

1-1-2010

Managing health care in a Libyan public hospital: A case study

Alexandria K. Osborne
Walden University

Follow this and additional works at: <https://scholarworks.waldenu.edu/dissertations>

 Part of the [Health and Medical Administration Commons](#)

This Dissertation is brought to you for free and open access by the Walden Dissertations and Doctoral Studies Collection at ScholarWorks. It has been accepted for inclusion in Walden Dissertations and Doctoral Studies by an authorized administrator of ScholarWorks. For more information, please contact ScholarWorks@waldenu.edu.

Walden University

COLLEGE OF MANAGEMENT AND TECHNOLOGY

This is to certify that the doctoral dissertation by

Alexandria Osborne

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

Review Committee

Dr. Anthony Lolas, Committee Chairperson,
Applied Management and Decision Sciences Faculty

Dr. Aqueil Ahmad, Committee Member,
Applied Management and Decision Sciences Faculty

Dr. Teresa Lao, Committee Member,
Applied Management and Decision Sciences Faculty

Chief Academic Officer

Denise DeZolt, Ph.D.

Walden University
2010

ABSTRACT

Managing Health Care in a Libyan Public Hospital: A Case Study

by

Alexandria K. Osborne

M.B.A., Western Michigan University, 2005

B.S., Pratt Institute, 1978

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Applied Management and Decision Sciences

Walden University

May 2010

Abstract

Libyan citizens who can afford private health care are opting out of the public health care system. They have a perception that the quality of public health care has deteriorated. The negative perceptions have resulted in a lack of trust by many of Libyan's citizens in the Libyan public health care system and consequently to unequal access to quality health care. The purpose of this study was to identify the factors that have led to the negative perceptions and mistrust. The conceptual support for the study was based on a construct of trust that defines trust as the state of readiness for unguarded interaction with someone or something. Key research questions examined the role Libyan cultural values and privatization of healthcare might have played in creating the negative perceptions and mistrust of the healthcare and its delivery and whether the perceptions and mistrust varied between the patients and healthcare providers. The research methodology used for this study was a qualitative exploratory single-case study. Fifty participants were interviewed during a one-month period. Responses were coded using ATLAS.ti. Study results provided an understanding of the cultural considerations, the impact of privatization, and the respondents' perceptions of Libyan public health care. Results indicated that respondents demonstrated the capacity to trust but did not consistently have positive perceptions of competence and intention of administrators of the public health care system. The findings suggest that patients view the behavior of providers as an indication of their level of skill. Additionally, respondents perceived that they will have a higher level of service if they have a personal recommendation. The social change implication for this study is that overcoming these negative perceptions and improving trust can lead to equal access to quality health care.

Managing Health Care in a Libyan Public Hospital: A Case Study

by

Alexandria K. Osborne

M.B.A., Western Michigan University, 2005

B.S., Pratt Institute, 1978

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Applied Management and Decision Sciences

Walden University

May 2010

UMI Number: 3397232

All rights reserved

INFORMATION TO ALL USERS

The quality of this reproduction is dependent upon the quality of the copy submitted.

In the unlikely event that the author did not send a complete manuscript and there are missing pages, these will be noted. Also, if material had to be removed, a note will indicate the deletion.



UMI 3397232

Copyright 2010 by ProQuest LLC.

All rights reserved. This edition of the work is protected against unauthorized copying under Title 17, United States Code.



ProQuest LLC
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106-1346

Dedication

This study is dedicated to the people of Libya; they inspired me to undertake this endeavor. Their openness, hospitality, curiosity, and kindness provided the motivation and enthusiasm for the study. God willing they will benefit from this humble effort.

Secondly, I dedicate this study to my father, Alfred Hamilton Osborne, who taught me the importance of education. My father exhibited confidence in me when at times I lost confidence. He never wavered and always encouraged me to reach for the next level.

I also dedicate this effort to memories of my beloved mother, Norma Kathleen Chaderton-Osborne, who we lost too early and her brother William Chaderton. They did not accept anything less than academic excellence from my brother, cousin, and me. I also hope that my effort inspires my young grandson, Nuri. Therefore, this dissertation is dedicated to the next generation in the hope that they are encouraged by my academic journey and the accomplishments of the generations that came before them.

Acknowledgements

This effort could not have been accomplished without the strength drawn from my faith. All benefits from this study must be contributed to God. Any deficiencies come from me.

My greatest appreciation and thanks go to Dr. Tony Lolas for his assistance and encouragement through the dissertation process. Thanks also to the committee members Dr. Aqueil Ahmad and Dr. Teresa Lao for their valuable input and feedback.

This study could not have been accomplished without the support of the doctors and staff at Tripoli Medical Center, especially Dr. Ali Massoud El- Mgadmi. The doctors exhibited professionalism, openness, and encouragement regardless of the path the study might take. Special appreciation is given to Dr. Mohamed Suliman Ellabib who introduced me to Dr. Mgadmi and who provided me support during my stay in Libya.

I could not have achieved the goals without the support of my employer (Pfizer Inc.), my management, and my colleagues. They provided financial and moral support throughout my higher education journey. Lastly but no less important, I thank my friends Darlene Abdullah and Thuraia Hussain who were the best listeners during this journey when I needed someone to listen.

Table of Contents

List of Tables.....	v
List of Figures	vi
Chapter 1: Introduction to the Study	1
Introduction.....	1
Background of the Problem	2
National Rankings.....	4
Health Policy.	5
The Trend towards Privatization.....	9
Statement of the Problem.....	17
Purpose of the Study.....	18
Research Questions	20
Conceptual Support for the Study	20
Assumptions.....	22
Scope.....	23
Delimitations	25
Research Design	25
Definitions of Terms.....	27
Significance of the Study.....	28
Chapter Summary.....	30
Chapter 2: Literature Review	32
Patient Satisfaction	33

Measurements and Assessments	36
Health System Integration.....	46
Socialization versus Privatization	50
Quality Improvement.....	54
Information Technology	58
Methodology Review	59
Chapter Summary	60
Chapter 3: Research Method.....	62
Description of the Research Design	63
Target Population	66
Sampling Procedure.....	67
Sample	69
Instrumentation.....	71
Data Collection Procedures.....	79
Data Analysis	97
Chapter Summary	105
Chapter 4: Results.....	105
Introduction.....	105
Interviews.....	106
Open and Axial Coding.....	110
Selective Coding	124

Relationship of Themes to Research Questions.....	268
Observation.....	270
Documents.....	278
Member Checking.....	280
Chapter Summary.....	286
Chapter 5: Summary, Conclusion, and Recommendations.....	288
Introduction.....	288
Interpretation of Findings.....	289
Conclusion about research question 1: Cultural considerations.....	289
Conclusion about research question 2: Effect of privatization.....	292
Conclusion about research question 3: Factors contributing to negative or positive perceptions.....	293
Relationship of findings to conceptual framework.....	299
Conclusion of Findings.....	301
Social Change.....	304
Recommendation for Action and Future Research.....	306
Closing Statement and Reflection.....	309
References.....	313
Appendix A: Questionnaire Obtained from an Empirical Study.....	333
Appendix B: Patient Survey.....	338
Appendix C: Staff Survey.....	341

Appendix D: Letter of Cooperation.....	344
Appendix E: Employee Qualification Report.....	345
Curriculum Vitae.....	352

List of Tables

Table 1: Matrix of link between research question and survey question	84
Table 2: Preliminary codes and families created in Atlas.ti	98
Table 3: Respondents by category.....	108
Table 4: Pretested research and survey question matrix.....	112
Table 5: Questions with responses by respondent.....	114
Table 6: Code count per question.....	115
Table 7: Codes discarded after deductive coding.....	118
Table 8: Code list and segment count.....	119
Table 9: Themes generated from axial coding	122
Table 10: Relationship of themes to research questions.....	269
Table 11: Private Sector Facilities.....	279
Table 12: Public Sector Facilities.....	279

List of Figures

Figure 1: Tripoli Medical Center Organization	67
Figure 2: Data collection plan.....	80
Figure 3: Open-coding network view	103
Figure 4: Observational Coding Sheet.....	271

Chapter 1: Introduction to the Study

Introduction

A quotation which I value as it relates to this study is, “The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being without distinction of race, religion, political belief, economic or social condition” (WHO, 2006, p. 1). According to Griffin (2006), health care must be accessible, psychologically and socially acceptable to its recipients, comprehensive, economically efficient, and delivered with reasonable quality. To achieve this, a health care system should include goals and objectives, information, evaluation of performance, expectations, and incentives (Kovner & Neuhauser, 2004b). This study is an exploratory case study. It explored the strengths and weaknesses of providing health care to patients at Tripoli Medical Center (TMC) located in Tripoli, Libya. Most of the supporting literature and texts used in this study focus on the challenges of health care in already developed nations. Yet, medical centers, such as TMC, serve metropolitan communities in a developing nation and their challenges need to be further researched and explored.

Globalization has heightened awareness of the importance of delivering quality health care in developing countries (Weiner, 1989). Libya is a rapidly emerging socialist republic that strives to deliver quality health care to its citizens. It faces the challenge of protecting the health of its citizens while opening up its borders to trade and tourism. The case of the Benghazi Six, accused of deliberately infecting Libyan children with HIV, increased the tensions between foreign health care providers and the Libyan public (Ahmad, 2000; Haviland, 2004). Five Bulgarian nurses and a Palestinian doctor were

initially sentenced to death for deliberately infecting at least 40 Libyan children with HIV at a hospital in Benghazi, Libya. Outrage from the international community and an undisclosed deal led to their eventual release. This study explored trust in Libya's medical system at the backdrop of the Benghazi Six case and the trend towards privatization in health care in developing countries. I explored the delivery of health care to Libyan families at the TMC hospital in Tripoli, Libya. Suggestions provide guidelines for future research to improve the management of health care in developing countries.

This chapter describes the background of the problem, the problem statement, the study's purpose, the research questions, the conceptual support, assumptions, the scope, delimitations, the study's significance, and the research design. The background section describes the TMC hospital. This section is followed by a discussion of national rankings, health, and the trend towards privatization. The problem statement, purpose, and research questions sections describe the focus and specific areas of inquiry. The conceptual support section describes a construct of trust used in this study

Background of the Problem

The human development index (HDI) is an indication of a country's level of development. The HDI of Libya is 0.818, which ranks it 56th of 177 countries (UNDP, 2007/2008). The HDI is an index of a country's life expectancy, literacy, and standard of living. Libya is classified as a developing country due to its level of industrialization, infrastructure, and technology. TMC, a major health center in Libya, plays a key role in Libya's HDI due to the large number of Libyans it serves.

TMC has a capacity for 1450 beds and employs 1000 physicians (Tripoli Medical Center, 2008). Its 2006 budget was approximately 600 million USD. Yet, TMC acknowledges gaps in such areas as computerized information systems (Mgadmi, personal communication, July 14, 2008). As such, TMC gives preference to non-Libya consultants and universities to bring best-practice methods to Libya (Tripoli Medical Center, 2008). TMC has a far greater capacity to serve the population but may be considered to be less efficient because of the greater number of beds. As a comparison, in 2001 there were 5,801 hospitals in the United States, with approximately one million beds. Of these hospitals, 249 had greater than 500 beds (Williams, 2005). According to Williams (2005), optimum efficiency is 150 to 250 beds. Developing nations can learn from similar challenges facing health care in the United States. Gains in health care have not been shared across all segments of society. As Turnock (2004) suggested, the greatest gains in health care can be achieved by closing the gaps, thus ensuring all members of society have equal access to health care.

Quinn, Anderson, and Finkelstein (1996) identified success factors to consist of recruiting the best performers, use of a well-designed information system, sharing of information, and an organizational structure aligned with professionals' skills. I contend that these factors cannot exist in a hospital without trust among administrators, medical staff, patients, and the entire health care system. In 2001, the Institute of Medicine (IOM) identified 10 patient-focused rules for 21st century health care (Stefl, 2004, pp. 194-196):

1. Care should be based on a continuous healing relationship.

2. Care should be customized based on patient needs and values.
3. The patient will be the source of control.
4. Knowledge will be shared and information will flow freely.
5. Decision-making will be evidence-based.
6. Safety will be a system priority.
7. The system should be transparent.
8. Needs should be anticipated.
9. Waste should be continually decreased.
10. Clinicians need to cooperate.

Health care systems and organizations are often assessed in the context of their national rankings and policies. A discussion of each follows. This section concludes with a discussion of health care privatization in developing countries.

National Rankings.

The amount a nation spends on health care does not equate to value or health outcomes (Savage, Campbell, Ford, & van der Reis, 2004). Furthermore, the link between health status and national wealth is weak (Turnock, 2004). Yet health care expenditures are often cited to assess a nation's health ranking. Libya spends 3.3% of its GDP or 222 USD per person on health care. More often the Health Adjusted Life Expectancy (HALE) is used as an indicator of health outcomes; it estimates the average number of years that a person will live without a disability. Libya has one of the highest HALEs in the region at 64 years (WHO, 2007), but falls behind globally.

Insurance systems have been used as a solution to many nations health care challenges. Savage et al. (2004) compared national health care systems in Argentina, Brazil, Canada, Germany, Greece, Indonesia, Mexico, the Netherlands, Sweden, Turkey, the United Kingdom, and the United States. Financial access to primary health care is lowest in countries that rely on voluntary insurance (Savage et al., 2004; Starfield, 1991). The average HALE of the six countries with universal health care access is 70.3 years. The average HALE for the five developing countries is 60.02 years. However, Starfield (1991) found that the benefits of access to primary health care were offset by underdeveloped social services.

Despite the various attempts to improve health care globally (e.g., the universal health care), there remains a large disparity of health in the world. In 1999, infant deaths per 1,000 live births were 18.6, 17.1, 10.6, 7.1, 4.6, 3.5, and 3.4 for Romania, Russia, Puerto Rico, United States, Switzerland, Singapore, and Sweden, respectively (S. J. Williams, 2005). Even though this study was not a comparison study, it explored patient and staff perceptions of Libya's health care system.

Health Policy.

The hospital is only one component of a nation's public health policy. Health care also addresses disease and prevention. According to Turnock (2004), public health care must include population-based health services, clinical preventive services, as well as diagnostic and treatment services. At the institutional level, the hospital must have enough autonomy to respond rapidly to local community needs (Fottler & Malvey, 2004).

Measuring community wellness requires considering more than outcomes. As an example, access to health care is an important measure of health. The Centers of Disease Control and Prevention Public Health Practice Program Office identified three types of health risk factors: determinants (e.g., low birth rate), direct contributing factors (e.g., use of prenatal care), and indirect contributing factors such as transportation (Centers for Disease Control, 2007). All three types of risk factors can contribute to health problems.

Population-based care provides intervention for community wide disease prevention, which is tied to public policy. The top preventable deaths in the United States are related to tobacco, diet, alcohol, microbial agents, toxins, sexual behavior, motor vehicles, and illicit use of drugs (Fielding & Halfon, 1994). Prevention has economic and human savings (Turnock, 2004). For example, Scandinavian countries provide comprehensive preventive pediatric services by using community-based, visiting nurses (Weiner, 1989). Prevention can be classified as primary, secondary, and tertiary. Primary prevention focuses on preventing disease (e.g., minimizing exposure). Secondary prevention focuses on identifying and controlling disease at early stages (e.g., removing a suspicious mole). Tertiary prevention restores the individual after health is compromised. In Libya, “secondary and tertiary care is provided through a network of general hospitals in rural and urban areas and specialized hospitals” (WHO, 2007, p. 13).

The patient should be the focus of health care systems. Emphasis is typically on specialty, hospital, and rehabilitation care. However, according to Griffith and White (2002), primary care, preventive care, health promotion, home care and hospice, and long-term care are often neglected.

The Healthy People 2010 government initiative in the United States has two overall goals: increase the quality and years of healthy life and the elimination of health disparities. The Healthy People 2010 model illustrates the relationship among policies and inventions, the physical and social environment, and access to quality health care in determining overall health status (Turnock, 2004). Hospitals as organizations are managed around a set of policies, handbooks, and procedures. Many of the latter are very specific, such as nursing procedures. Policies and procedures are the roadmap for behavior, decision making and thinking (Longest Jr., Rakich, & Darr, 2004). Procedures apply to specific situations. Charters and bylaws guide organizations and are used by the legal system to determine rights and obligations (Longest Jr. et al., 2004). Ethics codes go beyond legal obligations. According to Longest Jr. et al., ethics codes ensure patient confidentiality and regulate conflicts of interest. Institutional review boards (IRB), institutional ethics committee (IEC), and infant care review boards (ICRC) prevent and solve ethical issues. Policies and procedures are built on an organization's mission, vision, and values. An organization's mission, vision, and values describe its purpose. As an example, health care policy should consider the factors that effect demand for complex health care delivered by a medical center like TMC and the circumstances that influence patients to travel long distances to receive such care (Kovner, Elton, & Billings, 2004). Values support the philosophy, principles, ideals, and ethics of the organization (Zuckerman, 2000). Actions, objectives, goals, strategies, values, vision, and mission support each other respectively.

Mission statements summarize the organization's purpose. The vision describes the desired future state. Values are the organization's principles. Together, the mission, vision, and values are at the core of a health care organization's philosophy (Longest Jr. et al., 2004). Below is an example of an organization's mission, vision, and values:

Mission:

Upper Chesapeake Health is dedicated to maintaining and improving the health of the people in its communities through an integrated health delivery system that provides high quality care to all. Upper Chesapeake Health is committed to service excellence as it offers a broad range of health care services, technology and facilities. It will work collaboratively with its communities and other health organizations to serve as a resource for health promotion and education.

Vision:

The Vision of Upper Chesapeake Health is to become the preferred, integrated health care system creating the healthiest community in Maryland.

Values:

Excellence - We constantly pursue excellence and quality through teamwork, continuous improvement, customer satisfaction, innovation, education, and prudent resource management.

Compassion - People are the source of our strength and the focus of our mission. We will serve all people with compassion and dignity.

Integrity - We will conduct our work with integrity, honesty, and fairness. We will meet the highest ethical and professional standards.

Respect - We will respect the worth, quality, diversity, and importance of each person who works with or is served by Upper Chesapeake Health.

Responsibility - We take responsibility for our actions and hold ourselves accountable for the results and outcomes.

Trust - We will strive to be good citizens of the communities we serve and build trust and confidence in our ability to anticipate and respond to community and patient needs. ("Upper Chesapeake Health: Mission, Vision, Values," 2005)

William Foley, president and chief executive of Provena Trust, stated that mission and trust are inseparable (McPherson, 2006). Yet it is interesting that, from a United States perspective, he viewed nonprofit institutions as being more trusted since profit is not their priority. This may indicate that cultural considerations are important when establishing trust in health care.

The Trend towards Privatization.

Privatization is often viewed as the solution to health care systems constrained by facilities, skilled professionals, equipment, and various health services. The trend toward privatization in the health care systems in developing countries leads to greater charging in health care systems ("Charging for health services in the third world," 1992). This affects patient choice and can have a disproportionate affect on a nation's population (Spiegel et al., 2004). In developing countries, patients who can afford to pay for private health care will seek private medical treatment if they perceive that the public health care institutions are inadequate (McGregor, 1998). This can destabilize universal health, according to Spiegel et al. Social health insurance based on means is one of many

options a nation can take to assure equal access to health care, but coverage rates have varied (Carrin, Desmet, & Basaza, 2001). Carrin et al. also suggested that private insurance targets the wealthy and is increasingly being offered in developing countries. Nevertheless, health insurance can be used to achieve equality in health care (Russo, 1994) and universal health care (Carrin et al., 2001). Income, education, and gender equity are indicators of population health (Spiegel et al., 2004). Spending for hospital services has been found to be susceptible to household income changes (Russo, 1994). However, government policy, including the degree of privatization, can also affect population health (Spiegel et al., 2004).

Bangladesh was a pioneer in privatization in health care and also a model of failure in privatization (Akram, 2003). As Akram suggested, Bangladesh is not the only developing country struggling to deliver promised benefits (Akram, 2003). Privatization, regardless of the sector, must be regulated by policies that improve social welfare (Akram, 2003; Purohit, 2001; Russo, 1994).

China and India have been slow responding to regulating the growth of their private health care institutions (Bloom et al., 2008). Bloom et al. reported a “crisis of trust” in China and India’s health care systems (p. 952). Nonresident Indians have been increasingly investing in India’s health care system (Purohit, 2001). There has been a large growth in outpatient and inpatient private providers, unqualified providers delivered 80% of the outpatient care and inpatient care was equally unregulated, according to Bloom et al. This resulted in barriers of quality care to the poorest of India’s population.

Financial pressures and scarce resources drove privatization in India. These pressures can provide incentives that are contrary to trustworthiness (Gilson, 2006). Nevertheless, India is one of many developing countries that have leaned toward partial or complete health care privatization. Regardless of the impetus, many of these experiments in developing countries with privatization have a common thread; that common thread is a desire to increase patients' and providers' confidence and trust in the system. In India, privatization has attracted top professionals by using high-tech medical technology diagnostic centers (Purohit, 2001). Unfortunately, according to the World Health Organization (2007), Libya has high computer illiteracy among its health care professionals. This suggests that patients may not have equal access to these high-tech, high-cost solutions. Globalization can enhance disease diagnosis and treatments by the export of high-tech solutions (Spiegel, Labonte, & Ostry, 2004).

Many developing countries, like China, went through two phases of development: egalitarian and liberalization eras (Liu, 2004). China's economic growth exceeded its health care sector growth. The postliberalization era seeks to encourage market forces (Purohit, 2001). The assumption is that the free market will increase efficiencies. However, the recent global financial crisis supported Purohit's contention that this can only be successful if the role of government is refined. According to Liu, decentralization and marketization is not necessarily counter to positive health care development. However, the degree of privatization determines the opportunities of a market-driven health care system. An alternate view is that the private sector cannot provide sufficient services to meet a nation's health care needs (Russo, 1994).

Russo (1994) warned the global community that the control of contagious diseases must remain in the public sector and that the public sector may be in the best position to share the large risks by facilitating large diversified groups. SARS, HIV, and avian influenza epidemics highlight the importance of a global approach to health care (Blumenthal & Hsiao, 2005; Spiegel et al., 2004). The SARS epidemic highlights how well the international community can work together (Spiegel et al., 2004) and underscores the importance of an international health care body to establish a health care policy and objectives (Pollock & Price, 2002). Yet, Blumenthal and Hsiao suggested that a nation should consider its country's social and cultural environment when considering privatization. Spiegel et al. (2004) mentioned that the trend toward privatization raises questions about whether it compromises the ability of government to respond to global epidemics due to less collaboration. Similarly, Russo asserted that governments must maintain control of preventive, maternal, health care, immunization, and contagious disease management.

The SARS epidemic exposed the cracks in China's health care system (Blumenthal & Hsiao, 2005; Hu, 2004; Liu, 2004). Local cooperatives, private investors, military institutions, and state-owned enterprises owned and managed China's Epidemic Prevention Stations. This created a breakdown in communication and collaboration among China's health care institutions. Liu maintained that health care institutions must be rewarded for truthful reporting, especially in the fight of communicative diseases. Particularly in the rural areas, technical and ethical standards of medical professionals needs to be raised, according to Liu.

Distrust erodes legitimacy and the capacity to fulfill responsibilities (Gilson, 2003). The restructuring of China's health care system was at the expense of its rural populations (Blumenthal & Hsiao, 2005; Liu, 2004), where infant mortality and infectious disease are rising. Costs rapidly increased creating a climate of distrust (Bloom et al., 2008). Additionally, contracting of health care services can lead to an inadequate number of providers in rural areas (Siddiqi, Masud, & Sabri, 2006). Liu (2004) reported that privatization of China's health care system resulted in inequalities in health care and health status. Liu further suggested that improved health care services benefited those who had the ability to pay. Hu (2004) stated, "Differences in economic growth and in financing, organization and resources between urban and rural regions have made China a country with a two health-care systems" (p. 480). Blumenthal and Hsiao stated this more assertively, "its health care system nearly imploded, partly because China adopted (willingly or not) the strategies of some U.S. proponents of radical health care privatization" (Blumenthal & Hsiao, 2005, p. 1).

In the 1980s, China dismantled a thriving health care system and the result was less access resulting in undiagnosed and untreated health conditions (Liu, 2004), particularly in the rural areas (Blumenthal & Hsiao, 2005). The newly rich receive high-tech care in urban areas. Rural doctors, largely unregulated, chose to deliver core profitable services, which they were untrained to provide. The ability to pay became a predictor of access and quality of health care services in China, as suggested by Blumenthal and Hsiao. Fortunately, the health care system is slowly improving by establishing minimum requirements for rural doctors (Bloom et al., 2008).

There have been conflicting studies regarding the affect of health care fees and medical care demand in developing countries. In the Philippines, consumer fees did not impact demand (Russo, 1994) while the prevailing view is that increased user fees reduces demand (Hu, 2004; Liu, 2004; Purohit, 2001; Siddiqi et al., 2006). In Laos, private health care was the preferred choice and those who could afford to traveled abroad for treatment. The poor usually could only purchase drugs with no diagnosis and if they did use public clinics, the wait times were long, procedures were bureaucratic, and the staff was rude (Paphassarang, Philavong, Bouphe, & Blas, 2002). Cost of service, procedures, and staff attitudes were perceived differently by Laotian patients from high and low socioeconomic status backgrounds. Inquiries at TMC in Libya sought to understand which factors are transferable to Libya. For example, the dependency on village doctors in China and India created unique challenges that may not be transferable to Libya.

If Libya moves toward increased privatization of critical health care services, it should learn from the experiences of China and other developing countries. China's fragmented system requires strengthening of connections among its various health institutions to restore equitable access. Purohit (2001) contended that to relieve budgetary pressures, privatization may be best implemented in secondary and tertiary health care institutions while local clinics remain public institutions. Thailand permitted privatization of local clinics while Pakistan has moved more slowly in decentralization of its health care system (Russo, 1994). Both China and India have rural and underserved

communities that require public health care institutions (Hu, 2004; Liu, 2004; Purohit, 2001).

The strategy used for privatization determines the outcome. There is general agreement that complete privatization leads to exploitation of the public (Purohit, 2001). Additionally, Purohit suggested that those segments of the system that are privatized must be regulated to prevent unethical and inferior care. Judicious government and international regulation of both public and private health institutions can increase consumers' trust in their nations' health care systems. Governments should address quality of care, value for money, the social agreement, and accountability (Bloom et al., 2008). Given these recommendations, neither China nor India, two of the most populous countries, has a holistic health care strategy. According to Bloome et al., much of the populations of these countries rely on unregulated private institutions, and in India regulations have not improved the equity in the health care provided.

The goal, as implied of privatization, is to share social responsibility between governments and the private sector (Carrin et al., 2001; Purohit, 2001). Additionally, factors such as wait time, personalized contact with staff, and convenience were important to patients seeking private care in Lao (Paphassarang et al., 2002). Paphassarang et al. suggested that large bureaucratic public hospitals may not be the best model for providing outpatient services to the poor and less educated. These areas were explored at TMC. If privatization is driven by market forces, then it is important to know what the public values.

The public education of medical professionals is recovered by employing these same professionals at below market wages (Russo, 1994). Additionally, the public sector often leads in research. Medical professionals who work in an open environment, in which they can report errors without retribution, were found to have patients with higher satisfaction ratings. Callous attitudes by individual practitioners and unprofessionalism in a health care system can result in patient mistrust (Temkina & Zdravomyslova, 2008). For example, changes in the Russian health care system provided more choices but created unequal access. The change resulted in widespread distrust in the women's reproductive health care system and with individual providers. Temkina and Zdravomyslova found that distrust is based on cultural and structural factors. Unprofessionalism also led to lack of confidence in physicians' medical competence. Establishing trust among staff, patients, and the health care system should be an objective of public and private health institutions. Given the importance of trust, this study explored the perceptions and motivations of health care professionals and their trust in the public health care system.

Fortunately China and India recognize the shortcomings of their health care systems and they both are striving to develop "trust-based institutions" (Bloom et al., 2008, p. 953). Developing trust within any health care system is complex since it includes many organizations and individuals that must cooperate with each other (Gilson, 2006). Irrespective of the funding model, the government must be seen as legitimate and trustworthy (Gilson, 2003). Gilson argued that the government has a broad societal role in establishing trust in the whole system.

Developing countries have experimented with different models of health care privatization with mixed results. Regardless of the model, the government can play a vital role in assuring that health care systems reach the most vulnerable and marginalized populations, that there are standards and oversight, and that there is a coordination of efforts to prevent epidemics. On the other side, the private sector can compliment the public sector by providing high-tech solutions. It can relieve some of the burden placed on a public health care system.

Statement of the Problem

Libyan citizens who can afford private health care are opting out of the public health care system. According to the "Health system profile: Libya" (2007), the private health care sector is growing and the general public is increasing its use of private health care clinics and hospitals. There is a perception that the quality of public health care has deteriorated ("Health system profile: Libya," 2007). The negative perceptions have resulted in a lack of trust in the Libyan public health care system. The problem is that this negative perception and the lack of trust have led to unequal access to quality health care. The negative perceptions have resulted in a lack of trust and negative perceptions in the Libyan health care system. Determining the extent of, as well as the factors behind, this apparent negative perception and lack of trust in the public health care system led to recommendations that could improve the system.

Despite efforts to exchange technological knowledge among countries, the successes and challenges of managing health care remain. These challenges may impact trust in the public health care system. Savage, Campbell, Ford, and van der Reis (2004)

suggested exploring the struggle of developing countries to maximize health care access, cost, and quality. Globalization heightened awareness of the importance of delivering quality health care in developing and emerging countries (Weiner, 1989). Efforts to exchange technological knowledge among developed, emerging, and developing countries abound, but the successes and challenges of managing health care remain crucial in developing countries, such as Libya. Even though free medical care is provided to all Libyan citizens, Libyans are increasingly interested in purchasing private medical care to receive what is perceived to be a higher level of service and quality ("Health system profile: Libya," 2007).

Establishing trust among staff, patients, and the health care system should be an objective of public and private health institutions. Given the importance of trust, this study explored the perceptions and motivations of health care professionals and their trust in the public health care system. The incident of the Benghazi Six accused of deliberately infecting Libyan children with HIV increased the tensions between foreign health care providers and the Libyan public (Haviland, 2004). The Benghazi Six incident exacerbated the gap of knowledge in the delivery of health care to Libyan citizens and decreased the level of trust. This reduction in the level of trust is implicitly supported by the expansion of the use of the private health care system ("Health system profile: Libya," 2007).

Purpose of the Study

The purpose of this study is to identify the factors that have led to the negative perceptions and mistrust. Identifying the factors that lead to this apparent lack of trust in

the quality of care is the first step in developing a program in public health care institutions that could address this negative perception. It sought to provide a foundation to improve the enabling functions at TMC, hence improving health in the region. By examining TMC's administrative structure, this study sought to identify the strengths and weaknesses of health care delivery system in Libya through a case study methodology. It explored systemic, organizational, financial, political, and cultural factors that contribute to the identified strengths and weaknesses of the system studied.

This exploratory study provides a foundation to ultimately improve health in the region, and possibly in other developing countries. Specific areas of exploration included organizational policies, organizational structure, government regulations and Libya's overall health care system, leadership, organizational change, quality systems, and information processes. Although the specific areas that were explored are somewhat broad, the study site and subjects were narrowly defined. The issues that were explored in this study are common to most organizations: policies and procedures, organizational structure, departments and services, staff and leadership, quality and accreditation, and information technology. Nevertheless, this study focused on one hospital, TMC.

Medical centers are a part of a larger health care system. The study can assist TMC leaders in their delivery of quality patient-centered care through its recommendations on policies, procedures, and processes that are sensitive to cultural and political norms.

The study focused on the construct of trust. Additionally, internal culture varies among organizations (Kovner & Neuhauser, 2004d). As an example, Kovner and Neuhausuer (2004a) posited that faith based health care organizations have a different

culture than for profit organizations. Furthermore, most of the published public health care studies are focused on health care institutions in North America and Europe. By exploring the impact of TMC's financial and organizational structure; its implicit and explicit policies, procedures and values; and its technological maturity, the study provides a benchmark for other medical centers with similar demographic, political, and cultural characteristics.

Research Questions

This study explored the role of Libyan public hospitals in delivering health care. The following research questions guided this study:

1. What are the cultural considerations required in delivering health care in Libya?
2. How does privatization of health care impact Libya's public health care system?
3. What contributes to prospective patients' or providers' negative or positive perceptions?

Conceptual Support for the Study

Schlesinger stated, "public trustworthiness is a key element of the nonprofit sector" (McPherson, 2006, p. 190). He went on to identify three dimensions of trust in a relationship as the trusted party acts in a competent manner, acts as a good agent by not putting their own interest first, and that there is an emotional bond. Studying trust in the context of health care offered an alternative conceptual framework to the dominant approach of economic individualism, which drove much of public policy in health care (Gilson, 2003). This study sought to identify the factors that contribute to the development of trust at TMC.

Tway (1994) developed a construct of trust. It is not a theory, but according to Tway, the construct is based on a comprehensive review of the literature, quantitative research, and qualitative research. Tway (1984) developed a valid construct that is practical; organizations not only can identify factors affecting trust, but can also conduct interventions that improve trust. This construct formed the conceptual support for this study. Tway (1994) reported that there is little difference in the concept of trust at the individual and organizational level, as defined by the United States and other countries. Tway defined trust as “the state of readiness for unguarded interaction with someone or something” (p. 8). Three premises form the construct: (a) perception of competence, (b) perception of intention, and (c) capacity to trust. According to Tway, members of organizations view competence and intentions as important. The study at TMC sought to support or dispel the suggestion that health care organizations operate within an environment in which these three premises form a construct of trust, regardless of the social, political, and cultural construct.

Perception of competence was defined as “the degree of awareness, accuracy, and truth in representations of competence” (Tway, 1994, p. 10). This concept is consistent with Gilson’s (1993, 1996) description of competence as a cognitive process. On the other hand, perception of intention is an emotional response. Perception of intention was defined by Tway as “our perceptions of the degree to which there is a willingness to do what is needed, and our perceptions of the degree of awareness, accuracy, and truth in representations of intentions” (Tway, 1994, p. 10). The study of perceptions is important because perception may not be reality. Tway posited that understanding others’

perceptions can increase the level of trust and that the capacity to trust is based on “our beliefs about the natural order and benign nature of the universe” (Tway, 1994, p. 63). Therefore, the capacity to trust may vary among populations’ cultural values.

The construct of trust in this study was influenced by Tway (1994), which included self-disclosure, reliability (a measure of perceived competence), keeping promises (a measure of competence for the practitioner), cooperation (an outcome of trust), and predictability (an outcome of trust). However, it is important to note that some level of distrust maybe required to guard against abuse of power (Gilson, 2006).

Health care leaders seek to develop an environment of trust by motivating their staff, relying on specialized department governance, establishing mission and vision, and adhering to ethics-driven policies and procedures. Organizations should create a shared mission and vision to create a trusting environment (Tway, 1994). Tway hypothesized that transparency of purpose in revealing intentions, competence, and capacity, which increases trust. Previous discussions of trust have not addressed the concept of trust when cooperation or competition is not involved, as in the case of patients making choices on critical medical treatments (Tway, 1994). Therefore, the construct of trust was an applicable framework for the study at TMC.

Assumptions

This study assumed that TMC is a major provider of tertiary health care in northwest Libya. Based on TMC’s website, the research site embraces collaboration from global partners, “Preference is given to non-Libyan consultants and universities, who are selected to bring international know-how and best-practice methods to Libya”

(Tripoli Medical Center, 2008). Based on this contention, it was assumed that sufficient access to TMC's policies, procedures, staff, and patients will be given. Preliminary access was granted through Professor Ali Massoud El- Mgadmi. Professor El-Mgadmi is Director of the primary health care for Secretariat of Health (SOH) in Libya, Professor in the Pediatric Department at Alfateh University, and Head of Pediatric Respiratory and Intensive Care at TMC.

The study assumed that most written and oral communication with medical staff can be conducted in English. Libya has high reliance on foreign medical staff, especially for specialized nursing care ("Health system profile: Libya," 2007). In the case of those study participants who could not communicate in English, it was assumed that the researcher would acquire competent and unbiased translation.

Data collection occurred at the pediatric department of the research site, TMC). Due to financial and time constraints, it was assumed that data collection would occur within a four week timeframe. In an attempt to verify interpretation of data collected, member checking occurred prior to leaving the research site.

Tripoli Medical Center is a large tertiary care hospital. It is assumed that the findings from this study can be generalized to Libyan public hospitals that provide secondary and tertiary care. Libya has 21 tertiary hospitals and 62 secondary care hospitals (Health system profile: Libya," 2007).

Scope

The World Health Organization (WHO) in its 1946 constitution defines health care as mental, physical, and social well-being. In 1978, the WHO subsequently

expanded the definition of health to include having an economical and socially productive life. Therefore, health is more than the absence of illness. Health care is multidimensional (Turnock, 2004). It is also difficult to measure. Yet, current measurements of health measuring health still focus on disease and mortality. Hospital medical records are one of many sources of information on illnesses and morbidity. Measuring community health includes records from employers, schools, community clinics, doctors' offices, and surveys. The scope of this case study includes the range of the definitions in a developing country.

According to Turnock (2004), to close the health gap in developing countries, more attention must be given to (a) distribution of health services, (b) availability of appropriate technology, (c) management, (d) poverty, and (e) government programs (e.g., water quality). In the United States and in other areas of the world, poverty affects health outcomes. Globally, health inequalities are categorized as stemming from the social and physical environment, personal behavior, and health services. Since the scope of this case study was limited to TMC, this study did not explore the social and physical environments or personal behavior. It did, however, explore the factors that impact the delivery of health services in one specific setting.

In the United States, the measures of health now include self-reported data such as absences from school or work due to illness. Span of life or years of health (YHL) indicators are combined with mortality data and self-reporting health status (Turnock, 2004). Even though the overall health of Libyan citizens is of research interest, this study focused on specific indicators such as disease, illness, injuries, and maternity issues. Any

prevention programs administered by TMC were also examined. This study was not intended to examine all aspects of the Libyan health care system. However, due to the relationships and partnerships among Libyan health care institutions, it was expected that other health care institutions that partner with TMC would be implicitly studied.

Delimitations

Limitations were expected to be placed on the researcher regarding access to documents, staff, and patients. However, the researcher sought to collect and analyze all relevant and accessible data during the study timeframe. Additionally, language barriers were expected to impede data collection. Interpreters of the spoken word could possibly affect the quality of the data collected as they were not certified translators. Dr. Ali Massoud El- Mgadmi offered interns that were competent in English and proficient in Arabic as translators for this study. The translators were familiar with medical vocabulary as all medical training in Libya is conducted in English. The researcher was present for all interviews to obtain clarification if needed.

Research Design

A case design was used using Kovner's (2004) definition, "a *case* is a description of a situation or a problem facing a manager that requires analysis, decision, and planning a course of action" and it "represents selected details about a situation" (p. xv). This study was an exploratory case study that used qualitative research design. As such, the study evolved over time. For example, based on data collected through interviews, the study sometimes progressed in a completely different direction than anticipated. This alone was not a challenge to objectivity; however, the researcher interpreted the findings

along the way. Unstructured interviews were conducted and participant and nonparticipant observations were conducted within TMC.

This study consisted of unstructured interviews of 50 administrative staff, medical staff, and patients. The pediatric patients were represented by their parents or guardian. Unstructured interviews captured unexpected answers and allowed the respondent to elaborate and to ask clarifying questions. Observing the respondent kinetically also provided information. Self-administered surveys, such as the one developed by Hassan (2005), show promise. Hassan's survey was based on the quality principles and the Joint Commission International (JCI) standards. In addition, the Hassan study was conducted at a hospital in the United Arab Emirates with stated similar purposes as this study. Using pretested instruments such as the Hassan survey to develop the surveys used in this study strengthened the validity and reliability of this dissertation study.

Observation instruments such as the those used in other health care research sites were developed, modified, and utilized as-is (Fassaert, van Dulmen, Schellevis, & Bensing, 2007; Johnsson, Kjellberg, Kjellberg, & Lagerstrom, 2004; Singh, Wechsler, & Curtis, 2000; Warming, Juul-Kristensen, Ebbelhøj, & Schibye, 2004). One researcher captured the observational data.

Assessable data from hospital records, memos, and documents were requested. Metrics such as discharges, patient days, and patient registration can help determine physician utilization (Rakich & Wong, 2004). A physician instrument panel could be used to evaluate individual physicians (Neuhauser, 2004). It can include pathophysiological outcomes (e.g., glucose levels for diabetic patients), patient

satisfaction, health status (number of sick days), and future patient risk (e.g., percent of patients who have had screening procedures).

Corroboration, by use of multiple methods, ensures creditability and dependability. Triangulation was used to ensure that the conclusions drawn during data analysis were accurate and collaborated by more than one form of data. Data collected through interviews were coded to identify patterns. ATLAS.ti, a qualitative data analysis tool, was utilized to facilitate codification of the data. The aggregated data converged to thirteen themes.

Definitions of Terms

AlhamduAllah is a term used by Muslims to mean *Praise to God*. It is used when expressing that everything is good.

Casualty department is an equivalent term to Emergency Room.

Developing countries are countries that relatively low development in industrialization, infrastructure, and technology.

Facilities is a term used by study participants to indicate all resources such as equipment, supplies, buildings, investigations, testing laboratories, pharmacies.

Gatekeeper is the person who helps a researcher gain access to the study participants.

Healthy Adjusted Life Expectancy (HALE) is an indicator of health outcomes; it estimates the average number of years that a person will live without a disability.

Investigation is a term used by Libyan patients and staff to indicate diagnostic procedures.

MashaAllah is a term used by Muslims to mean *God has willed it*. It is often used to show joy, praise, or admiration.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is an organization that sets standards for health care organizations and issues accreditation to organizations that meet those standards.

Joint Commission International (JCI) is the counterpart of the JCAHO counterpart outside the United States.

OPD is an acronym used by study participants for Outpatient Department.

Patients in the context of this study include the mothers of the pediatric patients.

Polyclinic is a clinic that provides primary health care services.

Sisters is a term used by study participants for nurses.

Secretariat of Health is equivalent to Ministry of Health.

Significance of the Study

Gilson (2006) identified two primary reasons that trust is important in health care: “it enables the co-operation required across the multiple relationships present within a health system to deliver health care and produce health” and “a health system founded in trusting relationships can contribute to generating wider social value” (p. 361). The significance and social change implications of this study were built on the premise that Libya may be an example of a developing country with health care delivery issues. Recommendations from this study may be useful in similar developing countries. Even though this study focused on TMC, the lessons learned from this study may apply to

other organizations with similar structural, cultural, and demographic characteristics undergoing change.

According to McKinlay and Marceau (1999), small improvements in overall society health equate to great gains for the society compared to the improvements of a few. The hospital plays a major role in improving the lives of the community. James Shaw Billings stated at the opening of John Hopkins Hospital in 1889:

A hospital is a living organism, made up of many different parts having different functions, but all these must be in due proportion and relation to each other, and to the environment, to produce the desired general results. The stream of life which runs through it is incessantly changing; patients and nurses and doctors come and go, today it has to do with the results of an epidemic, tomorrow with those of an explosion or a fire, the reputation of its physicians or surgeons attracts those suffering from a particular form of disease, and as one changes so do the others. Its work is never done; its equipment is never complete; it is always in need of new means of diagnosis; of new instruments and medicine; it is trying all things and hold fast to that which is good (Kovner & Neuhauser, 2004c, p. 257).

Despite great improvements over the last 30 years (e.g., access to water quality and literacy), Libya is challenged to improve coordination, data sharing, and role definition between government and private entities (Health system profile: Libya, 2007). Despite the guarantee of free medical care to Libyan citizens, Libyans are increasingly seeking to purchase private medical care to receive a higher level of service (Health

system profile: Libya, 2007). Furthermore, the delivery of improved service improves public health by increasing access (Detmer, 2004; Turnock, 2004). Universal access and increased confidence in public health institutions should improve Libyan citizens' overall health. Health care is no longer a local issue. The immediate benefit of the study is to the patients who TMC serves. The long-term benefit is to the populations of the region. The region's hospitals can improve mortality. However, management improvements in a nation's infrastructure, including a nation's health care system, should lead to higher a Healthy Adjusted Life Expectancy (HALE).

By focusing on trust in health care, ethical dimensions and social justice can be explored (Gilson, 2006). Trust in a health care system ultimately develops self-esteem in the poorest and most vulnerable populations when inequalities are challenged (Gilson, 2003). Relationships include, "Partnerships among communities, civil societies, the private sector and government [which] represent an important strategy to pursue the achievement of health and welfare goals" (WHO, 2002, p. 46). Yet, Gilson suggested that within these relationships there must be trustworthiness influenced by communication, decision-making practices, patient trust in providers, and provider payment schemas.

