

Patient satisfaction at haematology and oncology clinics in the Free State & Northern Cape

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Abstract

The Free State and Northern Cape make up some 40% of the land area of South Africa, while being home to only 10% of the total population. Haematology and Oncotherapy outreach clinics were established in Kimberley, Bethlehem and Welkom to provide a more accessible service to the thinly spread population. A previous study showed these clinics to be cost-effective, but we had no idea how the patients experience them. Our aim was to obtain information about the demographics of the patients, the logistical support of the clinics, the medical needs of the patients and how they experience the clinics. This can help us to improve the service. A questionnaire was tested in a pilot study. The demographic questions covered age, sex and ethnicity. The logistical questions dealt with distance traveled to the clinic, mode of transport, length of time as a patient and cost. The medical need questions dealt with type of disease, treatment received, type of doctor seen and origin of referral. The questions about experience covered satisfaction with the service, staff, waiting times and involvement of non-governmental organizations. Of the 95 patients interviewed 42% were from the haematology clinics. The mean age was 59.5 and the male: female ratio was 0.6:1. Forty-six percent of the patients spoke Afrikaans and 31% spoke South Sotho. The black:white ratio was 1:1. Twenty-eight percent used the government ambulances (of whom 80% were satisfied) and 56% used their own cars. The median payment at a clinic was R20 (R0 to R200). Only 19% of patients were paying privately. Ninety-five percent of the patients were follow-ups, with the median length of follow-up being 24 months (1 to 468). The patients were mainly referred by local hospitals. Twenty-two percent of the patients had chronic haematological malignancies, while 68% had solid tumours. Thirty-seven percent of the patients received drugs to take home and only 6% got intravenous chemotherapy. Consultants saw 44% of the patients. The median waiting time to be seen was 1.5 hours (0 to 5). Consultation time averaged 10 minutes and most patients were satisfied with this. Despite the study's small size the system of outreach clinics seems to be delivering a satisfactory service. Criticisms were few. However there were suggestions to create better clinic facilities and to shorten the waiting times at the clinic.

Key words

Patient satisfaction, hospital outpatient clinics, rural health services, haematology service, oncology service

Introduction

The Free State & Northern Cape form 40% of the land area of South Africa but are home to only 10% of the population (Central Intelligence Agency 2001:1; Statistics South Africa 1997a:1; Statistics South Africa 1997b:1) (see Figure 1). The Departments of Oncotherapy and of Haematology and Cell Biology at the Academic Hospitals in Bloemfontein have held outreach clinics in Kimberley, Bethlehem and Welkom for some years.

At the haematology clinics patients with both malignant and non-malignant conditions are seen, while the oncology clinics attend to patients with solid tumours, including lymphomas. A previous study showed that the outreach clinics are cost-effective (Coetzee *et al* 1998:705). However, we had no idea how the patients experience the central clinics in Bloemfontein or the outreach clinics (Coetzee *et al* 1998:704). The aim of the present study was to obtain information about the demographics of the patients, the logistical support provided

