior decision regarding non-disclosure. Most participants reported positive experiences of receiving comprehensive information from their doctors and noted the calming and reassuring effects that this had on them. The following extracts illustrate this:

The doctors listened to my queries and clarified my doubts in detail. They took every step to inform me well at the start of treatment and also provided me with relevant information. (Participant 16)

I even had some misconceptions about radiation but they clarified the concepts and now I'm not scared of my treatment. (Participant 11)

Although many doctors were clearly listening to patients and offering them information on their treatment, information provision was problematic for some participants who reported long delays. Conceivably, this may have been for a number of reasons such as doctors' busy schedules and/or the hospital's policies preventing provision of certain information to patients by nurses. Also given the common practice of non-disclosure in the KSA, information provision could have been forbidden. As one participant noted:

I am waiting longer to get information about results from doctors, while nurses can't give me this information until the doctors do their round. This process makes me feel more worried and anxious about my stay. (Participant 5)

Care and compassion

Two main findings emerge in relation to compassion and the doctor-patient relationship. First, it was implied that an absence of compassion impacts negatively on the ability of the patient to cope with their illness. Second, the perception that doctors' lack concern was recurrent in the participants' narrative. 'Concern' here must be distinguished from general communication, it is more than just asking questions, rather it requires a 'patient-centred' attitude that allows doctors to address the patient's psychological needs as well as their clinical needs. It was certainly apparent that patient satisfaction was significantly impacted by the interpersonal skills of doctors in fulfilling all their responsibilities as perceived by patients:

To me, doctors aren't diagnosticians only but also the ray of hope. Their behaviour, words and facial expressions are important to me, and the means by which I judge the chances of getting well. (Participant 3)

By interpersonal skills I mean the communication skills and compassion. They need to have more kindness and understanding. Here doctors are good — I don't say they are bad — but in the situation of these skills and characteristics there is a lot lacking. (Participant 18)

The Nurse-Patient Relationship

Overall, most participants expressed positive experiences in their relationships and interactions with nurses. Thematic analysis identified two core elements within the main theme of nurse-patient relationship, which interplay to varying degrees and provide unique insights into the nurse-patient relationship. These two core elements are Clinical effectiveness and interpersonal skills. Each of these is considered below.

The clinical effectiveness of nurses in their roles within the service organisation emerged as a key sub-theme. As with the perception of doctors' roles, several participants indicated the importance of the psychological as well as physical aspects of nurses' roles in being clinical effective. They used words such as 'kindness', 'supportiveness', 'accuracy', 'responsiveness', 'trustworthiness' and 'understanding' when describing their nursing care. The importance of this holistic, patient centred approach to care is evident from the responses of two participants:

Another thing is the lack of psychological understanding among medical staff. They don't try to understand the patient's individual psyche. (Participant 6)

Nurses need to be specifically trained to deal with cancer patients. They should be aware of our psychological state and their attitude should provide confidence to patients as we sometimes have many questions or are worried about the next appointment or discharge. They should welcome questions and comfort us with patience and kindness. (Participant 21)

Furthermore, although many reported positive experiences when describing their relationship with nurses, a few participants felt that nurses did not have supportive attitudes, and were sometimes too busy to provide psychological support, as demonstrated by the following comments:

Generally, nurses are good but need to recognise the psychological status of the patient by allowing more time to spend with cancer patients when asking questions. (Participant 5)

The nursing staffs are good but there's a lot of need for further development. They are not able to adapt to patients of different mind-sets, having a generalised attitude which isn't sufficient at all. And that's the reason I'm not really satisfied. (Participant 7)

Notably, this perceived lack of time exposes problems with organisational constraints and resource issues, and by extension potentially clinical ineffectiveness. It certainly appears that nurse' time constraints, precluding them from interacting and communicating with patients, was a determinant of patient satisfaction within the nurse-patient relationship.