Chapter Summary

Public health care systems in developing countries have been strained due to financial constraints. The result is a trend towards healthcare privatization in developing countries. This has had mixed results. Populations in rural areas are often underserved due to the lack of facilities and skilled health care professionals. The strain in the public

health care systems can lead to a perception that the quality of the public health systems is inadequate. A qualitative case study was conducted that explored perceptions of the strengths and weaknesses of health care delivery at a Libyan public hospital.

The study was conducted at TMC, a 1400 bed tertiary care medical center. The target population was limited to the patients and staff in its pediatric department. The study's outcome enhanced the understanding of the factors that lead to trust at TMC. Triangulation of data from interviews, observation, interviews, and available documents enhanced the study's validity. Areas relevant to health care were examined which included health care rankings, health policy, perceptions of trust, and the trend towards privatization.

The significance of this study was to ultimately increase the trust of the population served by Libyan health care institutions. Improvements in the trustworthiness of prospective patients can improve the health of Libyan's population by increasing the patient elected utilization of preventive, diagnostic, and therapeutic services. The lessons learned can be applied to other organizations with a similar structure, culture, and demographics.

Relevant research that impacts trust in health care will be expanded in Chapter 2. Chapter 3 examines the research method used, Chapter 4 examines data collection and analysis processes that include coding of unstructured interview data, and Chapter 5 reports the findings, conclusions and future recommendations for research.

Chapter 2: Literature Review

Chapter 2 is a review of the literature on health care facilities with the focus on the trends and challenges of providing public health care in the developing countries. Additionally, the search included health care trends and standards in United States and Europe, as these articles help provide a frame of reference for much of the discussion. Health care in North America and western Europe was presumed to be a benchmark for other health care systems. Peer-reviewed articles that were less than 5 years old were found in online databases. EBSCO and ProQuest were used to search multiple databases. Additionally, Academic Search Complete, Academic Search Premier, Business Source Complete, and Business Source Complete were searched directly. The databases were searched on several combinations of keywords and phrases which included developing countries, health care, healthcare, privatization, trust, accreditation, quality, measurement, patient satisfaction, and Libya. However, occasionally secondary sources required a review of older but relevant articles that were not available online. Of the 85 references reviewed, approximately 127 were considered. References used were selected on the relevance to this study's problem, purpose, research questions.

Health care is a prevailing subject in the private, public, and government sectors. Not only is health care its own discipline, it is intertwined in political, social, financial, technological, and management sectors. Additionally, health care cannot be viewed as solely a local issue. The health of systems and populations across the globe has far-reaching implications. The literature review that follows provides an explication of the

problem and the research questions. The literature review does not provide answers; it facilitates the development of more focused questions (Yin, 2003).

The literature documents an array of studies and programs that measure the effectiveness of health care systems. Some of these measurements are for self-assessments and others serve as a tool for benchmarking on a global basis. The review which follows categorizes the topics in the literature into six categories: patient satisfaction, measurements and assessments, health system integration, socialization versus privatizations, quality improvement, and information technology. While the order is not critical, the researcher chose to start with patient satisfaction because the ultimate goal in health care is to improve the quality of patients' lives. Even though this study focused on one department within a large tertiary care hospital, the integration of each health care institution within the whole system is critical. These systems can be socialized, privatized, or mixed. Chapter 2 concludes with a review of quality improvement initiatives and the role of information technology.

Patient Satisfaction

Patient satisfaction leads to improved medical compliance, lower use of medical services, and greater willingness to return for follow-up (Taylor, Kennedy, Virtue, & McDonald, 2006). The Institute of Medicine (IOM) wants health care in the United States to be more patient-focused (Harris, 2001); patient satisfaction is regarded as a critical health care outcome (Gonzalez et al., 2005; Sweeney, Brooks, & Leahy, 2003). In the United States, consumers are expected to play a strong role in managing their health care (Moore & Coddington, 2002).

Patient satisfaction is considered an indicator of health care organizational effectiveness (Lebov & Ersoz as cited in Sweeney et al., 2003). Patient satisfaction should include quality control measures and a complaint system (Taylor et al., 2006). Health care performance should go beyond measuring administrative functions; it should also include customer expectations (Stewart & Lockamy III, 2001). Taylor et al. reported that information provision, interpersonal relationships, and wait time are important factors for patient satisfaction. Coulter (2001) reported that patients also want more information about their care. The majority opinion is that patient satisfaction is a good indicator of quality of care (Langle et al., 2003).

Taylor et al. (2006) found that, to improve patient satisfaction, hospital staff should receive customer service and communication skills training. Even though the findings were specific to a large tertiary care emergency room setting, they can be applied to other departments. Taylor et al. suggested that small measures like a welcoming video can reap great benefits. They also reported that communication and education are the most important factors impacting patient satisfaction. Communication training can close the gaps found in communication that negatively impact patient satisfaction at TMC.

Patient satisfaction is more related to perception than actual events (Schwappach et al., 2003). More specifically, Schwappach et al. suggested that patients' perception of emergency room wait time is more dependent on the information and communication they receive than the actual wait time. Swiss hospitals place a high regard on patient satisfaction (Coulter, 2001) and Schwappach et al. conducted a study in Swiss hospital

emergency rooms. Data was collected before and after quality improvements were put in place. Approximately 3,000 patients were surveyed and performance data was collected on approximately 9,000 patients for each measurement cycle. Schwappach et al. concluded that small improvements on patient satisfaction and performance measurements can be achieved by group benchmarking, preventing negative events, and implementing strategies for change. The hospital staff was actively involved in the measurement. They used the Plan-Do-Check-Act cycles for continuous improvement.

Global satisfaction, interpersonal skills, competence, equipment, continuity of care, accessibility, information conference, bureaucracy, and costs are all factors that determine patients' satisfaction with medical treatment (Hsieh & Kagle, 1991). Patient satisfaction can also be influenced by patient expectations, patient health status, psychosocial variables, and treatment (Hall & Dornan, 1988). Patients who are satisfied are more likely to collaborate with health services and adhere to medical instructions resulting in improved health outcomes (Sorlie, Sexton, Busund, & Sorlie, 2000).

Patients retain more information if physicians have good interpersonal skills (Barlett et al., 1984). A study conducted at the renowned Mayo Clinic found that patients value interpersonal skills more than technical skills (Bendapudi, Berry, Fry, Paeush, & Rayburn, 2006). The researchers acknowledged that this may be because interpersonal skills are easier to judge than technical skills. However, it does imply that patients assume physicians are technically competent unless otherwise indicated. Stewart, Brown, Boon et al. (Bendapudi et al., 2006) suggested that the quality of the patient-physician relationship affects medical outcomes. The patients in Bendapudi et al.'s study

viewed the ideal physician as being confident, empathetic, humane, personal, forthright, respectful, and thorough. Moore and Coddington (2002) reported that physicians perceive their own health care delivery as high quality. Fortunately, physicians see themselves as partners in delivering patient-centered health care.

Sorlie et al. (2000) reported that 25% of surgical treatment satisfaction is based on the quality of patients' contact with medical staff. This was by far the most important factor in patient satisfaction. Furthermore, the perception of receiving adequate information was associated with their contact with nursing staff. The skill of nursing care, respect for patients feelings and opinions, relief from pain, recovery from distress and anxiety, physicians' competence, and hospital reputation are indicators of inpatient satisfaction (Tokunaga & Imanaka, 2002). Additionally, the relationship between length of patient stay and patient satisfaction is important in planning improvements in patient care, according to Tokunaga and Imanaka.

Even though patient satisfaction is significant in delivery of health care, quality improvement initiatives cannot ignore the technical aspects (Donabedian, 2005). Yet, despite the inadequacy of health care, patients tend to report satisfaction of care (Urassa, Carlstedt, Nystrom, Massawe, & Lindmark, 2002).

Measurements and Assessments

The Institute of Medicine (IOM) wants an increased focus on performance in the United States (Harris, 2001). Quality assessment programs include the Quality Indicator Project in the United States (Conn, 2005) and PATH (Veillard et al., 2005). In comparison, 71% of Danish hospitals train their employees in quality management

(Wagner, van Merode, & van Oort, 2003). There are challenges to measuring nonfinancial performance in a health care system (Hassan, 2005). Much of the literature still supports single indicators to measure performance. Yet, Hassan (2005) suggested that a multidimensional holistic approach must be taken.

External peer reviews meet the demand for greater accountability, access, improved health care, and greater efficiency (Donahue & vanOstenberg, 2000). The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) provided standardized indicators to measure quality in United States hospitals (Williams, Watt, Schmaltz, & Koss, 2006). Its international equivalent, the Joint Commission International (JCI), provides standards that allow comparison of hospitals globally. The JCI provides a “common survey process, scoring method decision process and standards interpretation” (Donahue & vanOstenberg, 2000, p. 244). JCI evaluates functions and systems (e.g., access, patient and family education, and overall patient care) and management functions (e.g., leadership). Unlike other assessment frameworks, JCI accreditation considers the social, political, legal, cultural, regulatory, and economic environment of the country being assessed. Donahue and Van Ostenberg asserted that JCI accreditation is the best tool to facilitate the convergence of the multiple quality assessment frameworks. As of 2004, the JCI was involved in projects with more than 60 countries (Anonymous, 2004). However, Williams et al. mentioned that any accreditation that requires self-reporting requires monitoring to maintain confidence in the data. Yet, Williams et al. (2006) found that the indicators were reliably reported.

The JCAHO accredited 20,000 organizations in the United States in the year 2000 and 96% of its hospital beds (Schyve, 2000). Governments, purchasers, and the public have become users of accreditation. For example, Schyve reported that the United States federal and state governments used the accreditation process for licensing. Accreditation helps meet the need of public accountability. It is more critical for nations that have privatized health care.

Assessments and accreditation that provide comparisons across nations are valuable, but they do not absolve the need of a localized indicator system (Chiu, Yang, Lin, & Chu, 2006). Based on the United States Joint Commission's ORYX[®] initiative, which integrates outcomes and performance indicators and supports the JCI program (JCI, 2008), the Taiwanese government developed the Taiwan Healthcare Indicator Series (*THIS*). The program is led by Taiwan Healthcare Executive College, which seeks to improve the quality of individual hospitals. Organizations participate voluntarily with *THIS*; participating hospitals can only mention that they participate, but they can not share the actual results (Chiu et al., 2006). Hospitals participate in user group meetings and share their own experiences. Of the 227 health care institutions that participated, eight were large medical centers like TMC. *THIS* has become the largest health care assessment system in Taiwan (Chiu et al., 2006).

The Institute of Medicine (IOM) identified a framework that provides a path to transform large bureaucratic health care institutions into institutions based on collaboration and coordination of care (Gold, 2007). Gold shared the experience of University of Michigan Health System (UMHS). Based on the IOM framework, UMHS

used a new framework, The Ideal Patient Care Experience. Like the IOM model, coordination throughout the health care system is a recurring theme. Additionally, the UMHS framework incorporates the patient's beliefs and value systems. Gold reported that the implementation of The Ideal Patient Care Experience by UMHS reduced inpatient admissions that create a more efficient transition between its subsystems.

The European Foundation of Quality Management (EFQM) excellence model is another framework that can be used by health care institutions to measure and improve their quality. ISO standards and the EFQM are often integrated (Sanchez et al., 2005). The EFQM model has nine criteria: leadership, people, policy, strategy, partnership and resources, processes, people results, customer results, society results, and key performance results (Moeller, 2001; Sanchez et al., 2005). The Basque county health care system in Spain provides universal public health care. Sanchez et al. reported on the implementation of the EFQM framework by Basque county government over a 10 year period of time and commitment to the EFQM model was assumed to lead to positive quality outcomes. As mentioned by Sanchez et al., previous studies concluded that implementation of the EFQM framework in Europe and the Malcolm Baldrige framework in the United States improves organization performance.

Moeller (2001) evaluated the EFQM model by comparing it to other peer auditing and accreditation approaches in German health care organizations. The approach provided indicators of success and outcomes. It is not an accreditation process (Moeller, 2001). Jennings & Westfall stated the EFQM model does not address all aspects relevant to health care because its foundation is in industry (Moeller, 2001). Caspe Research

London, UK stated that a combination of EFQM with clinical standards and an accreditation program can lead to an excellent health care delivery system (Moeller, 2001).

Moeller (2001) described several lessons learned that can be applied to other early assessments. More specifically, Moeller mentioned that any assessment initiatives require a dedicated staff, good quality information systems, management and staff commitment, stable team membership, active management involvement, and standardized terminology.

Health care systems' international standards are accepted as being (a) available, (b) accessible, (c) acceptable, (d) quality, and (e) affordable (Wessen, 1999). Quality and accessibility are sometimes at the expense of affordability. According to Twigg (2002), the Soviet Union placed emphasis on accessibility and cost at the expense of quality and efficiency. However, in 1993, Russia moved towards decentralized funding of health care. The health care system reforms had mixed results (Twigg, 2002). Twigg found that doctors are split between favoring privatization and socialization of medicine. Twigg also found significant differences between head doctors and insurance fund directors; the latter strongly supported competition between state and private health care systems. Privatization and competition were found to be a secondary factor in quality improvement programs (Kim & Cho, 2000). Twigg's study revealed that there is less reluctance to health care reform than assumed, and reforms will not be accepted if they do not include the principles of universal access and equity. Twigg (2002) concluded that the Russian culture will not allow for an American-style health care system.

Therefore, there must be a balance among availability, accessibility, acceptability, quality, and affordability that does not conflict with Russia's social, cultural, and political norms. The study also revealed that resistance and support for reform differs among constituencies. For example, as Libya transforms itself from isolation and strong state control of all institutions, it can learn from Russia, and other similar nations' earlier experiences.

An appropriate hospital stay is defined as "inpatient stay, requiring continuous and active medical, nursing or paramedical treatment, which could not be provided through extramural care, daycare or outpatient care" (Lavis & Anderson as cited in Panis, Verheggen, & Pop, 2002, p. 57). Resuccia reported that the Appropriateness Evaluation Protocol (AEP) is used in the United States for utilization and has been found to be valid and reliable (Kaya et al., 2000). Several studies found it to be useful for quality assurance and utilization reviews (Smeets et al., 2000). The AEP was also found to be valid and reliable for assessing hospital stay appropriateness in Turkey (Kaya et al., 2000). Kaya et al. contended that the AEP tool is only valuable for improving and monitoring the utilization of services if physicians are highly engaged in the process. The AEP tool does not measure individual patient circumstances (Smeets et al., 2000) According to Panis et al. (2002), the protocol has been useful in studying American and European institutions. The AEP can help determine medical necessity of hospital stays, their duration, and number of hospital beds (Kaya et al., 2000; Panis et al., 2002).

The AEP was modified for use in the Dutch health care system. In 2002, the Dutch had 3.6 hospital beds per 1000 residents (Panis et al., 2002). Their goal was to

reduce the number to 2.0. Yet, to meet such goals, any hospital should consider the ethical issues in reducing the length of hospital stays. By performing a process analysis, Panis et al. (2002) identified bottlenecks that lead to inefficiencies. Management should also monitor the process. The Dutch report concluded that inappropriate hospital stays are due to hospital procedures and a lack of other clinics or providers to receive referral patients.

The methodology and results of the Dutch study were challenged, apparently because Panis et al. (2002) reported results lower than Rodriguez's affiliated hospital reported (Rodriguez-Vera, 2002). Yet, Panis and his colleagues acknowledged that the validity and reliability of the AEP needs to be improved (Smeets et al., 2000). Resuccia stated that Smeets et al. reported in their evaluation of Dutch hospitals that inappropriateness depends on the time, place, and instrument used (Smeets et al., 2000). They suggested that clinical performance indicators may be a better tool for assessing quality care. Yet they acknowledged that use of a common AEP tool for quality assurance and utilization reviews is needed.

Kelley (2007) credits the World Health Organization (WHO) and the Organization for Economic Cooperation and Development (OECD) for encouraging the international community to develop performance indicators. Kelley also mentioned that comparisons are rarely made on a global basis since countries do not have a common definition of quality or health care costs or patient safety (Weingart, 2005). However, Coulter (2001) cautioned pertaining to making international comparisons due to subjective survey approaches. As an alternative, the Picker Institute survey is more

factually-based; hence, Coulter asserted that it is a better instrument to compare patient satisfaction in different countries. Coulter reported that the most common problem reported in hospitals of OECD countries was communication about clinical issues. Furthermore, Kelley found that, even though gains in quality of health care and mortality rates have been made by OECD members, there is still variation among the countries. There are also still large differences in cardiovascular mortality rates. This is due to differences in spending and risk factors (e.g., obesity and tobacco use). The OECD initiated the Health Care Quality Indicators (HCQI) project in 2001 to address these disparities. The project solicited input from 20 countries; this has grown to more than 30 countries. According to Kelley, the project found that no one country performed worst or best on all indicators. All countries scored well on vaccinations. This is a strong area for Libya ("Health system profile: Libya," 2007). Kelley contended that the HCQI will provide a more precise assessment of differences among countries.

The WHO Regional Office for Europe developed PATH, a performance assessment tool for quality improvement in hospitals (Veillard et al., 2005). WHO sought to improve accountability and encourage continuous improvement, build on national and international comparisons, support hospitals in moving from measurement to interpretation, and support hospital administrators and staff in quality improvement initiatives (Veillard et al., 2005). The PATH framework considers six dimensions: clinical effectiveness, patient centeredness, efficiency, safety, staff orientation, and responsive governance. PATH is the result of literature reviews, workshops, and surveys. Participation was not limited to European countries.

Seventy percent of health costs are associated with retaining medical staff (Daviaud & Chopra, 2008). Resource allocation and utilization planning affect productivity, costs, and delivery of quality health care services (Badri & Hollingsworth, 1993). Several approaches have been used by health care institutions to determine the proper allocation of staff. Daviaud and Chopra asserted that the most commonly used approaches (i.e., needs-based, population-based, and utilization-based) are inadequate because they do not respond to changes in populations and diseases. Even when there is resource planning, they suggest that there is often poor monitoring and skill management. Daviaud and Chopra (2008) conducted a case study in South Africa using an adaptation of the WHO's workload indicator of staff needs (WISN) model. They suggested that the WISN tool, adapted for the environment, enhances resource planning and identifies gaps. They also maintained that the tool can be used at the local, municipal, or national level. Therefore, the WISN model may be a useful tool for determining optimum resource allocation at centrally controlled TMC and local Libyan health clinics.

Simulation modeling is one alternative to the WISN model. Badri and Hollingsworth (1992) used simulation at the Rashid Hospital in United Arab Emirates. They evaluated the impact of scheduling, number of doctors, number of nurses, number of beds, changes in demand, and patient priority (Badri & Hollingsworth, 1993). The study was limited to the emergency room, but they suggested that simulation modeling has broader application and can be used by health care administrators. Computer simulation helps determine the effectiveness of current practices and predicts the impact of changes (Badri & Hollingsworth, 1993).

Interestingly, patient and staff satisfaction were found to be dependent on bed utilization (Harrison, 2005). Single rooms were reported to reduce staff turnover, the rate of patient falls, medical errors, and health care acquired infections (Harrison, 2005). Bronson Hospital in Kalamazoo, Michigan, recipient of the Malcolm Baldrige Award, has single rooms for all inpatients. Bronson Hospital's values include "stewardship of resources" (Ament, 2006, p. 1). The Malcolm Baldrige Model for Excellence provides criteria for organizations for creating strategic and operational performance (Leonard & Reller, 2004). This researcher has been a patient at Bronson Hospital and concurs with the findings; single rooms enhance the quality of care.

Leonard and Reller (2004) developed two tools (the self-assessment matrix and opportunity for improvement (OFI) worksheets) that health care organizations can use to assess themselves against the Malcolm Baldrige criteria (e.g., leadership, focus on customers and employees, and monitoring of performance indicators). A secondary benefit is the team-based interactive process. Leonard and Reller mentioned that the Malcolm Baldrige Model for Excellence is emulated internationally. The two tools are examples of quality improvement tools that can be used by large hospitals such as TMC.

The literature highlights concerns over the diversity of measuring the quality of patient care. There is value to taking a holistic approach to health care quality (Nolan & Berwick, 2006). In response to these concerns, the Agency for Healthcare Research and Quality (AHRQ) developed "one tool to make sense of these measures mania" (Kelley, 2006, p. 1). According to Kelly (2006) the approach summarizes care over hundreds of measures; it concisely assesses performance. However, like many measures, it does not

provide a roadmap to improvement. Additionally, standardization may not be measuring the factors that have the biggest impact on global health (McKinlay & Marceau, 1999). McKinlay and Marceau suggested that, in decreasing relevance, health policy, environmental influences, and physiological factors influence coronary heart disease risk. Social capital has been shown to indicate health advantages (Kawachi, Kennedy, & Glass, 1999).

Health System Integration

The ultimate goal of health care systems is to improve the quality of life of the population they serve. Yet, as an example, inefficiencies in the United States' health care systems are well-known. Approximately 25% to 40% of health care expenditures are estimated to be waste (Moore & Coddington, 2002). To efficiently meet the goal of health care systems, partnerships should be established beyond health care institutions to improve health. This includes partnerships among public, private and government organizations (WHO, 2003).

Libya's biggest challenge is preventable diseases related to lifestyle such as diabetes, cardiovascular disease, and hypertension ("Health system profile: Libya," 2007). This is not unprecedented in developing and emerging countries (Codreanu, Perico, Sharma, Schieppati, & Remuzzi, 2006). Codreanu et al. reported the rise of noncommunicable diseases in Africa and the Middle East and suggested that the global community should intervene to reverse the growing crisis. The dominance of risk factors is changing at different rates among developed, developing, and emerging countries (Kelley, 2007).

Risk factors and risky behavior are related to social position and economic factors (McKinlay & Marceau, 1999). Cordreanu et al. (2006) called for population screening and intervention programs. A similar study drew similar conclusions, but also called for the education and training of health care professionals (Perico et al., 2005). Perico et al. asserted that developed countries have a moral obligation to train health care professionals from emerging countries, and they must develop research and development partnership with these countries. However, this researcher maintains that these efforts will be futile if governments of developing nations do not adopt campaigns to educate their populations on the affects of factors such as tobacco and obesity.

McKinlay (1999) suggested that the largest gains in quality health care are achieved when small interventions target the whole population. Yet, improving public health often focuses on causality of direct causes (McKinlay & Marceau, 1999). Resources that do not examine risk factors such as smoking, obesity, and nutrition will increase health risk for the majority of the population. Therefore, any health care system that looks to improve the overall health of the population it serves should have comprehensive preventive and education programs.

Primary health care case management assumes a pyramidal structure (English et al., 2004). District hospitals should provide local expertise for referral care; access to clinics is critical (WHO, 2003). Almost 2 decades ago, Weiner (1989) reported a philosophical shift from hospital-based services to services delivered outside the hospital system. Villar and Bergsjo (Urassa et al., 2002) reported that access to antenatal care needs to be a priority in developing and developed countries.

Additionally, English et al. (2004) asserted that these local centers of care should provide essential data that helps with the distribution of resources through the health care system. TMC, is a specialized center that treats patients from throughout Libya, is the recipient of such information.

Social capital can be defined, “as those features of social organization, such as the extent of interpersonal trust between citizens, norms of reciprocity, and density of civic associations, that facilitate cooperation for mutual benefit” (Kawachi et al., 1999, p. 1187). Social capital includes the access to health related information. Therefore, there is a relationship among socioeconomic status and overall health that goes beyond the commonly reported risk factors. Gender, social exclusion, and geographical isolation have also been reported as factors that affect health status (WHO, 2003). Research indicates an inverse relationship between socioeconomic status and self-reported health status (Malmstrom, Sundquist, & Johansson, 1999). Malmstrom et al. (1999) found that the depravity of a neighborhood was found to be associated with self-reported poor health. Kawachi et al.(1999) highlighted that even after adjustments for income, education, and smoking, there is still a relationship between social capital and poor self-reported health.

Research on quality of care is not complete without addressing prescription drugs. Drug appropriateness can be described as “the outcome of the process of decision-making that maximizes new individual health gains within the society’s available resources” (Buetow & Sibbald, 1997, p. 261). Tully and Cantrill (2005) maintained that both explicit criteria and implicit professional judgment are used

when prescribing medicine to patients. The former requires a comparison to a set of standards. They described 14 criteria that include medical records, which are part of the discharge summary. The latter is determined by the way medicines are used by patients (Britten, Jenkins, Barber, Bradley, & Stevenson, 2003). The revelation adds support to the importance of communication training for medical staff as discussed in the context of patient satisfaction. The burden is on the medical staff to justify the appropriateness of prescribed drugs and this justification should be in a patient's medical record.

Preventive noncommunicable diseases are the biggest health risk to Libyans. Even though communicable diseases are not Libya's biggest health challenge ("Health system profile: Libya," 2007), it still must be monitored. To control communicable diseases, it is important to have home follow-up of patients, local reporting by health officials of adverse drug reactions, confidential inquiry of mortality rates due to disease, and adverse events monitoring (Mehta et al., 2007). Any new programs established to combat disease or illness requires multifaceted monitoring to avoid serious complications.

Sixty percent of patients treated at TMC are from outside Tripoli (El-Mgadmi, personal communication, July 14, 2008). Moore and Coddington (2002) reported the urgency in delivering health care to patients in rural areas. Therefore, the study examined the demographic information (e.g., place of residence) and time from diagnosis to treatment. As an example, Merit Care has a health care system that allows patients from rural areas to be scheduled the same day (Moore & Coddington, 2002). Even though

TMC is a specialized medical center, the timeliness of service is an important aspect explored.

Hospitals are one component of a larger integrated health care system (Kovner & Neuhauser, 2004d). One of Islamic civilization's greatest contributions is the development of efficient hospitals (Wolper & Pena, 2004). According to Wolper and Pena, the seventh century Roman and Christian hospitals were no match for hospitals in the Arab world. The Muslim world contributed pharmacies, quarantine units, departments by specialization and disease, and asylums for the mentally ill. Much of the Muslim and Arab world is now part of the developing world. Libya is part of both.

Socialization versus Privatization

Chapter 1 discussed the trend towards privatization in developing countries. This section compliments that discussion by describing the strategic considerations when countries consider various degrees of privatization.

Governments' role in public health is to enforce policy including environmental and social conditions. Turnock (2004) contended that if public health agencies do not document their failures, they will not progress, "Public health professionals include anthropologists, sociologists, psychologists, physicians, nurses, nutritionists, lawyers, economists, political scientists, social workers, laboratorians, managers, sanitarians, engineers, epidemiologists, biostatisticians, gerontologists, disability specialists and dozens of other professions and disciplines." (Turnock, 2004, p. 20). Griffin (2006) defined public health as:

A broad social enterprise, more akin to a movement, that seeks to extend the benefits of current knowledge in ways that will have the maximum impact on the health status of a population. It does so by identifying problems that call for collective action to protect, promote, and improve in its interdisciplinary approach and methods, its emphasis on preventive dynamic adaptation to new problems placed on its agenda. Above all it is a collective effort to identify and address the unacceptable realities that result in preventable and avoidable health and quality of life outcomes, and it is the composite of efforts and activities that are carried out by people and organizations committed to these ends. (Griffin, 2006, p. 11)

Social justice is at the core of public health. The hospital is just one component of the public health enterprise. Hospitals play a critical role in health, wellness, and prevention and have recently become the focus of public health, including hospital admissions, patient discharges, and everything in between.

Access to health care has been recognized throughout the literature as a goal to improving world health. Hence, poverty reduction and health care go hand in hand (WHO, 2003). Socioeconomic status and education have been shown to be associated with self-reported health status (Malmstrom et al., 1999). For health to be prioritized in poverty reduction initiatives on the world stage, the WHO suggested there must be the development of partnerships among the public sector, private sector, governments, civil organizations, and international agencies. Delivery of health care and the partnerships between governments and the private sector were areas of exploration for this study.

World leaders, at a meeting sponsored by the WHO, World Bank, UK Department for International Development, and the European Commission, put forth a common agenda to advance the quality of health globally. They focused on the developing world and the poor. With recognition that the most critical asset for the poor is their bodies, good health should be a top priority. Libya fares better than many other developing country ("Health system profile: Libya," 2007). Health care is not denied based on ability to pay. However, the agenda put forth also recognized geographical isolation as one obstacle for citizens of some nations (WHO, 2003).

The goal of the privatization of health care systems is to enhance self-reliance, responsibility, choice, and competition among provider-agencies, hospitals, clinics, practices, advice centers, laboratories, insurance companies, purchasers, charitable organizations, and other health care businesses (Marsland, 2005). However, any attempt at privatization should protect the financially vulnerable. Therefore, Marsland suggested that a small public health care system that serves the few should remain and that any attempts at privatization should not underestimate the political component.

As the West struggled to solve its health care crisis, it looked at other models. It was reported in 1989 that the United States' health care and the socialized Scandinavian systems were converging (Weiner, 1989). In contrast to its Canadian neighbors, as an example, the United States does not have universal health care. According to Weiner, the United States' model assumes that patient care is best served when providers compete. Prior to the Soviet Union break-up, the USSR had a health care system with noble goals. Its principles were that "health care was a right of every citizen; it was provided by

society, and its keystone was prevention” (Field, 1990, p. 144). Soviet health care was viewed to be integrated with all other components of its society. Field attributed its failures to an emphasis on quantity instead of quality. Additionally, corruption, bureaucracy, inadequate equipment and facilities, and low salaries for medical staff led to system failures. Goldberg stated that privatization was introduced with *perestroika* but it too was plagued with bureaucracy and ideological resistance (Field, 1990).

Holm (1995) argued that even though a nation claims a 100% socialized health care system, there is always a privatization component. Holm (2005) assessed the Danish experience of socialized medicine. It has been plagued with patient dissatisfaction. Patients have long waiting lists for some services. As in Libya, the Danish and Finish systems are largely decentralized with a high level of patient access (Weiner, 1989). However, even with the continuity of care and patient centeredness provided by Danish General Practitioners (Weiner, 1989), patients experienced obstacles to receiving treatment outside their local districts (Holm, 1995). Weiner claimed that the United States’ HMO model demonstrates that a private system can ensure a high level of access. Yet, access is only one factor in assessing health care delivery.

Many in Denmark believed that freer access would increase competition and result in a higher quality of service (Holm, 1995). The introduction of financial incentives did not resolve the problem. To control costs, Holm recommended that primary care physicians serve as gatekeepers when patients are not free to go directly to specialized hospitals. He also acknowledged that there may be some ethical issues associated with this type of triage and that a two-tiered system is always available for

those that can afford to pay. However, depending on the health care system, two-tiered systems can have negative consequences. As an example, dermatologists have been reported to give priority to cosmetic patients over other patients who require medical treatment (Singer, 2008).

The British invested heavily in its public health care system (Marsland, 2005). According to Marsland (2005), it is inferior to the *market-plus-insurance-plus targeted assistance model* in the United States. He claimed that the size of the public National Health Service (NHS) system “inhibits innovation and encourages depersonalized routinization” (Marsland, 2005, p. 60). Some argue that competition with the British health care system would lead to a more efficient, cost-effective, innovative, and patient-centered system (N. Barr, 1993).

Equal and accessible health care have ethical considerations. Non-secular traditions view universal health care as just and ethical; likewise, there should be some caution against implementing a totally socialized system which can dampen individual autonomy (Novak, 2003). Nevertheless, a multi-tiered system to health care can leave less profitable patients with poor or delayed treatment. Novak asserted that any health care system must be built on religious traditions that respect both individual and collective rights.

Quality Improvement

Hospitals in the United States overwhelmingly report that they have a quality improvement program (Dranove et al., 1999). Eighty-five percent of hospitals were found to provide training on quality improvement methodologies (Kim & Cho, 2000).

However, even though quality improvement programs reaped short-term gains when tied to a government-sponsored assessment program, assessment programs are not reinforcing factors for long-term quality changes. Lack of knowledge and experience and low staff motivation were also impediments to implementing quality improvement initiatives (Kim & Cho, 2000). This underscores the importance of incentives for medical staff and administrators.

Concern over medical errors has called for coordination, monitoring, reporting, and analysis of the errors (Chang, Schyve, Croteau, O'Leary, & Loeb, 2005). Reporting systems are variable. Chang et al. recommended that the JCAHO Patient Safety Event Taxonomy facilitate standardized reporting. Additionally, hospitals that adopt the Baldrige 2006 Health Care Criteria for Performance reduce errors (Hosford, 2008). Hosford found that coercive monitoring by the public and government agencies were found to be ineffective at reducing medical errors and that JCAHO accreditation is an effective intervention for reducing errors.

Adequate procedures and policies are the foundation of quality health care systems. Adherence to procedures safeguards against medical errors. The large amount of information, new medications, changing technology, and the sheer complexity of medical care can contribute to errors (Becher & Chassin, 2001). Bosk (as cited in Ternov & Akselsson, 2005) contended that investigations of hospital errors often focus on health care personnel, but it is contended that errors are a result of system failures and inadequate barriers (Ternov & Akselsson, 2005). Harris (2001), in summarizing an

Institute of Medicine (IOM) report, noted that medical errors are not due to recklessness, but are in fact due to failures in the systems themselves.

Quality of care is dependent on the efficient use of resources during patients' stay (Qvist, Rasmussen, Bonnevie, & Gjorup, 2004). Coordination of care across treatment settings is also vital. Interdepartmental medical audits allow benchmarking against best practices (van Herk, Klazinga, Schepers, & Casparie, 2001). Additionally, the United Kingdom Department of Health asserted that hospital and national statistics from departments provide data to compare practices (Qvist et al., 2004). This study found that coordination is challenging in a large medical center such as TMC. As mentioned by Qvist et al., a Danish national program developed multidisciplinary standards to overcome these challenges. The standards required the coordination of the Secretariat and medical professionals who volunteered to participate in the Danish program. Departments volunteered to participate in the program, which is based on self-regulation. The data collected is entered into a database that enables them to compare themselves to similar departments. The data focuses on standards of multidisciplinary planning, medication, in-hospital wait times, documented patient information, and readmission. The Danish standards require that, within 24 hours of admission, a patient must be assessed, resulting in the development of an interdisciplinary plan. According to Qvist et al., improvements in the quality of care of participating Danish health care departments were based on self-regulation.

The World Health Organization (WHO) requires that countries implement a policy on management of equipment (Khalaf, 2004). In Palestine, health care delivery is

a partnership among the public, private, and relief workers. Khalaf claimed that the Palestinian experience in delivering health care is similar to other developing nations, that is, more than half of medical equipment is not operable. Due to poor infrastructures, it is often installed improperly. Palestinian hospitals suffer from the lack of a national policy of inspection, lack of policies and procedures on cost and maintenance, and the lack of accreditations (or certifications) for service providers. Scheduled maintenance, electrical safety awareness, codes and standards, reviews of scheduled and corrective maintenance logs, and in-service and factory training for medical treatment is needed, according to Khalaf. In addition, Khalaf suggested that hospital administrators should have the accountability for defining codes and standards for medical equipment and the engineering department should ensure adherence. Khalaf also recommended using the American Society of Healthcare Engineering life expectancy projections as a guideline for determining equipment expected life expectancy. Such programs are not only important components of a patient-centered health care system, but they are imperative for the timely delivery of critical health care. Through observation and survey, this TMC study sought to determine if availability of equipment impacts the delivery of care to the pediatric patients.

Small process changes lead and bring gains in patient satisfaction and health system efficiencies (Spear, 2005). By learning to work differently, nurses at Porter Adventist Hospital in Denver, Colorado, solved more than 100 problems, improved patient satisfaction, and increased staff productivity (Braaten & Bellhouse, 2007). The increased awareness of quality improvement is not limited to middle-level medical staff

and administrators. Fortunately, there has been an increased focus on quality strategic planning by hospital board committees (Lockee, 2008).

Information Technology

The Institute of Medicine (IOM) recommended using information technology to improve health care (Harris, 2001). It is challenging to assess the quality of health care in developing countries (Hongoro, McPake, & Vickerman, 2005). Hongoro et al. suggested that the immaturity of information management systems adds to the challenges.

In a study conducted by Prins, Kruisinga, Buller, and Zwetsloot-Sconk (2002), pediatricians required detailed information that is generally not included in electronic medical records. Pediatricians consider quality to be appropriateness and timeliness of intervention and patient outcomes (Prins et al, 2002). Electronic medical records were deficient in discharge diagnoses, patient conditions, and test results. They had to rely on paper records to close the gap to conduct medical practice assessments. The study highlighted the importance of a well-designed medical information system. This case study focused on patients within the pediatric department at TMC.

Implementation of electronic medical records is in its early stages in the United States (Moore & Coddington, 2002). Moore and Coddington performed a multi-case study. The 11 large health care systems studied invested substantially in the development of IT system. However, they found that there was variation among the 11 organizations studied on the degree of system integration and the elimination of paper systems. Similar to the organizations studied by Moore and Coddington, TMC is a large organization. Moore and Coddington's study showed promise for large health care institutions. The

organizations are improving in the areas of effectiveness, focus on patients, timeliness, convenience, and efficiency.

In 2005, the Joint Commission International (JCI) for patient safety launched a website that provides safety information to patients and medical professionals (Anonymous, 2005; “Joint Commission International Center for Patient Safety Launches New Patient Safety Practices Online Resource,” 2006; Poe & Brannan, 2006). The site offers information to medical professionals on the most common adverse events and their root causes (Anonymous, 2005). Additionally, the site guides patients to patient self-protection tools and resources (Poe & Brannan, 2006). Yet, the Internet is still not a panacea for the medical safety problem. Challenges remain in the standardization of reporting (Weingart, 2005). However, Libya may not yet reap the benefits of the gains that have been made, “The penetration rate of the Internet in health care institutions is low. Access to health information on the Internet and the use of Internet for delivery and promotion of health care services are still very limited” (“Health system profile: Libya,” 2007, p. 66).

Methodology Review

Structured surveys of patients are the prevailing methodology for accessing patients’ perceptions of health care institutions (Gonzalez et al., 2005; Hongoro et al., 2005; Langle et al., 2003; Schwappach et al., 2003; Sweeney, Brooks, & Leahy, 2003). Similarly, Khalaf (2004), Kim and Cho (2000), Hosford (2008), Lockee (2008), and Twigg (2002) used structured surveys of health care administrators and medical staff to access the quality of systems, records, and equipment. Document review, historical

record extraction, and observation are widely used to rate health care institutions on an array of quality indicators (Taylor, Wolfe, & Cameron, 2004; Chang et al., 2005; Qvist et al., 2004). Tully and Cantrill (2005) used both medical records and in-depth qualitative interviews to determine prescription appropriateness. Likewise, tools, such as the AEP and EFQM, measure appropriateness of stay and other measures of hospital efficiency (Sanchez et al., 2005; Smeets et al., 2000). Software tools and computer simulation can also measure institutional effectiveness (Badri & Hollingsworth, 1993; Daviaud & Chopra, 2008), but they fall short in measuring factors such as perceptions such as trustworthiness.

The dissertation study used unstructured interviews as its primary methodology. Cultural differences can create challenges for research participants to interpret predetermined choices or scale. Furthermore, even though longitudinal studies can provide useful information (Sorlie et al., 2000); it was not a practical approach for this dissertation study. Therefore, use of unstructured interviews, supported by observational and limited document review, was the most appropriate method to explore perceptions of trust of Libya's public health care system by the recipients and deliverers of health care services.

Chapter Summary

The health care industry has recognized the importance of patient and staff satisfaction in the delivery of quality health services. The current research identifies patient satisfaction as a prevailing factor in delivery of health care. Patient satisfaction is a major determinant when assessing and measuring health care organizations. A variety

of assessment tools have been tested and implemented to assess patient and staff satisfaction. These assessments reveal that improvements in the physical environment, scheduling can improve efficiency and ultimately patient and staff satisfaction.

Information Technology (IT) can improve the efficiency of health care systems. Electronic systems have also been shown to improve patient care by reducing errors in treatment. Furthermore, mature Information Systems can help deliver medical information to service providers that enhance diagnosis and treatments. The maturity of a health care institutions information technology is a factor in assessing and improving the delivery of health care. However, health care organizations are part of larger national and global health care system.

To optimize health care delivery, nations have experimented with various degrees of socialized and privatized health care. The overall political and cultural environment also affects where a nation falls on this continuum. Libya is primarily on the socialized end of the pendulum. Regardless of the dominant health care model and health care quality improvement initiatives, patients must have access to primary health care services. Nations are recognizing they must take a holistic approach to solving to improving the health of their populations.

Chapter 3 describes the methodology for data collection and analysis. Unstructured interviews dominated the data collection. A pilot was conducted to pretested the survey instruments. The data was analyzed using open coding, axial coding, and selective coding.

Chapter 3: Research Method

The purpose of this research was to determine through the actual experiences of the receivers of health care in a Libyan public hospital the factors that lead to negative perceptions and mistrust. The study answers three questions that provide insight to the conceptual framework for the study. The case study methodology provided answers to the research questions, which ultimately identified the factors that contribute to the development of trust at TMC. The research questions identified the cultural factors, impact of privatization, and the perceptions of study participants. The areas of inquiry that lead to this apparent lack of trust in the quality of care are the first step in developing a program in public health care institutions that could address this negative perception. Furthermore, the study sought to enhance the enabling functions at TMC. By examining TMC's administrative structure, the case identifies the strengths and weaknesses of the health care delivery system. This chapter describes the methodology that was used in the study.

A case study, exploratory, qualitative design was the most appropriate for this study. Exploratory, qualitative research is more freeform than other types of research. It is used primarily for new areas of exploration. TMC and its place in Libya's health care system is a new area of inquiry. This study did not seek to study a specific phenomenon, nor did it seek to develop a new model or framework. Therefore, case study research lends itself to the study of organizations like TMC.

Face-to-face interviews dominated the method of data collection. It gave an opportunity for the respondent to ask clarifying questions. Using this format, the

interviewer could develop a rapport and was more likely to get complete answers to open-ended questions. Relationships, including business and professional relationships, are critical in Libya. Furthermore, face-to face interviews have relative high response rate as compared to other survey methods. This is true in Middle Eastern cultures. The interviews gave the respondents a venue to provide insight

Description of the Research Design

A case study is used when a researcher wants to study a topic of special interest (Stake, 1995). According to Stake, a case study is particularization not generalization. In social services, case studies analyze people or programs (Stake, 1995). It answers the questions how or why (Yin, 2003). According to Yin, the researcher has little control of the events and seeks to retain the characteristics of the events and the case study encompasses contextual aspects. The literature review helps refine the research issues (Auerbach & Silverstein, 2003), while the research design describes the questions, purpose, units of analysis, and criteria for interpreting the results (Yin, 2003). Case study research relies on thick description, experiential understanding, and multiple realities (Stake, 1995, p. 43). The interview is the avenue for the latter. Interviews provided a vehicle for the researcher to explore diverse perceptions.

Schwandt (2000) described qualitative research as being “built on a profound concern with understanding what other human beings are doing or saying” (Schwandt, 2000, p. 200). It seeks to understand interrelationships. In contrast to quantitative research, qualitative research does not measure; it aims to question (Auerbach &

Silverstein, 2003). Qualitative research also avoids the pitfalls of quantitative studies because it does not assume uniformity of the subjects.

This study was a qualitative intrinsic single-case study. It was revelatory in nature (Yin, 2003). Qualitative single-case studies provide insight into an unexplored problem. Such studies seek to learn about a particular case of interest (Stake, 1995). Unlike quantitative research, its focus is on context. According to Stake (1995), situational factors are not known prior to the study commencing nor are they controlled. Cultural, political, social, and personal contextual factors were also explored. I contend that this study provided an opportunity to study an organization that was previously inaccessible to researchers in the West. Therefore, the findings can provide insight to similar organizations.

According to Stake (1995), situational factors are not known prior to the study commencing nor are they controlled. There are no universal truths in a case study. Therefore, naturalistic observation from this study can provide lessons that could advance health care in developing countries. A case study does not lend itself to a single outcome (Yin, 2003). Through the experiences of the study participants, an understanding of relevant contexts is gained (Auerbach & Silverstein, 2003). “Naturalistic generalizations are conclusions arrived at through personal engagement in life’s affairs or by vicarious experience so well constructed that the person feels as if it happens to themselves” (Stake, 1995, p. 85). According to Stake, validity in naturalistic generalization is based on whether what was reported actually did occur. The use of unstructured interviews provided an entry point into the perceptions of patients and staff at TMC. By using open-

ended inquiry, the coded data revealed the factors that patients and staff perceive as significant in the delivery of health care at TMC. Triangulation and the interviewing of three targeted populations helped determine if perception is reality.