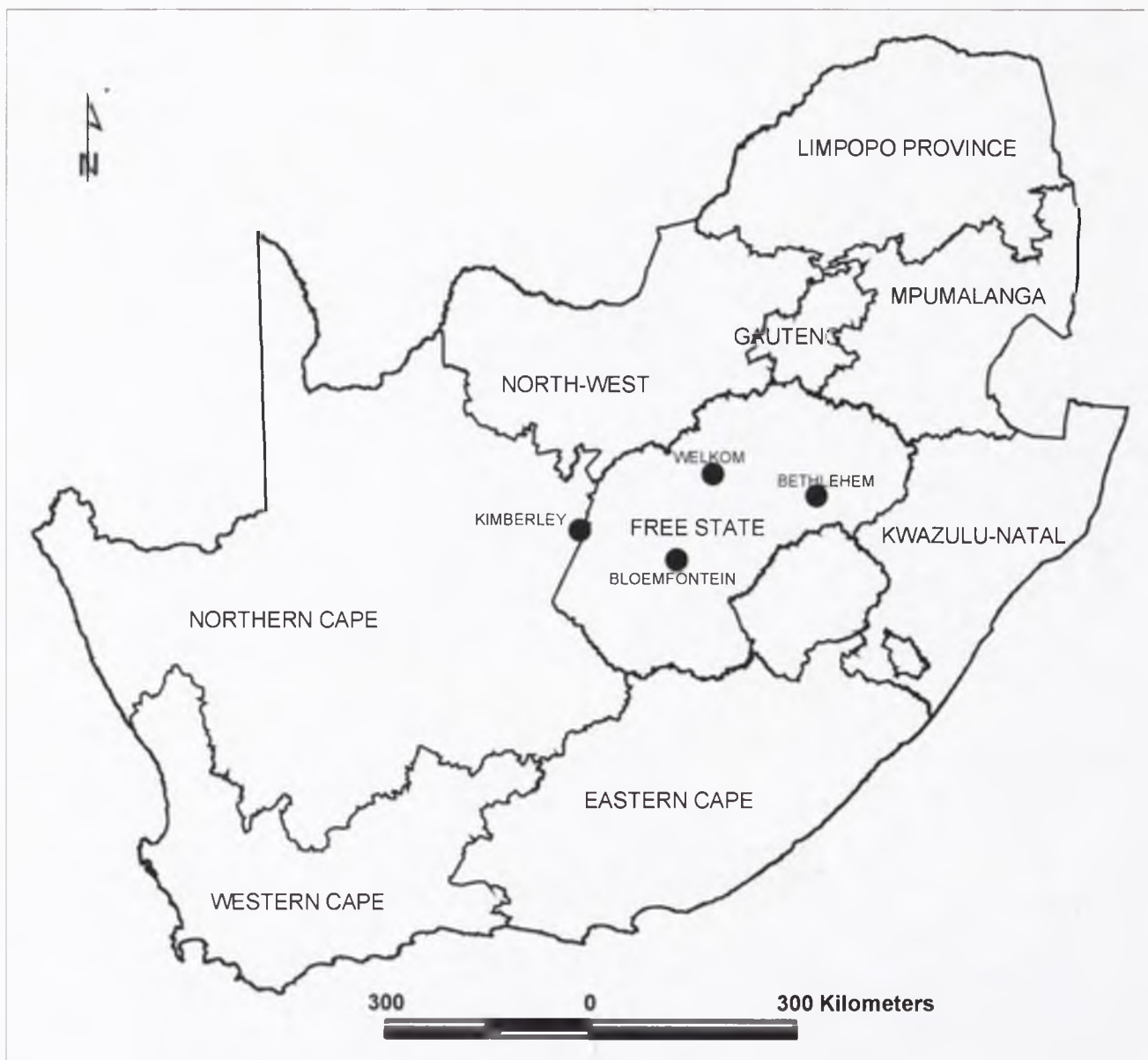
to the clinics, the medical needs of the patients and how patients experience the clinics. Such a study could guide us as to how to improve the clinic services.

Methods

We obtained approval for the study from the Ethics Committee of the Faculty of Health Sciences, University of the Free State. A descriptive study by means of questionnaires was undertaken to describe the activities of the haematology and oncology clinics and to gauge the satisfaction of the patients. As many patients were interviewed as were willing and as time allowed, thus the sample was somewhat biased. Two Welsh medical students on an elective (the first two authors) adminis-

tered a questionnaire to patients after they had seen their doctors. Where necessary nurses helped with translation. The questionnaire was designed according to general guidelines provided by Fitzpatrick (1992:162) and some ambiguous questions were rephrased after a pilot study. Emphasis was placed on aspects of the clinic services that the authors anecdotally considered to be problems. The questionnaire contained demographic questions (age, sex and ethnicity), logistical questions (distance travelled to the clinic, mode of transport, length of time as a patient and cost), medical need questions (type of disease, treatment received, type of doctor seen and origin of referral) and patient experience questions (satisfaction with the service, staff, waiting times and involvement of non-governmental organisations). The questions about logistics were designed to see if patients had difficulty getting to the clinics.

Figure 1: Map of South Africa showing the provinces and the location of various clinics



A major reason for establishing outreach clinics had been to bring the service closer to the patient. We were also not sure how effective the provincial transport services were, and if patients were lost to follow-up because of transport difficulties.

The medical need questions were designed to see what kind of patient saw what type of doctor and from where the patients were referred, how they were treated, and how they got medication. The questions about patient experience helped to determine if the shortage of healthcare workers and the large patient numbers adversely influenced the patients' experiences of the clinics. The study ran for the month of November 1999. Descriptive statistics, namely frequencies and percentages for categorical data and medians and percentages for continuous data, were calculated per group. The groups were compared by means of 95% confidence intervals (CI). The latter approach was used because most of the data was not parametrically distributed and confidence intervals give a better idea of the significance of findings than more conventional statistical methods.