They (the nurses) are good but they are very busy and there is a real staff shortage. (Participant 1)

Interpersonal skills

Participants highlighted several aspects of nurses' interpersonal skills as significant in facilitating a trusting relationship. In particular, taking time to communicate care and compassion appeared to significantly impact upon the patients' psychological well-being and their motivation of patients to get better, which, in turn, related to their level of satisfaction with their care:

They spent time talking with me. I found it so lovely and caring and sensitive to my needs, I really appreciate them and their way of dealing and sharing with patients. (Participant 8)

They were caring towards me...Their kindness and sympathetic attitude were always encouraging and helped me to cope during my stay, thank God...They always asked me if I had any complaints or if I needed pain medication. Even if I rang them they were quick to respond and provide me with comfort and help during either their day or night shift. (Participant 20)

However, a few participants appeared dissatisfied with aspects of nurses' interpersonal skills, largely relating to inadequate support and failing to attend to individual patients' needs. Possible reasons cited were nurses not having the time to devote to patients and language problems, since many nurses were non-Saudi nationals unable to speak fluent Arabic.

They should ask for a translator if the patient can't understand some points in conversations, such as helping with room transfer from a shared to a single room. (Participant 5)

Social-Cultural Communication Factors

Various context-specific influences relating to socio-cultural communication factors emerged from the interviews as significantly impacting upon patient experiences and satisfaction with care. The emergent subthemes are described in the following.

Patient perceptions of cancer

Within the KSA, cancer is generally viewed as a fatal disease. Indeed, upon diagnosis there was a general fear of death amongst many participants. Accordingly, there was a perception that cancer represents a medical priority, warranting urgent attention from medical staff.

Organisations should learn to treat cancer patients differently to other patients. They should understand that time is of utmost importance in our treatment. Any delay on their part could have a devastating impact. They could help us a lot by improving the pace of functioning. (Participant 1)

Doctor-patient power dynamics

There was a general perception that doctors were figures of authority who command respect and whose word should be trusted, rather than challenged. This is typical of the KSA culture, and was demonstrated by one participant's response.

The relationship with doctors is important to every patient. We actually give them, after God, the authority over our body and illness, so having a good trusting relationship with my doctors keeps me calm and satisfied. (Participant 9)

Other responses demonstrated the adverse effect that such a top-down, power imbalance can have on patients:

The doctors were not interested in patients' mental condition. They took care of treatment and that's it. We could not feel comfortable enough to express our concerns to them. This has adversely affected the whole situation by making us feel unmotivated. (Participant 19)

In contrast, to these findings other patients mentioned feeling well-informed by doctors; suggesting non-disclosure is not universally practiced. One respondent stated:

The doctors in oncology were so respectful and helpful, they tell me everything about my condition and options for treatment such as surgery, chemo and radiation, also they were honest about prognosis and this was so important for me to know (whether my disease is) curable or not. (Participant 8)

Influence of religion

The religion of Islam shapes the culture of the KSA and clearly influenced participants' perceptions of and satisfaction with the care they received. It directly impacted upon many patients' morale, with some indicating that their faith in God was more powerful than medicine. Moreover, one patient described how SRCC's visiting religious scholars helped keep spirits up:

The weekly official visit of a religious scholar was very helpful and motivating for me and other patients...When I felt lost I wished to see someone who could connect my heart with God so I could find some peace. (Participant 7)

I believe that my disease has been gifted from God as a test to see how I will be patient and deal with this fact; therefore, I accept my destiny of cancer and I will be working hard to deal with recovery by praying first to God to help me and then also to help my doctors to cure my disease in the near future. (Participant 8)

Influence of family

Many participants viewed family members as the principal decision-makers who, with guidance of doctors and other medical staff, agreed upon the care that the patient should receive. Interestingly, some participants were highly appreciative of doctors informing and reassuring family members of their condition, as demonstrated by the following extract:

My mother wasn't able to understand and she was very afraid. The doctors calmed her down and assured her that they wouldn't be doing anything wrong to me. (Participant 13)

Analysis of such discourse also unearthed evidence of the patriarchal social system within the KSA, characterised by masculine authority. Thus, overlying the family involvement in decision-making was the influence of male family members regarding decisions on women's healthcare; as demonstrated by Participant 22:

They (medical staff) explained all about the treatment to my husband. (Participant 22)

This contrasted with the care of male patients, where disclosure of information, advice given by a doctor or nurse and decision making was restricted solely to the male members of the patient's family; the patient's wife was excluded from these interactions.