As part of this inquiry, the researcher explored several areas of interest from multiple sources. The use of multiple sources increased construct validity. Methodological triangulation was used: observation, document review, and interview (Stake, 1995). Study participants answered the how and why of the organization. Stake suggested that observation should also include a description of the physical environment. Organizational procedures and policies were also requested. Nevertheless, it was expected that the source of most information will come from surveys (Yin, 2003). However, I anticipated limited availability and accessibility to other historical records. Medical records are imperfect vehicles for supporting patient care (Audit Commission, 1999). Tully and Cantrill (2005) contended that medical records are poor in operational validity since they often have incomplete data. However, if complete, they can enhance clinical audits and research. Those that are inspected must have the chain of evidence established (Yin, 2003).

As suggested by Auerbach and Silverstein (2003), the study explored participants' subjective experiences. Narrative interviews consisted of open-ended questions. Even though the translators were also provided with structured translated questions, they were instructed to allow the researcher to conduct the interviews as a guided conversation (Yin, 2003). The instruments were adapted from what has demonstrated validity and

reliability. Additionally, other documentation and observation helped ensure study reliability.

Validity in qualitative research is enhanced by having “incontestable description” through good record keeping (Stake, 1995, p. 62). Interviews were recorded in the researcher’s journal and cross referenced to a calendar. As recommended by Yin, a small pilot test provided conceptual clarification of the approach. The pilot was conducted at TMC to pretest the questionnaire.

Target Population

The unit of analysis for this study was TMC. This study explored the formal and informal organizational processes from the perspective of the parents of pediatric patients, TMC doctors and nurses, TMC pharmacists, and TMC administrators. The results included outcomes from interviews of 20 staff, and 30 patients.

Formal and informal gatekeepers give access to study participants (Seidman, 2006). Dr. El-Mgadmi served as a formal gatekeeper for this study. As suggested by Auerbach and Silverstein (2003), attempts were made to gain the trust of respected members of the culture. Preliminary meetings with Dr. El-Mgadmi and the interns helped establish personal relationships that increased access at the site. Parents were also gatekeepers for the pediatric patients in this study, as well as study participants when they represented the pediatric patient.

Sixty percent of patients at TMC are outside of Tripoli (El-Mgadmi, personal communication, July 14, 2008). Health data needs to include geographical locality (WHO, 2003). This information was collected as part of this study. Similar

demographic information was collected of the staff; Libyans and non-Libyans comprise medical staff.

As suggested by Sweeney et al. (2003), staff members were informed of the study and any subsequent surveys. Figure 1 depicts the medical and administrative audience who serves the patients. Additionally, as suggested by Dr. El-Mgadmi, the pharmacy staff was surveyed. The researcher was flexible to accommodate patients', medical staff, and administrators' schedules.

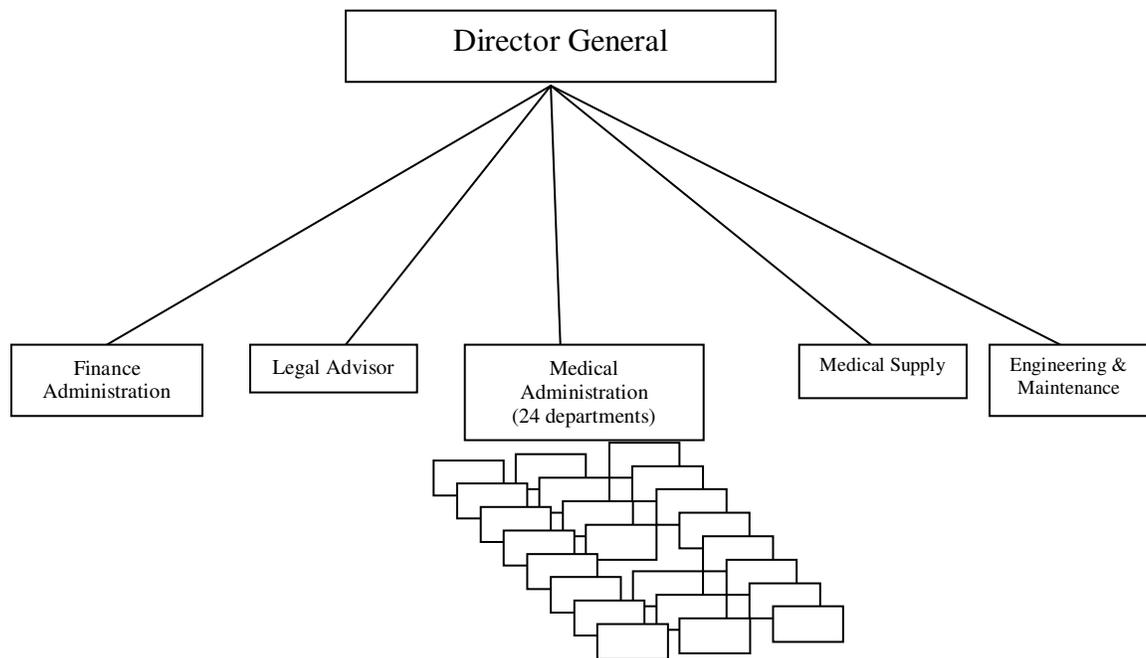


Figure 1. Tripoli Medical Center organization

Sampling Procedure

This study used nonprobability sampling. Since there is not equal access to the target population, a random sample is impossible (Auerbach & Silverstein, 2003).

Auerbach and Silverstein mentioned that qualitative design does not lend itself to determining sample size in advance. They also suggested that sampling is complete when no new information is obtained. This is referred to as theoretical saturation.

Convenience sampling of the patient population was conducted. TMC interns serving the pediatric department provided translation of interviews. The interviews were scheduled for a maximum of 60 minutes. The average in-patient stay for pediatric patients at TMC is two days (El-Mgadmi, personal communication, August 5, 2008). The pilot consisted of outpatients. However, the sample population for the study excluded outpatients due to the difficulty of securing a private venue for the interviews in the outpatient department. This study secured resources for approximately 10 patient or parent interviews per week over a four-week duration.

Staff interviews were conducted over the same four week period. Subjects were systematically selected randomly from a stratified sample. Dr. El-Mgadmi provided the list of all doctors from each pediatric department. The head nurse also provided a list of pediatric nurses by department. The size of the departments and the study timeframe determined the sampling plan. However, due to the lack of availability of many of the staff members, convenience sampling predominated. Additionally, participants were interviewed based on participants' recommendations. Therefore, this study included snowball sampling. Purposive sampling helped select department heads. Staff interviews were initially planned for three 60-minute interviews. However, pretesting of the instrument determined that one interview was more feasible for the study participants.

It is sometimes difficult to ascertain when enough interviews have occurred. Like most qualitative studies, this study was also bounded by resources. However, by limiting the study to the pediatric department, the researcher was hopeful that sufficient data could be collected. Seidman (2006) stated that sufficient data is collected when interviews reflect the full range of participants and when the information gathered has reached the saturation point.

Documents that are referenced by staff interviews were requested. Observational data was collected by the researcher. The researcher intended to use interns to collect observational data and to include observational counts. However, their schedules could not accommodate collecting data and they were utilized solely as translators.

Sample

Figure 1 depicts the overall TMC structure. The pediatric department is one of the 24 medical departments depicted. The pediatric department includes Endocrinology and Diabetic, Intensive Care Unit, Nephrology and Metabolic, Gastroenterology, Cardiology, Neonatology, and Oncology and Hematology (El-Mgadmi, personal communication, August 5, 2008). Each department has its own head.

The TMC staff was stratified. Interval sampling was conducted of each stratum prior to scheduling interviews. Dr. El-Mgadmi provided the list of staff members from each department that serves the pediatric department, in addition to the pharmacy and nursing staff (El-Mgadmi, personal communication, August 5, 2008). Attempts were made to interview the staff based on the nth from each department list. The frequency was based on department size and bounded by the timeframe of this study. The

researcher conducted all medical and administrative staff interviews and was accompanied by an English-speaking intern when needed.

The staff interviews were planned as a three day interview protocol intended to ask professionals to talk about their experiences and relationship with patients. Open-ended questions were carried out in a manner that focused the interviewer and participants on the objective of each session (Seidman, 2006). Seidman contended that the three-phase interactive and cumulative design requires that interviewer and interviewee keeps the objective of each interview in mind. Lincoln and Guba (as cited in Seidman, 2006) prefer the term trustworthy over valid when describing the characteristics of qualitative research. The three day interview design enhances trustworthiness, according to Seidman. Due to the difficulty of scheduling three interviews per respondent and based upon the pretesting of the questionnaire, the three day interview protocol was abandoned. Twenty staff interviews were conducted.

Patients were interviewed with the use of interns as translators. Interns were available 8:30 AM – 2:00 PM for 6 days per week. Some interviews occurred in the night to accommodate schedules and to ensure an ample sample size. Interviews were scheduled for 60 minutes. Thirty patient interviews were conducted. Four interns were trained on their role as translators. The pilot also provided an opportunity to reinforce the training and to validate and refine the survey.

The researcher directly observed interactions between the staff and patients. However, health care professionals alter their behavior when they know they are being observed (Rowe et al., 2006). Some studies only used existing data to avoid Hawthorne

effects (Panis et al., 2002). This study did not exclusively rely on data already captured. Rowe et al. found that, in large urban hospitals, fewer inpatient and outpatient treatment errors occur if health care workers are observed. Nevertheless, to minimize the Hawthorne effect, pediatric medical staff and administrators were encouraged to behave as they normally would and they were assured that the research purpose was to capture overall processes.

Instrumentation

Parlett and Hamilton (1976) advocate illuminative evaluation for social research. It is adaptive and eclectic. The process “facilitates the cross-checking otherwise tentative findings” (p. 147) through triangulation. They asserted that researchers move through three overlapping phases: observation, renewed inquiry, and explanation. Therefore, the research questions evolve. They contend that observation, interviews, questionnaires, tests documentary, and background sources are used within each stage. Parlett and Hamilton acknowledged that subjectivity and scope challenge this approach. The participants help define the issues. Hence, according to Stake (1995), the researcher becomes a noninterventionist. Stake also suggested that the best research questions evolve during the study.

This study used two survey instruments. The separate instruments surveyed patients (or their guardian) and TMC staff. Even though the instruments could have been delivered as self-administered surveys, an interview format was used. This allowed respondents to ask for additional clarification. Self-administration does not lend itself to explaining complex concepts (Hassan, 2005). Additionally, the interviewer could ask

follow-up questions in an unstructured interview. The instruments were available in English and Arabic. The instruments were adapted from other published studies in the literature; permission was requested from these studies. In most cases, the authors did not respond; however, the studies have been cited and the questions have been transformed to open-ended questions.

Parents of the patients were surveyed on seven dimensions. These dimensions were adapted from the literature and included overall impression, admission procedure, information given, care and assistance, tests and operations, pain management, and physical environment (Sweeney et al., 2003).

The Good Medical Department Program (GMDP), a Danish national program, audited several parameters that was also included in this study (Qvist et al., 2004). The GMDP included waiting time for examination; presence of case-specific clinical guidelines; assessments of pain, nutritional status, and processing times for admission and discharge; content of discharge summary, and rehabilitation plans.

Health status has been shown to affect patient satisfaction (Gonzalez et al., 2005). Gonzalez et al. (2005) developed a survey based on patient and staff focus groups, literature reviews, and expert opinion. The survey is self-administered and captures patient satisfaction at time of discharge. The authors recommended that similar surveys should also capture patient health status. Permission has been granted to use this instrument for this study. The study's first author provided the instrument in Spanish; it was then translated to English by the Hispanic American Council of Kalamazoo. It is

attached as Appendix A. The questions were converted to an open-ended format and included in the patient survey.

The survey includes applicable questions adapted from the following list (Sorlie et al., 2000). Several of the questions overlap with Gonzalez et al.'s (2005) instrument. This ensured a thorough exploration of satisfaction of treatment (Sorlie et al., 2000, p. 34).

1. Were you satisfied with treatment?
2. Were you discharged in an appropriate time?
3. Were you treated incorrectly?
4. Was the treatment important for your illness/health problems?
5. Were your expectations of the medical treatment fulfilled?
6. Did you get the necessary information about the results of examinations and tests?
7. Did you get the necessary information about how examinations were to be done?
8. Was the nursing staff caring?
9. Did the nursing staff engage you as a whole person?
10. Did you feel confidence in the professional skills of the nursing staff?
11. Did the same group of nursing staff take care of you during your hospital stay?
12. Did the nursing staff spend enough time speaking with you?
13. Did you manage to convey to the nursing staff what was important about your condition?

14. Did the medical staff take care of you as a whole person?
15. Did one physician have the responsibility for you?
16. Did the medical staff communicate in an understandable way?
17. Was the medical staff available when needed?
18. Did the medical staff convey a caring attitude?
19. Did you have confidence in the professional skills of the medical staff?
20. Did you get adequate information about the side effects of medicine?
21. Were you prepared for the difficulties in the home situation after hospital treatment?
22. If you had difficulties, was something done to reduce the problem?
23. Did you get instructions about what to do yourself to improve or to prevent aggregation?
24. Has the medical staff or nursing staff spoken to you about preventive self-care and lifestyle changes?
25. Has the information you received during your hospital stay resulted in any changes in your lifestyle?

Sorlie et al. (2000) also measured the degree to which patients perceived that their belief systems were supported. The TMC study explored the importance of spiritual support by TMC. Religion was expected to be an important factor for Libyan patients observed by this researcher.

There are 1400 primary care clinics in Libya (El-Mgadmi, personal communication, August 5, 2008). As a tertiary care facility, a factor of interest was

whether patients are self-referred or referred from Libya's primary care clinics. The researcher also collected background information that included how the patients arrived at TMC. This information supplemented the data from TMC staff to help describe the overall health care system.

Overall patient satisfaction with a hospital stay must be determined by measuring specific factors (Tokunaga & Imanaka, 2002). Tokunaga and Imanaka recommended measuring hospital staff's attitude and performance, as well as emotional communication, explanation of medical information, provision of care, living arrangements, and perception of hospital reputation. The Gonzalez et al. (2005) survey, presented in Appendix A, addresses these factors. Evaluations of a hospital can be biased (Donabedian, 2005). However, patients are more likely to report problems if asked specific questions about their care (Sweeney et al., 2003).

The Appropriateness Evaluation Protocol (AEP) was considered as the basis for surveying patients. It sets a criterion that can determine appropriate hospital admissions and stay for the pediatric department at TMC. The AEP is not without its critics. Some have claimed that it does not address nursing care. An earlier use of the AEP by the Dutch yielded poor agreement (Panis et al., 2002). However, a later Dutch study found the AEP a valid and reliable screening tool when properly modified for conducting hospital utilization reviews. It requires minimum training for those that administer the instrument. This study sought to examine patient satisfaction factors beyond determining the appropriateness of hospital stays.

Hassan (2005) measured performances at a 400-bed hospital based on Kanji's Business Excellence Model. The assessment used a multidisciplinary approach to identify areas in which to improve organizational performance. Trained coordinators were used to interview staff. Hassan found that staff perceived that the hospital focused on its patients at the expense of internal customers. The instrument administered to TMC medical and administrative staff explored the critical success factors perceived by the staff in the Hassan (2005, p.950) study. The critical success factors are listed below:

1. Leadership.
2. Delight the customer (patient).
3. Patient satisfaction.
4. Staff satisfaction.
5. Management by fact.
6. All work is process.
7. Measurement.
8. People-based management.
9. Team work.
10. People make quality.
11. Continuous improvement.
12. Continuous improvement cycle.
13. Prevention.
14. Organizational excellence.

This study also explored the desire for privatization through interviews with the three target groups: patients, medical staff, and administrative staff. Questions were adapted from Twigg (2002) and were included in both instruments. They included questions adapted from the following (Twigg, 2002, pp. 2256-2259):

1. I am satisfied with the quality of health care in my region.
2. Hospitals and polyclinics should remain state property.
3. Quality of care would improve if there was competition between state and private sector.
4. Financial incentives for doctors to improve quality of care are morally acceptable.
5. All our problems could be solved if we had enough money for health care.
6. The level and quality of medical services in my region are all the same.
7. The structure of healthcare delivery in my region has not changed in the last ten years.
8. Providers should have the right to receive payments directly from patients.
9. Physicians should be permitted to receive income from paid services in addition to state salaries.
10. Development of private practice should be encouraged.
11. We need to train more general practice/family physicians.
12. Head doctors should be trained in economics and management, in addition to medicine.
13. Medical associations are sufficiently strong and active in my region.
14. The Russian system of healthcare needs a tight vertical administrative structure.

15. The Ministry of Health in Moscow understands the specific problems in my region.

16. We need unified standards for healthcare across the Russian Federation, developed in Moscow.

The patient and staff surveys are depicted in Appendices B and C, respectively. Interviews should be piloted with a small number of participants (Seidman, 2006). This study included a pilot at the research site. Six patients, two doctors, and two nurses participated in the pilot.

TMC does not have a formal patient complaint system. Therefore data normally collected from such systems had to be captured from interviews. Data can be categorized as related to communication, access, treatment, rights, administration, and environment (Taylor, Wolfe, & Cameron, 2004). The following satisfaction items were included in a study conducted by Taylor et al. (2006, p. 241):

1. Informed about delays
2. Staff cared about you as a person
3. Standard of overall facility
4. Adequacy of information to family/friends
5. Courtesy shown to parents and friends
6. Informed about treatment by doctors and nurses
7. Courtesy of doctors and nurses
8. Doctors and nurses took time to listen

General observations were recorded. Quality assessments can be conducted in developing countries with minimal disruption of routine activities (Hongoro et al., 2005). Personal hygiene, nutrition, and structural factors were observed and recorded.

Data Collection Procedures

Figure 2 depicts the overall data collection plan. Approval for the study was obtained from the Medical Director of TMC and its Scientific Medical Committee. This request was sent to the researcher's internal advisor, Dr. Ali Massoud El-Mgadmi, Head Pediatric Respiratory and Intensive Care division at TMC. Permission to record interviews and to take photographs at the site was requested. However, patients overwhelmingly declined to be audiotaped for the pilot; therefore, audiotaping was not requested for the study. Stake (1995) suggested that an understanding of TMC's ability to make changes to the final report (e.g., final dissertation chapters), how and why TMC was selected, and specific access requests be included. A letter of cooperation was received from the Medical Director of TMC (see Appendix D.)

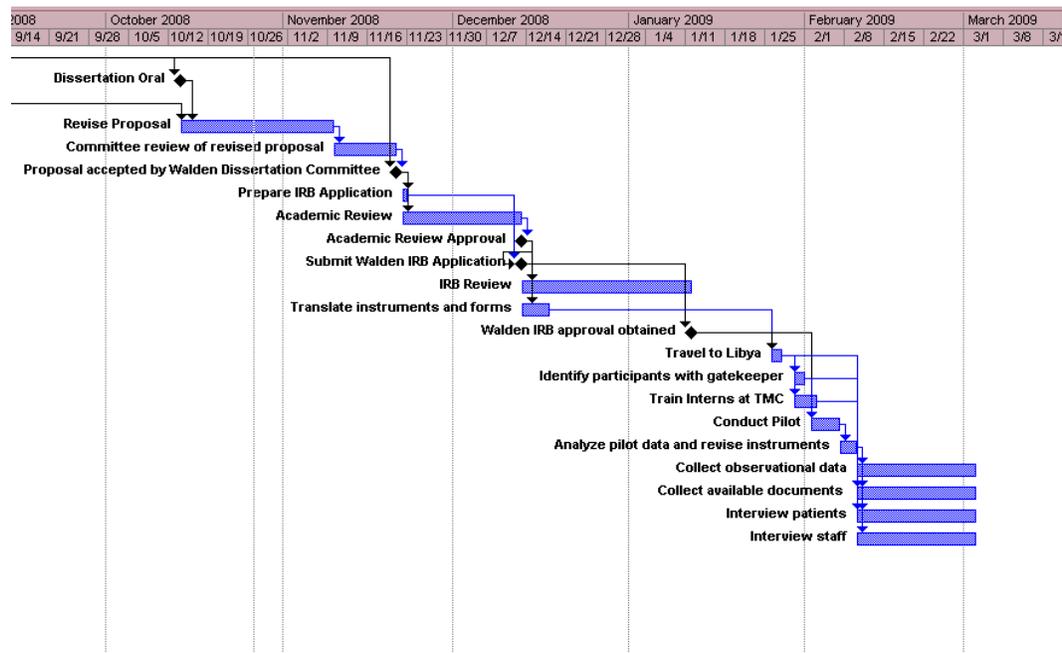


Figure 2. *Data collection plan*

Interviews of TMC medical and administrative staff were scheduled for a maximum of 60 minutes based upon the recommendation of Dr. El-Mgadmi (Mgadmi, personal communication, August 5, 2008). The first part of the interview explored opinions on operational and quality processes. The second part focused on strengths and weaknesses of medical and administrative staff. The final questions explored the view of the overall health care system.

According to Yin (2003), the answers in a case study expand and generalize theories. Narrative interviews were conducted. As suggested by Stakes (1995), participants were first given a brief description of this study. Auerbach and Silverstein (2003) recommended that only six questions should be asked based on the literature review. This type of interview allows participants to talk through their own experiences (Auerbach & Silverstein, 2003). Even though the pilot instruments included 56 and 36

open-ended questions for the patients and staff, respectively, questions evolved through progressive elaboration. The survey instruments were adhered to as much as possible without interrupting or redirecting the thinking of the interviewees (Seidman, 2006).

Informed Consent Forms were required. As suggested by Seidman (2006), the consent included a statement on the right of participants to withdraw at any time, that their participation is voluntary, that answers are confidential, that results will be disseminated in the dissertation and potentially published in journal articles, that minors must have parent consent, and the researcher's contact information. Sweeney et al. (2003) gained patient consent both before hospital discharge and after discharge. This was impractical for the TMC study, as access to patients via letters and telephone is not reliable. Patients and staff participants were assured confidentiality. They also were informed that their participation was voluntary. Participants were required to acknowledge that they read and understood the consent form. The consent form was read to illiterate patients. The form included statements of confidentiality, the voluntary nature of the study, the purpose of the study, permission to electronically record, and the researcher's contact information. The participant and the interviewer retained consent forms for each interview. The forms were available in English and Arabic.

Dr. Ali El-Mgadmi provided the interns who served as translators during interviews. All interns involved in data collection signed confidentiality agreements. The interns rotated every two months; therefore, scheduling was critical. Participation in interviews consumed most of their daily schedules.

The interns were proficient in Arabic and competent in English. All materials were translated into Arabic. However, audio equipment was available and was intended to be unobtrusive. Since audiotaping was abandoned for the study, the researcher was diligent in transcribing the interview. The following are interviewer skills suggested by Seidman (2006):

1. Listen more, talk less.
2. Follow-up on what the participant says.
3. Ask questions when you do not understand.
4. Ask to hear more about a subject.
5. Explore, do not probe.
6. Avoid leading questions.
7. Ask open-ended questions.
8. Follow-up; do not interrupt; task participants to reconstruct, not to remember.
9. Keep participants focused and ask for concrete details.
10. Limit interaction.
11. Only share experiences occasionally.
12. Avoid reinforcing participants' responses.
13. Tolerate silence.
14. Follow-up on hunches.

Interns did not only assist linguistically, but they were asked to interpret and confirm the observational and survey data. Interns were debriefed after interviews were complete. This was an opportunity to determine what hunches should be further

explored. Interviewees were allowed to tell their stories without the interviewer losing control of the interview, as recommended by Stake. That is, the interview sought to answer the research questions. Table 1 provides a matrix that illustrates the interview questions and their relationship to the research questions. An X indicates that the survey question sought to answer the research question indicated.

Table 1

Matrix of links between research questions and survey questions

	Research Questions			
	1.	2.	3.	
	What are the cultural considerations required in delivering health care?	How does privatization of health care impact the public health care system?	What contributes to the negative or positive perceptions by prospective patients or providers?	
Survey Questions				
<u>Patients</u>				
1.	Why did you come to Tripoli Medical Center?	X	-	X
2.	Describe your interaction with nurses during admission.	X	-	X
3.	How did the nurses respond to your questions?	X	-	X
4.	How would you describe the level of caring of the nursing staff?	X	-	X
5.	What was your impression of how attentive nurses were to you?	X	-	X
6.	What do you think about the nurses' ability to understand the patient's feelings when admitted?	X	-	X
7.	What do you think about the nurses overall treatment?	X	-	X

Table 1 (continued)

	Research Questions		
	1.	2.	3.
	What are the cultural considerations required in delivering health care?	How does privatization of health care impact the public health care system?	What contributes to the negative or positive perceptions by prospective patients or providers?
<u>Survey Questions</u>			
<u>Patients</u>			
8. Describe the nurses' preparation to handle your case.	X	-	X
9. Describe the skills of the nursing staff.	X	-	X
10. Describe the nursing team for your case.	X	-	X
11. Describe the how the doctors communicated with you.	X	-	X
12. How would you describe the manner in which doctors kept you informed?	X	-	X
13. How would you describe the level of understanding you had of the doctors' explanation?	X	-	X
14. How would your describe the answers the doctor gave to your questions?	X	-	X
15. How would you describe your overall interaction with the doctors?	X	-	X
16. Describe the doctors' preparation to handle your case.	-	-	X

Table 1 (continued)

	Research Questions		
	1.	2.	3.
	What are the cultural considerations required in delivering health care?	How does privatization of health care impact the public health care system?	What contributes to the negative or positive perceptions by prospective patients or providers?
Survey Questions			
17. How attentive were the doctors?	X	-	X
18. How well was the patient's pain managed?	X	-	X
19. Describe the communication among nurses, doctors, and administrators regarding your case?	X	-	X
20. How would you describe the availability of the staff?	X	-	X
21. Overall, how well informed were you about the patient's treatment?	X	-	X
22. How well informed were you about the patient's medicine?	X	-	X
23. How informed were you about side-effects of any medicine prescribed or dispensed?	X	-	X
24. How would you describe the physical environment such as noise or temperature?	X	-	X

Table 1 (continued)

	Research Questions		
	1.	2.	3.
	What are the cultural considerations required in delivering health care?	How does privatization of health care impact the public health care system?	What contributes to the negative or positive perceptions by prospective patients or providers?
Survey Questions			
25. How comfortable was the patient at night? (for inpatients only).	X	-	X
26. Describe the cleanliness of the bathroom.	X	-	X
27. Describe the cleanliness of the room.	X	-	X
28. Describe the overall condition of the room. (for inpatients only).	X	-	X
29. Describe the level of comfort for family and other visitors.	X	-	X
30. Describe the quality of the food.	X	-	X
31. How was the accessibility of visitors?	X	-	X
32. How would you describe the overall conditions and comfort of the hospital (temperature, cleanliness, comfort, noise, etc.).	X	-	X
33. Overall, describe the adequacy of information received at time of arrival.	X	-	X

Table 1 (continued)

	Research Questions			
	1.	2.	3.	
	What are the cultural considerations required in delivering health care?	How does privatization of health care impact the public health care system?	What contributes to the negative or positive perceptions by prospective patients or providers?	
Survey Questions				
34.	How do you think hospital personnel showed respect for the patient and family?	X	-	X
35.	How do you think hospital personnel showed respect for the beliefs and values of the patient and family?	X	-	X
36.	How satisfied are you with the treatment?	X	-	X
37.	Describe how the treatment addresses the patient's condition.	X	-	X
38.	To what degree did the medical treatment meet your expectations?	X	-	X
39.	Describe the adequacy of the information you received about the results of examinations, operations, and/or tests.	X	-	X
40.	Describe the adequacy of the information you received about how examinations were to be done.	X	-	X

Table 1 (continued)

	Research Questions		
	1.	2.	3.
	What are the cultural considerations required in delivering health care?	How does privatization of health care impact the public health care system?	What contributes to the negative or positive perceptions by prospective patients or providers?
Survey Questions			
41. Describe the adequacy of the information you received about home care?	X	-	X
42. Describe the adequacy of the information you received about preventive care? (for illnesses, injuries, or disease).	X	-	X
43. How are you satisfied with the quality of health care in the region you live?	X	X	X
44. What are the advantages and disadvantages of public hospitals and clinics?	X	X	X
45. What are the advantages and disadvantages of having more private clinics and hospitals?	X	X	X
46. What is the affect on the quality of care if there were more private health care institutions?	X	X	X

Table 1 (continued)

	Research Questions		
	1.	2.	3.
	What are the cultural considerations required in delivering health care?	How does privatization of health care impact the public health care system?	What contributes to the negative or positive perceptions by prospective patients or providers?
Survey Questions			
47. What would be the affect on the quality of care if doctors received financial incentives?	X	X	X
48. How would giving doctors financial incentives affect the fairness of the health care system?	X	X	X
49. How does spending more money on health care affect the quality of health care?	X	X	X
50. How would you describe the differences or similarities in health care across the region you reside in?	X	X	X
51. How would you describe the changes, if any, of health care where you reside?	X	X	X
52. What is your opinion on health care providers receiving payments directly from patients?	X	X	X

Table 1 (continued)

	Research Questions			
	1.	2.	3.	
	What are the cultural considerations required in delivering health care?	How does privatization of health care impact the public health care system?	What contributes to the negative or positive perceptions by prospective patients or providers?	
<u>Survey Questions</u>				
53.	What do you think the affect of more private practices would be on health care?	X	X	X
54.	Where do you think the emphasis on training of health care professionals and administrators should be?	X	X	X
55.	What do you think is the optimum administrative structure for the Libyan system of health care ?	X	X	X
56.	Describe the level of understanding of Secretariat of Health to the specific problems in my region.	X	X	X
<u>Staff</u>				
57.	Why did you come to Tripoli Medical Center?	X	X	X
58.	Describe the leadership style at TMC.	X	X	X
59.	How satisfied are patients on the care they receive at TMC?	X	X	X

Table 1 (continued)

	Research Questions			
	1.	2.	3.	
	What are the cultural considerations required in delivering health care?	How does privatization of health care impact the public health care system?	What contributes to the negative or positive perceptions by prospective patients or providers?	
Survey Questions				
60.	How satisfied is the staff at TMC?	X	X	X
61.	Describe the management style at TMC.	X	X	X
62.	Describe the work processes.	X	X	X
63.	Describe the teams that you belong to at TMC.	X	X	X
64.	How is performance measured?	X	X	X
65.	Describe one or more quality process at TMC.	X	X	X
66.	How does the staff contribute to quality?	X	X	X
67.	What improvement projects would you suggest?	X	X	X
68.	How would you describe the organization's commitment to excellence?	X	X	X
69.	How would you describe the level of caring of the medical staff?	X	X	X

Table 1 (continued)

	Research Questions			
	1.	2.	3.	
	What are the cultural considerations required in delivering health care?	How does privatization of health care impact the public health care system?	What contributes to the negative or positive perceptions by prospective patients or providers?	
Survey Questions				
70.	How would you describe the level of caring of the administrative staff?	X	X	X
71.	Describe the skills of the medical staff.	-	X	X
72.	Describe the skills of the administrative staff.	-	X	X
73.	Describe the skills of the pharmacy staff.	-	X	X
74.	Describe the communication among nurses, doctors, and administrators.	X	X	X
75.	How would you describe the availability of the staff?	X	X	X
76.	How would you describe the physical environment for patients?	X	X	X
77.	What are the biggest obstacles to providing quality health care?	X	X	X

Table 1 (continued)

	Research Questions		
	1.	2.	3.
	What are the cultural considerations required in delivering health care?	How does privatization of health care impact the public health care system?	What contributes to the negative or positive perceptions by prospective patients or providers?
Survey Questions			
78. What are the advantages and disadvantages of public hospitals and clinics?	X	X	X
79. What are the advantages and disadvantages of having more private clinics and hospitals?	X	X	X
80. What is the affect on the quality of care if there were more private health care institutions?	X	X	X
81. What would be the affect on the quality of care of doctors receiving?	X	X	X
82. How would giving doctors financial incentives affect the fairness of the health care system?	X	X	X
83. How does spending more money on health care affect the quality of health care?	X	X	X

Table 1 (continued)

	Research Questions		
	1.	2.	3.
	What are the cultural considerations required in delivering health care?	How does privatization of health care impact the public health care system?	What contributes to the negative or positive perceptions by prospective patients or providers?
Survey Questions			
84. How would you describe the differences or similarities in health care across the region you reside in?	-	X	X
85. How would you describe the changes, if any, of health care over the last 10 years you reside?	-	X	X
86. What is your opinion on health care providers receiving payments directly from patients?	X	X	X
87. What do you think the affect of more private practices would be on health care ?	X	X	X
88. Where do you think the emphasis on training of health care professionals and administrators should be?	-	-	X
89. What is the role of Medical associations?	-	-	X

Table 1 (continued)

	Research Questions		
	1.	2.	3.
	What are the cultural considerations required in delivering health care?	How does privatization of health care impact the public health care system?	What contributes to the negative or positive perceptions by prospective patients or providers?
Survey Questions			
90. What do you think is the optimum administrative structure for the Libyan system of health care?	-	-	X
91. Describe the level of understanding of Secretariat of Health to the specific problems in my region.	-	-	X
92. To what degree does Libya have unified standards for health care ?	-	-	X

Note. X indicates that research question that survey question aims to answer.

Researchers seek to gain an understanding of the lived experiences of others when conducting in-depth interviewing (Seidman, 2006). According to Seidman, interviews provide access to participants' behavior and put their behavior in context; when asked open-ended questions, patients reconstruct their experiences. However, Seidman cautions interviewers and researchers from developing too close of a rapport with study participants during the interview process.

Quantitative research designs collect data such as gender, age, level of education, employment, and housing status to confirm representative sampling (Langle et al., 2003). Although this study is qualitative, socio-demographic data was collected. Socio-demographic data about respondents was collected and included in the analysis (Lewins & Silver, 2007). Repeated identifiers, such as the speaker or topic, were used consistently throughout data collection to facilitate data analysis, which is a process suggested by Lewins and Silver (2007). As an example, 1S-2009-04-04-PAT is the first participant of the study and the interviewee was a patient interviewed April 4, 2009. To assure confidentiality, the latter part of the identifier is not reported but is being retained in the primary documentation.

Data Analysis

Data analysis must be transparent, communicable, and coherent (Auerbach & Silverstein, 2003). Auerbach and Silverstein suggested that the analysis is valid if it is supported by the data, despite the possibility of multiple interpretations of the qualitative data. However, participants' concerns must take precedence over the researcher's concerns. Auerbach and Silverstein also suggested that data analysis may lead to a reformulation of research concerns.

Both coded data and direct interpretation are used in case study research (Stake, 1995). This study relied more on coded data, but direct interpretation was also used. ATLAS.ti5 was used for the analysis of survey data. It is a Computer Assisted Qualitative Data Analysis (CAQDS) tool that facilitates storage, coding, retrieval, and reporting. It was used to store and analyze primary data (Lewins & Silver, 2007). The categories and variables were defined to code the survey data. Coding looks for patterns and reoccurrence of meanings in the data. Pre-established codes are useful but new ones should be looked for (Stake, 1995). According to Lewins and Silver, unused codes can be recoded so that they appear on the bottom of the code list (e.g., 'zz'). Codes were placed in code families to help establish links and themes. Table 2 is an output report from ALTAS.ti5 . It illustrates preliminary codes established for this study and their family groupings.

Table 2

Preliminary codes and families created in ATLAS.ti

Codes

Accred-JCAHO {0-0}

Accred-JCI {0-0}

Accred-Joint Commission International {0-0}

Accred-Joint Commission on Accreditation of Healthcare Organizations {0-0}

Accredit-certifications {0-0}

Admission-referral {0-0}

Admission-walk-in {0-0}

Change-reengineering {0-0}
Change-reorganize {0-0}
Communication-brochures {0-0}
Communication-information {0-0}
Department-Emergency room {0-0}
Department-ER {0-0}
Doc-handbook {0-0}
Doc-manual {0-0}
Doc-policy {0-0}
Doc-procedure {0-0}
Electronic-automatic {0-0}
Electronic-Decision Support Systems {0-0}
Electronic-DSS {0-0}
Electronic-EMR {0-0}
Electronic-information systems {0-0}
Electronic-IS {0-0}
Electronic-IT {0-0}
Electronic-medical records {0-0}
Fin-GDP {0-0}
Governance-mission {0-0}
Governance-leaders {0-0}
Governance-mission {0-0}

Governance-organizational change {0-0}

Governance-values {0-0}

HLTH-Healthy Adjusted Life Expectancy {0-0}

HTHL-HALE {0-0}

Measure-benchmarking {0-0}

Measure-outcomes {0-0}

Measure-performance {0-0}

MOTIV-incentives {0-0}

Patients-customer satisfaction {0-0}

Physical-medical offices {0-0}

Policy-consent {0-0}

Procedure-bed assignment {0-0}

Procedure-preadmission {0-0}

Quality-compliance {0-0}

Quality-continuous improvement {0-0}

Quality-Continuous Quality Improvement {0-0}

Quality-CQI {0-0}

Quality-customer satisfaction {0-0}

Quality-improve {0-0}

Quality-patient satisfaction {0-0}

Quality-training {0-0}

Referral-primary care {0-0}

Staff-leaders {0-0}

Staff-nursing {0-0}

Staff-training {0-0}

Sys-community {0-1}

Sys-institutional {0-1}

Sys-organizational change {0-1}

System {0-3}

Tripoli Medical Center {0-1}

Tripoli Medical Center-governance {0-1}

Trust {0-0}

Code Families

Accreditation (8)

Admission (3)

Change (2)

Communication (4)

Departments (2)

Documents (5)

Electronic (11)

Finance (1)

Governance (9)

Health Assessment (3)

Measure (3)

Motivation (2)

Patients (5)

Physical (1)

Policy (3)

Procedure (4)

Quality (13)

Referral (1)

Staff (5)

System (5)

Tripoli Medical Center (2)

Figure 3 is a network view of the codes and their relationships. However, the codes and their links and relationships evolved throughout the study. As mentioned by Lewins and Silver, ALTAS.ti5 does not create a hierarchical structure for codes, so prefixes were created to help categorize the codes.

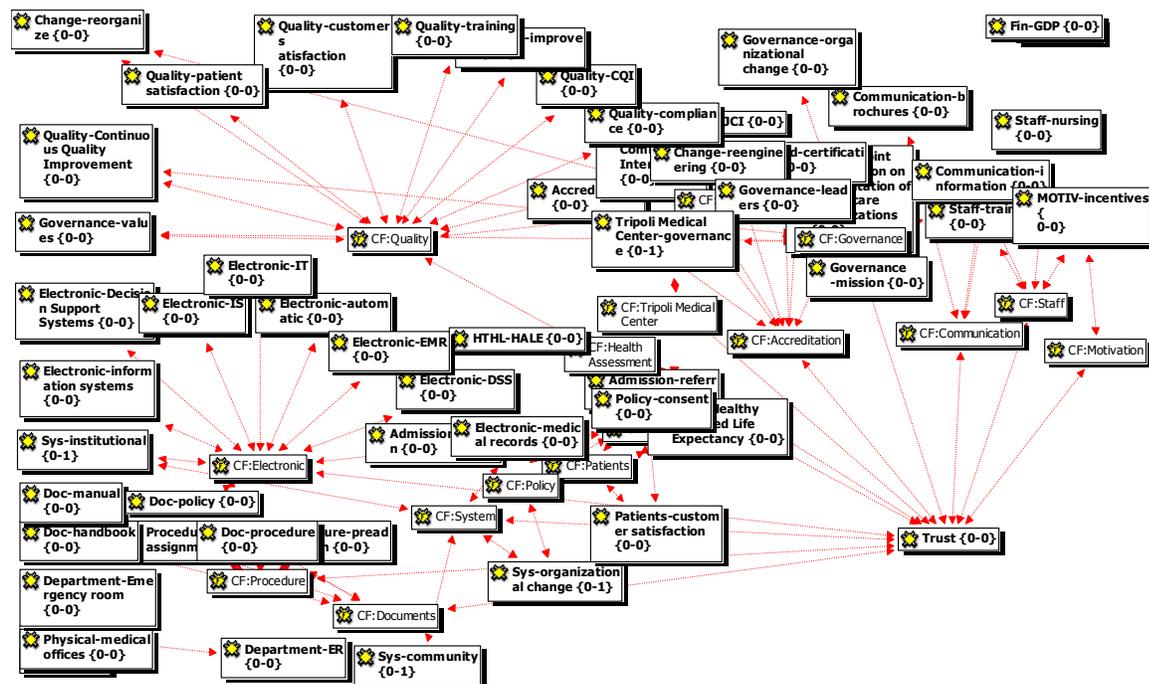


Figure 3. *Open-coding network view*

A mixed data analysis approach was used. At times, a constructivist approach was used. It helped link patterns of discourse (Lewins & Silver, 2007). Deductive coding was used to explore if the construct of trust, specifically in the coding of TMC medical and administrative staff data, is transferable. Inductive coding was also employed. Lewins and Silver suggested that inductive coding occurs in three phases: open coding, axial coding, and selective coding. Codes were generated by themes or topics that evolve from the interviews, ideas or concepts from the literature, and language or terminology used by respondents. Small sentences or words were first coded using open coding. The codes from the first phase were reconsidered during axial coding. Finally, during selective coding, the codes were reexamined and relationships, themes, and patterns were identified.

The steps for coding the data analysis are similar to those laid out by Auerbach and Silverstein (2003, p. 35) for grounded theory coding:

1. Research concerns.
2. Theoretical narrative.
3. Theoretical constructs.
4. Themes.
5. Repeating ideas.
6. Relevant text.
7. Raw data.

The data was refined and elaborated on the conceptual constructs found in the literature. Themes were combined to form theoretical constructs. Relevant text was identified from the surveys that are specific to the research concerns. An idea was relevant if it is mentioned by more than one participant. Repeating ideas were extracted from the relevant text. Auerbach and Silverstein (2003) recommended 40 to 80 repeating ideas. Direct interpretation of individual episodes and aggregation of many were required for analysis (Stake, 1995). Participants used different words to express the same idea. However, since coding was of the translated narratives from Arabic to English, there were fewer differences in expression of the same idea. A theme groups repeating ideas. Auerbach and Silverstein recommended 10 to 20 themes. Thirteen themes evolved from this study. The theoretical narrative summarizes the findings in the context of the research concerns.

One limitation is that coding was conducted by only one researcher. Additionally, participants were not presented with the repeated ideas or relevant text. However, member checking was conducted. To avoid racism, culturalism, ethnocentrism, and classism, it is imperative to use members from the same culture.

The findings of qualitative case studies are not normally generalized to populations. Yin (2003) described this as *analytical naturalization*. Therefore, generalizations did not automatically apply to departments outside the pediatric department at TMC. Unlike most health care institutions in Libya that are managed by one of the 22 municipalities, TMC is centrally controlled. Therefore, generalizations may not apply to other Libyan public hospitals.

Chapter Summary

An exploratory qualitative case study was conducted at TMC. Even though triangulation was employed to enhance validity, unstructured interviews dominated the data collection. The researcher recorded observational data, conducted all interviews, and requested supporting documents. The instruments were pretested during the pilot study. Data was codified, which identified themes based on the convergence of the data. The results and analysis are presented in Chapter 4.

Chapter 4: Results

Introduction

The purpose of this study was to explore the negative and positive factors that determine trust in the delivery of health care at a Libyan public hospital. This chapter presents the results collected at the Tripoli Medical Center (TMC) between March 9,

2009 and April 8, 2009. The parents of pediatric patients, nurses, doctors, administrative, and support staff were interviewed. Sixty respondents consented to participate in either the pilot or the study. Of the 60, 10 interviews were conducted solely to pretest the survey instruments and the participants' responses were not reported. Of the 50 participants included in the study, 30 were from the patient population and 20 were hospital staff members. Throughout the 32 days of data collection, the researcher completed memos and observation sheets. Additionally, attempts were made to collect procedures, organizational charts, and policy documents. In this chapter, the results from the interviews, observations, and document review are presented. Member checking occurred with this study's TMC gatekeeper and translators; results are discussed in this chapter.

Interviews

As part of the consent process, pilot participants were informed that the pilot was for the sole purpose of pretesting the questionnaires. The pilot was conducted March 9, 2009 - March 15, 2009. The responses of pilot participants are not reported. Pilot participants were excluded from the study. Interviews for the study were March 16, 2009 - April 7, 2009.

The Head of Pediatric Respiratory and Intensive Care hospital provided four translators for the pilot and the study. They received no monetary compensation. The translators were medical doctors at various levels of their medical training: two interns, one Registrar, and one Attachment. They were not certified translators, but all medical training in Libya is conducted in English. The translators were required when

respondents were not proficient in English. The consent process emphasized that their role was solely for translation and not as a service provider. Even though the translators have medical training and were provided with the questionnaires in Arabic, care was taken to ensure that the questions posed to the respondents came from the sole researcher. That is, questions were first asked in English then translated as needed. The translators were accessible to the researcher throughout the study.

Table 3 illustrates the respondents for both the pilot and the study by participant category: patient, doctor, nurse, and support staff. Each respondent is uniquely identified and each identifier indicates an interview.