Results

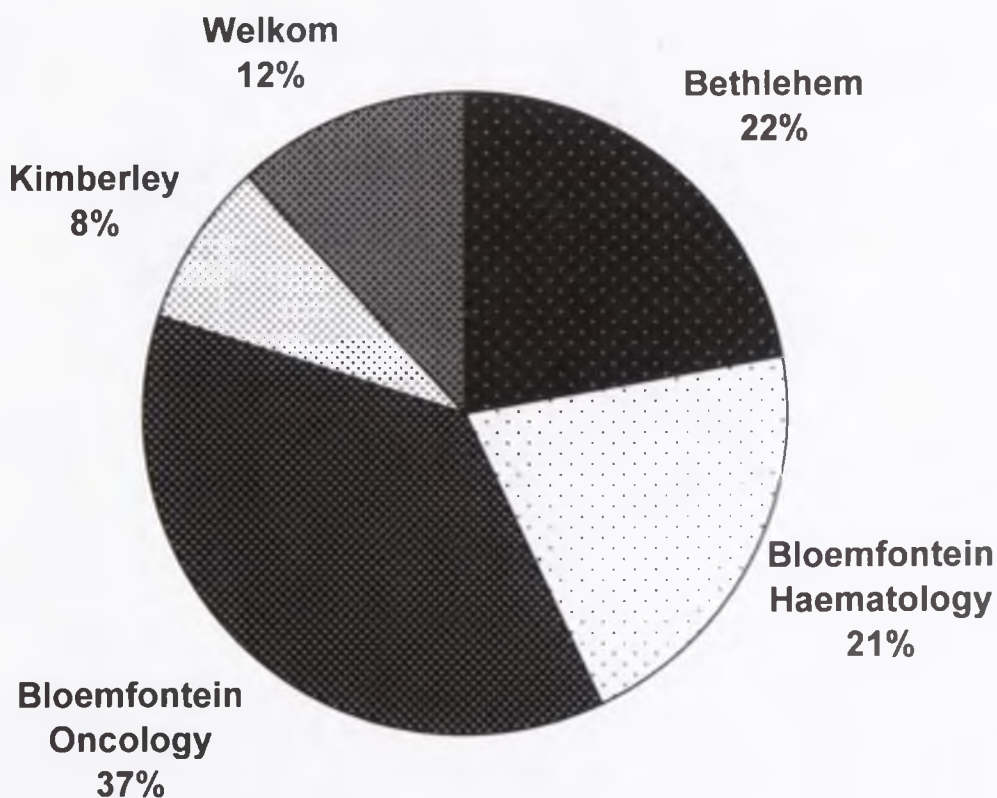
Ninety-five patients were interviewed. Forty-two percent were from the haematology clinics and 58% of patients were seen in Bloemfontein clinics (see Figure 2). The sample represented 4% of the oncology outpatients and 24% of the haematology patients seen in November 1999. The median age was 59.5 years (18.7 to 85.9) and the male:female ratio was 0.6:1. Forty-four percent spoke Afrikaans and 31% South Sotho (see Fig-

ure 3). Twenty-eight percent of patients used the government transport and of them 81% were satisfied with the transport. However, at the Kimberley clinics 75% were dissatisfied with the transport. Most of those using the government transport spoke black African languages. Fifty-six percent of the patients used their own cars. The median distance the patients lived from a clinic was 42.5 km, with a range of 1 to 380 km. Seventy-one percent of the patients fell in the lowest income bracket and only paid R20 per visit. R20 was also the median payment, with a range from zero to R200. Nineteen percent of patients had medical aids and nineteen percent paid nothing. Ninety-five percent of the patients were follow-ups with the median length of follow-up being 24 months (1 to 468). The median interval between follow-ups was 24 months (0.5 to 72).

Forty-seven percent of patients were referred to the nearest clinic from local hospitals. Twenty-two percent of patients had chronic haematological malignancies and 68% had solid tumours (see Figure 4). Thirty-seven percent received drugs to take home and only 6% got intravenous chemotherapy. Eighty-six percent of patients obtained their medication at the hospital pharmacy. Consultants saw 44% of the patients, while registrars saw 40%.