Influence of multi-cultural healthcare environment

Cultural factors in relation to the SRCC hospital environment were evident from some participants' responses. In particular, the large proportion of expatriate nursing and medical staff whose command of Arabic and appreciation of Saudi culture negatively impacted on some patients' satisfaction with care provision; as demonstrated by certain participants' comments:

Their (medical staff) language is a bit of problem; it would be easier to communicate with them if they were capable of speaking Arabic. (Participant 10)

Communication skills are the most important, for example, being able to talk freely and ask about treatment, but in my opinion the nurses need to understand more of the Arabic language to be able to deal with patients easily. (Participant 5)

Moreover, the use of English rather than Arabic amongst medical staff led one patient to feel excluded and anxious about her health. The following extract illustrates this:

The doctor requested tests...I felt lost because doctors speak English with them (nurses) in front of me, which is difficult for me to understand...That's why I felt worried (Participant 5)

Additionally, the need for privacy emerged as an important aspect of good patient care, which is an important cultural factor for females in the KSA. This is demonstrated by the responses of two female participants:

I feel so shy when I have nausea in a shared room as I can't tolerate the smells of food during lunch time. That's why I am so irritated at sharing a room with someone. But if I am in a single room, I feel comfortable and free to request from the nurse that no food should be supplied to my room due to my severe nausea. (Participant 3)

DISCUSSION

This is an important first study to explore the views of oncology patients regarding their care as inpatients in the KSA. The qualitative findings help address the lack of knowledge in this poorly researched field and provide considerable insight into how interpersonal aspects of care and sociocultural communication influence the level of patient satisfaction in oncology wards in the KSA.

Regarding interpersonal aspects of care, there was strong emphasis on the psychological as well as physical elements of care. Some participants felt satisfied with the doctor-patient relationship, suggesting that their doctors were frequently available to them, encouraging them to ask questions and providing all the information needed to address their concerns. However, it appeared that satisfaction in this area was not universal with some criticism of both doctors and nurses. Thus, many patients alluded to the fact that doctors and nurses should improve their interpersonal skills and take a more holistic, patient centred approach. This would mean understanding and responding to patients' anxieties about their illness as well as addressing their physical ill-health. In a similar manner, the need for clinical staff to improve their interpersonal skills and focus on more patient centred care with enhanced empathy towards patients with cancer was reported in reviews of patient satisfaction in the KSA [20,21].

Of note is research showing how the nature as well as the level of communication between doctor and patient can have a significant influence on patient satisfaction [28,29]. This is especially true in oncology settings, where the way that doctors communicate with their patients can also influence the patient's level of anxiety, and psychological well-being [30,31]. Many of the participants frequently reported experiences associated with compassion and care exhibited by their doctors, using terms such as tender, understanding, patient, concerned, and reassuring. It was clear that through such a patient-centred approach, doctors can play a vital role in raising and maintaining patient morale. These findings support evidence from previous studies that have highlighted the association between a trusting doctor-patient relationship and patients coping with their illness, which may result in improved patient outcomes [32,33]. It is thus important that health authorities address such aspects of interpersonal relationships, since it is well recognised that psychological distress has an impact on cancer mortality [34]. In a similar manner, Street demonstrated how doctors' attitudes towards their patients is important to a patient's outcome, for instance encouraging and motivating behaviours can improve patients' adherence to treatment and self-care. Ommen et al. [35] likewise suggests that by using motivating and encouraging communication with their patient, doctors' can have a significant impact on the patient's state of mind, such as lowering anxiety, and thus, may indirectly influence the overall outcome of the illness.

Of concern, however, is that evidence exists showing that although awareness of psychological distress is an essential aspect of patient care, oncology doctors often tend to avoid asking questions regarding patients' psychological health [36,37]. It seemed that although important dimension of patient satisfaction was the ability of the doctor to relate to and engage with the patient, not all doctors in this study were equipped with the necessary interpersonal skills.

Poor information provision by doctors was also alluded to by several participants and was directly linked to patient satisfaction with the quality of their care. This is also an area needing focus in the KSA, as was proposed by Aljubran [7] who maintained that good communications improve patients' well-being, which could potentially lead to better health outcomes for those being treated in an oncology setting. Indeed, this present study suggests an apparent change of attitude where patients wish to build relationships of trust with their doctors and openly verbalise their concerns. This growing preference for patient empowerment and advocacy is arguably at variance with historic cultural norms in the KSA.