Table 3
Respondents by category

	Patient/Guardian	Doctors	Nurses	Administrative	Support
Pilot	3P, 4P, 7P, 8P, 9P, 10P	1P, 2P, 1P, 1P	5P, 6P, 5P, 6P	-----	-----
Study	3S, 4S, 9S, 10S, 11S, 12S, 14S, 15S, 16S, 21S, 26S, 27S, 28S, 29S, 31S, 32S, 34S, 35S, 36S, 37S, 38S, 40S, 41S, 42S, 43S, 44S, 45S, 46S, 48S, 49S	8S, 18S, 19S, 20S, 22S, 25S, 47S, 50S	5S, 6S, 7S, 17S, 23S, 39S	1S, 2S, 13S	24S, 30S, 33S

Note. P indicates pilot subject and S represents study subject

Thirty of 50 parents of pediatric patients who were invited to participate in the study agreed to be interviewed. Parents represented the pediatric patients if patients were below assent age, if patients were too ill or shy to participate in the interview. Mothers are admitted into the ward with their child. Therefore, the term patient and the patient's parent are used interchangeably in this study unless otherwise specified. All the patients for the study were inpatients. Inpatients are afforded more privacy for the study. It was difficult to obtain a location for the interviews of patients during the pilot; the majority of patients for the pilot were outpatients. Additionally, the interviews were more disruptive to the outpatient department as they consumed precious time. The majority of the respondents were the mothers of patients. Mothers are admitted to the inpatient pediatric ward with the pediatric patient and they play a critical role to the care of patients while in the hospital. The exception to the admission of mothers is pediatric patients less than 28

days old which are in the neonatal department or patients who are in ICU. All pediatric patients interviewed had at least one parent who was Libyan. Fifteen of the 30 patient respondents were from the city of Tripoli, the hospital location.

Twenty hospital staff employees were interviewed. Staff consisted of nurses, doctors, administrators, and other support staff (e.g., pharmacist, security, social worker). Of the 20 staff members, 15 staff members were Libyan and 5 were non-Libyan. Two senior level doctors and approximately ten nurses declined to be interviewed.

Based on the pretest of the study, audiotaping was not requested of respondents. Audiotaping was planned to validate translation. However, English speaking professional staff was the more likely cluster to agree to be audiotaped. All pilot patient representatives refused audiotaping. Further inquiry of the staff confirmed speculation that in Islamic culture Muslim women, who were the majority of respondents, do not want their voices recorded. Additionally, the few interviews audiotaped during the pilot did not add any robustness to the transcribed interviews; translation during the interviews provided ample time to record responses in the researcher's journal. Since the audio tape did not provide additional information, to avoid the potential obtrusiveness of audiotaping and to solicit more candid responses, consent for audiotaping was not requested for the study. Furthermore, the translation and transcription did not extend interviews past the consented scheduled interview duration. Even though audiotaping attempts for this study were designed to be unobtrusive, Stake (1995), suggests that audio taping should not be relied on. Once data collection began for the pilot and study, it became obvious that the lack of audiotaping did not impact data collection.

The three interview protocol was designed for staff interviews. Dolbeare and Schuman (Seidman, 2006) suggested the three interview protocol in order to give respondents time to reflect between interviews. The staff survey instrument was easily completed within the time scheduled for one interview with most respondents, respondents overwhelmingly preferred to conduct the interview in one sitting, and scheduling three interviews for one respondent was challenging due to professional commitments. As a result, 19 of the 20 staff interviews were conducted in one sitting.

Open and Axial Coding.

As suggested by Auerbach and Silverstein (2003), the use of open-ended questions for the study was designed to explore participants' subjective experiences. Even though the interviewer and translators used structured questions, they conducted the interviews as a guided conversation (Yin, 2003). The pretest of the questionnaires revealed that some of the questions did not add any new information from the respondents and some questions were not clear to the participants. As an example, staff members overwhelmingly did not understand the question, "Describe one or more quality processes at TMC." During the pilot, examples provided by the researcher had to be given leading to conclusion that the question should be discarded. Answers included:

- Process difficult. Not good/not bad.
- Nothing for hospital.
- Nursing offices, need more help, facing many problems. Libyan and Foreigners same salary. Good for patients because free.

Additionally, the following series of questions led to the same answers with the same meaning:

- What was your impression of how attentive nurses were to you?
- What do you think about the nurses' ability to understand the patient's feelings when admitted?
- What do you think about the nurses overall treatment?
- Describe the nurses' preparation to handle your case.
- Describe the skills of the nursing staff.
- Describe the nursing team for your case.

As an example, one pilot participant responded to these series of questions, "behavior is not good, shout at patients," while another responded "very good."

The redundant and unclear questions were not used for the interviews conducted during the subsequent study. Table 4 illustrates the interview questions and their relationship to the remaining research questions.

Table 4

Pretested research and survey question matrix

Research Question	Question Number
What are the cultural considerations required in delivering health care in Libya?	1, 2, 3, 4, 5, 9, 11, 12, 13, 14, 16, 17, 20, 22, 23, 24, 25, 26, 27, 28, 32, 33, 34, 36, 38, 39, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 62, 64, 66, 67, 68, 69, 74, 75, 76, 77, 78, 79, 82, 83
How does privatization of health care impact Libya's public health care system?	43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 62, 64, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 82, 83
What contributes to prospective patients' or providers' negative or positive perceptions?	1, 2, 3, 4, 5, 9, 11, 12, 13, 14, 16, 17, 20, 22, 23, 24, 25, 26, 27, 28, 32, 33, 34, 36, 38, 39, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 62, 64, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 82, 83, 88, 90, 91, 92

Questions 1 through 56 were asked of the patients' parents and questions 57 through 92 were asked of the staff. It was important to allow respondents to tell their stories without losing control of the interview, as recommended by Stake (1995). The interview sought to answer the research questions.

Table 5 indicates the questions that were explicitly responded to by the survey participants. Since the interviews were designed to be unstructured interviews, questions were occasionally skipped at the discretion of the researcher. The most common reason for omitting a question was that the respondent already addressed the subject thoroughly or the question was not relevant to the interviewee (e.g., asking about comfort at night for

a patient recently admitted). As specified in the consent form, some participants choose not to respond to one or more questions.

The questions generated responses that were coded. Table 6 displays the number of coded segments generated for each question.

Table 6:

Code count per question

Question	Code Count
1. Why did you come to Tripoli Medical Center?	28
2. Describe your interaction with nurses during admission.	27
3. How did the nurses respond to your questions?	21
4. How would you describe the level of caring of the nursing staff?	18
5. What was your impression of how attentive nurses were to you?	15
9. Describe the skills of the nursing staff.	23
11. Describe the how the doctors communicated with you.	30
12. How would you describe the manner in which doctors kept you informed?	25
13. How would you describe the level of understanding you had of the doctors' explanation?	16
14. How would your describe the answers the doctor gave to your questions?	8
16. Describe the doctors' preparation to handle your case.	22
17. How attentive were the doctors?	9
20. How would you describe the availability of the staff?	29
22. How well informed were you about the patient's medicine?	29
23. How informed were you about side-effects of any medicine prescribed or dispensed?	28
24. How would you describe the physical environment such as noise or temperature?	29
25. How comfortable was the patient at night? (for inpatients only).	21
26. Describe the cleanliness of the bathroom.	25
27. Describe the cleanliness of the room.	22
28. Describe the overall condition of the room. (for inpatients only).	15
33. Overall, describe the adequacy of information received at time of arrival.	7

Table 6 (continued)

Question	Code Count
34. How do you think hospital personnel showed respect for the patient and family?	26
36. How satisfied are you with the treatment?	8
38. To what degree did the medical treatment meet your expectations?	24
39. Describe the adequacy of the information you received about the results of examinations, operations, and/or tests.	25
41. Describe the adequacy of the information you received about home care?	22
42. Describe the adequacy of the information you received about preventive care? (for illnesses, injuries, or disease).	20
43. How are you satisfied with the quality of health care in the region you live?	29
44. What are the advantages and disadvantages of public hospitals and clinics?	28
45. What are the advantages and disadvantages of having more private clinics and hospitals?	27
46. What is the affect on the quality of care if there were more private health care institutions?	12
54. Where do you think the emphasis on training of health care professionals and administrators should be?	29
55. What do you think is the optimum administrative structure for the Libyan system of health care?	25
56. Describe the level of understanding of Secretariat of Health to the specific problems in my region.	24
57. Why did you come to Tripoli Medical Center?	19
58. Describe the leadership style at TMC.	20
59. How satisfied are patients on the care they receive at TMC?	20
60. How satisfied is the staff at TMC?	18
62. Describe the work processes.	18
64. How is performance measured?	18
66. How does the staff contribute to quality?	17
67. What improvement projects would you suggest?	18
68. How would you describe the organization's commitment to excellence?	17
69. How would you describe the level of caring of the medical staff?	16

Table 6 (continued)

Question	Code Count
70. How would you describe the level of caring of the administrative staff?	15
71. Describe the skills of the medical staff.	15
72. Describe the skills of the administrative staff.	15
73. Describe the skills of the pharmacy staff.	17
74. Describe the communication among nurses, doctors, and administrators.	15
75. How would you describe the availability of the staff?	13
76. How would you describe the physical environment for patients?	13
77. What are the biggest obstacles to providing quality health care?	13
78. What are the advantages and disadvantages of public hospitals and clinics?	16
79. What are the advantages and disadvantages of having more private clinics and hospitals?	16
80. What is the affect on the quality of care if there were more private health care institutions?	1
82. How would giving doctors financial incentives affect the fairness of the health care system?	13
83. How does spending more money on health care affect the quality of health care?	10
88. Where do you think the emphasis on training of health care professionals and administrators should be?	14
90. What do you think is the optimum administrative structure for the Libyan system of health care?	17
91. Describe the level of understanding of Secretariat of Health to the specific problems in my region.	14
92. To what degree does Libya have unified standards for health care?	17

The table illustrates the interview questions that generated the richest amount of data. Initially, codes were considered that were generated prior to data collection. This deductive approach tested the conceptual framework for the study as well as the prevailing themes discussed in Chapter 3. Table 2 lists the codes initially considered.

Through an iterative approach, many of the codes initially considered were discarded. The codes eliminated were primarily themes that did not surface during the interviews or were repetitive. As recommended by Lewins and Silver (2007), unused codes were recoded with a 'zz' prefix in ATLAS.ti so that they appear on the bottom of the code list. The eliminated codes are listed in Table 7. Open coding generated additional codes.

Table 7

Codes discarded after deductive coding

zzAccred-JCAHO
 zzAccred-JCI
 zzAccred-Joint Commission International
 zzAccred-Joint Commission on Accreditation of Healthcare Organizations
 zzChange-reengineering
 zzChange-reorganize
 zzCommunication-brochures
 zzDepartment-ER
 zzDoc-handbook
 zzDoc-manual
 zzDoc-policy
 zzElectronic-automatic
 zzElectronic-Decision Support Systems
 zzElectronic-DSS
 zzElectronic-EMR
 zzElectronic-information systems
 zzElectronic-IS
 zzElectronic-medical records
 zzFacilities-human resources

Table 8 depicts the codes that remained after the deductive coding and open coding process. The number of segments coded with the each code is also listed.

Table 8

Code list and segment count

Code List	Segment Count
Accred-certifications	1
Admission-communication	24
Admission-referral	9
Admission-walk-in	13
Behavior	4
Communication-home care	10
Communication-information	122
Communication-relationship	61
Communication-system	9
Community-service	31
Community-trust	2
Community-values	15
Confidence	26
Culture-family	10
Culture-General	6
Department-admission	9
Department-Emergency room	33
Department-medical	61
Dept-nonmedical	1
Doc-procedure	4
Electronic-IT/IS	1
Facilities- General	15
Facilities-capacity	36
Facilities-General	10
Facilities-lab	10
Facilities-medicine	39
Facilities-supplies	33
Financial-patient services	76
Financial-salary	22
Governance-values	3
Human Resource	107
Insurance	5
Investigation	60

Table 8 (continued)

Code List	Segment Count
Libyan	17
Measure-benchmarking	3
Measure-outcomes	10
Measure-performance	20
Medical ethics	1
Motivation-financial	35
Motivation-incentives	17
Motivation-leadership	3
Motivation-power	3
Motivation-staff	45
Patient-behavior	5
Patient-education	21
Patient-outcome	23
Physical-bathroom	25
Physical-general	8
Physical-hygiene	67
Physical-room	88
Physical-security	9
Physical-service	19
Policy-staff	18
Procedure-administrative	36
Procedure-medical	40
Procedure-visit	8
Quality-customer service	56
Quality-improve	21
Quality-patient satisfaction	108
Quality-staff satisfaction	28
Records-medical	5
Referral-abroad	7
Referral-from private	11
Referral-from public hospital	24
Referral-primary care	2
Relationship-among staff/team	38
Relationship-behavior	104
Relationship-communication	29

Table 8 (continued)

Code List	Segment Count
Staff-doctors	266
Staff-education	35
Staff-English language	10
Staff-nursing	232
Staff-pharmacist	12
Staff-skill	130
Staff-support	8
Staff-TMC managers/admin	58
Staff-training	80
System	34
System-capacity	14
System-community	21
System-hospitals/clinics	96
System-leadership (SOH)	58
System-organizational change	2
System-pharmacies	7
System-primary care	36
System-recommendation	13
System-research	3
System-staff	14
TMC-capacity	11
Tripoli	10
Tripoli Medical Center	65
Tunisia	12

The codes generated in Table 8 were reconsidered. The researcher reconsidered similarities and common themes. Using ATLAS.ti, the codes were combined into families. Table 9 depicts the themes generated from axial coding. The themes, ATLAS.ti families, are the logical groupings of the codes generated from open-coding. The following discussion provides more detail to the thematic analysis conducted that resulted in the 13 themes.

Table 9

Themes generated from axial coding

Theme	Open coding codes	Number of quotations
Behavior/Relationship	Behavior Communication-relationship Relationship-among staff/team Relationship-behavior Relationship-communication	201
Capacity/Availability	Facilities-capacity Human Resource System-capacity TMC-capacity	154
Communication	Communication-home care Communication-information Communication-relationship Communication-system Relationship-communication	199
Culture	Community-values Culture-family Culture-General	24
Leadership	Staff-TMC managers/admin System-leadership (SOH)	114

Table 9 (continued)

Theme	Open coding codes	Number of quotations
Libyan System	Community-service	298
	Referral-abroad	
	Referral-from private	
	Referral-from public	
	hospital Referral-primary	
	care	
	System	
	System-capacity	
	System-community	
	System-hospitals/clinics	
	System-leadership (SOH)	
	System-organizational	
	change	
	System-pharmacies	
	System-primary care	
	System-recommendation	
	System-research	
System-staff		
Tripoli	84	
Tunisia		
Motivation-financial		
Motivation-incentives		
Motivation-leadership		
Motivation-power	141	
Motivation-staff		
Physical-bathroom		
Physical-general		
Physical-hygiene		
Physical-room		
Physical-security	64	
Physical-service		
Doc-procedure		
Policy-staff		
Procedure-administrative		
Procedure-visit	Records-medical	
Records-medical		

Table 9 (continued)

Theme	Open coding codes	Number of quotations
TMC-Organization	Department-admission Department-Emergency room Department-medical Dept-nonmedical TMC-capacity Tripoli Medical Center	160
Facilities	Facilities- General Facilities-capacity Facilities-General Facilities-lab Facilities-medicine Facilities-supplies	122
TMC Staff	Staff-doctors Staff-education Staff-English language Staff-nursing Staff-pharmacist Staff-skill Staff-support Staff-TMC managers/admin Staff-training	564
Trust	Community-trust Confidence	26

Selective Coding.

Through a process of open and axial coding, 13 themes were generated. Each of the 13 themes generated through an iterative process of deductive and inductive coding will be discussed in this section. Typical translated comments of respondents are listed for each theme. The comments are appended with the respondents' unique identifier. Each respondent was labeled sequentially for the study and the "S" indicates the

respondent was a participant of the study and not the pilot. The intent is to give the reader the sentiment of the respondents and the overall environment at the research site.

Behavior/Relationship.

Behavior, Communication-relationship, Relationship-among staff/team, Relationship-behavior, and relationship-communication were synthesized into a common theme of behavior/relationship. The respondents, patients and staff, commented on behavior over skills. Overwhelmingly, the behavior of nurses towards patients and their parents, specifically Libyan nurses, was cited as an area that needs improvement. Yet, several respondents were satisfied with the nursing care and specifically stated that both non-Libyan and Libyan nurses communicated well with the patients. Nevertheless, when there were negative responses about nurses, they were usually contributed to Libyan nurses. Libyan nurses were considered to have poor behavior manifested by a lack of responsiveness to patient needs. Additionally, when differences between public and private health care were cited, respondents mentioned poorer behavior and friendliness of nurses in the public health care system.

Typical comments on nursing staff behavior were as follows:

- Need more control of nursing staff and behavior. (15S)
- Nurses need more training in how to deal with patient. (29S)
- Nice communication, attentive, very nice, skills very nice of nurses (31S).
- You have to teach (Libyan nurses) everything headache for respondent. They need to study more, nursing care, patient to patient

interaction. (7S)

- Patients like pleasant interaction. Not all happy, if good communication they are happy. Good psychological support will help patient get better. Good psychological support will help patient get better. Depends on how relationship is with patient. (23S)
- Non-Libya nurses have better skills and relation. (42S)
- Skill is OK, problem is with the relationship with nurses. (14S)
- Nurses help very much, very friendly. Very nice, they love sister (patient) very much. Very excellent. (32S)
- In private health care there is more caring from nurses (and even doctors). More resources, someone always besides patient. (20S)
- Mother not satisfied, bad relationship, treatment not on time, when asked to measure temperature or change beds, or change catheter they do not come fast. Sometimes nurse says she is busy or going to lunch, they neglect care. (14S)
- Recommend smiling and good communication. (2S)
- Ask nurses many times, they say OK but they do not follow through. (8S)
- More comfort and more smiling nurses needed. (25S)
- Relationship between doctors and patient better than between nurses and patients. (42S)
- In private health care, communication is better because patients have

to pay everything. (23S)

- OK, good relationship with child. Relationship good with child (Libyan and non-Libya nurses). (46S)
- Nurses-not good; they talk badly to her. (11S)
- Nurses should be taught how to deal nicely with patients. Nurses: more education on what to say but availability affects this. (25S)
- Relationship with patient, care should be good. Improve thinking of people of nursing staff, defect in thinking of Libyan people on perception of nursing staff. (17S)
- Gentle relationship with mother, played with child, gentle when remove canula, both Libyan and non-Libya nurses. (41S)
- Good relationship with patient, they try to create relationship with mother. (nursing) (16S)
- Nursing staff needs better behavior. (49S)
- Problem is the staff: nurses (skills and behavior). (11S)
- Nurses have defect. Nurses not doing job exactly. Delay in medicine. Need more contact with baby. (48S)
- Some nurses difficult to communicate, some lazy. (8S)
- Need training: behavior for nurses and doctors. (14S)
- Nurses have no sense of responsibilities, can not find them, should stay in nursing station. (7S)
- Patient talks to doctors not nurse because nurse not good. (34S)

- Only one nurses yesterday good, others not good. (34S).
- Some nurses refuse to touch patient but should. (35S)
- Nurses give treatment on time, good communication. (12S).
- Very nice explanation from nurses, explain if vague. (29S)
- Nurses have better relationship with patient than General hospitals.
Medicine on-time, skills better. (45S)

Patients were generally satisfied with their relationship with doctors. They considered them competent and compassionate. Patients were satisfied with the interaction doctors had with patients during morning rounds. However, they often did not distinguish between the various levels of doctors (i.e., Consultant, Specialist, Senior Registrar, Registrar, Attachment, or Intern). Respondents' typical comments related to doctor-patient relationship, behavior, and communication follow.

- Doctor stayed more than an hour with patient late at night. (16S)
- Mother satisfied with doctors (esp. doctors on surgical ward). No difference between ward and ICU. (42S)
- Doctor should make discussion with patient. (12S)
- They listen to patient and mother, good communication and discussion with doctor. (12S)
- According to Doctor. Some good/some not. (11S)
- Very, very good with doctors, doctor answered every question, transferred patient to other department for tests with doctor instead nurse, gave update if investigation is early and possible. (16S)

- Nice communication with Doctor. Dr gives inadequate info initially. (21S)
- Doctors try to be nice. Sometimes lose patience when lots of admissions. (25S)
- Patient loves some doctors more than nurses. (35S)
- Doctors are highly educated, communication nice. (6S)

Additionally, patients and staff commented on the relationships between patients and medical staff as a whole:

- Patient comfortable with nurses and doctors. (14S)
- Need good communication skill with patient. Spend time with patients, make things clear. (staff) (50S)
- Patients respond to communication from staff. (23S)
- Communication determines behavior. (2S)
- Sometimes you can tell that staff cares for patient. (39S)
- Staff needs training in communication skills. (33S)
- Good relationship with patients and visitors. (staff) (17S)
- If more doctor and nurses they could have patience. (25S)
- Nice, no one shouts, everyone nice. (staff) (46S)
- Relationship between pharmacy staff and patient difficult. (18S)
- Pharmacist knows how to deal with drug and patient. (22S)

Communication among the staff was also explored.

- Lack of coordination especially between doctors and admin lots of disadvantages. (25S)
- No respect for doctors by nurses. Doctors do work for nurses. (7S)
- Between doctors and nurses communication is bad. Give advice to nurses but the next day find nothing is done. Do not know how to improve. (20S)
- Difficult relationship between doctors and administration, should try to improve relationship with doctors; facilities (esp. doctors) (18S).
- Relationship between nurses and doctors not good. (14S)
- No relationship with admin. Do not agree with what doing. Should look at staff as human beings, not machines. (25S)
- Poor communication between admin and staff. They write paper and make change. Between doctors and nurses also bad. Only follow orders. (50S)
- OK, nurses to nurses in unit wonderful. Know each other a long time. (6S)
- The staff (doctors) improves quality by their work, supports to each other, during rounds collaborate with each other.(19S)
- Communication not that good. (among staff) (24S).
- Not good between nurses and doctors (lazy nurses). (22S)
- Libyan doctors not comfortable with Libyan nurses. Doctors more comfortable with non-Libya nurses. (Respondent implies it is a

cultural issue.) (39S)

- No meetings between nurses and supervisor of nurses about unit. Nurse-consultant no connection. Communication not good. No connection between GP and consultant. It is the job of admin to fix. (33S)
- Bad relationship with nursing staff, hide medicine, no confidence with pharmacy staff. (17S)
- Need collaboration among doctors throughout TMC (between doctors). (50S)
- Work needs to be coordinated, “everyone plays there own symphony”. (staff) (25S)
- Between nurses and doctors good. (relationship) (18S)
- Dr. has to do job of nurses and helpers. (8S)
- Satisfied. Some problem because of daily interaction. (22S)
- Doctor to doctor communication good. (8S)
- No problem in unit among nurses. (6S)
- Comfortable with doctors, doctors have good communication in this department. (10S)
- Bad communication in respondent’s department (non-medical). (30S)
- Flexible, they (Administrators) listen, good cooperation from admin at top of TMC. (6S)
- Food worse (no coffee or water for staff) unless doctor has special

relationship with Administration; in that case they even bring breakfast to the consultant. There is “discrimination”. (40S)

- Leadership is with medical staff. Good relationship. Decisions making is not sharp. Good socially with doctors. (50S)
- Administration is OK. Director and chief very polite. They listen, they are trying but no results. Need to be more strict, too many absences, its habit. Disturbs the routine and are obvious.
Administration is very nice. They try to solve problem and address complaints. (6S)
- Pharmacist tough in communication. (2S)
- Respondent hopes SOH (Ministry of Health) comes to hospital to check availability: hygiene, availability of treatment, courses for doctor, communication and behavior of medical staff with patients. (12S)
- Leadership has lack of coordination. (25S)

Several respondents commented that relationships are better in private health care than public. Respondents mentioned behavior and communication over skill, procedures, investigations, and medical outcome. However, the respondents were split on if this was a positive aspect. In some cases, the patients considered the positive relationship as being expected because of the financial motivation of private clinics. These respondents tended to express that the skill and resources were lacking and medical outcome was more important than staff behavior. Other respondents implied that behavior and relationships

of staff in public institutions should be like private health care facilities.

- Advantage of private: relationship, answer questions, care. (14S)
- Advantage of private: relationship, medical care. (45S)
- A disadvantage of public health care is the relationship between Doctor and patient. (41S)
- Advantage of private is more care to patient (behavior). (49S)
- People knowledge for doctors and nurses. (training needed) (35S)
- Communication with patients needs improvement. (2S)

Security has a very visible role at Tripoli Medical Center. Visitors may only enter the hospital during open visiting hours which is limited to a few hours each afternoon. Parents, especially fathers, have difficulty visiting their children or bringing personal items to the mother. This was also observed by this researcher.

- Security talks roughly, difficult to get in. (44S)
- OK, when husband came to visit with paper difficult to enter; at visiting time OK. (42S)
- Defect in security (just shout). Defect in nurse. Should be better relation with staff and patients. "Patient is not here by choice." (49S)

Capacity/Availability.

Patients and staff often replied that *facilities* were inadequate. Facilities included buildings, equipment, medicine, procedures, and lab reagents. Additionally, the availability of beds, medical staff, and clinics were often cited as challenges. The codes

facilities-capacity, human resources, system-capacity, and TMC-capacity were aggregated into the theme capacity/availability. Respondents often compared capacity and availability when comparing the public health care system to the private health care system. Additionally, patients and staff compared Tripoli Medical Center (TMC) and its capacity to other hospitals and clinics in the Libyan public health care system. The following are typical responses made regarding capacity and availability of resources when comparing the public centers, hospitals and clinics system to private hospitals and clinics.

- Public-overcrowding, can not bring everything, not like private. (38S)
- DISADV of public: number of beds, waiting, Casualty only 2 doctors (esp. General Hospital). (46S)
- Public: less crowding to meet with doctors. (26S)
- Public: DISADV: number of doctors and nursing staff, number of beds. (17S)
- Available 24 hours, all the time. (26S)
- DISADV: availability of beds in all public hospitals, height of toilet. (16S)
- Private: more time and availability. (3S)
- DISADV: other public hospitals. Defect in equipment. No empty bed. (29S)
- Private: advantage is availability of doctors when needed. (49S)

- Public: advantage is more doctor staff, consultants and specialist. (45S)
- Public: DISADV: more time waiting for follow-ups from doctors. (26S)
- Public: ADV: a lot of people to serve. (20S)
- Private: Small # of patients/no overcrowding. (8S)
- Has went to private clinics and they were perfect. Baby gets more care, doctor available at all time, receive investigation early, Doctor has more availability in private (comes when called. (42S)
- Private: ADV: help many patients, more availability for overflow from public. (18S)
- Private: Advantage: not so crowded. (6S)
- Private: Advantage: more caring from nurses (and even doctors). More resources, someone always besides patient. (20S)
- Public: DISADV: overcrowding. (49S)
- Public: DISADV: more crowding, more time waiting for follow-ups from doctors. (26S)
- Public: DISADV: overcrowding, come from all cities in Libya. (8S)
- Referred from private clinic, no empty bed in private clinic. (28S)
- Public: early diagnosis, more doctor staff. (15S)
- Only 20 to 40 beds in private hospitals; they decrease load for public hospital, rich people use and alleviate strain on public system. (47S)

Even though patients and staff overwhelmingly cited the capacity of the Libyan public health care system as a disadvantage, Tripoli Medical Center was viewed as a hospital that has more capacity than other public hospitals. Tripoli Medical Center was built as a tertiary level care medical center. Yet, it accepts the overflow from the other public hospitals. When patients were asked why they came to TMC, typical responses were because there were no empty beds at the General Hospital.

- Came to TMC because empty bed available. (35S)
- General hospital has facilities-they send patient to TMC without checking if room in TMC. Hospital to hospital. Don't call ahead. (8S)
- Much better if distribute doctors outside TMC. (9S)
- Referred from General Hospital in Tripoli because no empty beds. (48S)
- Primary care: Doctors OK, availability of doctors and medicine lacking. (46S)
- Referred from overcrowded hospital. (4S)
- Referred from General Hospital, no empty bed. (46S)
- Beds not adequate, more numbers of patients, many patients coming from other hospitals (referral hospitals). Too many patients. (5S)
- Transferred from General Hospital because no empty beds. (11S)
- TMC serves everything-first level through tertiary. Overcrowding makes services limited and quality not so good. (47S)
- No empty bed at general Hospital. (45S)

- Referred from public hospital because no beds. (31S)
- Tajura hospital was small and had no empty beds. (41S)
- General Hospital usually does not have empty bed. (40S)
- Referred from other hospital because of capacity problem. (4S)

The responses of availability of staff at TMC were mixed. Patients were often satisfied with the availability of staff and procedures. The professional medical staff tended to feel overworked due to the number of patients. This contention is supported by the typical statements that follow:

- Public (TMC): DISADV: overcrowded, no special way to select patients. (47S)
- Need more care, increase procedure, increase beds in wards and ICU especially. Only 6 beds in ICU, need at least 10. Increase number of nursing staff, especially in ward. Respiratory and cardio patients are together need more nurses. (17S)
- Problem in number of doctors, number of Sisters (nurses), amount of work too much. (18S)
- Availability of doctors in Casualty and Ward good. (40S)
- Need Casualty in ward (nurse and equipment). (22S)
- In general hospital have big staff admission day. (8S)
- Maybe do not have Specialists in all departments. (24S)
- Nurses must go to lab and do canula. (38S)
- Admission day, sometimes admit 10 patients, 3 or 4 patients in a room,

not a separate room for special cases. (8S)

- Only one pharmacist for ward. (22S)
- Sometimes OK but when busy or at lunch, not available. (nursing) (16S)
- Available but no benefit from availability of nurse. (14S)
- Staff available, more than enough. (31S)
- Doctors try to be nice. Sometimes lose patience when lots of admissions. (25S)
- Sometimes only 2 nurses on duty. So can not have patience. Nurses only have time to dispense medication. Lots of patience. Only have time for basic needs. (25S)
- Staff is generally available. Sometimes nurses are scarce. Some doctors work without a nurse. (8S)
- Available 24 hours, all the time. (26S)
- At the time of the interview there are 960 inpatients at TMC, overcrowded today. (13S)
- 7 to 8 nurses every day in department. Some are absent. Some difficulty. Ped. Resp/cardio. 2 Sisters at night/adequate. (23S)
- Nurses very good, overcrowded ward, only one nurse, can not respond to all orders. Sometimes seek her out many times. After 2PM only one nurse, in morning OK. They must go to lab and do canula. (38S)
- Availability of nurses and doctors OK, day or night. (45S)

- Heavy duty in pediatrics. Ten duties per month in Unit D is a lot (ward, admission duties). Nursery needs more doctors. They work emergency. Sometimes in 1 subgroup only 3 but should be more. (25S)
- Available all the time. Excellent, perfect. (nursing) (32S)
- Need more nurses. (7S)
- Need to increase # of doctors. (8S)
- Not enough doctors to cover ward. (22S)
- Staff available in any emergency. (2S)
- Nurse just wants to sleep at night. Doctors OK. (49S)
- Available morning or night. (46S)
- Availability in dept OK, need more doctors in Casualty. (15S)
- Doctor available at night, nurses available 24 hours. (41S)
- TMC: sometime overcrowding. ICU patients put with other patients. (8S)
- Staff enough, distribution wrong (e.g., need lots of nurses in oncology). (6S)
- Everyday doctors here, afternoon here, evening here. (9S)
- Nurses. Winter time on the ward, 50 patients and only two nurses. Other times two are sufficient. (19S)
- Care of doctors (2X/day). (34S)

- 24 hours staff availability. (32S)
- As needed, staff availability (11S).
- More times available, sometimes not (availability of staff) (39S).
- Always shortage of staff. Fixed number by contract, does not consider vacation. Eighty percent are female and they have higher lost time. Accept doctors with out contract to cover gap. (50S)
- Overworked, at TMC there is a sea of cars. TMC is a hospital for the whole country and all levels. (47S)
- When need Sisters they come. (9S)
- Now doctors give more hours. They attend all patients. (7S)
- Staff always available, wife said good. (27S)
- Staff available. (21S)
- Incubators ready, came by ambulance. (36S)
- Know all things, is satisfied but has too many orders. (38S)
- No contact with family clinic in region. Come directly to TMC, availability of medicine, skills of doctor of staff, availability of doctor staff (24 hours). Would come directly to TMC regardless of time of day. (15S)
- Not clean bathroom, some patients are dirty. Only 2 bathrooms for ward. (34S)
- Follow-up with patient. 9AM - 11AM rounds, Admission Day- difficult, many patients, only 2 doctors (1 GP and 1 Attachment).

(18S)

- Satisfied with number of staff, no defect. (3S)
- Doctor available, take round at midnight also, nurse-depends on nurse.

(34S)

- 50 patients with 2 nurses affects level of caring. No time to observe, sit with patients, mothers not sufficient, barely enough time to take vitals, give IV. (6S)

- People complain about Casualty. Not enough numbers. Mixing of HIV with non-HIV patients. No enough rooms. In observation room patients are mixed.(social problem too, patients are afraid). (50S)

- Sometime shortage of nursing staff. “to tell the truth” Sometimes patients getting inadequate care. Sometimes shortage of nursing staff. (5S)

- Enough availability of administrative. Supervisors of nurses and doctors complain about availability of nurses and doctors respectively. (2S)

- If more doctor and nurses they could have patience. (25S)

- Staff satisfaction is sometimes good/some times not good when crowded. Doctors and nurses are overloaded. (39S)

- Heavy duty, not enough doctors, large number of patients. (18S)

- Need to increase number of doctors. (18S)

- Doctors and nurses are available. (35S)

- Need more doctors when asked for in pediatrics, not enough, only 2 doctors, with 1 intern. (8S)
- Came at 4AM and doctor available. Diagnose early. Took chest x-ray at 4AM. (41S)
- After 2:00 doctor not found. Some doctors on duty not found. If case critical, doctor called. (28S)
- Same problem with availability as nurses. Take time, one doctor with many patients (20 patients). One doctor after 2 PM, heavy workload, overloaded. OK in daytime. (38S)
- Staff available, AlHamduAllah. (43S)
- Staff available, especially in ICU. (48S)
- Doctors available anytime. By phone also available. Nurses available morning and night. nurses contact doctor when needed. (42S)
- Availability of staff is the same in day and night. Must ask for night because no rounds. (10S)
- Need to increase medical staff at TMC. (25S)
- Not enough staff (Doctors and nurses). In pediatric not enough. (20S)
- Staff availability is the main issue. (25S)
- Patients can not get the doctors they want at TMC. (24S)
- Doctor stayed more than an hour with patient late at night. (16S)
- If doctors with no contract leave, pediatric will stop. They come to learn. (50S)

- Need helpers, but not available. (24S)
- Respondent has seen 2 patients in one bed; this is against medical ethics. (47S)
- When managers help staff OK. When she needs vacation, holiday, or training not available because not enough numbers. (39S)
- Very crowded at TMC because people come from all over Libya. Need to increase beds at TMC. (32S)
- Large quantity if patients come to TMC. Can not provide everything. (18S)
- Pediatric: 50 patients (huge number), long day, only 2 nurses, large volume of medicine and IV. Barely can cover work. Sometimes work not done 100%. Distribution of nurses in hospital is not good (e.g., pediatric during winter). (6S)
- Spending more money would result in more doctors and sisters. (18S)
- Incubators available at TMC. (37S)
- Availability good of staff good at TMC. (33S)
- Availability no problem at TMC because big Center. Not enough doctors and medical staff at other hospitals. (22S)
- Need more doctors in Casualty, need more observation rooms, lots of patients. (15S)
- Availability of staff not good. For 36 patients, 1 or 2 nurses. Sometimes 1 nurse on night duty. For pharmacist also, there should be

more. 1 pharmacist for 7 pediatric departments. Can not go to conferences. (24S)

- Generally, we are whiners, always something to complain about lack of staff (nurses and doctors), lack of facilities (supplies, lab). (25S)
- Not enough patient parking for Casualty. (50S)
- Distribution of qualified nurses varies department by department. (6S)
- Laboratory is far, in first building. Creepy going to lab at night with only 2 nurses, 1 is going back and forth. (6S)
- Patient believes that a single room will help the recovery of her child. (12S)
- No parking at TMC (problem for staff). (50S)

The distribution of resources throughout the Libyan system was noted by several respondents. The distribution was mentioned from the point of views of geography, level (i.e., primary, secondary, or tertiary), and sector (private vs. public). Many respondents did not explicitly address the allocation of resources throughout the Libyan health care system; however, Chapter 5 will discuss in more detail the impact of the respondent's perception of Libya's distribution of resources throughout the health care system. The following comments were offered by study participants.

- Libya gave more salary. Now consultants in public hospital. Before difficult to find consultants in public, they were in private. (20S)
- Work is same level and some work is heavier for others-distribution, management of departments. (24S)

- Happy about system. Doctor and medicine available. (34S)
- Doctors available in polyclinic. (41S)
- Not enough doctors and medical staff at other hospitals. (22S)
- Need more courses outside the country, Europe and U.S. to update skills (nurses and doctors), new doctors should be sent outside the country for training, to increase income of doctors and nursing staff, health care is the most important thing, Libya is better than Tunisia, will increase confidence if medical staff gets training outside. (16S)
- Not satisfied, need more facilities throughout country. (17S)

Communication.

Communication closely overlaps with the theme of *behavior/relationship* previously discussed. Similar to *behavior/relationship*, patients were generally satisfied with communication and most communication came from doctors. Patients viewed their information about the medicine they were prescribed as adequate; however, they rarely were informed of side-effects. Furthermore, communication among doctors, nurses, and administrators was seen as lacking among the staff members. Typical comments on communication between staff and patients were as follows.

- Patient receives info on preventive care, no dust, temperature (cold), stay away from other sick babies, especially post hygiene, site of incision and before feeding. (43S)
- Not informed, just how to give, mother gives medicine. (27S)
- Very nice, nurses informed Mom step-by-step. (29S)

- Very good, but maybe because Mom is a doctor, maybe that is why. First day Mom very worried and nagged doctors, child is very young. With other patients also good. (38S)
- All good, staff informed patient of side effects, told how to use. (10S)
- Some information delayed. If bad news is not well informed, delayed receiving information from doctors. (14S)
- Nice communication, nurses attentive, very nice, skills very nice. (31S)
- Nurses help very much, very friendly. Very nice, they love sister (patient) very much. Very excellent. (32S)
- Some time simple answer, other times medical terms (especially when doctors talk among themselves in English). (49S)
- All information, informed, do not told about follow-up after discharge. (9S)
- Doctor communication with patient is good. (37S)
- Patient talked to doctors. Consent for surgery done in home town. (37S)
- Satisfied with doctors' communication, diagnosed early, result of investigation, understood explanation. (15S)
- Relationship with doctor is good. (14S)
- 50% understanding, daughter does not know, father explained to patient. (35S)

- Patient not well informed. (11S)
- Medicine side-effects not informed, informed about operation, considered simple. (26S)
- Receive medication on time, nurses answered questions. (42S)
- Patient informed about investigation, examination, and treatment. (29S)
- Simple understanding from doctor's explanation. (11S)
- Informed of investigations. (35S)
- No problem, nurses cooperative. (4S)
- Did not know what day to come. Surgery had been done already. (37S)
- Transferred by paper but received all information. (16S)
- Recommend smiling and good communication. (2S)
- Not informed on side-effects of medicine. (12S)
- Received all investigation, knew diagnosis before she arrived. Came to TMC for follow-up. (4S)
- Informed about investigation but will be informed about more. (31S)
- No problem in communication from nurses with patient, contact freely. (45S)
- Informed about medicine but not informed about side-effects. (34S)
- Nurses answered questions, respond to requests, check canula. (41S)

- From first visit Mom knows diagnosis, everything clear. Doctors are the best one. Received good and bad information. Clear communication with doctor. (42S)
- Wife does not ask lots if question so husband asks. (14S)
- Communication not good between nurses and doctors (lazy nurses). (22S)
- Not informed about anything. Cover for bed not there, had to call Sister repeatedly. (28S)
- Patient understood doctors 100%.
- Patient satisfied with doctors. Kept informed. (49S)
- Not complete communication about disease from SOH, limited. From public health informed. Some other patients have HIV, hear from other people. (35S)
- Not informed about side effects but informed about drug. (35S)
- Informed. Patient asks questions and doctors answer. (34S)
- Training needed: communication skills. (35S)
- Doctor communication very well, explanation clear, explanation understood, answer clear not vague. (31S)
- Satisfied with communication from staff and well informed.
- Not informed about preventive care. (11S)
- Well informed at TMC. (3S)
- Usually answered by doctor, sometimes does not, answer sometimes

just give reassurance, most time satisfied. (12S)

- Nurses answer. (37S)
- Simple communication from doctors. (37S)
- Very nice response from nurses (3S)
- Patient informed about examination and investigation. (12S)
- Informed of medicine, antibiotics, not informed of side-effects (after probing during the interview). (31S)
- Satisfied so far with nurses in both department and ward. (45S)
- Informed about medicine. Take medicine from TMC pharmacy. Pharmacist instructs patient on how to use medicine. (34S)
- Interaction with nurses is good. (35S)
- Patient understands, informed of all investigations and procedures. (27S)
- Doctors listen to patient and mother, good communication and discussion with doctor. (12S)
- Communication from doctors is 100%. (36S)
- Informed about investigations. (11S)
- Patient received all information on tests and investigations. (49S)
- Doctors in ward communicated. (43S)
- Yes received instructions on homecare, keep milk and natural, ORS. (4S)

- When baby was in ICU would call nurse by telephone. (36S)
- Doctors are easy to understand. (10S)
- Doctors give simple answer. (10S)
- Early diagnosis, doctors tried to simplify medical terms, some difficult, after that OK. (48S)
- Receives info on preventive care, no dust, temperature (cold), stay away from other sick babies. Esp. post hygiene, site of incision and before feeding. (42S)
- Very nice communication from doctors. (3S)
- Need communication of patients with doctors and communication of nurses and doctors with patients. (22S)
- Information good from staff. (10S)
- Informed about all medicine. Antibiotics for meningitis. Not informed about side-effects. (36S)
- Received all information but kidney function. Will be discharged today. (21S)
- Doctor communication is nice. (35S)
- Investigations not informed but examination informed. (26S)
- Adequate information received upon admission. (4S)
- She understood information. The specialist informed her that kidney function is high. Does not know what this means. Seems to be vague. Specialization saying OK but kidney function... needs more

information. (21S)

- Missing some information not clear. Using medical terms, so missing information. (14S)
- Informed by doctors on questions. (37S)
- Being discharged today. Must come to outpatient next Saturday. No information given on home care. (37S)
- Antibiotics, does not know benefit of dose. (14S)
- Good . Mother satisfied with doctors (esp. doctors on surgical ward). No difference between ward and ICU. (42S)
- Not informed of medicine side-effects. (29S)
- Nurses-not good; they talk badly to her. (11S)
- Nothing on home care, father asks. (35S)
- Very good communication from doctors. (29S)
- Have not received all investigation, tried to follow-up with specialist epileptic inpatient with wait time of receiving info for TMC doctor. (45S)
- Nurses should be taught how to deal nicely with patients. Nurses: more education on what to say but availability affects this. (25S)
- Hospital (TMC) took phone number of father, when patient was transferred to ward TMC called and told to bring mother. (29S)
- Informed about homecare. (11S)
- Not informed about medicine. (28S)

- Not informed of investigation on the same day, but informed. Did not have to ask. (10S)
- Mom understands doctors' explanation. (43S)
- Interaction with nurses is good. (10S)
- Very, very good interaction with doctors, doctor answered every question, transferred patient to other department for tests with doctor instead nurse, gave update if investigation is early and possible. (16S)
- Told she will be informed at discharge about homecare. (3S)
- Every question answered by nurses. (46S)
- Doctors highly educated, communication nice. (6S)
- Husband came with patient in ambulance. Received information when at other hospital. (29S)
- Social services needed, need communication with people. (35S)
- If I do not understand, I ask and doctors explain. (29S)
- Simple explanation from doctors. (36S)
- Patient informed about investigation. All investigation put in file and she reads file. (34S)
- Informed of new results. (3S)
- Satisfied with responses from nurses. (12S)
- Informed of medicine but not side effects. (15S)
- Very nice explanation from nurses, explain if vague. (29S)

- Informed about procedures and operation. Operation very simple.
(27S)
- Not informed but all things available. (27S)
- Understand 90% of what doctors communicate, doctors inform other patients in room. (34S)
- Nurses give treatment on time, good communication. (12S)
- Well informed from doctors. (36S)
- No information at admission. (9S)
- Doctor tried to contact with mother and make explanation simple. Mother understands. (46S)
- Daily updates without asking. Many doctors come without asking just to check. (32S)
- When asked about side effects she is told but if not asked not told. (9S)
- Good communication from doctor and nurse, and patient security.
(10S)
- Received all information of exams, result of image, investigations.
(48S)
- Patient is well informed. (4S)
- Doctors communication is very good, informed patient. (32S)
- Some nurses difficult to communicate, some lazy. (8S)
- First week some delay in time for medicine, some nurses did not respond to questions but then it got better. (48S)

- Patient asked questions, nurse had to refer questions to doctor. (10S)
- Communication of doctors good on ward. (45S)
- Communication with patients needs improvement. (2S)
- Patient asks doctors not nurses. (26S)
- Comfortable with doctors, doctors have good communication in this department. (10S)
- Communication from doctors is clear. (29S)
- Informed about investigations. (37S)
- Excellent communication from doctors. (40S)
- 100% communication from doctors. (26S)
- Not informed of medicine, only informed about name only (antibiotics). (28S)
- Patient is well informed. (12S)
- Doctors keep patient informed. (4S)
- Patient receives all results (exams, echo). (42S)
- Gave information from beginning. With report. Talked about care at home. (32S)
- Staff needs training in Communication skills. (33S)
- Very good understanding of communication from doctors. (9S)
- Informed upon arrival. (36S)
- Until now communication with doctors OK. (44S)

- Good communication with doctors. (2S)
- Nurse answers questions. (27S)
- Full information received, mother is educated. (26S)
- All questions answered, informed her of diet for when she is discharged. (10S)
- Do not answer about investigation. Does not give information or test results, just says OK. (14S)
- Respondent greets patient, ask about night, keeps ward clean. Needs better contact between patient and staff. (23S)
- Patient talks to doctors not nurse because nurse not good. (34S)
- Security talks roughly, difficult to get in. (44S)
- Mother understands diagnosis. (41S)
- Nice communication with Doctor. Dr gives inadequate info initially. (21S)

The Secretariat of Health (SOH) and other leadership were seen as being competent in communicating information on infectious diseases and the importance of vaccinations. Yet, respondents felt that they should be doing more in other areas of health care.