The median waiting time to get an appointment was zero weeks (range 0-12). Patients waited a median of 1.5 hours (range 0-5) to be seen by their doctor at the clinics. Eighty-one percent of patients were satisfied with this. The median length of consultation was 10 minutes (range 4-30) and 99% said this was long enough. All except two patients said they were treated well by the staff and 26 patients made suggestions about how to improve the service. We were interested in the extent of discrimi-

Figure 2: Pie diagram of the numbers of patients interviewed at various clinics



nation, but there were no differences in waiting times to get an appointment, waiting times at the clinics and the length of consultation, according to financial class or patient language. The Cancer Association was mainly involved with the oncology patients. It was involved with all the patients with solid tumours in the Bloemfontein clinics and approached 78% of such patients in the outreach clinics. Sixty-five percent of patients it contacted were indigent. Hospice only contacted 2% of patients, but is only involved with terminal patients and does not have branches everywhere.

Limitations of the study

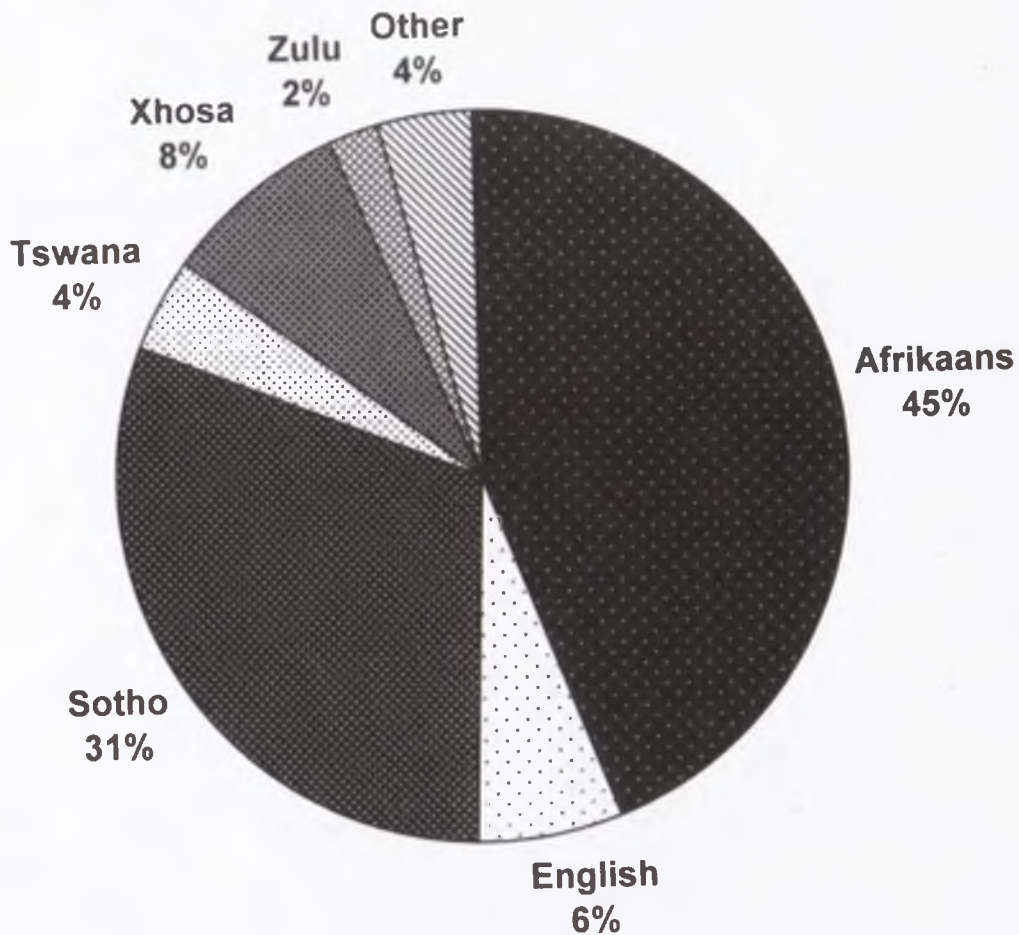
Ideally we should have undertaken a baseline study when the clinics started so that we could monitor any change in satisfaction. This would have given a firmer foundation for planning. The haematology clinics have been running since 1994 and the oncology clinics for many years. The study was small, being a biased sample representing less than 25% of the patients seen

in November 1999. The fact that the students wore white coats and that nurses had to translate may have influenced the patients' response. In the future we will rather use a tested patient satisfaction scale, such as that developed by Westaway et al (2001).