Just as with doctors, nurses' interpersonal skills were deemed important as they impact on the quality of patients' experiences. Although generally satisfied with nursing care, some patients perceived nurses as lacking in compassion and responsiveness, although this was potentially linked with nursing shortages and the observed lack of time that nurses had to interact with patients. Similar, it has been revealed in a review by Rchaidia et al. [38] which investigated cancer patients' perceptions of the 'good nurse'. The findings suggest that 'being present' both physically and mentally in

terms of their openness to patients' psychological needs is an important indicator of a good nurse, based on the perceptions of cancer patients. These findings also concur with those of Shattell ^[39] who indicate that patients want nurses who are approachable, available, empathic and willing to talk with them, as well as nurses who are not rushed because of their workload and responsibilities.

Another potential reason for the perceived lack of care and compassion by nurses is language difficulties, due to the high proportion of expatriate nursing staff. Indeed, previous research indicates that, without a shared culture and language, it is difficult for expatriate nurses to deliver effective nursing care to Saudis ^[40,41]. The effect of language barriers on communication between patients and non-Saudi nurses has been reported by a number of studies ^[5,40]. Likewise, Rchaidia et al. ^[38] highlights how language barriers may lead nurses to appear to patients as being detached and remote. This would be contrary to the fundamental traits of a clinically effective nurse, namely being caring, showing compassion and relating to the patient as a person. Language barriers were also problematic in doctors who would speak English with their colleagues and nursing staff, thereby engendering a feeling of exclusion and anxiety amongst some patients. The findings support the Saudi government's Saudisation programme to encourage more Saudis to train as health care professionals thus gradually replace non-Saudis in the KSA health care system ^[41].

A number of contextual factors unique to the socio-cultural landscape of the KSA were evidenced by this study. For example, cultural perceptions of the doctor as a figure of authority and power in relation to one's health often engendered a top-down power dynamic. In addition, there was evidence of the influence of males within the family setting. These findings align with the fact that Saudi culture has traditionally been hierarchic and patriarchal in nature ^[8,42]. These cultural norms meant that many patients in this study felt reluctant to ask the doctor questions or question their treatment. However, it is encouraging that in some instances patients felt dissatisfied with this situation and want doctors to respect their needs and respond to their requests.

One cultural factor which was a significant area of concern for several participants, especially females, was the need for privacy. This is consistent with published evidence where as a lack of privacy negatively impacted on oncology patients' satisfaction ^[43,44]. This is obviously an important area needing attention by health authorities offering care for cancer patients. Notably, the importance of religion and spiritual well-being of patients to help deal with their illness is an area which is recognised by SRCC, as patients are offered spiritual support within the hospital setting.

A further positive aspect arising from the data is that it appears that there is a tendency for some doctors to practice disclosure and share information with the patients themselves, rather than with their families. Non-disclosure is a complex issue in KSA and negatively influences patient satisfaction. In the West, it is common practice that the patient is well informed and involved in decision-making in terms of treatment ^[45]. However, in the KSA, non-disclosure is acceptable. This is despite evidence from the KSA and internationally ^[27,46,47] showing that patients prefer to have full disclosure of information about their illnesses. Of note is that surveys of physicians in the KSA ^[48,49] have revealed their preference for discussing patients' condition and treatment with patients' close relatives rather than with the patients themselves. It represents a contentious issue but one which must urgently be resolved. Fortunately, attitudes are changing; growing public awareness of medical issues, as well as ethical consideration, in the KSA are reportedly driving a change in doctors' attitudes and behaviour ^[7,27,49,50]. Thus, full disclosure of the person's health status to themselves, rather than their relatives, is becoming increasingly common in the KSA and was apparent to some degree in this present study.

RECOMMENDATION FOR FUTURE RESEARCH

It is evident from this study that patient satisfaction is subjective and based on a number of socio-cultural and demographic expectations of care, which may be impacted by the nature and severity of the disease, for example the poorer the patient's prognosis the higher a patient's expectations of rapid and high-quality care. This is an area which could be investigated in a larger, multicentre study through stratification of disease severity against constructs of patient satisfaction.

CONCLUSION

This study has provided new evidence supporting the need for stronger interpersonal relations and a more patient-centred approach in the oncology health system in KSA. In particular, the role of cultural issues in influencing patient satisfaction in an oncology ward setting was apparent. Evidence provided by this research will make a substantial contribution to policy makers and hospital management teams in the KSA wanting to improve patient satisfaction in oncology wards and in other health care settings.

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CONFLICT OF INTEREST

The author(s) declare that they have no conflict of interests.

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