- SOH is good, have vaccination. Have education on immunizations on TV, in school, when discharged from the hospital, and in newspaper. (36S)
- Hope SOH to come to hospital to check availability: hygiene,

availability of treatment, courses for doctor, communication and behavior of medical staff with patients. (12S)

- 2002 - WHO has office in Tripoli. They supply TMC with infectious disease information. New research available from WHO. (13S)
- Ministry of Health gives education by TV (epidemic diseases), some they do not talk about disease (HIV). (35S)

Respondents perceive that communication among staff and other governing bodies of the system need improvement. The responses indicate that communication among intradisciplinary teams was better than communication among interdisciplinary units.

- General hospital has facilities-they send patient to TMC without checking if room in TMC. Hospital to hospital. They don't call ahead. (8S)
- The system priority should be communication. (30S)
- 80% of diseases covered in pediatric dept., should consult with doctors to compliment in other hospitals. (50S)
- Between doctors and nurses communication is bad. Give advice to nurses but the next day find nothing is done. Do not know how to improve. (20S)
- Communication among nurses, doctors, and administrators is not so strong, too many of staff does not; too many of staff does not love their job. Afraid from leadership, need salary. Communication not

that good. (24S)

- Pharmacist tough in communication. (2S)
- Doctor to doctor communication good. (8S)
- There was contact between two hospitals. (29S)
- Communication among staff OK in general. (25S)
- Need more research, send doctors outside Libya, how to communicate with patients-more than skills, skills are OK. (45S)
- Need to communicate with other hospitals: Germany, U.S. share best practices and expertise. (13S)
- Communication not that good among staff. (24S)
- Nurse reported good cooperation from doctors and colleagues. (5S)
- No meetings between nurses and supervisor of nurses about unit. Nurse-consultant no connection. Communication not good. No connection between GP and consultant. It is the job of admin to fix. (33S)
- Bad communication in respondent's department. (30S)
- Flexible, Administrators listen, good cooperation from admin at top of TMC. (6S)

Several staff respondents recognized the importance of good communication skills for the overall well-being of the patient. Improved communication can lead to more cohesive relationships between caregivers and patients.

- Patients respond to communication from staff. (23S)

Communication in private is better because they have to pay everything. (23S)

- With good communication can work OK. Have good communication among staff. (23S)
- Patients like pleasant interaction. Not all happy, if good communication they are happy. Good psychological support will help patient get better. Good psychological support will help patient get better. Depends on how relationship is with patient. (23S)
- Doctor should make discussion with patient. (12S)
- There needs to be good communication skill with patient. Spend time with patients, make things clear. (50S)

Culture.

The Libyan people are relatively homogeneous culturally. The majority of the respondents were Libyan, and all Libyan respondents were Muslim. The cultural implications of providing health care at a Libyan public hospital were subtle. Nevertheless, since this study was limited to the pediatric department of Tripoli Medical Center, some aspects of culture became immediately evident that may not have otherwise been apparent. As an example, most respondents were mothers of the pediatric patients. More fathers were available for outpatient pediatric patients, but outpatient interviews were limited to the pilot study. Mothers are admitted with pediatric patients that are not in ICU or the neonatal wards.

- Father stays with a friend when daughter is admitted. (27S)

- Father in hotel; daughter in hospital. (35S)

Patients often used Islamic phrases in Arabic to describe satisfaction.

AlHamduAllah (praises are due to God) and MashaAllah (as God has willed) indicate positive satisfaction. Additionally, several responses from staff highlight importance of faith and accountability among the Muslim and Arab people.

- Every human being knows themselves. (33S)
- Everyone tries to do the best. (25S)
- Everyone and their belief. (33S)
- Gift from God (working for TMC). (13S)
- As Arabs, we have the sensation of “caring”. No problem in level of caring from staff. (24S)
- Some staff like going to other Arabic countries to work (instead of western countries) for their families. (24S)

Women and men have professional roles at Tripoli Medical Center. Men dominate senior level administrative and physician positions. Yet, female doctors noted that a spouse that is also a doctor would be more understanding of their long and unconventional working hours. Even though there is a significant number of female medical staff, female nurses and doctors must juggle their careers with their family obligations.

- For married women, problem working at night. (6S)
- Works at TMC because near where she lives. (22S)
- Chose TMC as employer because geographical, close to home. (25S)

- Some days nurse (respondent) is attached to night. From family difficult, only girl in the family, first time a problem but now they are used to it. (39S)

A more direct concern potentially impacting the quality of medical care is the perceived risk of HIV infection from casual contact. The lack of information could create carelessness leading to infection as well as prevent infected patients from getting the compassionate care.

- People complain about the Casualty department. Not enough numbers. Mixing of HIV with nonHIV patients. No enough rooms. In observation room patients are mixed (social problem too, patients are afraid). (50S)
 - Not complete communication about disease from doctors, limited. From public health informed. Some other patients have HIV, hear from other people. (35S)
 - Patient had suppression disease. Some nurses refuse to touch patient but should. (35S)

Leadership.

The respondents viewed leadership as coming from senior level doctors (Consultants), hospital administrators at department levels, senior hospital administrators, the Libyan Board, and the Libyan Secretariat of Health (SOH). Comments specifically made regarding the SOH follow. The comments do not lend themselves to concluding a particular leadership style as this was not the specific area of inquiry for this study. However, the respondents' comments do indicate that they perceive the SOH as being

distant from the concerns of the population it serves. Yet, they were acknowledged for several public health campaigns. Generally and not surprisingly, the respondents link the competence and level caring to their satisfaction with the health care system. The responses indicate an expectation that accountability for the quality of the system rests with top leadership; in this context it is the SOH.

- SOH know all problems but do nothing. (48S)
- SOH: do not care. Polyclinic empty, no doctors, no medicine. (40S)
- SOH does not have a good understanding. (20S)
- Public health care is under the control of the government (Ministry of Health). Can arrange if good administration. To make TMC a specialty hospital. (47S)
- Level of understanding of SOH is bad, this is the problem. (19S)
- SOH understand the problem but does not provide solutions. (33S)
- Decisions are not good by SOH. Many are surgeons so they do not focus on primary health care. (50S)
- Some things SOH understands. Some things they do not. (43S)
- If big problem, SOH responds. If no problem, no response. (8S)
- SOH understands but not serious. They need to go deeper. (7S)
- SOH has good understanding. (10S)
- SOH: they understand and are helpful. (31S)
- Even if SOH is trying, there is no change. (25S)
- SOH only think about tertiary care. (50S)

- Respondent hears SOH will improve things, they promise but nothing done. (2S)
- SOH does not understand problems. (11S)
- SOH knows but do not care. (17S)
- SOH gives education by TV (e.g., epidemic diseases,), they do not talk about disease (HIV). (35S)
- SOH delays in solving problem, not very responsive. (18S)
- SOH opened another ICU. (8S)
- SOH: they do not do their best. They have lots to do. They know the problems. (12S)
- SOH understanding is better than before, all departments available. (42S)
- Responding to SOH understanding: no special people for health care group in area. (i.e., not local). (44S)
- SOH need to spend more care outside Tripoli; should not concentrate only on hospitals inside Tripoli. (46S)
- SOH knows problem but ignore. (30S)
- SOH has no understanding of problems. (22S)
- SOH knows problems, they have ideas to go to ideal level, improve quality. (7S)
- Health committee should send doctors and nurses outside for more training. (21S)

- Not complete communication about disease, limited. From public health informed. Some other patients have HIV, hear from other people. (35S)
- SOH is good, have vaccination. Have education on immunizations on TV, in school, when discharged from the hospital, and in newspaper. (36S)
- Yes, SOH understands. They have skin disease in area and people were educated, government provided insecticide. (26S)
- Libya mafia behind people in Ministry of health; they tell him what to do. Decisions are not good. Many are surgeons so they do not focus on primary health care. They do not spend enough; 25% of what is spent goes in pocket (buy cars, spend money outside) even less spent on the people. Do not spend money on primary health care and polyclinics. (50S)
- SOH: do not understand, do not know. (37S)
- SOH has no understanding. (49S)
- SOH: they do not understand, only collect money, car, do not worry about care. (14S)
- They (SOH) know everything but ignore. (21S)
- Hope SOH to come to hospital to check availability: hygiene, availability of treatment, courses for doctor, communication and behavior of medical staff with patients. (12S)

- Health Secretary monitors all health systems. (33S)
- Libya is ready for a change in its health care system, especially now with normalized relations. Hopefully, the ministry for health accepts new ideas and studies and recommendations by team (e.g., idea of insurance). (47S)
- SOH understands but do not care. (16S)
- Obstacle is by the government. Need the right man at top. Lack the skills or it will be better. (24S)
- SOH understands well. (6S)
- Level of understanding of SOH: Before 5 years ago there were some programs, visit home, see social and hygiene of home, do not do anymore. (39S)
- Level of understanding of SOH: everything perfect. (4S)
- SOH understands, better than before. (15S)
- SOH understands problems. They are Libyan they live here. Maybe their best, maybe not. (24S)
- SOH does not understand. They go outside for their own care. They do not need to; they do not care. (38S)
- SOH will help if there are problems. (23S)
- Like a shop, overcrowded, most drugs available but too many people. No continuous supply of drugs. No door to make a new drug available; late getting new drugs, working off the same list. List stays

with Administration of Health for 5 years with no change. (47S)

- Health committee should send doctors and nurses outside for more training. (21S)

The researcher asked study participants to describe the leadership style of TMC management. Respondents did not identify a particular leadership style. Their comments were primarily based on outcomes. These comments, in addition to the comments made on the SOH, tend to indicate a leadership style more on the end of the attribute theory (e.g., personality and trait approaches) of the leadership style pendulum than the motivational theory (e.g., transformational and team approaches) end.

- TMC administration should do better. (48S)
- Management of hospital is a problem. (11S)
- Flexible, they listen, good cooperation from admin at top of TMC. (6S)
- Administration skills need improvement. (7S)
- Not good management and administration. (35S)
- Lack of coordination especially between doctors and admin lots of disadvantages. (25S)
- Administration needs to be tougher with “trouble makers”. They have rules but some not followed. (6S)
- Administration nice but criteria for selecting patients to go outside not fair. Most critical not sent. (19S)
- Administration needs to help. (47S)

- Administration not so good, based on outcome, if good, the level of all would be good. (24S)
- Work is same level and some work is heavier for others-distribution. management of departments. (24S)
- Difficult relationship between doctors and administration, should try to improve relationship with doctors; facilities (esp. doctors). (18S)
- Consultants must be a guide. Someone must oversee consultants. (50S)
- If good judgment in how to spend money things would improve. (2S)
- Administration is not bad, big hospital, admin need facilities: admin in building #1 only, need supervision in each building (admin group). To solve problems should have admin in each of the 3 TMC buildings. General Administration is centralized. (47S)
- Performance measurement: Depends on relationship with you and leadership of department. Not structured. (24S)
- Administration should be more strict with Libyan staff. (6S)
- Public health care is under the control of the government (Ministry of Health). Can arrange if good administration. To make TMC a specialty hospital. (47S)
- Respondent, a TMC support staff member, does not use decision-skills, uses opinion. (30S)

- Courses taken by administration, go outside Libya for nothing. More admin go outside country for training than medical staff. (50S)
- If administration know ideal, all will follow, we do not know how to follow. (7S)
- Managers need improvement. (33S)
- Management at TMC: fixed time like respondent, here in morning, off at 3:00 PM, off on Friday. (17S)
- Not all satisfied with management. (19S)
- Leaders are not in their places so they do not see. Absent by mind (but not by body). Do not live the problem. Just tell staff that they have to work. They do not care if problem is solved. If you suffer as staff or patient, no one hears complaint. (24S)
- Leadership attends conferences. (33S)
- Sometimes someone from leadership comes and has a check if there is a complaint. (1S)
- Need to change person at top of administration. (1S)
- Biggest obstacle to improved health care is from Admin. (19S)
- Some consultants only show-up occasionally, do not come regularly but come to take attendance of others, but they do not punish themselves. Consultants not watched. (50S)
- Need “right man in the right place at the right time”. (25S)
- Leadership has no care. Afraid from their position only. Take money

inside pocket. Take commission from companies (e.g., pharmaceutical). Courses taken by administration, go outside Libya for nothing. More admin go outside country for training than medical staff. (50S)

- Main problem is Administration. “Right man not in right place”. (30S)
- Some problem related to management. Place scrub nurse in pediatrics wrong skill. (33S)
- Do not expect anything to improve. No response from Admin. (19S)
- Some nice people in administration. (2S)
- Food worse (no coffee or water for staff) unless doctor has special relationship with Administration; in that case they even bring breakfast to the consultant. There is “discrimination”. (50S)
- Respondent thinks of leadership not in a good way. (8S)
- Change behavior for Consultant and Admin. Think first of patient and not themselves and their financial gain. Happy if punish doctors (about absence); why not happy if patient suffers. Need to change leadership (even at department level). Need new brain. Need to do something new. Should be max 8 years in position. Need new brains, so be active (like Obama). (50S)
- Need to change person at top, high person to more qualified, more polite, more educated. (1S)

- Administration is OK. Director and chief very polite. They listen, they are trying but no results. Need to be more strict, too many absences, its habit. Disturbs the routine and are obvious. Administration is very nice. They try to solve problem and address complaints. (6S)
- Leadership not in right place. You do not need physician to run department, need someone with management skills. “Not the right man in the right place”. Not the right skills for a large hospital. (24S)
- Skills of administration is good. (33S)
- When managers help staff OK. When she needs vacation, holiday, or training not available because not enough numbers. (39S)
- Need “right man in the right place at the right time”. (25S)
- TMC has good management. (34S)
- Management/administration needs to concentrate on important things for patients and doctors. Think they do not care to improve quality. (8S)
- Too many of staff do not love their job. Afraid from leadership, need salary. (24S)
- There are no meetings between nurses and supervisor of nurses about unit. Nurse-consultant no connection. Communication not good. No connection between GP and consultant. It is the job of admin to fix. (33S)

- Need new brain. Need to do something new. Should be max 8 years in position. Need new brains, so be active (like Obama). (50S)
- Administrators' skills OK. Not the level needed. They do not triage, priorities (drugs, who to send outside). (50S)
- Administration does not improve state, they need to come and see, only come when recommended patient, too distant. (8S)
- No excellence, no commitment to quality. (1S)
- understands, better than before. (15S)
- Respondent has no relationship with admin. Do not agree with what they are doing. Should look at staff as human beings, not machines. (25S)
- The level of caring of medical staff depends on department, head of department and specialist. (2S)
- Office of admin no benefit, should do him or her job -do not care. (14S)
- Not satisfied with skills of administration because head of department is relative of officer. (17S)
- Sometimes family does not have confidence in management even though they do their best. (19S)
- Admin staff is biggest obstacle. (30S)
- Hospital administrators only come when recommended patient. (8S)

- If there is more money, it should be given to the right man to get more medications and instruments. (39S)
- Each department has administrators; they represent admin (like liaisons). 90% of departments are satisfied. (13S)

Libyan System.

The following codes were aggregated into the theme Libyan System: (a) community-service, (b) referral-abroad, referral-from private, (c) referral-from public hospital, referral-primary care, (d) system, (e) system-capacity, (f) system-community, (g) system-hospitals/clinics, (h) system-leadership (SOH), (i) system-organizational change, (j) system-pharmacies, (k) system-primary care, (l) system-recommendation, (m) system-research, (n) system-staff, (o) Tripoli, and (p) Tunisia. Codes such as system-leadership (SOH) and system-capacity have a more predominate relationship with themes already discussed; therefore some aspects will not be repeated in the discussion here. As already alluded to, patients are often transferred from other facilities to TMC because of capacity. Additionally, comments on the SOH were described in the discussion of leadership. Yet, some responses are repeated because of their importance in understanding the entire system and the Libyan people's confidence in the public health care system.

Many of the responses highlighted the lack of confidence patients have with the Libyan health care system for more critical cases. Patients and staff mentioned the need to see treatment and training, respectively, outside of Libya. In some cases, respondents

acknowledged that the lack of confidence is based on perception and not reality. The following responses illustrate this.

- Wants treatment here in Libya, not Tunis. Some go to Tunisia but come back to Libya. Some specialists in Libya teach doctors in Tunisia. (32S)
- Complicated cases difficult to give good care; that is why patients go outside of the country. (38S)
- TMC communicates with other hospitals: Germany, U.S. share best practices and expertise. Sometimes send patients to Germany or Italy (Oncology). Central Lab has updated equipment from Germany. (13S)
- Criteria for selecting patients to go outside not fair. Most critical not sent. (19S)
- Health committee should send doctors and nurses outside for more training. (21S)
- Need more courses, send doctors outside to get more updates. No difference with doctors in Libya and Tunisia. Get same diagnosis. (43S)
- Tunisian doctors get more opportunity to go outside. (48S)
- Need all people the same (e.g., like Tunisia) so no difference in public and private. (47S)
- Need more public than private, not all people can pay, care without money, Tunisia lots of money but care is less or the same.

Psychological problem with people. They have lack of confidence in Libyan Doctors, emotional problem, try to get better confidence in Libyan doctors. (16S)

- Need increase for medical staff development (technical), continuous education, attend conferences all across the world. Usually only Consultants go to conferences. Need permission to go. (24S)
- In Tunisia patients spend lots of money but care is less or the same. (16S)
- Patients do not accept diagnosis, think food, bed, diagnosis is better outside (Tunisia). Sometimes family does not have confidence in management even though they do their best. (19S)
- Sometimes TMC sends patients to Germany or Italy (Oncology). (13S)
- Libya is ready for a change in its health care system, especially now with normalized relations. Hopefully, the ministry for health accepts new ideas and studies and recommendations by team (e.g., idea of insurance). (47S)
- Patient wants treatment here in Libya, not Tunis. (32S)
- People think doctor staff not good but they are good. Very satisfied with doctor staff and skills. People think Tunisia and Egypt or better but diagnosis is the same as Libya. (41S)
- Investigations not done here send patients to Germany and Paris. Cost is paid by TMC. Many benefits from it. (19S)

- 3 months to do report to get approval to send patients for treatment outside Libya; patients die while waiting. Can take 3 to 4 month to get approval for treatment abroad. (50S)
- People go to Tunisia and they just spend money but there is no improvement. (15S)
- Health care patient's region is according to type of disease. Neurosurgery and orthopedic not available or good. Primary, gyno, pediatrics available. Complicated cases difficult to give good care; that is why patients go outside. Takes time to get referral to go outside, there is a long list. (38S)
- TMC spent 200,000 dinar to send patient to Germany. Patient received injections each month for 890 dinar each, free chemo, free cardiac surgery. (13S)
- Complicated cases difficult to give good care; that is why patients go outside. Takes time to get referral to go outside, there is a long list. (38S)
- No difference between doctors in Libya and those outside in Tunisia or Egypt. She went to both countries and no difference. Just a problem with the way the Libyan people think. (45S)
- Complicated cases difficult to give good care; that is why patients go outside. Takes time to get referral to go outside, there is a long list.(38S)

- The SOH needs to spend more care outside Tripoli; should not concentrate only on hospitals inside Tripoli. (46S)
- Tunisia lots of money but care is less or the same. Psychological problem with people. They have lack of confidence in Libyan Doctors, emotional problem, need better confidence in Libyan doctors. (16S)
- Respondent was expecting worse, she was planning to go to Tunis but not needed because of level of caring at TMC. (3S)
- Criteria for selecting patients to go outside not fair. Most critical not sent. (19S)
- Libya needs more public than private, not all have money to go to private. People go to Tunisia and they just spend money but there is no improvement. (15S)

The Libyan system tends to align with adaptive organizational change models as change in the system is gradual and internally driven. Additionally, the system does not appear to reward innovation and creativity. An evolutionary model to organizational change, political approach, may also represent Libya's health care system; it assumes that organizational groups have divergent interests and that managers use their political influence to navigate informal networks. More research would be required to determine which model best describes the organizational change of Libya's health care system and how best the change should be managed given the political, economic, and social environment.

Many of the respondents acknowledged that the system works best for patients who have a recommendation from an influential friend or family member. People residing in countries that have a high power distance, like countries in Africa and the Middle East, navigate the system better knowing someone who can streamline the complicated system. Unfortunately, this seems to be the perception in Libya's health care system that is built on free access. The following statements illustrate this,

- Recommendation (friends) determines who enters TMC (outside visiting hours). (30S)
- If not referred, frustration (hardness) or at least you know someone. Appointments for ultrasound and other equipment or they say its in-patient. Sometimes have to go outside. Some procedures need to know someone, only if not available outside will it be done at TMC. (24S)
- TMC leadership only come when recommended patient. (8S)
- If you have recommendation its good. Should be equal for all. Recommendation should disappear. (10S)
- Lots of recommendation, if recommended things will go smooth, hospital will not improve until this change. (30S)
- Came to TMC because patient has many friends at TMC. (38S)
- Depends on personal relationship if a private clinic can be opened. (50S)

- If recommended you will achieve target, if not recommended you will get tired and get lots of complications. (2S)
- In Benghazi need more recommendation to be admitted, TMC welcomes you. (27S)

One of the biggest strains on Tripoli Medical Center is the referral of patients from primary and secondary health care facilities. Many patients are either referred or travel great distances due to the lack of primary clinics. If the clinics are available, they lack the resources to serve the patients. Where regions have adequate primary and secondary health care facilities, resources were often inconsistent. There was a variation among regions. The following comments illustrate the variation in accessible health care throughout the country.

- Family clinic simple but good. (36S)
- Good family care in region where patient lives (not because of money). (32S)
- There is a lot of difference between TMC and polyclinic in doctor skill and investigations. (42S)
- Neurosurgery and orthopedic not available or good in local regions. Primary, gyno, pediatrics available. (38S)
- Should be like 1975; spend on primary health care and secondary level care. People live far, they suffer; spend money on hotels and travel. (50S)

- There is no polyclinic in area where patient lives, go 5 minutes in car, its OK, does not have pharmacy. (34S)
- SOH does not spend enough; 25% of what is spent goes in pocket (buy cars, spend money outside) eve less spent on the people. Do not spend money on primary health care and polyclinics.
- Polyclinic-empty, no doctors, sometime doctors only stay one week. (40S)
- Al HamduAllah, uses polyclinic in home region for vaccines. (43S)
- Primary centers need improvement. (8S)
- Primary care in patient's home region: Doctors OK, availability of doctors and medicine lacking. (46S)
- 70% satisfaction in health care where patient lives, not like Tripoli. Limited facilities (they have to buy investigation in private because not available in public.) (29S)
- Good health care in patient's home region, family clinic good, ped. not good. (10S)
- TMC is the city (not rural). Difficult because polyclinics closed. (50S)
- Very crowded at TMC because people come from all over Libya. Need to increase beds at TMC. (32S)
- Respondent not satisfied with health care system, need more facilities throughout country. (17S)
- General Hospital usually does not have empty bed. (40S)

- 70% satisfied with health care in home region. (12S)
- Doctors are available in polyclinic. (41S)
- Patient is satisfied with health care in region you can go to clinic free of charge. Goes to public clinic. Advantage is its co-operative be seen by doctor or nurse, free of charge. (3S)
- Need to return back to old system Primary health care (vaccines for pediatric patients, checks, school health, pre-natal, geriatrics, contraception. Secondary hospitals in cities (chest infections, simple operations, trauma), tertiary (complicated cases and major surgery). Select patient starting from primary level. (47S)
- Training should be emphasized in primary health care , not in big hospital. (20S)
- Casualty cases seen that should be seen in clinic. (8S)
- Tripoli health care is better than Benghazi. (50S)
- Many patients coming from other hospitals (referral hospitals). (5S)
- Polyclinics should be closed, more patients transfer to TMC, polyclinics do not work. (33S)
- Referred from secondary hospital where she lives. (9S)
- TMC serves everything-first level through tertiary. Overcrowding makes services limited and quality not so good. (47S)
- SOH only thinks about tertiary care. (50S)
- Shortage of medicine in polyclinic. (43S)

- Health care in patient's home region is good, has family clinics, they can do some investigations. (11S)
- Health in the region where respondent lives just has defect in medicine and investigation. Doctors available in polyclinic. (41S)
- MashaAllah-not polyclinic, it is being turned into a hotel. The polyclinic now must go to General Hospital, polyclinic was public. Polyclinic was good-vaccinations and medicines were available. Now it is closed and must go to General Hospital. (16S)
- TMC is a hospital for the whole country and all levels. (47S)
- Sanctions affected the system; there was a breakdown in primary health care. (47S)
- Need to select patients and make TMC a tertiary care center. Will have to improve primary care, first line and second line in the country. Small infections should be taken care of in another level. (47S)
- Primary clinic: just a building, transfers patients (see and transfer), no medicine, no diagnosis, no treatment, just one doctor, empty place-drink coffee. (49S)
- No doctors visit home. No family doctors, if baby not well take to doctor, no special clinic. Doctors good, technician and investigation not present, lack of lab, machines not available. (44S)
- Yes patients are satisfied, patients come from all over Libya to TMC. TMC is last stop. (18S)

- Family care- not good, only building. Availability of instruments in family clinic when asked about needles (as patient) said building only. (39S)
- 50% satisfied with health care in the region. Needs lot. (21S)
- Referred from General Hospital. (45S)
- Not clean hospital where she lives. (36S)
- Patient has no contact with polyclinic. Goes to general hospital and private clinic. (45S)
- 100% care in patient's home region. (27S)
- Do not use general hospital properly. (38S)
- There is no health care infrastructure, no primary health care (was excellent from 1975-1985), had good supply of primary care clinics (more than 500). They are empty, no doctors, some nurses, they give vaccine. (50S)
- Health care in patient's home region is OK. One doctor in day and one doctor in night. Treat simple cases only. (48S)
- Decisions by SOH are not good. Many are surgeons so they do not focus on primary health care. (50S)
- TMC OK (80% of problems covered). But outside Tripoli only 20% of problems are covered. (50S)
- Health care in the region that patient lives just defect in medicine and investigation. (41S)

- Quality of health care is good, in hospital, not clinic. (9S)
- Quality of health care is good, in hospital, not clinic. (9S)
- 0% satisfaction with health care in the patient's home region, defect in region, clinic closes at noon. Delivered child 8KM from region in hospital. (14S)
- TMC is better. Center hospital in home town not enough services. Family clinic simple but good. (36S)
- Health care in the region patient lives is not good, has to come to TMC. Some good. (35S)
- Quality of health care is good, in hospital, not clinic. (9S)
- Good treatment given at TMC, better than her region. (10S)

Libyan people overwhelming support a public health system. Free medical care is the expectation of the people. Yet, some acknowledge that the private health care system can supplement the health care system by offloading the strain of the public health care system. The private health care system is seen as offering better services for less critical patients, but it falls short in offering treatments that require highly skilled staff and procedures. Most positive remarks on the private health care system were related to communication, behavior, and aesthetics. Regardless of the support of a public health care system, there was wide criticism of the management of the system, as an example, the overcrowding of the system. The respondents felt that the system could be better in the availability of medicine and services. The following responses represent comments on the private and public sectors of Libyan's health care system.

- People are friendly. Private and public are the same. TMC the same as private. (32S)
- Better than before, all departments available. (42S)
- Social services are needed, communication with people. (35S)
- Doctor from other hospital sent respondent to TMC for financial reasons. (14S)
- If money, give to right man to get more medications and instruments. (39S)
- Has went to private clinics and they were perfect. Baby gets more care, doctor available at all time, receive investigation early, Doctor has more availability in private (comes when called. (42S)
- Patient paid at (private) clinic and referred to TMC immediately. (21S)
- Private system should be expanded but need more equipment. (50S)
- Facility in hospital better than private for serious patients. (8S)
- Emergency should be free but in private must pay. (26S)
- Public system is overcrowding. (49S)
- Should be more public because some families do not have money. (49S)
- Public health care does not have good management and administration
- Hospital is better than clinic. Public is better than private because doctors are better and all facilities are in public. (44S)
- There are problems in private care. (13S)

- Public Advantage: None (21S)
- Optimum structure should be by the government. Need the right man. Lack the skills or it will be better. (24S)
- Need more public because more people do not have money. 100 LYD to visit private. (41S)
- Better to have public (cost). (46S)
- Private- respondent does not know system. More materialistic, they abuse money for cases like oncology then refer to hospitals like TMC. (13S)
- Public has more crowding, more time waiting for follow-ups from doctors. (26S)
- Better if more private clinics and hospitals. There are many now. (7S)
- Public is overcrowded, no special way to select patients. (47S)
- Dislike idea of more private, should pay more attention to public. (29S)
- Public facilities are open 24 hours, more care 24 hours. (26S)
- No good private clinic in Libya. No sophisticated operations done in private. (50S)
- Public is better but does not know why. (37S)
- Took other daughter to private clinic, but no Consultant, room was good. (38S)

- Public health care institutions are 100% on health caring system. Have not dealt with private. No disadvantage from public. Doctors and nurses have no defect. Before Moroccan system was better now both are the same. (31S)
- It depends on income of the family if there should be more private clinics and hospitals. (43S)
- Patient bought one drug from outside. 2 antibiotics from TMC. Nephrolizers from outside but finished. (38S)
- Public health care advantages: free, clean, care. (10S)
- Private Healthcare: DISADV: expense. Has same doctor skills. (41S)
- Patient transferred from a private hospital. (14S)
- Everything is available in public. (12S)
- Private has only 20 to 40 beds, they decrease load for public hospital, rich people use and alleviate strain on public system. (47S)
- Just a problem in public hospital (MRI, CT takes too long (investigations). (43S)
- Public DISADV: other public hospitals. Defect in equipment. No empty bed. (29S)
- Good health care in region patient lives in: Central hospital (public), polyclinic (public, and private clinic.
- Public pharmacies only in hospital. (34S)
- In general hospital have big staff admission day. (8S)

- In public-overcrowding, can not bring everything, not like private.
(38S)
- Prefers health insurance (given as choice). (30S)
- Libya does not need more private clinics. (40S)
- Need more public. (44S)
- Patient thinks there could be private department in public hospital with reasonable cost. (3S)
- Public has overcrowding. (38S)
- Referred from private clinic in Tripoli. Oncology patient. (32S)
- There is a hospital in area of residency but more specialists in Tripoli.
(48S)
- Patient referred from private clinic, no empty bed in private clinic.
(28S)
- In public there is more time waiting for follow-ups from doctors. (26S)
- Things would improve if there was more money spent on health care ,
more investigations. (33S)
- Patient is more satisfied with TMC than private. (38S)
- Public disadvantages: need more care, relationship between Doctor
and patient. (41S)
- Public is very good. (13S)
- Private has less crowding to meet with doctors. (26S)

- Patient referred from private. (3S)
- Private clinics take money then transfer patient to public. (33S)
- Patient referred from public hospital where she lives for special care. Spent 7 days at hospital in region. (29S)
- Private: not good, not good facilities, not good doctor staff, transfer complicated cases, no consultant. Consultants now have contract in public. Private only has GP and seniors only. In other countries private is better but not Libya. Private is new concept in Libya. Only 5 years or so private in Libya. (38S)
- Need more public not private. (45S)
- Patient transferred from general hospital. (16S)
- TMC is best hospital in Tripoli. (34S)
- Doctors not prepared well, relative of patient that works at TMC helps. (14S)
- Public health care has no disadvantages, advantage does not know. (40S)
- Public health care has more advantages than disadvantages. (36S)
- Libyan health care system (public) is good, equipment is available. (4S)
- Advantage of public: same diagnosis in public and private, free. (41S)
- Non-serious patients can be seen in private. (8S)

- DISADV of public: number of beds, waiting, and Casualty only 2 doctors (esp. General Hospital). (46S)
- No one should open a (private) clinic without an ICU; no one dies in private because they are transferred. (50S)
- No money taken from patient in public, work with you as patient for no money. Some in private: do investigation only to take money not needed. (38S)
- Medicine is available, some medicine free but in private pharmacy expensive. Sometimes not available at TMC and must go to private pharmacy. (34S)
- Should be more public. (48S)
- Patient referred from private clinic. (10S)
- Quality better in public. (19S)

The Libyan health care system is viewed as competent in the area of child immunization and in some areas of education of the public. This was also reflected in the comments made in the system's leadership.

- Education is given on TV. (35S)
- People have skin disease in area and people were educated, government provided insecticide. (26S)
- Vaccine/immunization program very good. (50S)

Patients receive medicine free from public health care institutions. In the hospital setting, the pharmacist does not interact directly with the patient. When medicine is not

available, patients often have to purchase the medicine from private pharmacies. The comments reflect the inconsistency in availability of medicine. Several of the comments indicate that the role of the pharmacist is not clear, and the pharmacist is often held responsible for inventory.

- Pharmacist skills are according to availability of drugs. If not available, gets help from other pharmacists at TMC. (39S)
- No continuous supply of drugs. No door to make a new drug available; late getting new drugs, working off the same list. List stays with Administration of Health for 5 years with no change. (47S)
- Happy about system. Doctor and medicine available. (34S)
- Drugs had to be gotten from outside. Mom paid, not available at TMC. (38S)
- In TMC need written prescription. Outside just show previous medicine (bottle) to get medicine. (34S)
- No medication outside Tripoli. (50S)

General comments about the Libyan system follow. Respondents commented on the disparity of services across the country and among health care facilities. Standards for care could not be clearly articulated. Several respondents wanted the country to expend more resources on research. Additionally, a few respondents indicated that health insurance would be a good mechanism to relieve the strain on the public health care system while creating equitable health care for the Libyan people.

- Some doctors no contracts. They do their best, only one. A specific number of doctors have a contract, no place else to go, waiting for a spot. Participant has no contract most. (19S)
- Administration needs to help. (47S)
- Much better if distribute doctors outside TMC. (9S)
- Managers need improvement. (33S)
- Each hospital has different standards. (13S)
- Training is needed in Tripoli: for doctors, nurses, helpers. (22S)
- TMC OK (80% of problems covered). But outside Tripoli only 20% of problems are covered. (50S)
- No difference in standards between hospitals. (17S)
- Health insurance would be best for patient. (13S)
- Respondent is satisfied with work at TMC but not the system. (47S)
- Leadership knows optimum structure, they have ideas to go to ideal level, improve quality.
- Need more research. (46S)
- Need new brain. Need to do something new. Should be max 8 years in position. Need new brains, so be active (like Obama). (50S)
- Problem is the whole country. (47S)
- Not enough doctors and medical staff at other hospitals. (22S)
- Center hospital in home town does not have enough services. (36S)

- Standards not like America or U.K. need to improve standards. (6S)
- Need more research. (48S)
- Libya's health care system needs social office to provide service.
(33S)
- Before 5 years some programs, visit home, see social and hygiene of home, do not do anymore. (39S)
- Patient, neurosurgery pediatric infant, referred from Center hospital.
(36S)
- If transfer to another hospital it is the same, the standards are the same.
(24S)
- Staff performance is measured using a rating scale, an evaluation form is used, administration evaluates and asks colleagues, nurses, and doctors. (5S)
- Libya is spending lots of money on health care. They spend enough.
(6S)
- There are only 2 Road Travel Accident (RTA or Trauma) hospitals in Tripoli. No RTA in other hospitals. Health care outside Tripoli very poor, inside good. (50S)
- More research is needed. (45S)
- Many members of the SOH are surgeons so they do not focus on primary health care. They do not spend enough; 25% of what is spent goes in pocket (by cars, spend money outside) even less spent on the

people. Do not spend money on primary health care and polyclinics.

(50S)

- Big difference between hospitals. Some have acceptable standards (e.g., TMC, Benghazi), not excellent. Every city has one Center hospital, quality is low, patients do not go, corruption, shortage. (47S)
- General hospital has facilities-they send patient to TMC without checking if room in TMC. Hospital to hospital, don't call ahead. (8S)

Motivation.

The theme motivation is comprised of the axial codes motivation-financial, motivation-incentives, motivation-leadership, motivation-power, and motivation-staff.

The biggest affect on the Libyan health care system is the drain of the most skilled to the large medical center like Tripoli Medical Center. The recent increase of pay of Consultants resulted in a concentration of the most highly skilled physicians at metropolitan medical centers. Not only was their pay increased, but their contract prevents them from supplementing their incomes in private clinics. Additionally, because of the high level of skill at TMC and its role as a teaching hospital, many doctors come to TMC to increase their skill. For other staff members, there seems to be a weak link between pay and performance.

- Libyan nurses not involved 100% in work. Need to care. Try to solve problem (Libyan nurses). They need deeper probing. Libyan nurses give up, need more follow-up. Try to care, need follow-up. (6S)

- Respondent signed contract. “so lucky”. All doctors once finish internship must work many months without income so doctors get depressed, they work many hours. (8S)
- Doctors are working with no contact/no money/waiting for a shot. (20S)
- Came to TMC because was looking for better job. Only possibility to get outside with contract. (6S)
- Giving doctors financial incentives: “everyone and their belief” (33S)
- Need good nurses. Most nurses are lazy. (22S)
- Performance measurement: You report on other doctors. There are verbal reports of doctors. Write for nurses. Reviews for doctors are twice per year, only for those that are not good. There is negative reinforcement not positive reinforcement. Report on nurses of mistake (or transfer to another department). Pay depends on degree not performance. (50S)
- Maybe more money for doctors will motivate doctors. (12S)
- Performance measurement of staff: Every human being knows themselves. (33S)
- Respondent suggest financial bonus, incentive, higher status for TMC staff. (5S)
- More money for doctors does not help. (39S)
- Nurses have no initiative, no care, just work then go. (7S)

- Some doctors in another unit are lazy. (19S)
- More money for doctors does not help. (39S)
- Libya gave more salary. Now consultants in public hospital. Before difficult to find consultants in public, they were in private. (20S)
- Respondent tries to learn from doctors. Tries to overhear to learn. Came to TMC to learn. (23S)
- Staff signs in and signs out, affects pay if late or absent. (30S)
- At some level giving doctors more financial incentives would, improve. There is threshold, can provide. (50S)
- TMC is largest Center in Tripoli, lots of patients, lots of knowledge, after attach you learn a lot. (19S)
- Most doctors have half care in heart, 70% care. Some do not care. (50S)
- Some nurses do OK but others do minimum. (rush through routine). (26S)
- More financial incentives for doctors would give more drive to work. (25S)
- TMC is best Center for training, many departments for pediatrics, best center. (22S)
- Things are better because increased doctor salary, good for them. (7S)

- Performance measurement: supervisor gives mark, affects income, annually. Complete job on time, give medication better contact with patient and staff. (17S)
- Respondent applied at TMC, 1st for money, TMC for earnings. (7S)
- Not all participants (staff) taking rights, not taking advantage of opportunities. (24S)
- Timing by Libyan nurses: they do not respect time. Unfair for non-Libya nurses. 30 minutes to 1 hour late. Leave earlier than they are supposed to. (6S)
- Came to TMC because interested in respiratory pediatrics. (47S)
- Some nurses are lazy. (8S)
- Nurses have no sense of responsibilities, can not find them, should stay in nursing station. (7S)
- Give more money to doctors and they will do a better job. (46S)
- Everything (training) available for nurses but they do not take advantage. (13S)
- Some have no contracts. They do their best, only one. A specific number of doctors have a contract, no place else to go, waiting for a spot. Participant has no contract most. (19S)
- Worked without money at TMC, worked 6 months to work for government. (33S)
- For TMC, no affect on giving doctors more money. The same. (24S)

- Doctors in primary and secondary get paid little money. (50S)
- Came to TMC because it was famous for senior consultants. Came to learn. (50S)
- Giving doctors more money would not change much, once pay was increased doctors stay at TMC. (18S)
- #1 problem laziness of nursing staff. (7S)
- Staff has commitment to patient. (22S)
- No advantage to giving doctors more financial incentives. Medical relationship not determined by money in public. Level of caring the same. (22S)
- Too many of staff do not love their job. Afraid from leadership, need salary. (24S)
- If doctors with no contract leave, pediatric will stop. They come to learn. (50S)
- Performance measurement: Consultant tries to figure out who is active or not. If you do your job you will stand out. No financial advantage. (25S)
- Performance measurement: Most do good job, some lazy. Same benefit for those who do a good job and those who are lazy. Exam determines what job. No relationship with exam and job. Some score good on exam but not good on job. (22S)
- Libyans (staff) are more then satisfied. Respondent satisfied. (6S)

- Came to TMC to work because short distance from home. (39S)
- Took job at TMC because of geographical, close to home. (25S)
- Not rewarded for doing a good job. 1st thing needed is staff development. (24S)
- Salary quite good for Libyan Doctors. Non-Libyans had much better salary now its better for Libyan. Did not see big or proportionate improvement in care by Libyans after increase in salary. (6S)

There are several expatriates working at Tripoli Medical Center, especially among the nursing staff. Their motivation is primary financial. However, one cited that she came to TMC to experience new culture and new people.

There were several comments related to the leadership. Even though leadership is a theme and was previously discussed, it is mentioned again under the theme of motivation. There tends to be a negative perception of the motivation of leaders within TMC and of the Libyan health care system.

- Administration does not care. Afraid from their position only. Take money inside pocket. Take commission from companies (e.g., pharmaceutical). Courses taken by administration, go outside Libya for nothing. More admin go outside country for training than medical staff. (50S)
- People in high position looking for themselves, there is no commitment. (2S)

- Staff us not satisfied because people in leadership do not do their job. Leadership is materialistic; just get benefit for their position. (1S)
- SOH: they do not understand, only collect money, car, do not worry about care. (14S)

Respondents were suspicious of the motivation of the private health care system. Even through the nature of private enterprise is for profit, in regards to health care it is a delicate issue to profit in an industry that serves a population's health needs. This is exacerbated in a country that is predominately socialized and Muslim. The respondents' comments that follow reflect the Libya's social context and the study participants' expectations.

- Private only care about money, no advantage. (21S)
- Private- respondent does not know system. More materialistic, they abuse money for cases like oncology then refer to hospitals like TMC. (13S)
- In private, only care about money. Private requires more money for more investigations. (15S)
- Less expert doctors in private due to contracts at TMC. New doctors are in private. (22S)
- Private is the most bad thing in Libya. Only want money from patients. Maybe trying to get help but do not. (24S)
- Private has more staff, higher salary, so in return give good care. (7S)

- Before private practice with TMC consultants now with contract can only work at TMC. (7S)
- Private: not good, not good facilities, not good doctor staff, transfer complicated cases, no consultant. Consultants now have contract in public. Private only has GP and seniors only. In other countries private is better but not Libya. Private is new concept in Libya. Only 5 years or so private in Libya. (38S)
- In private service is nice because you gave money and they take care. (34S)
- Private is costly, sometimes do things not needed for money. (20S)
- Libya does not have good private clinics, only care about money. Problem for patient. They take money then transfer patient to public. (33S)

Several TMC staff members expressed a desire to do good job regardless of financial gain. These individuals are self-actualized individuals despite the pedagogical approach to learning at TMC. They exploit their full talents and capacities. This study did not explore, indepth, staff members' motivation, but presumably it is partly driven by their Islamic values and Arab culture.