Discussion and recommendations

There were no significant differences between haematology and oncology clinics regarding the distances patients traveled to clinics (CI -11 to 29 km), waiting time at the clinics (CI -1.0 to 0.5 hours) and percentage of complaints (CI -23% to 12.6%). There were significant differences regarding length of consultations (CI 5 to 5 minutes). At haematology clinics the median length of a visit was 15 minutes (range 5-30) and at the oncology clinics the median was 10 minutes (range 4-30). However,

Figure 3: Pie diagram of the languages spoken by the patients interviewed



the latter had a greater workload, and there was no difference in the number of complaints about length of consultations at the different clinics. The only significant differences between central and outreach clinics were that the waiting time at outreach clinics was less (CI -1.5 to -0.5 hours) and that the consultations were shorter (CI -5 to 0 minutes). There was no difference in the cost to patients. The clinics seem to be delivering a satisfactory service, as criticisms were few.

The suggestions that 26 patients made could be grouped as follows: 31% suggested that better physical facilities be introduced, 35% suggested that more staff (especially multilingual staff) be appointed, 3% wanted the provision of cancer education, 23% thought the clinics should be organised better and 8% suggested that the Central Government or private institu-

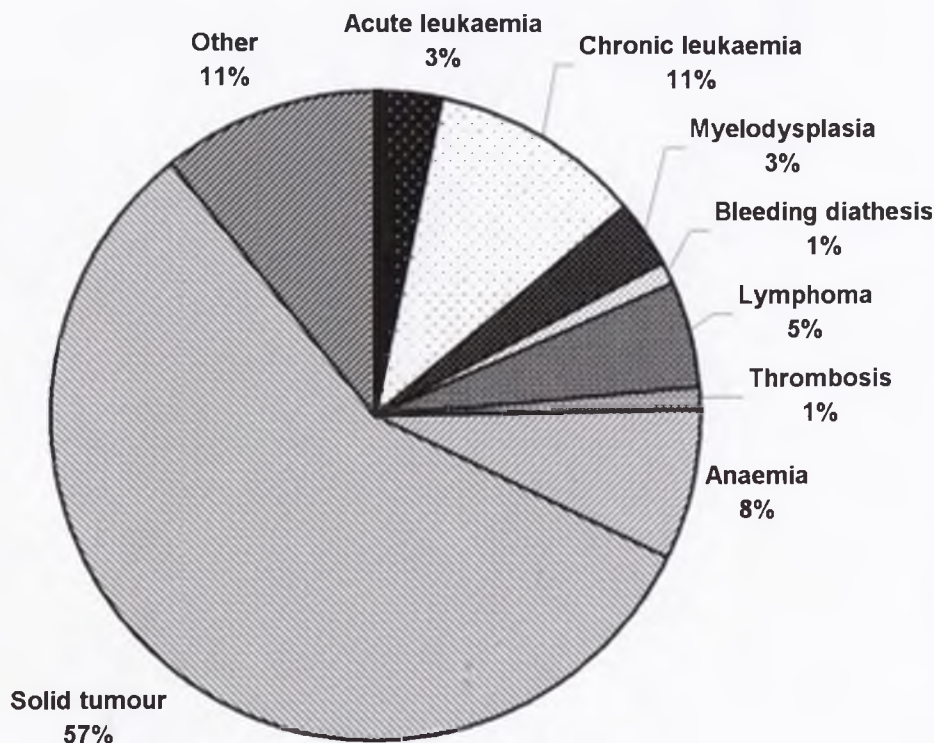
service.

The enthusiasm of staff, especially the nursing staff, at the clinics is inspiring. Most of the staff are multilingual and like to interpret for the doctors. The volunteer organisations resolve many of the patients' problems. The patients are grateful and their serenity in the midst of their ill health encourages us to improve the service.

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Figure 4: Pie diagram of the diagnoses of the patients interviewed



tions (and not only the Provincial Departments of Health) fund the clinics. Unfortunately the problems with inadequate physical facilities and staffing are difficult to address, unless outside institutions provide funding. The clinics can be organised better, for instance by starting earlier and streamlining the management of patients. If the staff cannot provide cancer education, the Cancer Association could probably help. We intend to repeat the study in order to monitor the quality of

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