- Staff in pediatrics “do their best”. (2S)
- Respondent (admin staff) helps doctors, nurses and even patients. If they need anything. Admin helps patients get supplies. (2S)

- Respondent (staff) prepares new OPD for cardio. Tries to help children who need as much as possible. (1S)
- Everyone (staff) tries to do the best. (25S)
- Respondent (TMC staff) likes to help people and patient. (2S)
- 75% or less for pharmacy staff skills. No development, based on personality and reading on their own. (24S)
- In public hospital staff is trying. (24S)
- Staff contribution to quality depends on the person. (8S)
- Staff satisfaction is very good in this ward (pediatrics), consultants, seniors, nurses, helpers do their best. Sometimes use their own money to help patient. Use connections to benefit patient. Very nice. (19S)

Patient Physical Environment.

Patients and staff study participants were asked about the physical environment at TMC. The responses from inpatients were mixed. Respondents generally only commented on the condition of the rooms and bathrooms unless specifically asked. The physical environment did not seem to be the most important concern for the parents of the pediatric patients. The axial codes physical-bathroom, physical-general, physical-hygiene, physical-room, physical-security, and physical-service were aggregated into the theme patient physical environment. The participants' responses follow:

- Until now room is OK. Mother is nervous about staying in room alone, wants another patient and Mom in the room. (43S)

- Satisfied with cleanliness, some Moms have problem with temperature. (17S)
- A patient (mother) from another room came and used her bathroom during interview. She pointed this out. Respondent asked for a single room. She believes that a single room will help the recovery of her child. (12S)
- Room is comfortable. (9S)
- Public is not like private. Need better cleaning. According to public it is OK. They change sheets. OK, no bad smell. Facilities overall is good. (38S)
- Bathroom is no problem, some bathrooms above ground toilet is too high, cleanliness OK. (16S)
- Room is clean, not sterile like home. (11S)
- Room is dirty. (44S)
- Bathroom is OK, good, cleanliness OK, no separate receptacle for dirty diapers. (42S)
- Good room, now TV-not before, single room. (35S)
- Adult bed not good, patient is 11 years old, miserable bed, Mom has no bed, sits in baby chair. (34S)
- Very important thing (physical environment). Sometimes vents over babies. (19S)
- TMC is cleaner than before. (50S)

- Cleanliness is the biggest obstacle to quality health care. (23S)
- Disadvantage in public is cleaning. TMC needs better cleaning(38S)
- Comfortable at night, use TV. (38S)
- Bathroom cleanliness acceptable. (12S)
- TV good. No overcrowding, resource of water good. (46S)
- They do not know how to clean the room. (38S)
- Sleep OK at night. (45S)
- Not clean hospital where she lives. (36S)
- Had lights and air condition serviced. Sheets changed daily. (32S)
- Bed not good for mother, for baby good. (11S)
- Room clean, bed clean (good). (35S)
- Room is not clean, TV not connected. (44S)
- Temperature of room is good. (41S)
- Private has better caring, nutrition, and hygiene. (22S)
- Bathroom is clean. (37S)
- Comfortable at night. (49S)
- The room is no problem, TMC OK and better than most public hospital. (15S)
- Room is clean. (10S)
- Sheets, blankets, everyday changed. (32S)
- Room is noisy because pediatric, temp OK. (9S)

- Room and bathroom are clean. Helper clean room daily. Satisfied with cleaning. (29S)
- 100% satisfied with room. (46S)
- Temperature is not good. In a single room. TV is good. (38S)
- Room is nice, but patient (father of child) does not care about room. Only care about care of baby. Did not talk to wife about it. (14S)
- Comfortable at night. (41S)
- Bathroom OK, clean. (49S)
- Room clean. 2x/day. (34S)
- Has private room, so clean. (26S)
- Bathroom is clean. (35S)
- All things good in room. (36S)
- Room is 50%. (21S)
- Physical environment is good, patients are comfortable. (39S)
- Cleanliness of bathroom is OK. (45S)
- Patients are comfortable, cleanliness OK, food is good, breakfast, snack, lunch, fixed TV. OK. (6S)
- Comfortable at night. (4S)
- Cleanliness of room is OK. (45S)
- Comfortable at night. (31S)
- Bathroom is clean; it has no bad smell. Mother uses bathroom at home

as a habit. (38S)

- Room is good, baby comfortable. Sometimes mother hot. (36S)
- In private advantage is room, cleanliness but superficial. (44S)
- TV is good, room is good. (41S)
- Bed sheets are changed daily. (50S)
- In hospital physical environment is OK. (7S)
- Comfortable in night. (32S)
- OK cleanliness (not good-not bad). OK for public hospital. (42S)
- Should clean more than 2 times per day (especially in gastro room). (49S)
- Night is quiet. (3S)
- Patients are comfortable, more or less. But can make better. Gardens not used. Just TV, not good for those in for a long stay. In general, OK. (24S)
- Room is quiet/ good temperature. (40S)
- 1 bathroom close to her, clean. (28S)
- Room cleanliness is OK. (41S)
- Room temp. OK, room comfortable, a little noisy from crying babies. Acceptable. (12S)
- Noise: depends on time, rounds crowded, visitors noisy. (11S)
- No noise, room temp OK. (35S)

- Room is nice, too quiet (boring). Night comfortable. (29S)
- Cleanliness of bathroom is good. (41S)
- Cover for bed not there, had to call Sister repeatedly. (28S)
- Bathroom clean in this department, but others not. (9S)
- Now patients have TV in room (this year). (50S)
- Overall satisfied with room. (45S)
- Room is hot, noise Ok, with door. (34S)
- Cleanliness of room not good. (38S)
- Room should be cleaner, come daily, only clean floor, hope they clean more than just the floor. Not enough time to clean between patients.
(12S)
- Room is noisy because pediatric, temp fine. (10S)
- Patients have TV, bed, patients are comfortable. (22S)
- Some bathrooms need more service. Cleaned regularly. But OK.
(32S)
- Room is checked for cleanliness every 4 hours. (41S)
- Bathroom clean, regularly cleaned with antiseptic. (4S)
- Food is better (improved) for patient. (50S)
- Patient is satisfied with room, comfortable. (3S)
- Room is cleaned room 2 times per day, experience from previous stay.
(40S)

- Took other daughter to private clinic, but no Consultant, room was good. (38S)
- Not clean bathroom, some patients are dirty. Only 2 bathrooms for ward. (34S)
- Public: aesthetics looks good., furniture etc. (14S)
- Everyday room is cleaned, 2 times per day. (36S)
- Room is clean. (9S)
- Satisfied with cleanliness of room and bathroom. (31S)
- Not satisfied with bed and room. (14S)
- Bathroom cleanliness is 50%. (21S)
- Room always clean. Corridor always clean, 24 hours, every 3 hours. (32S)
- Did not use bathroom yet but from a previous admission OK. (40S)
- Comfortable at night. (21S)
- Room is just hot/quiet. (4S)
- Room temperature is OK. (44S)

Some staff members have a general concern about hygiene at TMC. Their concerns are well founded and will be discussed further under the discussion of researcher's observation. Comments on hygiene were more likely offered by participants that have experience working outside Libya. This indicates a need for policies, procedures, standards and training on hygiene. Hygiene concerns follow.

- Need better hygiene at TMC. (22S)

- Need courses in nursing care, sterilization. (6S)
- Should have disposable gloves, provide facilities. (25S)
- Staff tries to make environment more sterile, providing disinfectant. (24S)

The security staff has a very visible role at TMC. Even though there were no questions specifically directed to respondents on security, several respondents articulated concerns about the security at TMC. Visitation is strictly controlled and the staff expects the wards to be free of visitors outside visiting hours. The comments reflect the frustration of the pediatric patients' parents:

- Security during visitation difficult for father; sometimes doctor had to call. (48S)
- Security - difficult for father to bring food and clothes at 2 PM (before visiting time). Need paper to enter. (45S)
- Respect for patient is good, from doctor and nurse, and patient security. (10S)
- Security talks roughly, difficult to get in. (44S)
- OK, when husband came to visit with paper difficult to enter; at visiting time OK. (42S)
- Defect in security (just shout). (49S)
- Laboratory is far, in first building. Creepy going to lab at night with only 2 nurses, 1 is going back and forth. (6S)

Policy/Procedures/Records.

Doc-procedure, policy-staff, procedure-administrative, procedure-visit, and records-medical were aggregated in to the theme policy/procedure/records. Triangulation for this study was difficult since there were no written procedures available for this study. This is evident by some of the responses.

- Big difference between hospitals. Some have acceptable standards (e.g., TMC, Benghazi), not excellent. Every city has one Center hospital, quality is low, patients do not go, corruption, shortage. (47S)
- Libya has no health care standards. (30S)
- Need “one rule to follow”. (7S)
- There is no routine. (7S)
- Researcher asked for polices and procedures-too complicated, referred to another doctor who has stats on things like number of MRIs performed. (13S)
- To a certain degree Libya has standards. In a contract (work hours, absences, best interest of patients). We know it, no written procedures. Nothing to tie procedure to performance. (25S)
- Policy is the same, mind is the same, the standards are the same. That is why one place is not better than another. (24S)
- Administrative: different from department to department. When people come and go not tracked consistently. Look at performance of doctors and nurses more than administrative. Sometimes someone

from leadership comes and has a check if there is a complaint. (1S)

- We have no written procedures. (23S)
- Each hospital has different standards. (13S)
- Libya is not like America or U.K. need to improve standards. (6S)
- Have not seen written procedure. (24S)
- Verbal instructions by procedure. (39S)
- Time is wasted with inefficiency (24S)
- Some posters, have not seen manual or handbook. (6S)
- Casualty and surgical are different departments. Medical Casualty is a problem. The buck is passed among doctors in Casualty so patients stay a long time. (50S)
- Every committee has special work to do. Example: related medical committee have different responsibilities. 8 to 10 committees report to Manager. Each committee has its own policy. (13S)
- Nice but criteria for selecting patients to go outside not fair. Most critical not sent. (19S)
- If transfer to another hospital it is the same, the same. (24S)
- Organizational commitment to excellence: far from excellent. Provide lab investigation, do not loose, should have disposable gloves, provide facilities. (25S)

Some respondents articulated concerns about the discipline of coworkers. There are performance reviews, but many respondents had difficulty describing the criteria to

rate performance. Many of the respondents hold TMC administration responsible for human resource tasks such as disciplinary action. The comments did not reflect a team atmosphere for resolving conflict as described by some of the comments.

- When someone does something wrong they should be disciplined. (20S)
- Administration is OK. Director and chief very polite. They listen; they are trying but no results. Need to be stricter, too many absences, its habit. Disturbs the routine and are obvious. Administration is very nice. They try to solve problem and address complaints. (6S)
- Need to be tougher with “trouble makers”. They have rules but some not followed. (6S)
- Obstacle to quality health care: Admin needs to be stricter with Libyan staff. (6S)
- Performance measurement: Supervisor gives mark, affects income, annually. Complete job on time, give medication better contact with patient and staff. (17S)
- Management at TMC: fixed time like respondent, here in morning, off at 3:00 PM, off on Friday. (17S)
- Administration is better than before. Before not systematic. (7S)
- Start 9AM (non-Libya nurses). (7S)
- Need more control of nursing staff and behavior. (15S)
- Administrator comes suddenly to check attendance record. (1S)

- In a contract (work hours, absences, best interest of patients). (25S)
- Nurses are 30 minutes to 1 hour late. Leave earlier than they are supposed to. (6S)

The visitation policy was mentioned by several study participants. As discussed earlier, frequently the respondents mentioned the relationship with hospital security. The security staff is the gatekeeper to the hospital and responsible for enforcing the visitation policy.

- Problem is visitors come anytime and doctors are not comfortable. (13S)
- OK, when husband came to visit with paper difficult to enter; at visiting time OK. (42S)
- Visiting time short-need to see family more. (50S)
- Patient was not informed of visiting hours, informed by other patients. (36S)
- Patients do not respect visiting time, disturb medical staff. Should be 3PM ~6PM., especially in non-private rooms during rounds. Now does not interfere when doctors are there, especially male doctors. (6S)
- Security during visitation difficult for father; sometimes doctor had to call. (48S)
- Security - difficult for father to bring food and clothes at 2 PM (before visiting time). Need paper to enter. (45S)

Tripoli Medical Center does not utilize electronic medical records. This will be

discussed further under observation in this Chapter. The lack of electronic records and standards for dispensing of medicine are evident in the responses below. The reliance on parents to supplement care of pediatric patients is an area that should be explored to improve the reliability and accuracy of care.

- Mother dispenses antibiotics to her child (inpatient). (43S)
- Mother of patient reads investigation from file. Asked for another investigation, changed investigation (hemo dropped). (44S)

Respondents were asked about their admission. Patients are either referred or are transferred from Casualty to the applicable medical ward or department. No patient is refused treatment at TMC. Mothers are admitted into the pediatric ward with children; fathers from outside Tripoli must find other accommodations. If a child is in neo-natal or ICU departments, parents maintain contact with the hospital through various means.

- Transferred by paper from downstairs. Waited in treatment room (upstairs in dept.) before getting room (about 30 minutes). (15S)
- Admin says accept everyone at TMC. (47S)
- Every patient is admitted. (8S)
- Hospital (TMC) took phone number of father, when patient was transferred to ward TMC called and told to bring mother. (29S)
- Transferred from Casualty by paper. (45S)
- Admission was systematic by admitting doctor. (12S)
- Father stays with a friend when child is in TMC. (27S)
- Father in hotel; Daughter in hospital. (35S)

- Consent for surgery done in home town. (37S)

TMC-Organization.

The theme that describes the TMC organization at a more holistic level is comprised of the following axial codes: department-admission, department-emergency room, department-medical, dept-nonmedical, TMC-capacity, and Tripoli Medical Center. In this discussion, I will not repeat quotes that have a stronger link to previously discussed themes. The quotes that follow provide a picture of the TMC organization. Overall, the patients are more satisfied with TMC than other public health care facilities.

- TMC nursery is OK, Ward not OK. Nurses do not give medicine on time. Call and do not respond. At night they do not answer or just say take it easy. (21S)
- Need emergency training for doctors. (25S)
- TMC Nurses need training in care of patients, procedures. (39S)
- Administrative staff does not have much care. (25S)
- Pediatrics like one family. (2S)
- Patient always deals directly with TMC. (49S)
- TMC Leadership: lack of coordination (sometimes lack of facilities). (25S)
- TMC has one of the best cardio surgeons. (13S)
- Availability in dept OK, need more doctors in Casualty. (15S)

- In Benghazi need more recommendation to be admitted, TMC welcomes you. (27S)
- Casualty needs to change, no seniors in Casualty, still not as good as in patient, esp. medical arrangements. (50S)
- When baby was in ICU, nurses would call nurse by telephone. (36S)
- TMC noisy because pediatric, temp OK. (9S)
- Idea that best care is at TMC. (12S)
- Government pays 100% of cost for all patients who come in the emergency room. (13S)
- Spent 1 to 2 hours in Casualty. (40S)
- Staff satisfaction: very good in this ward (pediatrics), consultants, seniors, nurses, helpers do their best. Sometimes use their own money to help patient. Use connections to benefit patient. Very nice. (19S)
- Obstacles to quality health care: no problem at TMC because big Center. (22S)
- Patient came to OPD endocrine, then admitted by advice of consultant. They were well prepare when she came to ward, the bed was ready and the doctor on duty was prepared. They did what they should do. (12S)
- TMC better than General Hospital. General Hospital usually does not have empty bed. (40S)
- TMC administration is not bad, big hospital, admin need facilities: admin in building #1 only, need supervision in each building (admin

group). To solve problems should have admin in each of the 3 TMC buildings. General Administration is centralized. (47S)

- Heavy duty in pediatrics. 10 duties per month in Unit D is a lot (ward, admission duties). Nursery needs more doctors. They work emergency. Sometimes in 1 subgroup only 3 but should be more. (25S)
- No contact with family clinic in region. Come directly to TMC, availability of medicine, skills of doctor of staff, availability of doctor staff (24 hours). Would come directly to TMC regardless of time of day. (15S)
- Communication among staff: very, very, good for pediatrics. (2S)
- Not enough patient parking for Casualty. (50S)
- Each department there are administrators, they represent admin (like liaisons). 90% of depts. Satisfied. (13S)
- Serious cases transferred to ICU. (5S)
- Differences among departments. (22S)
- Best hospital in Tripoli. (34S)
- Physical environment no problem, TMC OK and better than most public hospital. (15S)
- Communication from doctors to patient was good on ward. (45S)
- Cardiac department in 3 weeks, waiting for diagnosis. They discovered her disease there. No difference in staff between

departments. (32S)

- Patients are from all over Libya. (32S)
- Leadership not in right place. You do not need physician to run department, need someone with management skills. “Not the right man in the right place”. Not the right skills for a large hospital. (24S)
- Lots of recommendation, if recommended things will go smooth, hospital will not improve until this change. (30S)
- Bathroom clean in this department, but others not. (9S)
- A lot of difference between TMC and polyclinic in doctor skill and investigations. (42S)
- Best place for specialty. Facilities (equipment available). (47S)
- TMC: sometime overcrowding. ICU put with other patients. (8S)
- Transferred by paper. Waited 10-15 minutes for bed. Stood in ward waiting for bed. (46S)
- TMC serves everything-first level through tertiary. Overcrowding makes services limited and quality not so good. (47S)
- There is caring in pediatrics. (2S)
- Skilled nurses: Most critical departments, ICU, Casualty by good system and most qualified nurses. (13S)
- Medical staff caring: depends on department, head of department and specialist. (2S)
- Need to select patients and make TMC a tertiary care center. Will

have to improve primary care, first line and second line in the country.

Small infections should be taken care of in another level. (47S)

- Increasing financial incentives for doctors enhancing medical care: not much, once pay was increased doctors stay at TMC. (18S)
- At night investigation was done, was sent home, no improvement in patient, came to Casualty next day. It was busy with about 12 patients. (43S)
- There are differences from department to department. (20S)
- Patient came through Casualty. (40S)
- Patient came by Casualty. Was only in Casualty 10 minutes. Re-examined in ward and was decided to admit patient. (44S)
- Nursing skill: in the morning good, afternoon not good, previous stay in surgical department had better nurses. (10S)
- More satisfied with TMC than private. (38S)
- Doctors in ward communicated with patient. (43S)
- Some doctors not skilled in private-TMC better. (18S)
- Hospital (TMC) took phone number of father, when patient was transferred to ward TMC called and told to bring mother. (29S)
- Came to direct to TMC, near to home, better care at TMC. (44S)
- Nursing skill: AlHamduAllah. Were all Libyan nurses in Casualty. (43S)
- Patient's second time in TMC, nurses gave medicine during time.

(40S)

- TMC is better. Center hospital in home town not enough services. Family clinic simple but good. (36S)
- Need more doctors in Casualty, need more observation rooms, lots of patients. (15S)
- Maybe do not have Specialists in all departments. (24S)
- Satisfied with TMC. (12S)
- Casualty refused treatment because there is an epileptic center. But Mom insisted to be seen. (45S)
- Bad communication in respondent's department. (30S)
- Satisfied with respect in ICU. (48S)
- Told by private clinic that TMC is the best. All instruments and procedure are available. (32S)
- Casualty in 3 hours, give oxygen, and cortisone. Ward prepared and doctors saw her. Gave oxygen and cortisone when arrived on ward. (34S)
- Comfortable, some members of family wanted to transfer to private clinic but refused, she likes TMC. (16S)
- Comfortable with doctors, doctors have good communication in this department. (10S)
- TMC is overcrowded, no special way to select patients. (47S)
- People complain about Casualty. Not enough numbers. Mixing of

HIV with non-HIV patients. No enough rooms. In observation room patients are mixed.(social problem too, patients are afraid). (50S)

- Nice, nursing staff is best one. (15S)
- Nurses have better relationship with patient than General hospitals. Medicine on-time, skills better. (45S)
- Staff needs training in Intensive Care unit and Casualty departments. (19S)
- TMC: if patient not satisfied it is because of poor nursing care. (7S)
- Casualty did prioritize by criticality. (43S)
- Patients provided with good medicine, good care, food provided, mothers are comfortable and can stay in hospital. (5S)
- As a whole, patients improved more than before. Before they refused to come, they thought they would die at TMC. (50S)
- Administrative: different from department to department. When people come and go not tracked consistently. Look at performance of doctors and nurses more than administrative. Sometimes someone from leadership comes and has a check if there is a complaint. (1S)
- Before private practice with TMC consultants now with contract can only work at TMC. (7S)
- Need Casualty in ward (nurse and equipment). (22S)
- Yes, patients come from all over Libya to TMC. TMC is last stop. (18S)

- Physical environment is very nice at TMC. (18S)
- Patient transferred by paper from Casualty. 6AM-1PM in Casualty. 2PM-1AM in ward waiting for a bed. Waited for consultation in treatment room before admission into ward. Casualty very busy (critical patients given priority). (49S)
- Admin is flexible, they listen, good cooperation from admin at top of TMC. (6S)
- Patient was expecting worse; she was planning to go to Tunis but not needed because of level of caring at TMC. (3S)
- Best Center for training, many departments for pediatrics, best center. (22S)
- TMC is the city (not rural). Difficult because polyclinics closed. (50S)
- Better than before, all departments available. (42S)
- Hygiene, need better hygiene at TMC. (22S)
- Same problem with availability as nurses. Take time, one doctor with many patients (20 patients). One doctor after 2 PM, heavy workload, overloaded. OK in daytime. (38S)
- Overworked, at TMC there is a sea of cars. TMC is a hospital for the whole country and all levels. (47S)
- TMC has one of the best cardiac pediatrics in Libya. (26S)
- TMC Casualty better than other hospitals. Patient has more contact with Casualty than outpatient. (15S)

- Hospital facilities fine (11S)
- Very late investigation at TMC. (35S)
- Very rare cases in this department. Sister (patient): 1 in 150,000 treated in department. (32S)
- Patient is satisfied with nursing so far in both department and ward. (45S)
- Nursing good in ICU, ICU better, more care, more questions answered by nurses. (36S)
- TMC has more experience, neo natal, availability in subspecialty. (29S)
- Nurses know all things, is satisfied but has too many orders. (38S)
- TMC only place for cardiac care. Benghazi has cardiac but not all instruments are available (27S)
- Another ICU opened by SOH at TMC. (8S)
- TMC offers 85% of what a patient needs. (13S)
- Incubators ready, came by ambulance. (36S)
- Respondent tries to learn from doctors. Tries to overhear to learn. Came to TMC to learn. (23S)
- Casualty empty at 4AM, 40 minutes for exam. (38S)
- Nurses: monitor nurses every hour, they need more skill, nurses are not good in a previous admission in gynecological department. Respondent asks for drug from nurse and still has not received it.

(11S)

- Casualty filters (triage) then observation. They will divide patients. Then will divide patients. All for surgical or other specialty. Takes too long (waiting for doctor). Some stay 10 hours, some next days. Below 15 years old patients go to pediatric. Casualty and surgical are different departments. Medical casualty is a problem. The buck is passed among doctors in casualty so patients stay a long time. Some doctors do not see stroke patients. There is no geriatric department.

(50S)

- Not adequate information when admitted, especially in Casualty (diagnosis). (49S)
- At the time of the interview there are 960 inpatients at TMC, overcrowded today. (13S)
- Incubators available. (37S)
- Patient only comes to TMC. (34S)
- Large quantity if patients come to TMC. Can not provide everything. (18S)
- Only one pharmacist for ward. (22S)
- Nice, all teams good. Very comfortable at TMC. (9S)
- Noisy because pediatric, temp fine. (10S)
- Mother satisfied with doctors (esp. doctors on surgical ward). No difference between ward and ICU. (42S)

- Dr. attentive at TMC no problem. (14S)
- Patient trust public more (due to experience in TMC). (29S)
- Distribution of qualified nurses varies department by department. (6S)
- People are friendly. Private and public are the same. TMC the same as private. (32S)
- Casualty good (only 4 or 5 patients in casualty). (46S)
- Very crowded at TMC because people come from all over Libya. Need to increase beds at TMC. (32S)
- Not enough staff (Doctors and nurses). In pediatric not enough. (20S)
- Staff available, especially in ICU. (48S)
- Not big procedures in pediatrics. (23S)
- TMC is more clean than before. (50S)
- Availability of doctors in Casualty and Ward good. (40S)
- Doctor follow-ups with patient. 9AM-11AM rounds, Admission Day-difficult, many patients, only 2 doctors (1 GP and 1 Attachment). (18S)
- TMC is a teaching college. (32S)
- Organizational commitment: built nursery, increased income. (17S)
- TMC OK (80% of problems covered). But outside Tripoli only 20% of problems are covered. (50S)
- Doctor has ward duty and Admission. (25S)

- 7 to 8 nurses every day in department. Some are absent. Some difficulty in Ped. Resp/cardio. 2 Sisters at night/adequate. (23S)
- Libya gave more salary. Now consultants in public hospital. Before difficult to find consultants in public, they were in private. (20S)
- Hospital full-prepared when referred. (29S)
- Staff enough, distribution wrong (e.g., need lots of nurses in oncology). (6S)
- Drugs are very expensive but free at TMC. (32S)
- Nurses good. Same care on ward and ICU. (37S)
- Less expert doctors in private due to contracts at TMC. New doctors are in private. (22S)

Facilities.

Respondents used the term facilities to describe tangible resources. The axial codes facilities-general, facilities-capacity, facilities-lab, facilities-medicine and facilities-supplies were aggregated into the theme Facilities. Quotes regarding general capacity (e.g., availability of beds) are not discussed in this section as they were illustrated under the theme capacity-availability.

Medicine falls under this theme. Even though patients and staff comment on the lack of medicine in the system, TMC has a stronger chain of supplies than other public facilities. Additionally, patients appreciate that there is no cost for medicine at TMC and other public health care facilities.

- Shortage of medicine in polyclinic. (43S)

- Drugs are sometimes not available (system). (8S)
- More spending on health care would affect for drugs and instruments. (20S)
- Drugs are very expensive but free at TMC. (32S)
- Drugs not available in Libya. (22S)
- Patient is happy about health care system. Doctor and medicine available. (34S)
- When there is availability of doctors and nurses, and drugs than good for patient. (39S)
- Staff tries to bring new equipment, to bring new drugs. (24S)
- Sometimes drug shortage in country, 80% available. (50S)
- Disadvantage of public health care: does not have enough medical care, availability of drugs and instruments. (39S)
- Medicine is available to patient at TMC, some medicine free but in private pharmacy expensive. Sometimes not available at TMC and must go to private pharmacy. (34S)
- Advantage of public health care is the availability of medicine. (48S)
- Not all medicines are available. Some patients advised to buy outside. (25S)
- Need to provide materials (drugs, machines). (8S)
- Advantage of public is medication availability. (34S)
- Just defect in medicine and investigation in patient's home region.

(41S)

- Public pharmacies only in hospital. Some areas have public but only antibiotics are available. (34S)
- Still have problem because antibiotics are weak. (11S)
- Informed about medicine. Take medicine from TMC pharmacy. Pharmacist instructs patient on how to use medicine. (34S)
- Advantage of public health care: availability of medicine, procedures, available any time, free, investigations. (16S)
- Patient has no contact with family clinic in region. Come directly to TMC, availability of medicine, skills of doctor of staff, availability of doctor staff (24 hours). Would come directly to TMC regardless of time of day. (15S)
- Medicine not available at TMC. (35S)
- No medication outside Tripoli. (50S)
- Meds some not available at TMC, not ideal. (7S)
- Defect in availability of medicine in public health care. (2S)
- Drugs had to be gotten from outside. Mom paid, not available at TMC. (38S)
- One drug bought from outside. 2 antibiotics from TMC. Nephrolizers from outside but finished. (38S)
- Drugs are not available for the patients. (39S)
- Public good-but need more. Facilities, money, good doctors,

medicine, need everything for patient. (38S)

- Organization tries to bring new drugs. (24S)
- Primary care: Doctors OK, availability of doctors and medicine lacking. (46S)
- TMC patients are provided with good medicine, good care, food provided, mothers are comfortable and can stay in hospital. (5S)
- TMC is like a shop, overcrowded, most drugs available but too many people. No continuous supply of drugs. No door to make a new drug available; late getting new drugs, working off the same list. List stays with Administration of Health for 5 years with no change. (47S)

Similar to the accessibility of medicine, TMC has more availability of diagnostic equipment and supplies than other health care facilities. Nevertheless, it still falls short in meeting the expectations of some respondents as illustrated by the responses that follow.

- Other public hospitals have defect in equipment. No empty bed. (29S)
- Everything is available (e.g., equipment and investigation) in private clinics/hospitals. (2S)
- Not good facilities (supplies). Small things not available. (22S)
- Need subspecialty courses (new machines). Instruments are not available because people not trained to use them. (50S)
- Central Lab has updated equipment from Germany. (13S)
- For equipment at TMC (75 to 85% OK). (50S)
- TMC does its best for supplies and availabilities. (13S)

- Incubators available at TMC when patient arrived. (37S)
- In public health care investigations or equipment not available. (33S)
- Simple things at TMC sometimes not available but should be. (19S)
- TMC is best place for specialty. Facilities (equipment available). (47S)
- Organization commitment to excellence shown by bringing new equipment (but not for all departments). (24S)
- Told by private clinic that TMC is the best. All instruments and procedure are available. (32S)
- TMC needs Casualty in ward (nurse and equipment). (22S)
- Libyan system is good, equipment is available. (4S)
- Problem is equipment. Continuous supply of disposable items and machines. Some investigations need continuous supply of disposable items for equipment (e.g., buffer solution). Outside, other countries have a company attached to the hospital to help with supplies. (47S)
- If more money is available, give to right man to get more medications and instruments. (39S)
- Need more availability of equipment and facilities at TMC. (1S)
- Private health care should be expanded but need more equipment. (50S)
- Family care- not good, only building. Availability of instruments in family clinic when asked about needles (as patient) said building only.

(39S)

- If money in correct state it would improve. Needed facilities, supplies, syringes. (8S)
- Generally, we are whiners, always something to complain about lack of staff (nurses and doctors), lack of facilities (supplies, lab). (25S)
- Patients and staff use the term investigations to describe medical procedures and lab work. Patients come to TMC to obtain medical procedures not offered at other private and public health care facilities.
- Organizational commitment to excellence: far from excellent. Provide lab investigation, do not loose, should have disposable gloves, provide facilities. (25S)
- Problem in public hospital (MRI, CT takes too long (investigations). (43S)

- In home region no doctors visit home. No family doctors, if baby not well take to doctor, no special clinic. Doctors good, technician and investigation not present, lack of lab, machines not available. (44S)
- 70% satisfied in health care where patient lives, not like Tripoli. Limited facilities. (they have to buy investigation in private because not available in public.) (29S)
- Lab has a gap in TMC, needs development, defect in lab tests. (47S)
- TMC needs more care, increase procedure, increase beds in wards and ICU (esp.). Only 6 beds in ICU, need at least 10. Increase number of

nursing staff, esp. in ward. Resp. and cardio patients are together need more nurses. (17S)

- Some investigations not available and take too long. (8S)
- Public: big advantage, lots of machine, offer lots of procedures. (6S)
- 50% of the time the reagents in the lab is not available, investigations get lost and not available. Canulas are not good quality.

TMC Staff.

Quotations related to TMC staff were the most frequent. The following axial codes were aggregated into the theme TMC Staff: staff-doctors, staff-education, staff-English language, staff-nursing, staff-pharmacist, staff-skill staff-support, staff-TMC managers/admin, and staff-training.

Even though some patients were satisfied with nursing care, nurse competency is of concern of many patients and staff. Administrators, nurses, and doctors acknowledged that the skill level of the nursing staff needs improvement. Libya has compensated for the gap by hiring foreign nurses, placing the most skilled nurse in the more critical units, and initiating new training programs.

- Nurses are not good. Foreign nurses are not well selected. Libyan Sisters are not qualified. Need some control. (47S)
- Nurses answered questions, respond to requests, check canula. (41S)
- Sometimes only 2 nurses on duty. So can not have patience. Nurses only have time to dispense medication. Lots of patience. Only have time for basic needs. (25S)

- Nurses-not good; they talk badly to patient (Mom). (11S)
- Need good nurses. Most nurses are lazy. (22S)
- Nurses just want to sleep at night. (49S)
- Nurse has gentle relationship with mother, played with child, gentle when remove canula, both Libyan and non-Libyan. (41S)
- Talk to doctors not nurse because nurse not good. (34S)
- There is no respect for Doctors by nurses. Doctors do work for nurses. (7S)
- Philippine nursing skill-good; Libyan-according to the nurse. (11S)
- Sometimes nursing care not good. (6S)
- Nursing skill: OK, but extraction of blood. Sometimes has difficulty. Does not know if because baby is small or nurse needs more training. (29S)
- Nurses have defect. Nurses not doing job exactly. Delay in medicine. Need more contact with baby. (48S)
- Nurses are available but no benefit from availability of nurse. (14S)
- Same problem with availability as nurses. Take time, one doctor with many patients (20 patients). One doctor after 2 PM, heavy workload, overloaded. OK in daytime. (38S)
- Nurses: Nursery OK, Ward not OK. Nurses do not give medicine on time. Call and do not respond. At night they do not answer or just say take it easy. (21S)

- Nursing staff needs better behavior. (49S)
- Libyan nurse inserted canula very fast. Good. Prepared drugs.
Libyan and non-Libyan nurses the same. (38S)
- Level of nursing needs to improve. Libya is starting courses for nursing staff since 1 year back, to improve English, bought expert to improve level. (13S)
- Sisters (nurses) give medicine, patient must call nurse for medicine. (28S)
- Problem is the staff: nurses (skills and behavior). (11S)
- Nurses are not doing job directly, do not measure temperature, only when Mom asks does nurse bring medication, at night more difficult. (49S)
- Thankful to yesterday's nurse. (34S)
- Nursing skills bad, especially when inserting IV, no difference among Libyan and non-Libyan nurses. (49S)
- Nurses are technically good. (44S)
- Nurses know all things, is satisfied but has too many orders. (38S)
- Disadvantage of public: nursing staff. (49S)
- Non-Libyan nurses good. Libyan nurses not good, drugs not given on time respondent ask for drugs, advice of doctors. (11S)
- Problem with nurses, not qualified, need more qualified Libyan nurses. Even though have some imported nurses, still not satisfied. (13S)

- Nurses need more advice, need to improve nurses, they are always here if we improve nursing staff it will be better for patient. (20S)
- Nice, nursing staff at TMC, is best one. (15S)
- Nursing staff has nice communication, attentive, very nice, skills very nice. (31S)
- Nurses have good English, they try to take more (classes). (32S)
- Patient had good relationship with doctors (especially doctors in Casualty). (43S)
- In public health care, nursing staff used to be good but now not good. (34S)
- No problem with nurses, contact freely. (45S)
- 1st admission, relationship good with nurses. (15S)
- Need good education for medical skills for nurses and doctors. (35S)
- Nurses have better relationship with patient than General hospitals. Medicine on-time, skills better. (45S)
- Not good relationship between nurses and doctors (lazy nurses). (22S)
- Nurses know their job, thankful to nurses. (32S)
- Philippine nurse very good. Libyan nurse yesterday good, attend every hour. Nurse did not give antibiotics today. Every 2 hours. She asked nurse, in same room patient removed IV. (34S)
- Skills of nurse: not excellent/normal, according to nurse. (26S)
- Nurse had to refer questions to doctor. (10S)

- Second time in TMC, nurses give medicine during time. (40S)
- Small number of Sisters (nurses) not good, most are very good. (18S)
- Nurse training should be care of patients, procedures.
- Nurses have good relationship with patient, they try to create relationship with mother. (16S)
- Nurses skills good, only experienced (ICU, Oncology, neonatal good), others need more training (esp. new ones). (8S)
- Nursing skill is not good. Many times, inserted catheter in jugular vein because visible (but difficult for patient). (28S)
- Nurses need 7 years of study, now 4 years. (34S)
- Nurses informed Mom step-by-step. (29S)
- Libyan nurses not taking proper responsibility. (23S)
- Nurses need training on cauterization on IV fluid. (29S)
- Nurse stayed with child. Satisfied with nurse. (43S)
- TMC nursing staff is understaffed. (7S)
- Some nurses are lazy. (8S)
- OK, nurses to nurses in unit wonderful. Know each other a long time. (6S)
- #1 problem is laziness of nurses. (7S)
- Not satisfied with medical treatment, 80%. Doctors good but not nurses. (28S)

- Non-Libyan nurses have better skills and relation than Libyan nurses. (42S)
- Ask nurses many times, they say OK but they do not follow through. (8S)
- Need to improve thinking of people of nursing staff, defect in thinking of Libyan people on perception of nursing staff. (17S)
- Nursing staff best in skill. (14S)
- Nurses not skilled just lazy, miss doses. (22S)
- Some nurses difficult to communicate, some lazy. (8S)
- Nurses need training. (6S)
- Nurses very good (responsive), overcrowded ward, only one nurse, can not respond to all orders. Sometimes seek her out many times. After 2PM only one nurse, in morning OK. They must go to lab and do canula. (38S)
- Nurses should be taught how to deal nicely with patients. Nurses: more education on what to say but availability affects this. (25S)
- Not good procedures-nurse (IV). (34S)
- Older nurses not satisfied. (7S)
- Nurses help very much, very friendly. Very nice, they love sister (patient) very much. Very excellent. (32S)
- Nurses give treatment on time, good communication. (12S)
- Nurses gave very nice explanation, explain if vague. (29S)

- Some nursing staff OK, some not, need education not staff. (17S)
- Most critical departments, ICU, Casualty by good system and most qualified nurses. (13S)
- With Libyan nurses not satisfied. Libyan nurses under qualified. Libyan nurses. Libyan nurses are lazy-just come in. (7S)
- Nurses must go to lab and do canula. (38S)
- Libyan nurses not good. (11S)
- Satisfied with nurses, received treatment on-time. (41S)
- Skills OK of nursing staff. (48S)
- Nursing care is good but is according to nurse (IV, injection). Patient had immune suppression disease. Some nurses refuse to touch patient but should. (35S)
- Nurses' skill: some OK-some not. (33S)
- Nurses have no sense of responsibilities, can not find them; they should stay in nursing station. (7S)
- 1st day nurses skill is OK, not enough. Mother bought medicine with her. (45S)
- There is no clear training for nurses. Nurses come from middle school. Teach only theory to nurses, no practical knowledge, no good experience. (47S)
- Nurse took blood without gloves (needing more education). (12S)

- Sometimes nurses responsiveness is OK but when busy or at lunch, not available. (16S)
- It is Sisters (nurses) responsibility to know about patients at home, preventive care; they should educate the patient to how to stay healthy.
- Nurses should be monitored every hour, they need more skill, nurses are not good in a previous admission in gynecological department. Respondent asks for drug from nurse and still has not received it. (11S)
- Nurses need their own room (lounge). (32S)
- Nurses skills are OK, MashaAllah. (41S)
- English classes are very important. All files are in English. (6S)
- Level of caring of nurses is not good. (34S)
- Nurses should be trained, esp. new ones and Libyan ones. (8S)
- Nurses need more education in English language. (12S)
- Need more control of nursing staff and behavior. (15S)
- Nurses need more training in how to deal with patient. Behavior (her experience good). (29S)
- Patient is satisfied with interaction with nurses, received medicine on-time. (46S)
- Skills of nursing staff: MashaAllah, Al HamduAllah (27S)
- Nurses are attentive in the morning good, afternoon not good, previous stay in surgical department had better nurses. (10S)

- Patient asks questions of doctors not nurses. (26S)
- Nurses, helpers, technicians have defect. (30S)
- Nurses are available 24 hours. (41S)
- You have to teach Libyan nurses everything headache for respondent. They need to study more, nursing care, patient to patient interaction. (7S)
- Nurses use good procedures, patient did not cry. (10S)
- Nurses were cooperative. (4S)
- Nurses are good in ICU, ICU better, more care, more questions answered by nurses. (36S)
- Older nurses have skill, newer (1 or 2 years on job) ones do not (39S)
- Some nurses' skill is OK, some defect. (21S)
- Nurses (non-Libya) learned from non-Libya nurses, its enough for them. (7S)
- Timing by Libyan nurses: they do not respect time. Unfair for non-Libyan nurses. 30 minutes to 1 hour late. Leave earlier than they are supposed to. (6S)
- Must improve Sisters (nurses), not taking proper responsibility. Not attentive to patient, patients get angry. (23S)
- Nurses have no initiative, no care, just work then go. (7S)
- Patient not satisfied with nurses, unless you call. Nurse told her take medicine and bed outside hospital. Nurse took bed and medicine

outside hospital for money. (28S)

- Missing some information from doctor, not clear. Using medical terms, so missing information. (14S)
- Nurses defect affect patient satisfaction; there are nurse mistakes (e.g., side effects), patient complications. (50S)
- When need Sisters (nurses), they come. (9S)
- There is defect in nurse. (49S)
- Nurses skills OK, good relationship with child. Relationship good with child (Libyan and non-Libyan). (46S)
- Satisfied with nurses, nurses did what she asked. (16S)
- Nurse has caring and skills; respondent referred to IV lines. (3S)
- Started nursing school in University. Instructors are Philippine. They will have same curricula. Eleven nursing students now. Best solution. (7S)
- Only one nurse yesterday good (attentive), others not good. (34S)
- Libyan nurses not involved 100% in work. Need to care. Try to solve problem (Libyan nurses). They need deeper probing. Libyan nurses give up, need more follow-up. Try to care, need follow-up. (6S)
- There is negative reinforcement not positive reinforcement. Report on nurses of mistake (or transfer to another department). Pay depends on degree not performance. (50S)
- Every question answered by nurses. (46S)

- Nurses were available all the time. Excellent, perfect. (32S)
- Nurses still not good. Libyan nurses worse than non-Libyan. No good reporting by nurses on patients. (50S)
- Nurses have good care with baby, especially with IV and giving medicine. Non-Libyan nurses have better skills and relation. (42S)
- Everything available (training) for nurses but they do not take advantage. (13S)
- Nurses “are so bad” (skill), not all in general. (24S)
- Some nursing staff OK, some not, need education not more staff. (17S)
- Interaction with nurses is very good, all staff very, very good. (27S)
- Dr. has to do job of nurses and helpers. (8S)
- Nurses and doctors need training in emergency, trauma, how to take investigation (ultrasound), and resuscitation (including population). (44S)
- 50 patients with 2 nurses affects level of caring. No time to observe or sit with patients, mothers not sufficient, barely enough time to take vitals, give IV. (6S)
- Need to bring more qualified nurses. (25S)
- Nurses have no advice to give. (11S)
- Nurses need more training. (8S)
- On nursing skill: AlHamduAllah. Were all Libyan nurses in Casualty. (43S)

- Helpers need to complete work. (8S)
- Nurse answered all patient questions. (27S)
- Respondent is satisfied so far with interaction with nurses in both department and ward. (45S)
- Defect is with nurse. (14S)
- Private hospitals/clinics have more comfort more smiling nurses. (25S)
- Sometime shortage of nursing staff. “to tell the truth” Sometimes patients getting inadequate care. Sometimes shortage of nursing staff. (5S)
- 7 to 8 nurses every day in department. Some are absent. Some difficulty, Pediatric Respiratory and Cardio. Two Sisters at night/adequate. (23S)
- Suggested improvement projects: Increase number of nursing staff, especially in ward. Respiratory and cardio patients are together need more nurses. (17S)
- Disadvantage of public health care is the nursing staff. (28S)
- For Libyans, nurses are satisfied with job. (7S)
- Some nurses do OK but others do minimum. (rush through routine). (16S)
- Public health care has defect in nursing staff. (48S)
- Patient is 0% satisfied with nurses response. (28S).
- Need more nurses. (7S)

- At 3:00 PM do not find any nurses. (28S)
- Patient receives medication on time from nurses, answer questions. (42S)
- Mother not satisfied with interaction with nurses, bad relationship, treatment on time, when asked to measure temperature or change beds, or change catheter they do not come fast. Sometimes nurse says she is busy or going to lunch, they neglect care. (14S)
- Private health care needs better skills of nursing staff. (49S)
- First week some delay in time for medicine, some nurses did not respond to questions but then it got better. (48S)
- TMC: if patient not satisfied it is because of poor nursing care. (7S)
- Nurse staff does not work good. (33S)
- Nurses have good skills. (40S)

Doctors include several levels. Consultants are the highest level and interns are the lowest. Consultants have managerial and teaching responsibilities. There is a wide level of skill among the doctors, and patients often do not distinguish, nor can they distinguish, the difference in level or skill. Consultants have more experience and all the Consultants this researcher met had training outside of Libya.

- Dependent on Consultant, able to give opinion and it is taken. (22S)
- There is a lot of difference between TMC and polyclinic in doctor skill and investigations. (42S)
- Patient is satisfied because doctor is qualified. (3S)

- Patients not satisfied with Libyan doctors. (18S)
- Most doctors have half care in heart, 70% care. Some do not care. (50S)
- TMC only place for cardiac care. Benghazi has cardiac but not all instruments are available. (27S)
- Some time doctors give simple answer, other times medical terms (especially when doctors talk among themselves in English). (49S)
- Respondent signed contract. “so lucky”. All doctors once finish internship must work many months without income so doctors get depressed, they work many hours. (8S)
- Doctor to doctor communication good. (8S)
- Giving doctors more money will not change anything much, once pay was increased doctors stay at TMC. (18S)
- Problem is visitors come anytime and doctors are not comfortable. (13S)
- There is very good communication from with doctor, but maybe because Mom is a doctor, maybe that is why. First day Mom very worried and nagged doctors, child is very young. With other patients also good. (38S)
- MashaAllah. Doctors are good, patient hemorrhage-doctors come. (34S)
- Came at 4AM and doctor available. Diagnose early. Took chest x-ray

at 4AM. (41S)

- Patient relationship with doctor is good. (14S)
- Performance measurement: knowledge of doctor, caring of patient by doctor, some doctors in another unit are lazy. Some have no contracts. They do their best, only one. A specific number of doctors have a contract, no place else to go, waiting for a spot. Participant has no contract most. (19S)
- Doctors need more experience, send doctors outside. (48S)
- Doctors preparation was very good. (10S)
- Everyday doctors here, afternoon here, evening here. (9S)
- In private some doctors not skilled-TMC better. (18S)
- Primary care: Doctors OK, availability of doctors and medicine lacking. (46S)
- Public health care has better doctor staff. (48S)
- Disadvantage of public health care: need more care, relationship between Doctor and patient. (41S)
- TMC has very good doctors (consultant, GP, specialist). (22S)
- Level of understanding of doctors was 100%. (36S)
- Doctors are good and give good advice but do not see doctors often. (11S)
- Most doctors do good job, some lazy. Same benefit for those who do a good job and those who are lazy. Exam determines what job. No

relationship with exam and job. Some score good on exam but not good on job. (22S)

- Consultants must be a guide. Someone must oversee consultants. (50S)
- Doctors: no comment but they are young. (6S)
- Not enough doctors to cover ward. (22S)
- No contact with family clinic in region. Come directly to TMC, availability of medicine, skills of doctor of staff, availability of doctor staff (24 hours). Would come directly to TMC regardless of time of day. (15S)
- Patients can not get the doctor they want (TMC). (24S)
- Good interaction with doctors. (41S)
- Doctors were well prepared when admitted. (21S)
- Very satisfied with doctor staff and skills. (41S)
- Performance measurement: Consultant tries to figure out who is active or not. If you do your job you will stand out. No financial advantage. (25S)
- Everyone (TMC doctors) tries to do the best. (25S)
- Very good communication from doctors, informed patient. (32S)
- Communication good on ward from doctors. (45S)
- When spasms, call doctors, doctors come fast. Nurses OK. (36S)
- Doctor performance measurement: deal with patients nicely, handling,

canulas. (47S)

- Good communication from doctors. Satisfied with doctors. Kept informed. (49S)
- Doctors highly educated, communication nice. (6S)
- Doctors tried to make contact with mother and make explanation simple. Mother understands. (46S)
- Patient asks questions and doctors answer. (34S)
- Patient informed by doctors on questions. (37S)
- Doctor (respondent) follows advice of consultant. (25S)
- Receive daily updates from doctors without asking. Many doctors come without asking just to check. (32S)
- Dr. at TMC no problem, they are attentive. (14S)
- Doctors and staff prepared when she arrived. (31S)
- Doctors have very good skills, very much improved-doctors only. (50S)
- Nice doctors at TMC and they do their best. (30S)
- Disadvantage of public: number of doctors and nursing staff, number of beds. (17S)
- TMC has one of the best cardiac pediatrics in Libya. (26S)
- Simple understanding of Doctors explanation. (11S)
- Public has better doctor staff. (46S)

- Private has same doctor skills. (41S)
- TMC is better than hospital, better doctors, better facilities. (18S)
- No doctors visit home. No family doctors, if baby not well take to doctor, no special clinic. Doctors good, technician and investigation not present, lack of lab, machines not available. (44S)
- Patient is satisfied with doctors, diagnosed early, result of investigation, understood explanation. (15S)
- Leadership is with medical staff. Good relationship. Decisions making is not sharp. Good socially with doctors. (50S)
- Some doctors have skill. (39S)
- People think doctor staff not good but they are good. Very satisfied with doctor staff and skills. People think Tunisia and Egypt or better but diagnosis is the same as Libya. (41S)
- Patient came to OPd endocrine, then admitted by advice of consultant. Doctors were well prepared when she came to ward, the bed was ready and the doctor on duty was prepared. Doctors did what they should do. (12S)
- Much better if distribute doctors outside TMC. (9S)
- Consultant attends rounds, follow advice of consultant. (25S)
- Admission systematic by admitting doctor. (12S)
- If patient does not understand, she asks and doctors explain. (29S)
- Maybe more money for doctors will motivate doctors. (12S)

- 90% of what doctors explain is understood, doctors inform other patients in room. (34S)
- Mother satisfied with doctors (esp. doctors on surgical ward). No difference between ward and ICU. (42S)
- Doctor skill is OK, problem is with the relationship with nurses. (14S)
- Need to increase # of doctors. (8S)
- Problem is doctors (behavior). (11S)
- More money does not help doctors performance. (39S)
- Doctors excellent at collecting history. Assisting the patient. Doing physical examination. Diagnosing condition. Doing procedure. Giving management. (5S)
- To a certain degree Libya has health standards. In doctor's contract (work hours, absences, best interest of patients). We know it, no written procedures. Nothing to tie procedure to performance. (25S)
- Attentive of doctor: according to Doctor. Some good / some not. (11S)
- Doctor answered all questions, informed her of diet for when she is discharged. (10S)
- Before private practice with TMC consultants now with contract can only work at TMC. (7S)
- Public health care has more doctor staff, consultants and specialist. (45S)

- Patient satisfied with contact with Doctor staff, doing her job. (15S)
- Doctors skill is 75%. (24S)
- Doctor available at night. (41S)
- Doctors gave early diagnosis, tried to simplify medical terms, some difficult, after that OK. (48S)
- Libya gave doctors more salary. Now consultants in public hospital. Before difficult to find consultants in public, they were in private. (20S)
- Some doctors like going to Arabic countries for their families. (24S)
- Some information from doctors delayed. If bad news is not well informed, delayed receiving information from doctors. (14S)
- For TMC, no affect on giving doctors more money. The same. (24S)
- Nice communication with Doctor. Dr. gives inadequate info initially to patient. (21S)
- At some level care from doctors will improve if given financial incentives. There is threshold, can provide. (50S)
- Doctors try to be nice. Sometimes loose patience when lots of admissions. (25S)
- Patient is comfortable with doctors, doctors have good communication in this department. (10S)
- Doctors' skills are acceptable. (47S)
- Consultant gave advice on phone to intern when patient was admitted.

(28S)

- Complicated cases done by consultant. (5S)
- Doctors do good jobs and procedures. (33S)
- There is a hospital in area of residency but more specialists in Tripoli.

(48S)

- Doctors usually answer, sometimes do not, answer sometimes just give reassurance, most time satisfied. (12S)
- Hospital better than clinic. Public is better than private because doctors are better and all facilities are in public. (44S)
- “everyone and their belief” (regarding giving doctors more financial incentives). (33S)
- Patient (child) loves some doctors more than nurses. (35S)
- Difficult relationship between doctors and administration, should try to improve relationship with doctors; facilities (esp. doctors). (18S)
- Availability of doctors in Casualty and Ward good. (40S)
- TMC does not have Specialists in all departments. (24S)
- Upon admission of patient there was a small meeting with doctor. (35S)
- Doctors available anytime. By phone also available. Nurses available morning and night nurses contact doctor when needed. (42S)
- From first visit Mom knows diagnosis, everything clear. Doctors are the best one. Received good and bad information. Clear

communication with doctor. (42S)

- Very, very good communication from doctors, doctor answered every question, transferred patient to other department for tests with doctor instead nurse, gave update if investigation is early and possible. (16S)
- Doctor has no relationship with admin. Do not agree with what they are doing. Should look at staff as human beings, not machines. (25S)
- There is no advantage in giving doctors more financial incentives. Medical relationship not determined by money in public. Level of caring the same. (22S)
- Financial incentives for doctors is better because increased their salary, good for them. (7S)
- Doctors contact Consultant for difficult cases, consultant decides. (18S)
- Doctor listened to patient and mother, good communication and discussion with doctor. (12S)
- Need to increase number of doctors. (18S)
- The level of caring by medical staff depends on department, head of department and specialist. (2S)
- Standards are dependent on doctor and consultant. Different thinking. (22S)
- Heavy duty, not enough doctors, large number of patients. (18S)
- Duties of some doctors include teaching, daily round, all day

consultation for pediatrics and other departments (esp. pediatric surgery), post admission rounds, post graduate studies for Libyan Board. (47S)

- Doctors in ward communicated. (43S)
- After 2:00 PM doctor not found. Some doctors on duty not found. If case critical, doctor called. (28S)
- If doctors with no contract leave, pediatrics will stop. They come to learn. (50S)
- Less expert doctors in private due to contracts at TMC. New doctors are in private. (22S)
- Doctor should make discussion with patient. (12S)
- Both mother and father satisfied with doctors. (48S)
- Clear explanation from doctors. (4S)
- Major procedures done by qualified doctors with nursing assistance. Complicated cases done by consultant. (5S)
- Private health care has availability of doctors when needed. (49S)
- Patient understood information. The specialist informed mother that kidney function is high. Does not know what this means. Seems to be vague. Specialization saying OK but kidney function... needs more information. (21S)
- TMC has one of the best cardio surgeons. (13S)
- Took other daughter to private clinic, but no Consultant, room was

good. (38S)

- Give more money to doctors and they will do a better job. (46S)
- Doctors were attentive, consultant sent for surgeon to evaluate. They see case everyday. Respondent is satisfied. (12S)
- Now doctors give more hours. They attend all patients. (7S)
- Not all are doctors good. 99% good. (8S)
- Doctor stayed more than an hour with patient late at night. (16S)
- Doctors were prepared upon admission. (29S)
- There is no difference between doctors in Libya and those outside in Tunisia or Egypt. She went to both countries and no difference. Just a problem with the way the Libyan people think. (45S)
- Some Doctors need to study. (7S)
- Doctors check non patient every day check. (36S)
- Need more doctors when leadership is asked for pediatrics, it is not enough, only 2 doctors, with 1 intern. (8S)
- Doctors not prepared well, relative of patient who works at TMC helps. (14S)
- Private: not good, not good facilities, not good doctor staff, transfer complicated cases, no consultant. Consultants now have contract in public. Private only has GP and seniors only. In other countries private is better but not Libya. Private is new concept in Libya. Only 5 years or so private in Libya. (38S)

Some consultants only show-up occasionally, do not come regularly but come to take attendance of others, but they do not punish themselves. Consultants not watched. (50S)

- Communication from doctors is easy to understand. (10S)
- Doctor communication is very well, explanation clear, explanation understood, answer clear not vague. (31S)
- Respondent is satisfied with skill of doctor staff. (17S)
- Doctors' explanation is 100% understood. (37S)
- In public hospital there is good communication with doctors. (2S)
- Doctors were prepared upon admission. (4S)

Respondents have variable expectations of the role of the pharmacist. There is one pharmacist at TMC for the pediatric departments. The expectations range from consultation to dispensing. The nursing staff is the liaison between the pharmacist and the patients. The potentially misunderstood role of the pharmacist by the nursing staff seems to have created tension between the nursing staff and the pharmacy staff. This is illustrated in the following responses.

- Pharmacist has bad relationship with nursing staff, hide medicine, no confidence with pharmacy staff. (17S)
- 75% or less skill for pharmacy staff. No development, based on personality and reading on their own. (24S)
- Patient informed about medicine. Take medicine from TMC pharmacy. Pharmacist instructs patient on how to use medicine. (34S)

- Pharmacist: sometimes laziness, not systematic, not complete. (7S)
- TMC pharmacist supplies all medication needed. They are qualified. (5S)
- Pharmacist tough in communication. (2S)
- Pharmacist knows how to deal with drug and patient. (22S)
- Skills of pharmacy staff are not good, relationship between pharmacy staff and patient difficult. It is through Sisters (nurses). (18S)
- There is only one pharmacist for ward. (22S)
- If medicine is not available, pharmacist gets help from other pharmacists at TMC. (39S)
- Pharmacist gives drug. Only dispense like a shop keeper. Do not discuss side-effects. (50S)

The comments that follow indicate that staff and patients responded on the need for additional training. Training includes soft and hard skills for both nurses and doctors. Staff members also expressed the desire to attend more conferences, and the staff does not always perceive they have the opportunity. Staff comments indicate that ability to attend training is based on position, capacity (i.e., capacity to temporarily leave duties at TMC), and motivation.

- Staff needs more experience. (46S)
- There is not good education for all staff. Some doctors and nurses do not have information about caring for patients. (39S)
- Need more courses outside the country, Europe and U.S. to update

skills (nurses and doctors), new doctors should be sent outside the country for training, to increase income of doctors and nursing staff, health care is the most important thing, Libya is better than Tunisia, will increase confidence if medical staff gets training outside. (16S)

- Need courses to improve skill of nursing staff (impression is from a previous visit). (15S)
- is new orientation for Sisters. Ask if you have questions. Based on knowledge of Staff Nurse, “we have no written procedures”. Training is because they have to know. It is up to people to know. (23S)
- Training is still not good. After finish high school no courses, no refreshing. Dr. still not good. Libyan Board has exams but no good lectures. Libyan Board is responsible for training after doctors finish Bachelors. Idea is good but implementation is poor. Doctors do not “take care” of Libyan Board, given a chance they go outside. (38S)
- Education is biggest obstacle to providing quality health care. (2S)
- TMC is famous for senior consultants. Came to TMC to learn. (50S)
- TMC is a teaching college; this is an advantage. (32S)
- Skills are more important than behavior, skills are available. (14S)
- Can not learn from Libyan nurses. Need continuous education of nurses. (7S)
- Staff training on communication skills needed. (33S)
- Should meet with other doctors outside Libya, send doctors outside

Libya to gain more experience. (46S)

- It is difficult to leave job/duties to go to conferences. (24S)
- Training on communication skills needed for staff. (35S)
- Staff needs more conferences. (46S) German doctors trained some Libyan doctors. (13S)
- Staff needs training in English language. (33S)
- Doctors (interns) need training how to advise patient how to take medicine. (34S)
- Nurses and doctors need training for behavior. (14S)
- Lots of knowledge offered at TMC. (19S)
- Staff skills are according to person is variant, know basics, extra skills variant. (25S)
- Better if doctors from U.K. and America come to Libya, even for nurses. Otherwise, you will get deteriorated skills. (7S)
- Training should be in primary health care, not in big hospital. (20S)
- Courses are organized, everything is free for staff. (6S)
- Need more education for doctors. (12S)
- Training should be on the practical, procedures (hand practice). Theoretical is good/excellent. (50S)
- Need to improve training of doctors and nurses. (8S)
- Medical staff is adequate (skill). (24S)

- Doctors should be trained by experienced ones, esp. when new.
Should attend Libyan Medical Board/attend conferences. Need chance to attend. (8S)
- Need more training outside TMC for new Doctors. The ones who are trained outside are better. (7S)
- Need courses to improve level of education of staff. (1S)
- For doctors: should have rotations to increase knowledge. (39S)
- Staff (doctor) satisfaction is about 65%. Need more courses, more procedures. Static. (50S)
- Respondent tries to learn from doctors. Tries to overhear to learn.
Came to TMC to learn. (23S)
- Proper English is a problem. Want everything in Arabic. (23S)
- Public health care is good for doctors to gain experience. (47S)
- Training needed: more care of nurses (behavior). (49S)
- Training needed on how to manage patients. (33S)
- Need courses in nursing care, sterilization. Need to organize courses, lots to organize. (6S)
- Need to improve language of local staff. (5S)
- Training: Increase for medical staff development (technical),
continuous education, attend conferences all across the world. Usually only Consultants go to conferences. Need permission to go. (24S)
- Private or public both. Need some training (nurses and doctors). (24S)

- Tunisian doctors get more opportunity to go outside. (48S)
- Need training in communication of patients with doctors.
Communication of nurses and doctors with patients. (22S)
- Need more courses for clinical practice, send doctors outside. (17S)
- Health committee should send doctors and nurses outside for more training. (21S)
- Need routine visits from visiting doctors. No internet connection with other hospitals, need online discussions. (50S)
- Staff needs to go to conferences. (48S)
- TMC is best Center for training, many departments for pediatrics, best center. (22S)
- Need more courses, send doctors outside to get more updates. No difference with doctors in Libya and Tunisia. Get same diagnosis. (43S)
- Need more research, send doctors outside Libya, how to communicate with patients-more than skills, skills are OK. (45S)
- Need to send doctors out earlier in training to become specialists and consultants. (49S)
- Need subspecialty courses (new machines). Instruments are not available because people not trained to use them. (50S)
- Need in-service education by qualified staff for staff on medical profession, up-to-date knowledge. (5S)

- Staff needs experience in some investigations. (48S)
- Staff needs better language skills (English). Using U.S. and U.K. and Canadian system for diagnosing because “we use English”. Is the best countries. (24S)
- Libyan system now better than before. They should concentrate on training the doctors (courses). (44S)
- Can not go to conferences (too busy). (24S)
- Need emergency training for doctors. (25S)
- Doctors need continuous medical training (must enjoy program). (47S)

TMC staff includes administrators. Administrative responsibilities are shared by Consultants (senior doctors), department level administrators, and top TMC management. Some of the comments were illustrated under the leadership theme, but are repeated here to complete the picture of the TMC staff.

- For administrative staff-need more courses, English language, computer, secretarial skills. (2S)
- TMC administration should do better. (48S)
- Need to change person at top. (1S)
- Food worse (no coffee or water for staff) unless doctor has special relationship with Administration; in that case they even bring breakfast to the consultant. There is “discrimination”. (50S)
- Leadership style is not ideal, need improvement. (7S)
- Hospital administrators only come when recommended patient. (8S)

- Management of hospital (TMC) is a problem. (11S)
- Not satisfied with skills of administrators because head of department is relative of officer. (17S)
- Health care should be by the government. Need the right man. Lack the skills or it will be better. (24S)
- In public disadvantage is administration. (30S)
- Skills of administrative staff is not so good, based on outcome, if good, the level of all would be good. (24S)
- TMC administrators do not improve state, they need to come and see, only come when recommended patient, too distant. (8S)
- Courses taken by administration, go outside Libya for nothing. More admin go outside country for training than medical staff. (50S)
- When managers help staff OK. When she needs vacation, holiday, or training not available because not enough numbers. (39S)
- If Admin more strict with Libyan staff. (6S)
- Leaders are not in their places so they do not see. Absent by mind (but not by body). Do not live the problem. Just tell staff “have to work”. They do not care if problem is solved. If you suffer as staff or patient, no one hears compliant. (24S)
- Not for all satisfied with management. (19S)
- Performance measurement depends on relationship with you and leadership of department. (24S)

- Leadership has no care. Afraid from their position only. Take money inside pocket. Take commission from companies (e.g., pharmaceutical). Courses taken by administration, go outside Libya for nothing. More admin go outside country for training than medical staff. (50S)
- Some problem related to management. Place scrub nurse in pediatrics wrong skill. (33S)
- Management/administration needs to concentrate on important things for patients and doctors. Think they do not care to improve quality. (8S)
- If administration know ideal, all will follow, we do not know how to follow. (7S)
- Office of admin no benefit, should do him or her job do-do not care. (14S)
- Leadership style: not in a good way. (8S)
- Management at TMC: fixed time like respondent, here in morning, off at 3:00 PM, off on Friday. (17S)
- In public health care leadership is not in right place. You do not need physician to run department, need someone with management skills. “Not the right man in the right place”. Not the right skills for a large hospital. (24S)
- Need to change behavior for Consultant and Admin. Think first of

patient and not themselves and their financial gain. Happy if punish doctors (about absence); why not happy if patient suffers. Need to change leadership (even at department level). Need new brain. Need to do something new. Should be max 8 years in position. Need new brains, so be active (like Obama). (50S)

- TMC Management: need “right man in the right place at the right time”. (25S)
- Sometimes family does not have confidence in management even though they do their best. (19S)
- Administrative skills need improvement. (7S)
- Admin staff is biggest obstacle to improved health care. (30S)
- Some nice people in administration. (2S)
- Too many of staff do not love their job. Afraid from leadership, need salary. (24S)
- Biggest obstacle to health care is from Admin. (19S)
- Do not expect anything to improve at TMC. No response from Admin. (19S)
- Need new brain. Need to do something new. Should be max 8 years in position. Need new brains, so be active (like Obama). (50S)
- TMC has good management. (34S)
- Admin is flexible, they listen, good cooperation from admin at top of TMC. (6S)

- Main problem is Administration. “Right man not in right place”. (30S)
- Need right man in the right place at the right time. (25S)
- Leadership is not bad, big hospital, admin need facilities: admin in building #1 only, need supervision in each building (admin group). To solve problems should have admin in each of the 3 TMC buildings. General Administration is centralized. (47S)
- Administration is OK. Director and chief very polite. They listen, they are trying but no results. Need to be stricter, too many absences, its habit. Disturbs the routine and are obvious. Administration is very nice. They try to solve problem and address complaints. (6S)
- Administrators need to be tougher with “trouble makers.” They have rules but some not followed. (6S)
- Administrative staff is OK but not the level needed. They do not triage, priorities (drugs, who to send outside). (50S)
- Each department there are administrators, they represent admin (like liaisons). 90% of depts. Satisfied. (13S)
- Need to change person at top (TMC), high person to more qualified, more polite, more educated. (1S)

The researcher coded quotations from respondents for other TMC staff members. Typical comments in this category follow.

- There are 24 social workers at TMC. (33S)

- Defect in availability of security. (30S)
- Defect in security (just shout). (49S)
- Security talks roughly, difficult to get in. (44S)
- Security makes decision on who enters based on opinion. (30S)

Trust.

The conceptual support for this study is based on a construct of trust. There were several statements that directly captured the respondents' perception of confidence in Libyan public health care system. More often trust was related to leadership as reflected in the responses below. The link between the data collected for this study and the construct of trust will be discussed in more detail in Chapter 5.

- Doctors do not “take care” of Libyan Board, given a chance they go outside. (38S)
- Bad relationship with nursing staff, hide medicine, no confidence with pharmacy staff. (17S)
- Need more courses outside the country, Europe and U.S. to update skills (nurses and doctors), new doctors should be sent outside the country for training, to increase income of doctors and nursing staff, health care is the most important thing, Libya is better than Tunisia, will increase confidence if medical staff gets training outside. (16S)
- Need right man in the right place at the right time (25S)

- Relationship with patient, care should be good. Improve thinking of people of nursing staff, defect in thinking of Libyan people on perception of nursing staff. (17S)
- Patient was expecting worse; she was planning to go to Tunis but not needed because of level of caring at TMC. (3S)
- They (SOH) know everything but ignore. (21S)
- As a whole, patients improved more than before. Before they refused to come, they thought they would die at TMC. (50S)
- Leadership (SOH) knows problems but do not care. (17S)
- Leadership (SOH) does not understand. They go outside for their own care. They do not need to; they do not care. (38S)
- Respondent trust public more (due to experience in TMC). (29S)
- TMC is best hospital in Tripoli. (34S)
- No difference between doctors in Libya and those outside in Tunisia or Egypt. She went to both countries and no difference. Just a problem with the way the Libyan people think. (45S)
- Comfortable, some members of family wanted to transfer to private clinic but refused, she likes TMC. (16S)
- Do not expect anything to improve. No response from Admin. (19S)
- Between doctors and nurses communication is bad. Give advice to nurses but the next day find nothing is done. Do not know how to improve. (20S)

- Need more courses, send doctors outside to get more updates. No difference with doctors in Libya and Tunisia. Get same diagnosis. (43S)
- Need more care for (from) doctors and nurse staff to increase confidence. (16S)
- People think doctor staff not good but they are good. Very satisfied with doctor staff and skills. People think Tunisia and Egypt or better but diagnosis is the same as Libya. (41S)
- If there is good judgment in how to spend money it would improve. (2S)
- Sometimes family does not have confidence in management even though they do their best. (19S)
- Wants treatment here in Libya, not Tunis. Some go to Tunisia but come back to Libya. Some specialists in Libya teach doctors in Tunisia. (32S)
- People complain about Casualty. Not enough numbers. Mixing of HIV with non-HIV patients. No enough rooms. In observation room patients are mixed.(social problem too, patients are afraid). (50S)

- Need more public than private, not all people can pay, care without money, Tunisia lots of money but care is less or the same.

Psychological problem with people. They have lack of confidence in Libyan Doctors, emotional problem, try to get better confidence in Libyan doctors. (16S)

- Need more public than private, not all have money to go to private. People go to Tunisia and they just spend money but there is no improvement. (15S)

Relationship of Themes to Research Questions

Table 1, previously discussed, is a matrix that illustrates the relationship between the interview questions and each of the three research questions. The matrix was developed prior to data collection and analysis. Each question asked of the participants in the study sought to answer one or more of the research questions. Furthermore, the derived themes generated as a result of open and selective coding from the study participants' responses can be mapped to one or more research questions. Table 10 illustrates the degree that the themes evolved address the research questions where S indicates a strong link and W indicates a weak link.

Table 10

Relationship of themes to research questions

Themes	What are the cultural considerations required in delivering health care in Libya?	How does privatization of health care impact Libya's public health care system?	What contributes to prospective patients' or providers' negative or positive perceptions?
Behavior/Relationship	S	NS	S
Capacity/Availability	NS	S	S
Communication	S	NS	S
Culture	S	NS	S
Leadership	S	NS	S
Libyan System	W	S	S
Motivation	S	S	S
Patient Physical Environment	W	W	W
Policy/Procedures/Records	S	W	W
TMC-Organization	W	W	S
Facilities	W	S	S
TMC Staff	S	W	S
Trust	W	S	S

Note. S=Strong Link; W=Weak link; NS=Not Significant

Table 10 highlights that the themes that evolved addressed patient and staff perceptions of the quality of care. Additionally, coding resulted in themes that highlighted cultural considerations in the delivery of health services. The degree that privatization affects the public health care system was impacted more by behavior of staff, perception of facilities, their role in relieving strain on the system (i.e., capacity), motivation (i.e., financial incentives for medical staff), and overall trust.

Observation

The researcher completed three observational sheets. The observation sheet template is displayed as Figure 4. Data was collected during the pilot. Observations were coded using the codes established prior to data collection. This deductive approach tested the conceptual framework for the study. Other notes were made throughout the study. The first observations were documented on March 7, 2009, from 9:30 AM - 11:00 PM in the Endocrinal Pediatric Inpatient department. At this time it was noted that TMC does not have medical records and the Internet is slow. Many sites are blocked that could be valuable in dispersing information to the professional staff. The ward was crowded and patients had to wait up to 2 hours to see a doctor. During rounds there were many doctors and frequent consultation, which reinforced that TMC is a teaching hospital. Patients do not seem to mind the large contingency of staff and the lack of privacy. A social worker often accompanies doctors on rounds. There was no obvious waiting room for parents and chairs for waiting parents were scarce. Cleaning of the floors involved flooding the floor with large quantities of water; water could be seen pouring from the bathroom into the hall.

Observational Coding Sheet

Date: _____ Time: _____ Location: _____

Circle the family code(s) observed. Indicate the number of the code referred to in each comment.

1. Accreditation	8. Accreditation	15. Finance	22. Policy
2. Admission	9. Admission	16. Governance	23. Procedure
3. Change	10. Change	17. Health	24. Quality
4. Communication	11. Communication	Assessment	25. Referral
5. Departments	12. Departments	18. Measure	26. Staff
6. Documents	13. Documents	19. Motivation	27. System
7. Electronic	14. Electronic	20. Patients	28. Tripoli Medical
		21. Physical	Center

Comment:

Figure 4. Observational coding sheet

Observational data was collected on March 10, 2009, 10:00 AM - 12:30 PM, in the Endocrinal Pediatric Outpatient department. Similar to observations made in the in-patient department, there was a team of doctors that meets with the patients. The

Consultant was the teacher during these sessions. Senior staff was very efficient, fast in making diagnosis, apparently very skilled. Doctors that were still awaiting a contract and were not paid were very active in patients' care. The staff was in constant dialog (i.e., Registrar, Attachment, and Consultant).

Many patients came from outside Tripoli. The wait time to see the physician was 2 hours. The outpatient department was open from 9:30 AM - 2:00 PM each day, but served different types of patient needs (e.g., endocrinal, diabetes). Patients still come to the pediatric department after adulthood because of their comfort. Similar to inpatients, privacy for outpatients cannot be guaranteed as patients walk-in to other consultations. Patients came to doctors in the outpatient department instead of doctors coming to exam rooms. Cloth is on exam table and not disposable paper. I did not see a process for changing the table's cover between patients.

There is a reliance on paper records in the outpatient department. Patients have a card with a number on it to cross reference with chart at TMC. At least one patient came with records of biopsy performed in Tunisia. Other patients came in with X-rays from radiology and sometimes carried their own charts from department to department. Even though doctors can read pictures from radiology, a patient was sent out to get the report, and gently reprimanded for causing the problem. The physician examined the patient without the report because the patient picked up the scan himself. Consultants and other doctors seemed very caring. They also have the authority to write referrals to a social worker (e.g., for chronic cases to give family salary for special diet).

The third set of observational data was collected March 12, 2009, 10:00 AM - 12:30 PM, in Endocrinal Pediatric Outpatient department. Many of the same observations were noted as previously. Interruptions continued while patients were in the room. One patient traveled 100 km to receive an injection that is required every 2 weeks; the doctors wrote a note to the patient's school as the child misses school when seeking treatment at TMC. Healthy babies also came to the TMC Outpatient department for a check-up. A physician mentioned that Libya does not have a well-baby system. Many patients mentioned that they have a doctor in the family and speculation is that if they mention this they will get better care.

The researcher made other general observations throughout the study. The comments below are from general observations made by the researcher or comments made to the researcher. In the latter case, the conversation with the researcher was with a person aware of the researcher's role.

March 12, 2009:

- Interruptions while outpatient consultations are common.
- Patient travels 100 km for injection every 2 weeks, misses school.
- Patients mention that family member is a doctor so they think they will get better care.
- Healthy babies came to TMC outpatient for check (need baby-well system).
- March 14, 2009:
- Diabetic outpatient patient AM. Thursday and Saturday are the only

days. Saturday there is no school so OPD is very busy.

- Not enough seats for everyone who is waiting

March 19, 2009:

- A patient (mother) from another room came and used another patient's (single room) bathroom during interview.
- "Country can not be trusted if people are not qualified."-translator
- Doctors alone in their duty, but no contract, many doctors not paid.
- Upset patient looking for consultant. Information is vague, did not clear answer about grand daughter in ICU.
- Libyan nurses seem not to want to be interviewed.
- Some mothers of pediatric patients are hesitant to talk without their husband's permission.

March 21, 2009:

- Libyan nurse agreed to be interviewed, then became busy, and then went home, 3-Libyan nurses refused to be interviewed. Comment from translator/doctor: "there is no benefit from interviewing them, they have no answer".
- Children's Day was celebrated in pediatric department
- Sheet not fully covering bed.
- Hospital staff distributed activity book to patient during interview, temporarily stopped interview.

- Two mothers refused to be interviewed, one of them because husband was not there.
- Even though it was mentioned by staff that visitors do not adhere to hours of visitation, I observed that this must be the exception. Around 3:00 PM, 100s of visitors flock to TMC carrying water, juice, cookies, bread, thermos (coffee and tea). A vendor is present outside that is well stocked with cookies, juice, water, bananas, and yogurt that is not there when I arrive each morning around 10:00 AM. Visitors can also purchase flowers at the hospital entrance. Before visiting hours there is security at the hospital entrance. Security checks for appropriate access prior to open visitation. More often I am not checked but my face became familiar. I am more likely to be checked if I come through Casualty in the evenings. It is not clear if it is because I am recognized because I was never checked after my first and this is the entrance I regularly used.
- Internet access is inconsistent.

March 22, 2009:

- Translator thinks Indian nurses have the best relationship with patients (behavior). Philippine nurses have the best skill (just do their jobs but do not build relationship). Libyan nurses have the worse relationship with patients but there are some exceptions.

March 23, 2009:

- Another senior Doctor mentioned the under qualification of Libyan nurses. Due to shortage, under qualified nurses are placed in positions. Hesitance by nurses to be interviewed is not because of fear but knowledge of deficiency. Consultants returned from 4 day medical conference in Zawia. The 6th Libyan Medical Conference. Topics included HIV/AIDS, vaccinations, heart disease, elderly diseases, psychiatric diseases, ethics, medical screening, and dentistry. They returned to a diabetic international conference at TMC.
- Several senior physicians have worked outside Libya but returned for less pay to what appears to their devotion to their people. The critical patients seem the most satisfied because they get the attention of the most senior and skilled physicians.
- Translator late because patient died after coming through Casualty. Patient family did not know for 2 hours. Patient was not transferred to department for 10 minutes. Arrived in Casualty department but not determined to be dead in Casualty. Examination determined patient had been dead for 2 hours prior to arriving in hospital. He stated that Casualty doctors should have best skills but best skills are in the department.
- Patient (or Patient's family member) carry paper files, sits on coffee stand and almost forgets it.

March 24, 2009:

- According to the head of Neonatal at TMC there are the Neonatal department has nine ventilators, 9 C-Pack breathing machines, 50 beds, 25 incubators, 4 Consultants, 4 Senior Registrars, 5 Registrars, 12 Senior House Officers. There are usually one Registrar and two SHOs on duty each night. She desires more equipment to keep level of department current with technology.

March 25, 2009:

- 21S: noisy construction during interview, single room
- 22S: female doctors married to doctors will have more flexibility and understanding from spouse. They would understand late hours. Same demands on female and male doctors, 3 month leave for birth for money.

April 1, 2009:

- 35S: father of HIV patient infected daughter carrying glass vial of daughter's blood to another facility for testing. Sample not in bio container. Daughter does not attend school. No bio receptacle seen at TMC.

April 4, 2009:

- 41S: needle with clear fluid (saline) on dresser. Mom uses to relieve baby's nasal congestion.

April 6, 2009:

- No seating for patients, patients standing in hall.

- Consultant made the following comments:
 - TMC has subspecialty in pediatrics (Cardiac surgery)
 - Those that get best training leave.
 - Need more financial incentives
 - There are ~ 70 cardio procedures/year

Documents

There were several inquiries for documents made throughout the study such as policies, procedures, organizational charts, and mission statements. A performance rating form for doctors was offered. The form is in Arabic and was translated to English. The translated version is attached as Appendix E. Despite many of the responses from staff members, the qualification form clearly defines the criteria Consultants use to measure performance of doctors with a contract. The first criteria could be defined as negative enforcers. Absences, disciplinary penalties, and sick leaves are not common categories for rating professionals. However, the second category evaluated, performance efficiency and personal traits, does evaluate the colleagues in areas of quality and quantity of work, preparation, and relationships. Yet, in this category *persistence at work* is defined as adherence to work schedules.

The second document offered was a small multipage card published by the Libyan Health Information Center (General People's Committee for Health & Environment, 2008). The small brochure includes demographic information, health indicators, socioeconomic indicators, and morbidity statistics. Of more relevance to this study are

the statistics on the number of health care providers, hospitals, and private clinics. Table 11 displays the 2008 indicators for the private sector facilities.

Table 11

<i>Private Sector Facilities</i>	
Indicator	Value
Inpatient Clinics	67
Beds	1433
Outpatient clinics	268
Dental clinics	159
Labs	166
Diagnostic center	4
Pharmacies	1543

Table 12 indicates the public sector facilities. The table illustrates public facilities have more capacity than the private sector. The data supports the comments that the private sector cannot relieve the strain of the public sector. Overall, there are 9,276 physicians or 17 physicians per 10,000 Libyan people.

Table 12

<i>Public Sector Facilities</i>	
Indicator	Value
Hospitals	96
Beds	20,289
Polyclinics	37

Member Checking

The researcher conducted member checking on April 5, 2009 and April 8, 2009 with Dr. Mgadmi, and two interns who served as translators respectively. The initial findings from the interviews and observations were shared. Over the length of the study, there were opportunities to discuss the findings; therefore, Dr. Mgadmi and the interns confirmed the findings discussed in this section.

The level of education of nurses is poor. As early as 1994, researchers noted that critical nursing care skill development must consider the need for research, innovation and standards (Redshaw & Harris, 1994). Furthermore, clinical judgment and decision-making skills should be integrated in nursing education (Standing, 2007); yet, Libyan nurses are highly criticized for having no decision-making or clinical knowledge. Continuing professional education can enhance the critical practice of nurses (Wildman, Weale, Rodney, & Pritchard, 1999). Additionally, continuing education programs can improve nursing confidence (Shipman et al., 2008). Even though the three-year diploma and graduate programs are quite typical for nurses for clinical competence (Clinton, Murrells, & Robinson, 2005), some staff providing nursing care at TMC had as little as one year post secondary education. Only a small number of Libyan nurses have been educated in a higher level nursing institute. Mothers are admitted with pediatric patients to compensate for the deficiency of skills and availability nurses. The doctors prefer to communicate with non-Libyan nurses instead of Libyan nurses because of their superior

skills not because of cultural differences alluded to by one of the study participants.

Doctors believe that Libyan nurses declined to be interviewed because of laziness, not because of insecurity in their positions. One senior doctor stated on March 23, 2009 that Libyan nurses are under qualified. He went on to state that the hesitance by nurses to be interviewed is not because of fear but knowledge of deficiency. This was also restated during member checking:

- The level of education of nurses is poor. Only a small number have higher level institute nursing.
- Nurses decline to be interviewed because of laziness, not insecurity.

Other comments related to the nursing staff by TMC staff supported this assertion:

- Libyan nurses under qualified. Libyan nurses are lazy-just come in. (7S)
- Some nurses are lazy. Doctors OK. Ask nurses many times, they say OK but they do not follow through. (8S)
- Some nurses difficult to communicate, some lazy. (8S)
- Need good nurses. Most nurses are lazy. (22S)
- Nurses not skilled just lazy, miss doses. (22S)
- “Libyan Sisters are not qualified. Need some control.” (47S)
- Problem with nurses, not qualified, need more qualified Libyan nurses. (13S)
- New nurses can not learn from Libyan nurses. Need continuous education of nurses. (7S)

Medical professionals should have respect for patients. However, there tends to be a positive relationship between patient satisfaction and medical outcome. Patients are less concerned about the physical environment or behavior if the pediatric patient is recovering well. This assertion was based on the responses to questions on medical treatment expectations and the physical environment: The following are responses to the listed questions:

Respondent 40S:

To what degree did the medical treatment meet your expectations?

-Better than morning, happy with care.

Response to questions on physical environment.

-All is good.

Respondent 10S:

To what degree did the medical treatment meet your expectations?

-Very-very good.

Response to questions on physical environment.

-Same respondent that the room was clean and comfortable.

Respondent 14S:

To what degree did the medical treatment meet your expectations?

-Satisfied difference from day of admission, child improved a lot from day of arrival.

Response to questions on physical environment.

-Nice, but do not care. Only are about care of baby. Did not talk to wife about it.

Respondent 26S:

To what degree did the medical treatment meet your expectations?

-So far very good.

Response to questions on physical environment.

-Respondent stated bathroom and room was clean and comfortable

Respondent 48S:

To what degree did the medical treatment meet your expectations?

-Al HamduAllah, big difference between now and day of admission.

Response to questions on physical environment.

-Respondent stated that she was satisfied with all accommodations.

Respondent 45S:

To what degree did the medical treatment meet your expectations?

-No more convulsion, so better.

Response to questions on physical environment.

-Respondent stated she was satisfied overall with the room and bathroom.

Respondent 41S:

To what degree did the medical treatment meet your expectations?

-From first day noticed change (improvement).

Response to questions on physical environment.

-Respondent stated that room was comfortable, bathroom was clean.

Temperature of room was good. Was comfortable at night.

Respondent 46S:

To what degree did the medical treatment meet your expectations?

-Baby condition much improved.

Response to questions on physical environment.

-Mother responded 100% satisfied with room. TV good. No overcrowding, resource of water good.

The following comments tend to indicate that patients with less than a satisfactory medical outcome are more critical of the physical environment.

Respondent 49S:

To what degree did the medical treatment meet your expectations?

-No difference in outcome. Today just started treatment, still vomiting.

Response to questions on physical environment.

-Mother responded that should clean more than 2 times per day.
(especially in gastro room)

Respondent 42S:

To what degree did the medical treatment meet your expectations?

-No difference, loss weight (Mom brought baby back).

Response to questions on physical environment.

-Mom responded to question about physical environment of room. Good, OK cleanliness (not good-not bad). OK for public hospital. Bathroom OK, good, cleanliness OK, no separate receptacle for dirty diapers.

Despite the responses that imply that there is not a mechanism to measure performance, Consultants conduct performance reviews annually for Senior House Officers (SHO), Registrars and Senior Registrars. They get promoted based on review. Appendix E supports the point that attendance, skills, and professionalism determines rating. Regarding performance, Mgdami (personal communication, April 5, 2009) stated “should be performance #1, not just by recommendation.” He added that the selection process should have open competition and interviews. Performance is the most important. Attachments, which is a category of doctors, are not rated; they come from somewhere else.

Primary health care is of great concern. Dr. Mgdami (personal communication, April 5, 2009) added, “There is no good health system without strong and effective primary health care.” One result for TMC, a tertiary care facility, is that self-referrals are a challenge. Primary public health care is free and some foreigners pay for health care, which is dependent on nationality. Emergency care is free for all non-Libyans. Ambulances do not bring patients from home to the hospital; they are used to transfer patients between hospitals.

Salary and contract determine where doctors work. Additionally, some Consultants have responsibilities that include delivering population education on TV, serving on the Libyan Board (responsible for training 275 doctors), and administering

exams for undergraduate and post graduate medical students. The Scientific pediatric board is part of Libyan Board.

Respondents did not cite any explicit standards, leading to concerns about hygiene. As an example, there are sinks in the pediatric inpatient rooms, but not in all departments. There are no safety boxes for needles (i.e., biohazard receptacles). There is no auditing or continuous assessment. Libya does not use Electronic Medical Records, and the entire health information system is not electronic. Even though it was observed and stated that mothers dispense drugs to inpatients, it is not the policy. It was also stated that mothers sometimes bring their own medicine from home. Albeit accreditation efforts were not offered as responses during the interviews, there have been efforts to obtain department accreditation; it is in stage 1 with WHO.

Private health care in Tunisia was stated as being medical tourism, which utilizes skilled communication. In contrast to the perception of many study participants, hospital administrative leadership does not determine who gets sent abroad; the determination is made collectively by medical senior staff. Seven colleagues collectively determine in pediatrics, which patients should be sent abroad.

Chapter Summary

Chapter 4 described the results of data collected at Tripoli Medical Center between March 7, 2009 and April 7, 2009. Observational data throughout the entire period was presented. Interview data only includes data collected after the pilot. The pilot was conducted between March 7, 2009 and March 15, 2009 solely to pretest the

survey instruments. Despite several inquiries, few documents were available for this study. Member checking was conducted and was presented in this chapter.

The parents of pediatric patients and TMC staff participated in the study. Parents and doctors were willing to participate in the study. All parents interviewed were Muslim; and, all patients had at least one Libyan parent. The majority of the parents interviewed were mothers; but, there was no obvious differences in responses that could be contributed to gender. Male and female doctors were interviewed. Doctors were open and tended to support the study. As with the patient population, there was no significant differences in most responses that were based on gender. However, some female doctors shared their challenges of balancing a family and professional responsibilities.

Additionally, female doctors sometimes felt that parents of patients had less confidence in them than male doctors. All nurses interviewed were female. Participation from Libyan nurses was less than expected. Non-Muslim and non-Libyan nurses did not give any responses that could be directly contributed to differences in religion or ethnicity.

The responses from the study participants were coded. The results of open, axial, and selective coding were presented. The successive steps of coding resulted in 13 themes. Typical responses were presented with the intent of immersing the readers in the study. Despite its weaknesses, study participants tended to support the public health care system and encouraged further investment in the system. The parents indicated trust in physicians. Staff and parents cited weaknesses in leadership and management systems as a contributing factor to poor health care delivery services. Doctors and patients viewed the nursing staff as unskilled. This results indicated that relationships and behavior in

delivery of health services are major factors that determine patients' preference for where to receive services (e.g., the private or public sector). The respondents also perceived that patients with a personal recommendation will receive a higher level of care as compared to patients that do not have a personal recommendation. Chapter 5 will present the conclusions and recommendations from the study.

Chapter 5: Summary, Conclusion, and Recommendations

Introduction

This chapter discusses the findings that resulted from the study. The results of the interviews are more prominent than the data collected from observation and documents. The study was bound by time and resources. Only one researcher was available to collect observational data. However, the data obtained from the interviews was richer than what could be collected from one researcher collecting observational data in the timeframe studied. The discussion that follows answers the three research questions for this study:

1. What are the cultural considerations required in delivering health care in Libya?
2. How does privatization of health care impact Libya's public health care system?
3. What contributes to prospective patients' or providers' negative or positive perceptions?

This chapter also discusses the relationship between the findings and the conceptual framework for the study. The construct of trust is based on the premises that trust is based on (a) perception of competence, (b) perception of intention, and (c) capacity to trust. The findings for the study are summarized. The chapter concludes

with a discussion of the social significance of the study, recommendations for action and future research, and the researcher's closing statement and reflection.

Interpretation of Findings

In chapter 4 the questions posed to the respondents were mapped to the research questions. The questions attempted to draw out responses from the study participants who could help answer the research questions for this study.

Conclusion about research question 1: Cultural considerations.

There is a wealth of information on delivery of health care in the West. Chapter 3 discusses the delivery of health care in the West and in other developing countries. However, little has been written about Libya's health care system. This study attempted to identify any cultural findings that will bring insight to providing improved quality health care in Libya.

The study explored cultural considerations required in delivering health care in Libya. All study patients who participated in the study were Muslim. All pediatric patients in the study have at least one parent who is Libyan and the majority of the patients have a Libyan mother and father. Many of the responses reflected the Islamic manners and culture. Typical responses of *MashaAllah* and *AlHamduAllah* reflected the importance of Islam in the life of the Libyan people. Additionally, staff members often responded that the quality of an individual's work was between the individual and their own conscious or in their desire to please God. That is, the intention to do good work is more a relationship with God than with anything that can be administered.

Specific to the pediatric department, mothers are admitted with pediatric patients if the patient is well enough to be on the general patient ward. Therefore, the ward is essentially a woman and child ward. Fathers are treated as visitors. It is important to understand this aspect of Libyan and Muslim culture as the separation that ensures privacy and dignity of women must be considered when administering health care. Yet, the mothers do not have any trepidation in interacting with male doctors during rounds. All nurses in the pediatric department are women; there are some male nurses in other departments.

The professional female staff occasionally offered insight into the challenges of being a female professional at TMC. Like many women in the west, balancing home and career is challenging. However in Libya, many of the women who are studying to be doctors have delayed marriage. Those who are married tend to marry another doctor who understands the demands of being a doctor. One female doctor commented that some of the questions posed to them on various applications and the criteria for annual performance reviews (e.g., attendance) works against women who are married or are mothers. One male doctor commented that because of the high percentage of women doctors, the department is often understaffed due to absences (e.g., pregnancy leaves). One female nurse commented that patients often express more confidence in male doctors than in female doctors. At least one single nurse commented on the challenges of convincing their family of the need to work nights. The dialog follows:

- 50S: always shortage of staff. Fixed number by contract, does not consider vacation. 80% are female and they have higher lost time.

Accept doctors without contract to cover gap. If doctors with no contract leave, pediatric will stop. They come to learn.

- 6S: Public health care has a big advantage, lots of machines, offer lots of procedures. Disadvantage is that patients don't respect visiting time, disturb medical staff. Should be 3PM - 6PM., especially in non-private rooms during rounds. Now patients do not interfere when doctors are there, *especially male doctors*.
- 39S: Respondent works everyday 8AM - 2:30 PM. Some days attached to night. From family difficult, only girl in the family, first time a problem but now they are used to it.

Arab and Muslim societies are collective. That is, the benefit to the individual does not take precedence over the benefit to the family and society (Haller, 2003; Naber, 2005). Yet, when it comes to teams, the staff members do not seem to have a team concept. They are conscious of their individual responsibilities and the individual responsibilities of other team members. The collective nature of the society also carries over to patient rights. Medical papers are shown to security in order to gain access.

There is a perception that if a patient is treated at TMC with a recommendation from a person in an area of influence, the patient will be treated better. Influence in this context can be due to educational level or position. Libya, like many countries in the developing world, has a high power distance. This means that educational level and position are highly regarded. The researcher observed that it is important to address medical doctors as doctor. The affect on the health care system is that patients perceive

that those who come with a recommendation from an influential person, or who knows someone in an influential position at TMC, or is a person who is influential, will get better care. Several respondents cited this phenomenon but it is not clear if most felt this could be changed. There is a perception that all patients are not treated equally.

Conclusion about research question 2: Effect of privatization.

The findings and the respondents' perceptions of privatization in health care in Libya were somewhat surprising. Regardless of the improvements wanted in the public health care system, the respondents overwhelmingly supported improvements and even an expansion of Libya's health care system. In attempting to answer research question #2, the study found that the effect of Libya's public health care policy had an impact on private clinics and hospitals. When doctor salaries were increased approximately 10 fold, doctors were also required to sign a contract that limited them to practice at TMC. As a result, the most skilled doctors no longer supplemented their incomes in private clinics. Respondents have a lack of confidence in the private health care system. Private clinics can only administer the most routine of care, and do not offer the procedures and diagnostics for more complex cases. Many respondents indicated that the motivation of private institutions is solely financial, and that they often take fees and then transfer patients to TMC or other public health care institutions. Yet, in the areas of behavior, patient/staff relationship, and communication the private health care system is perceived as better than the public health care system.

The tendency to support public health care is likely a result of the collective Libyan culture. Yet, despite Libya's strongly socialist society, Libya rewards

entrepreneurship. Those that can afford private health care and support an expansion of the private health care, also contend that the public health care system needs to be strong so that health care can be provided to all Libyans regardless of a patient's ability to pay. Several study participants believed that health care insurance was the solution to Libya's ability to provide equal access to quality health care while not overburdening the public health care system. The respondents' support of the public health care system did not imply a total rejection of private health care institutions.

Conclusion about research question 3: Factors contributing to negative or positive perceptions.

In this section, the most frequently cited themes are discussed that contributed to prospective patients' or providers' negative or positive perceptions of the Libyan health care system. The items discussed here are not all inclusive, but are the prevailing factors derived from the comments of the respondents.

Soft skills such as communication, behavior, and relationships were important to patients. Patients had a negative impression of the level of caring of the nursing staff even though there were exceptions. Even when comparing private health care to public health care, the behavior towards patients by the nursing staff was often cited as superior in private clinic and hospitals.

Parents of pediatric patients had a more favorable opinion of the medical staff (especially of doctors) if the child makes a quick recovery. Yet, regardless of outcome, patients had a favorable opinion of senior medical staff. There were few comments expressing disappointment in the doctors' skills. The skills of doctors at TMC were often

cited as an advantage of coming to TMC over primary care public facilities and private clinics. These are reflected in the responses that follow. The comments are grouped by respondent:

Respondent 40S:

Response: Better than morning, happy with care.

Question 11: Describe the how the doctors communicated with you.

Response: excellent

Respondent 41S:

Question 38: To what degree did the medical treatment meet your expectations?

Response: From first day noticed change (improvement)

Question 11: Describe the how the doctors communicated with you.

Response: good interaction. Came at 4AM and doctor available.

Diagnose early. Took Chest x-ray at 4AM. Took taxi from Tajura hospital

Question 12: How would you describe the manner in which doctors kept you informed?

Response: mother satisfied. Round daily, positive change in baby. improvement.

Additionally patients indicated their confidence in the experience of doctors at TMC with is indicated with the following statements:

Respondent 29S:

She trusts public more due to experience in TMC. Dislike idea of more

private, should pay more attention to public.

Respondent: 32S:

TMC is a teaching college. Patient wants treatment here in Libya, not Tunis. Some to Tunisia but come back to Libya. Some specialists in Libya teach doctors in Tunisia. There are very rare cases in this department.

Respondent 45S:

Advantage of TMC and public health care are free cost, more doctor staff, consultants and specialist.

Respondent 48S:

Referred from General Hospital in Tripoli because no empty beds. There is a hospital in area of residency but more specialists in Tripoli.

Respondent 13S:

Private clinics are more materialistic than public, they abuse money for cases like oncology then refer to hospitals like TMC.

Respondent 15S:

Patient comes directly to TMC, availability of medicine, skills of doctor staff, availability of doctor staff (24 hours). Would come directly to TMC regardless of time of day.

Respondent 20S:

Libya gave more salary. Now consultants in public hospital. Before difficult to find consultants in public, they were in private.

Respondent 29S:

Patient trust public more due to experience in TMC. Dislike idea of more private, should pay more attention to public.

Respondent 35S:

Libya does not have good private clinics, only care about money. Problem for patient. They take money then transfer patient to public.

Respondent 38S:

Private: not good, not good facilities, not good doctor staff, transfer complicated cases, no consultant. Consultants now have contract in public. Private only has GP and seniors only. In other countries private is better but not Libya. Private is new concept in Libya. Only 5 years or so private in Libya.

Respondent 44S:

Public is better than private because doctors are better and all facilities are in public.

The distribution of resources throughout the public health care system is the area of greatest concern. The staff at TMC is overwhelmed by cases that should be treated at primary and secondary facilities. All patients who come to TMC are accepted even though it is a tertiary medical center. In addition to human resources, the availability of investigations, medicine, and procedures affects the perception of prospective patients. All categories of respondents acknowledged that TMC is the last stop in the country; it has more resources than other facilities in the country. Nevertheless, respondents state

that TMC has an inconsistent supply of medicine, equipment, procedures, lab regents, and supplies. Staff and patients frequently expressed frustration with the Libya's supply chain for health care. Their frustration was directed towards TMC and the country's health care leadership.

Hygiene is a secondary factor observed and mentioned by many respondents. The lack of written procedures, inconsistent availability and use of items like disposable gloves, and the absence of biohazard receptacles provide evidence that hygiene concerns are well founded. This is substantiated with the following responses:

Respondent 12S:

Question 55: What do you think is the optimum administrative structure for the Libyan system of health care?

Response: Hope SOH to come to hospital to check availability: hygiene, availability of treatment, courses for doctor, communication and behavior of medical staff with patients.

Respondent 22S:

Question 79: What are the advantages and disadvantages of having more private clinics and hospitals?

Response: Disadvantage: take lots of money from people. Less expert doctors due to contracts at TMC. New doctors are in private. Advantage: better caring, nutrition, hygiene.

Questions 90: What do you think is the optimum administrative structure for the Libyan system of health care?

Response: Hygiene, need better hygiene at TMC. Drugs not available.

Not good facilities (supplies). Small things not available.

Respondent 12S:

Question 54: Where do you think the emphasis on training of health care professionals and administrators should be?

Response: Nurses need more education in English language, nurse take blood without gloves (needing more education).

Respondent 25S:

Question 68: How would you describe the organization's commitment to excellence?

Response: far from excellent. Provide lab investigation, do not loose, should have disposable gloves, provide facilities.

Question 92: To what degree does Libya have unified standards for health care ?

Response: to a certain degree. In a contract (work hours, absences, best interest of patients). We know it, no written procedures. Nothing to tie procedure to performance.

Respondent 23S:

Question 92: To what degree does Libya have unified standards for health care ?

Response: not big procedures in pediatrics. New orientation for Sisters.

Ask if you have questions. Based on knowledge of Staff Nurse, "we have no written procedures". Training is because they have to know. It is up to

people to know. Respondent tries to learn from doctors. Tries to overhear to learn. Came to TMC to learn.

TMC is a teaching hospital and many of the Consultants were educated outside of Libya. There is a perception by respondents that Libya should not operate in a vacuum and still must obtain best practices from outside of Libya. This is evident by the greater confidence in non-Libyan nurses over Libyan nurses, the confidence in those educated abroad, the desire of staff and patients to send medical staff abroad for training, and the concern of the fairness of the process to send complicated cases for treatment in Europe.

Relationship of findings to conceptual framework.

The study sought to support or dispel the suggestion that health care organizations operate within an environment in which members of organizations view competence and intentions as important. The construct of trust is based on the three premises that in order to trust there must be: (a) perception of competence, (b) perception of intention, and (c) capacity to trust.

This researcher contends that the respondents have the capacity to trust. They overwhelmingly demonstrated trust in health care providers outside of Libya and trust in skilled specialists at TMC. In the case of the former, many respondents discussed their perception of the criteria for selecting patients for treatment abroad. In all cases treatment abroad was considered positive for the patient. The respondents clearly demonstrated the capacity to trust but the remaining two premises of trust are not so obvious.

This study revealed that the *perception of competence* varies among the respondents. The main categories are the perception of trust for the nursing staff, doctors, TMC leadership, Secretariat of Health, private health institutions, and public health care system. System and institution trust is based on the people who work and manage the institutions and system. Competence of the nursing staff varied but when more descriptive comments were made they tended to be negative. Doctors had a more negative impression of the nursing staff than patients; and non-Libyan nurses were considered more competent than Libyan nurses. Respondents tend to consider TMC doctors as competent and because of contract and more specialization, TMC doctors are considered more competent than doctors in the private care system. Additionally, doctors with experience and education from outside Libya are perceived as more skilled. Due to the depth of services at TMC, doctors are also considered more competent at TMC than in primary care public facilities.

The perception of competence in the TMC leadership is complex. Department administrators, Consultants, department heads, and TMC executives were referred to as leaders. Consultants and department heads are physicians. Respondents, especially the staff, did not demonstrate a perception of competence in the TMC executives. The lack of confidence in their competence is based on the outcomes (e.g., disciplinary problems and shortage of resources). There is also concern that TMC is not managed by individuals with academic training in hospital administration. Consultants and Department heads are viewed as competent in their medical duties, but there is less confidence in their managerial skills. Comments on department administrators were

neutral; respondents stated that they are trying their best and are nice people.

Respondents generally believe that the individuals who comprise the Secretariat of Health (SOH) are competent. They are given credit for Libya's vaccination program and public health education campaigns. At least one respondent commented that the SOH is not competent in dealing with the primary health system. Respondents tend to suspect the intention of the SOH.

The *perception of intention* conjured up the strongest emotional responses when respondents were asked about the Secretariat of Health. Respondents believe they understand the problems in the system and that if they cared the system would be better. This is the best example of respondents linking outcome to intention in this study. Doctors were perceived as trying hard. Several respondents mentioned that senior doctors have used their own money to help patients. Junior level doctors often work long hours without pay; however, there have been conflicting comments on their intention. Some respond that it is for the interest of the patients and others have commented that it is to get precedence in obtaining a contract. As earlier alluded to, competence in nursing is an area of concern. Respondents who indicated a lack of competence in nurses often indicated that nurses were not motivated to deliver a quality service. In other words, the nurses perceived as incompetent were also perceived as not having the intention of fulfilling their duties of providing patient care.

Conclusion of Findings

The staff did not appear to have a clear understanding of how performance is measured and what constitutes average, above average, and exceptional performance.

Yet, there is a process to periodically review performance but this was rarely cited. The concept of individual performance takes precedence over team performance to improve quality of care. There does not seem to be a strong relationship between performance and compensation; therefore, financial incentives should not be the only motivator to improve staff performance. However, salary is a determination of where someone chooses to work (e.g., contract). There is an emphasis on academic accomplishments; and, academic accomplishments determine position in lieu of practical experience and performance. There is greater confidence in doctors who have been educated and have experience in the United States or United Kingdom.

The medical staff would like more ongoing, continuous education beyond formal academic training. It is perceived that there is not equal opportunity for training. Training on soft-skills (e.g., behavior and communication) was overwhelmingly cited by respondents as needed. Several respondents stated that training of personnel and staffing of the Casualty department is needed. Medical education is in English. Doctors vary on conversational English and Libyan nurses do not speak English. Improving English was cited several times as an opportunity. Libyan nurses have a wide range of training. TMC compensates for the wide range of skills by placing non-Libyan nurses and more experienced and trained nurses in more critical care wards. There is recognition that nurses need more training and Libya has initiated new training programs.

Regardless of the frustrations of doctors, the researcher observed that doctors are extremely devoted to patients and compassionate. They have love for their people and patients they serve. Furthermore, Consultants are medically trained and serve patients

and medical students. They have administrative and managerial responsibilities. Hospital administration is a shared responsibility among administrators, doctors, and TMC executives. TMC, a teaching hospital, has a hierarchy structure of doctors. Patients do not expect privacy compared to patients in the United States. Up to 15 doctors can be seen during rounds visiting patients in shared rooms. Patients did not consider lack of privacy as an issue.

TMC receives patients who could be served by regional primary care clinics. Primary care clinics lack resources. There is an inconsistent supply of skilled medical staff, medicine, and supplies. This is one of the biggest obstacles to providing quality health care throughout Libya. Often patients must visit private pharmacists to obtain medicine that, if available, would be received free within the public health care system. Patient satisfaction seems to be dependent on criticality of patient, as most critical patients receive the most specialist care. Patients from rural areas seem the most satisfied with the care they receive at TMC; in this case TMC exceeds their expectations. Educated parents are more critical of the care they receive at TMC. Respondents also perceive that who you know determines the ease of navigating the system.

Patients do not show a preference for using private health care if public health care is available. It is a matter of convenience. Crowding and wait time are the primary reasons for choosing private health care over public health care. The respondents indicated that the motivation of private institutions is solely financial. Even those who prefer private, acknowledged that TMC is better staffed with consultants and specialists, primarily driven by contracts and increased pay. Libyans perceive that patients can get

quicker and better care in Tunisian private clinics. However, respondents indicated that these clinics did not offer a different diagnosis or treatment than TMC. Additionally, patients consistently stated that private clinics often transfer patients to TMC (esp. more critical cases).

Most respondents could not suggest a better system. Yet, Libyan people generally perceive that the leadership, both TMC and SOH, do not care or the system would be better managed. They cite competency and motivation of the leadership as problems. Better management of the current system is needed in the areas of better equipment, availability of drugs, and services in primary care clinics. Insurance was suggested as a potential improvement to the system. However, they acknowledged efforts in immunizations and education of infectious diseases.

Social Change

According to Gilson (2006) multiple relationships must be trustworthy within a health system to deliver health care and ultimately produce health and to generate wider social value. This conceptual framework of this study is based on the construct of trust (Tway, 1994). By identifying the prevalent factors that impact confidence in the Libyan health care system, the leaders of Libyan health care system can focus limited resources on improving the perception of Libyan's public health care system.

Several themes emerged during this study. The themes overlapped, but several of the themes are more prominent in the respondents' perception of Libyan's health care system. This study found that trust in Libyan's health care system is best served if there is a balanced distribution of resources throughout the country. Additionally, positive

relationships among the staff, and between patients and the staff, are important to the study participants and would improve trust. Confidence in Libyan trained medical staff would increase Libyans' trust in the health care system. Trust in leadership will be an outcome of an improved system.

There were two compelling findings from this study. First, the parents of pediatric patients tend to view behavior and communication of providers as an indication of the level of skill. Respondents would delay receiving care to avoid negative interactions with medical staff. Patients who seek care in private clinics do so to have shorter wait times and to have better interactions even though these private clinics have less equipment, are at a higher cost, and often have less experienced staff. Secondly, respondents perceive that they will have a higher level of service if they have a personal recommendation. Hence, there is an informal referral system. Despite the intent of Libyan's public health care system to provide free medical care to all Libyan citizens, respondents do not perceive that there is equal access to quality care due to the financial barriers of receiving private health care services, and based on the perceived need to have a personal recommendation to receive quality health care and services at a public health care facility. Improvements in staff behavior and elimination of the perception of preferential treatment on Libyan's public health system will improve trust. Health care must be accessible, psychologically and socially acceptable to its recipients, comprehensive, economically efficient, and delivered with reasonable quality (Gibson, 2006). A lack of trust in the health care system results in delayed care as patients seek care outside Libya or travel to health care facilities outside their home region.

Overcoming negative perceptions and improving trust can lead to equal access to quality health care.

Recommendation for Action and Future Research

As stated in Chapter 1, policies and procedures are built on an organization's mission, vision, and values. Together, the mission, vision, and values are at the core of a health care organization's philosophy (Longest Jr. et al., 2004). An organization's mission, vision, and values describe its purpose. Respondents could not state a clear mission, vision, or purpose. Additionally, when entering TMC, there are no posters or other displays that communicate TMC's philosophy for delivering health care. Without this, it is difficult to develop standards and policies. This researcher recommends a program that develops a values and purpose based on the mission and vision. The program should include a campaign to train its employees on TMC's philosophy for serving its patients. The mission, vision, purpose, and values should be clearly displayed. Staff should be rated on how they contribute and display TMC's values. Standards on hygiene and customer service will be based on this foundation. Employees trained and rewarded on embracing this new culture will result in cohesive teams that contribute to continuous improvement. Improvements will be the responsibility of every individual and work team and not solely the responsibility of TMC leadership. Once TMC establishes its philosophy based on a mission, a vision, values, and purpose embraced by its staff, it can accelerate accreditation efforts.

The inconsistent supply of medicine and other supplies should be studied. Improvement in Libya's supply chain will relieve stress from staff and improve patient's

confidence in the system. A supply chain professional can access the trends and determine the deficiencies in the supply chain. He or she could recommend improvements to minimize disruptions.

Disruptions in providing services are not limited to TMC. A comprehensive study should be done that considers the country's demographics. Respondents have more confidence in health care in major metropolitan areas (e.g., Tripoli) and find services lacking in rural areas. Patients often travel great distances to receive care. The study should not only include geography, but also the three levels of health care, which are primary, secondary, and tertiary. Primary care must be at the center of coordination (WHO, 2008). According to WHO (2008), primary health care must (a) focus on health needs, (b) provide an enduring personal relationship, (c) be comprehensive, continuous and person-centered, (d) be responsible for the health of all in the community along the life cycle (e) tackle determinants of ill-health, and (e) have people become partners in managing their own health and that of their community.

In order to support a more equitable distribution of resources, the compensation system needs additional analysis. The most qualified medical professionals seek employment in facilities like TMC. Doctors in a tertiary medical facility like TMC are compensated more than physicians in a rural primary care facility. Additionally, Libya needs to prevent the loss of their most talented physicians. Given the opportunity, doctors seek employment outside Libya where they are more highly compensated. Senior doctors who chose to remain in Libya do so because of their families and other personal ties to Libya and its people.

Nursing care is critical to the delivery for health care. Nurses have more contact with patients than doctors. The perception of care from Libyan nurses must improve to advance the perception of quality care at Libyan public hospitals. Further research should be conducted to explore the source of this perception in greater detail. Libyan nurses overwhelmingly (explicitly) declined to be interviewed for this study; therefore, this study did not collect enough data to determine their motivation and challenges.

All staff, including medical, administrative, and other support staff, should be trained in customer service. Respondents comment that parking is difficult, visiting hours are short, disabled patients must walk far from their cars or taxis to hospital entrances, security staff can be discourteous, seating is scarce, and medical staff often is abrupt. However, many respondents indicated that staff would have more patience if they were not so overwhelmed by the number of patients. Therefore, until resources are appropriately distributed throughout Libyan's health care system, and there are clearly communicated mission and vision statements, this recommendation will be difficult to implement.

Internet at TMC is slow and unreliable. Additionally, not all medical staff has access to personal computers. This affects the ability of the medical staff to access state of the art information and to share best practices. The staff who have personal computers cannot reliably participate in web conferences due to the poor network connectivity. Furthermore, there are no electronic medical records. Records are paper and patients often transfer their own records. The reliance on paper medical records and the reliability of information on the records (e.g., medicine dosages) can affect patient care. It is

recommended that TMC improves its technical infrastructure. The secondary benefit would be access to patient information by security or a receptionist to better serve patient visitors. Security staff could determine if a visitor (e.g., father of a pediatric patient) is authorized to visit outside visiting hours.

A goal would be to improve Libya's emergency response system. Patients must be brought from their home to the hospital by taxi or car. Ambulances are used to transport patients between hospitals. Homes and streets are not clearly marked and street addresses for most residences are nonexistent. Critical patients should have mechanism to be quickly transported to a medical facility in a well equipped ambulance.

Closing Statement and Reflection

Libya is a country rebuilding from decades of sanctions, embargos, and isolation. It had built the foundations of a world class health care system in the 1970s. As an oil rich country, it is fortunate to have the resources to improve its health care system. In today's world, Libya can no longer do this in isolation. Global travel reduces the ability of a country to isolate itself from diseases that were previously rare in Libya (e.g., HIV). Additionally, to retain Libya's brightest staff it must compete globally and motivate its professionals to stay in Libya. Financial motivation is only part of it; professionals want to work with state of the art technology and have the newest medicine available to best serve Libya's population.

Libya's health care policy is compassionate. As an example, Libya provides social services and refers patients for care outside the country at no cost to the patient. Medical care and medicine is free to Libyans. Even though study participants did not

perceive that the process for sending patients outside the country for care as well-defined, it is related to the criticality of the case and recommendation by consultant and approval by hospital leadership. Libya has the ability to develop a health care system in which the private and public sectors work together. They have bright medical professionals, but like many developing countries require help in managing its resources. Investing in educating future professionals in areas of hospital administration, human resources, business, and management could pay huge dividends. It also will relieve the technical medical staff from managerial duties so that they can focus on their core competencies.

Libya should take a holistic approach to reengineering its health care system to avoid the troublesome trends which is a concept provided by Dr Margaret Chan, Director-General of the World Health Organization in an overview of health care systems: (a) have a disproportionate focus on a narrow portfolio of specialized care, (b) take a command-and-control approach to disease control with a focus on short-term results and fragmented service delivery, and (c) use a hands-off or laissez-faire approach to governance leading to a growth in unregulated commercialization of health (WHO, 2008). By placing primary health care at the center, Libya can reverse these trends where they are realized.

Increasing Libya's HALE (e.g., fighting obesity, reducing tobacco use, and increasing pre-natal care) can only be done at the primary health level. Family physicians who can perform baby-wellness checks, annual physicals, and diabetes screening can help reduce the most prevalent obstacle to good health of Libyans, preventable diseases. Secondly, working hand and hand with other government agencies,

the Secretariat of Health should increase its efforts in educating the population on the dangers of tobacco use, the importance of exercise, improving hygiene, utilizing good nutrition, and preventing littering. Furthermore, to reduce trauma cases, Libya should make efforts in establishing more pedestrian crossings with crossing lights and adding bicycle lanes. Reducing preventable diseases by investing in primary care and education, minimizing trauma cases through an improved infrastructure, managing its resources, investing in technology, and providing incentives for medical professionals and administrators will enhance the health and quality of life of the Libyan people. The Libyan people deserve nothing less.

This research highlighted the importance of relationships and behavior in delivery of health services. Relationships, behaviors, and communication are entry points to the entire health care system. These factors determined patients' preference for where to receive services (e.g., the private or public sector). Yet, relationships are not sufficient in maintaining trust if the overarching need of receiving quality medical treatment is not met. Hence, the provider must also have the technical capacity to provide essential services. This study enlightened this researcher to the importance of behavior. Patients expect to be treated with dignity and respect regardless of where a country falls on the capitalist versus socialist pendulum. I also presume that this observation is not limited to the health care industry nor solely to countries with primarily socialized services. People expect to be treated compassionately, regardless if it is a financial, educational, judicial, or medical institution. Furthermore, it is important that customers (e.g., patients) view institutions as fair; that is, there is no preferential treatment based on nepotism, racism,

sexism, spiritualism, or any other ism. Only after a nation's citizens are given equal access to basic services, that should be allotted to all human beings, will a systemic and sustainable positive change be made in their lives.

References

- Ahmad, K. (2000). Death penalty threat to doctors in Libya. *The Lancet*, 356(9236), 1178.
- Akram, T. (2003). Formulation of a model of ineffective privatization in the context of developing countries. *Journal of Financial Management & Analysis*, 16(1), 27.
- Ament, L. (2006). Pursuit of excellence leads Bronson Hospital to Baldrige Quality Award. (cover story). *AHA News*, 42(1), 1-3.
- Anonymous. (2004). Joint Commission International opens office in Europe. *Association of Operating Room Nurses Journal*, 80(6), 1063.
- Anonymous. (2005). International center for patient safety launches web site. *Association of Operating Room Nurses Journal*, 81(6), 1276.
- Audit Commission. (1999). Setting the record Straight. A review of progress in health records services. Retrieved August 25, 2008, from <http://www.audit-commission.gov.uk/Products/NATIONAL-REPORT/89105478-F18A-449C-B4BE-396856FBE366/SettingtheRecordsStraight.pdf>
- Auerbach, C. F., & Silverstein, L. B. (2003). *Qualitative data: An introduction to coding and analysis*. New York: New York University Press.
- Badri, M. A., & Hollingsworth, J. (1993). A simulation model for scheduling in the Emergency Room. *International Journal of Operations & Production Management*, 13(3), 13-24.

- Barlett, E. E., Grayson, M., Barker, R., Levine, D. M., Golden, A., & Libber, S. (1984). The effects of physician skills on patient satisfaction; recall and adherence. *Journal of Chronic Diseases, 37*, 755-764.
- Barr, N. (1993). *The economics of the welfare state*. Oxford: Oxford University Press.
- Becher, E. C., & Chassin, M. R. (2001). Improving quality, minimizing error: Making it happen. *Health Affairs, 20*(3), 68-81.
- Bendapudi, N. M., Berry, L. L., Fray, K. A., Paeush, J. T., & Rayburn, W. L. (2006). Patients' perspectives on ideal physician behaviors. *Mayo Clinic Proceedings, 81*(3), 338-344.
- Blumenthal, D., & Hsiao, W. (2005). Privatization and its discontents - The evolving Chinese health care system. *The New England Journal of Medicine, 353*(11), 1165-1170.
- Braaten, J. S., & Bellhouse, D. E. (2007). Improving patient care by making small sustainable changes: A cardiac telemetry unit's experience *Nursing Economics, 25*(3), 162-166.
- The Blue Ridge Group. (2000). In pursuit of greater value: Stronger leadership in and by Academic Health Centers. Retrieved September 20, 2008, from http://www.whsc.emory.edu/blueridge/pdf/blue_ridge_report_4.pdf
- Britten, N., Jenkins, L., Barber, N., Bradley, C., & Stevenson, F. (2003). Developing a measure for the appropriateness of prescribing in general practice. *Quality and Safety in Health Care, 2003*(12), 246-250.

- Buetow, S. A., & Sibbald, B. (1997). Appropriateness in health care: Application to prescribing. *Social Science & Medicine*, 45(2), 261.
- Carrin, G., Desmet, M., & Basaza, R. (2001). Part 3: Privatization: A tool for governance? 10. Social health insurance development in low-income developing countries: New roles for government and nonprofit health insurance Organizations in Africa and Asia. In *Building Social Security The Challenge of Privatization - International Social Securities Series* (pp. 125-153): Piscataway, New Jersey: Transaction Publishers.
- Center for Disease Control. (2007). National Public Health Standards Performance Program, Acronyms, Glossary, and Reference Terms. Retrieved from http://www.cdc.gov/od/ocphp/nphpsp/documents/07_110300%20Glossary.pdf
- Chang, A., Schyve, P. M., Croteau, R. J., O'Leary, D. S., & Loeb, J. M. (2005). The JCAHO patient safety event taxonomy: A standardized terminology and classification schema for near misses and adverse events. *The International Journal for Quality in Health Care*, 17(2), 95-105.
- Charging for health services in the third world. (1992). *Lancet*, 340(8817) 458.
- Chiu, W.-T., Yang, C.-M., Lin, H.-W., & Chu, T.-B. (2006). Development and implementation of a nationwide health care quality indicator in Taiwan. *International Journal for Quality Health Care*, 19(1), 21-28.
- Clinton, M., Murrells, T., & Robinson, S. (2005). Assessing competency in nursing: a comparison of nurses prepared through degree and diploma programmes. *Journal of Clinical Nursing*, 14(1), 82-94.

- Codreanu, I., Perico, N., Sharma, S. K., Schieppati, A., & Remuzzi, G. (2006).
Prevention programmes of progressive renal disease in developing nations .
Nephrology, 11(4), 321-328.
- Conn, J. (2005). Leading indicator. *Modern Healthcare*, 35(33), 38-39.
- Coulter, A. (2001). Which patients get the worst deal? *Organisation for Economic
Cooperation and Development. The OECD Observer*, 229(Nov 2001), 29-31.
- Daviaud, E., & Chopra, M. (2008). How much is not enough? Human resources
requirements for primary health care: A case study from South Africa. *Bulletin of
the World Health Organization*, 86(1), 46-51.
- Detmer, D. E. (2004). A new health system and its quality agenda. In A. R. Kovner & D.
Neuhauser (Eds.), *Health services management: Readings, cases, and
commentary* (8th ed., pp. 307-327). Washington D.C.: Health Administration
Press.
- Donabedian, A. (2005). Evaluating the quality of medical care. *Milbank Quarterly*, 83(4),
691-729.
- Donahue, K. T., & vanOstenberg, P. (2000). Joint commission international
accreditation: Relationship to four models of evaluation. *International Journal for
Quality Health Care*, 12(3).
- Dranove, D., Reynolds, K. S. E., Gillies, R. R., Stortell, S. S., Rademaker, A. W., &
Huang, C.-F. (1999). The cost efforts to improve quality. *Medical Care*, 37(10),
1084-1087.

- English, M., Esamal, F., Wasunna, A., Were, F., Ogutu, B., Warmae, A., et al. (2004). Assessment of inpatient paediatric care in first referral level hospitals in 13 districts in Kenya. *The Lancet*, 363(June 12, 2004).
- Fassaert, T., van Dulmen, S., Schellevis, F. O., & Bensing, J. (2007). Active listening in medical consultations: Development of the active listening observation scale (ALOS-global). *Patient Education & Counseling*, 68(3), 258-264.
- Field, M. G. (1990). Noble purpose, grand design, flawed execution, mixed results: Soviet socialized medicine after seventy years. *American Journal of Public Health*, 80(2), 144-145.
- Fielding, J., & Halfon, N. (1994). Where is the health in health system reform? *JAMA: Journal of the American Medical Association*, 272(16), 1292.
- Fottler, M. D., & Malvey, D. (2004). Organized delivery systems. In L. F. Wolper (Ed.), *Health care administration: Planning, implementing, and managing organized delivery systems* (4th ed., pp. 55-91). Sudbury, MA: Jones and Bartlett Publishers.
- General People's Committee for Health & Environment. (2008). *Health Indicators*. Health Information Center, Great Socialist People's Libyan Arab Jamahiriya.
- Gilson, L. (2003). Trust and health care as a social institution. *Journal of Health Organization and Management*, 20(5), 349-358.
- Gilson, L. (2006). Trust in health care: Theoretical perspectives and research needs. *Journal of Health Organization and Management*, 20(5), 359-375.
- Gold, K. S. (2007). Crossing the quality chasm: Creating the ideal patient care experience. *Nursing Economic\$,* 25(5), 293-296.

- Gonzalez, N., Quintana, J. M., Bilbao, A., Escobar, A., Aizpuru, F., Thompson, A., et al. (2005). Development and validation of an in-patient satisfaction questionnaire. *International Journal for Quality Health Care*, 17(6), 465-472.
- Griffin, D. (2006). *Hospitals: What they are and how they work* (3rd ed.). Boston: Jones and Bartlett.
- Griffith, J. R., & White, K. R. (2002). *The well-managed healthcare organization* (5th ed.). Chicago, IL: Health Administration Press.
- Hall, J. A., & Dornan, M. C. (1988). What patients like about their medical care and how often they are asked: A meta-analysis of the satisfaction literature *Social Science and Medicine*, 27(9), 935-939.
- Haller, M. (2003). Europe and the Arab-Islamic world. A sociological perspective on the socio-cultural differences and mutual (mis)perceptions between two neighbouring cultural areas. *Innovation: The European Journal of Social Sciences*, 16(3), 227-252.
- Harris, J. (2001). Shaping the system and culture of health care. *Dermatology Nursing*, 13(2), 86-86.
- Harrison, S. (2005). Single rooms boost morale. *Nursing Standard*, 19(31), 5-5.
- Hassan, D. (2005). Measuring performance in the healthcare field: A multiple stakeholders' perspective. *Total Quality Management & Business Excellence*, 16(8/9), 945-953.
- Haviland, P. (2004). Quiet diplomacy is not enough. *BMJ: British Medical Journal*, 329(7462), 409-409.

- Health system profile: Libya. (2007). *Eastern Mediterranean Regional Health Systems Observatory*. Retrieved from <http://gis.emro.who.int/HealthSystemObservatory/PDF/Libya/Full%20Profile.pdf>
- Holm, S. (1995). "Socialized Medicine," resource allocation and two-tiered health care- The Danish experience. *The Journal of Medicine and Philosophy*, 20, 631-637.
- Hongoro, C., McPake, B., & Vickerman, P. (2005). Measuring the quality of hospital tuberculosis services: A prospective study in four Zimbabwe hospitals. *International Journal for Quality Health Care*, 17(4), 287-292.
- Hosford, S. B. (2008). Hospital progress in reducing errors: The impact of external interventions. *Hospital Topics: Research and Perspectives on Healthcare*, 86(1).
- Hsieh, M.-O., & Kagle, J. D. (1991). Understanding patient satisfaction and dissatisfaction with health care. *Health & Social Work*, 16(4), 281-290.
- Hu, T.-W. (2004). Financing and organization of China's health care. *World Health Organization. Bulletin of the World Health Organization*, 82(7), 480.
- IOM. (2001). *Crossing the quality chasm: A new health system for the 21st century*. Retrieved from <http://site.ebrary.com/lib/wmichlib/Top?id=10032412&layout=document>.
- JCI. (2008). Facts about ORYX® for hospitals, core measures and hospital core measures. Retrieved from http://www.jointcommission.org/AccreditationPrograms/Hospitals/ORYX/oryx_facts.htm

- Johnsson, C., Kjellberg, K., Kjellberg, A., & Lagerstrom, M. (2004). A direct observation instrument for assessment of nurses™ patient transfer technique (DINO). *Applied Ergonomics*, 35(6), 591-601.
- Joint commission international center for patient safety launches new patient safety practices online resource. (2006). *PT: Magazine of Physical Therapy*, 14(7), 76-76.
- Kawachi, I., Kennedy, B. P., & Glass, R. (1999). Social capital and self-rated health: A contextual analysis. *American Journal of Public Health*, 89(8), 1187-1193.
- Kaya, S., Vural, G., Eroglu, K., Sain, G., Mersin, H., Karabeyoglu, M., et al. (2000). Liability and validity if the appropriateness evaluation protocol in Turkey. *International Journal for Quality Health Care*, 12(4), 325-329.
- Kelley, E. (2006). All or none measurement: Why we know so little about comprehensive care. *International Journal for Quality Health Care*, 19(1), 1-3.
- Kelley, E. (2007). Health, spending, and the effort to improve quality in OECD countries: A review of data. *The Journal of the Royal Society for the Promotion of Health*, 127(2), 64-71.
- Khalaf, A. (2004). Maintenance model for minimizing risk and optimizing cost-effectiveness of medical equipment in Palestine. *Journal of Clinical Engineering*, 29(4), 210-217.
- Kim, C.-Y., & Cho, S.-H. (2000). Institutionalization of quality improvement program in Korean hospitals. *International Society for Quality in Health Care*, 12(5), 419-423.

- Kovner, A. R. (2004). Learning through the case method. In A. R. Kovner & D. Neuhauser (Eds.), *Health services management: Readings, cases, and commentary* (8th ed., pp. xv-xvii). Washington, DC: Health Administration Press.
- Kovner, A. R., Elton, J. J., & Billings, J. (2004). The challenge: Making better-informed strategic decisions. In A. R. Kovner & D. Neuhauser (Eds.), *Health services management: Readings, cases, and commentary* (8th ed., pp. 9-33). Washington, D.C.: Health Administration Press.
- Kovner, A. R., & Neuhauser, D. (2004a). Accountability: Commentary. In A. R. Kovner & D. Neuhauser (Eds.), *Health services management: Readings, cases, and commentary* (8th ed., pp. 301-305). Washington, DC: Health Administration Press.
- Kovner, A. R., & Neuhauser, D. (2004b). Control: Commentary. In A. R. Kovner & D. Neuhauser (Eds.), *Health services management: Readings, cases, and commentary* (8th ed., pp. 65-71). Washington, DC: Health Administration Press.
- Kovner, A. R., & Neuhauser, D. (2004c). *Health services management: Readings, cases, and commentary* (8th ed.). Washington, DC: Health Administration Press.
- Kovner, A. R., & Neuhauser, D. (2004d). Organizational design: Commentary. In A. R. Kovner & D. Neuhauser (Eds.), *Health services management: Readings, cases, and commentary* (8th ed., pp. 131-138). Washington, DC: Health Administration Press.

- Langle, G., Baum, W., Wollinger, A., Renner, G., Uren, R., Schwarzler, F., et al. (2003). Indicators of quality of in-patient psychiatric treatment: The patients view. *International Journal for Quality Health Care*, 15(3), 213-221.
- Leonard, D., & Reller, M. K. (2004). Simplify Baldrige for healthcare. *Quality Progress*, 37(9), 35-44.
- Lewins, A., & Silver, C. (2007). *Using software in qualitative research: A step-by-step guide*. Los Angeles, CA: Sage Publications.
- Liu, Y. (2004). China's public health-care system: Facing the challenges. *World Health Organization. Bulletin of the World Health Organization*, 82(7), 532-538.
- Lockee, C. (2008). Board structures and practices. *Healthcare Executive*, 23(2), 62-64.
- Longest Jr., B. B., Rakich, J. S., & Darr, K. (2004). *Managing health services organizations and systems* (4th ed.). Baltimore, MD: Health Professions Press.
- Malmstrom, M., Sundquist, J., & Johansson, S.-E. (1999). Neighborhood environment and self-reported health status: A multilevel analysis. *American Journal of Public Health*, 89(8), 1181-1186.
- Marsland, D. (2005). The British experience with socialized medicine. *Society*, 42(5), 59-64.
- McGregor, A. (1998). WHO reviews health-care privatisation in developing countries. *Lancet*, 351(9101), 508.
- McKinlay, J. B., & Marceau, L. D. (1999). A tale of 3 tails. *American Journal of Public Health*, 89(3), 295-298.

- McPherson, B. (2006). Nonprofit Health Care Organizations and the Public Trust. *Inquiry Excellus Health Plan*, 43(3), 190-194.
- Mehta, U., Durrheim, D., Mabuza, A., Blumberg, L., Allen, E., & Barnes, K. I. (2007). Malaria pharmacovigilance in Africa: Lessons from a pilot project in Mpumalanga Province, South Africa. *Drug Safety*, 30(10), 899-910.
- Moeller, J. (2001). The EFQM excellence model. German experiences with the EFQM approach in health care. *International Society for Quality in Health*, 13(1), 45-49.
- Moore, K. D., & Coddington, D. C. (2002). Models of care that meet the standards of crossing the quality chasm: A new health system for the 21st century. *Journal of Ambulatory Care Management*, 25(1), 12.
- Naber, N. (2005). Muslim first, Arab second: A strategic politics of race and gender. *Muslim World*, 95(4), 479-495.
- Neuhauser, D. (2004). The primary care instrument panel at Central Community Health Plan. In A. R. Kovner & D. Neuhauser (Eds.), *Health services management: Readings, cases, and commentary* (8th ed., pp. 106-115). Washington D.C.: Health Administration Press.
- Nolan, T., & Berwick, D. M. (2006). All-or-none measurement raises the bar on performance. *JAMA: Journal of the American Medical Association*, 295(10), 1168-1170.
- Novak, D. (2003). A Jewish argument for socialized medicine. *Kennedy Institute of Ethics Journal*, 13(4), 313-328.

- Panis, L., J.G.G., Verheggen, F. W. S. M., & Pop, P. (2002). To stay or not to stay. The assessment of appropriate hospital stay: A Dutch report. *International Journal for Quality Health Care, 14*(1), 55-67.
- Paphassarang, C., Philavong, K., Boupcha, B., & Blas, E. (2002). Equity, privatization and cost recovery in urban health care: The case of Lao PDR. *Health Policy and Planning, 17*(S1), 72-84.
- Parlett, M., & Hamilton, D. (1976). Evaluation as illumination: A new approach to the study of innovatory programs. In G. V. Glass (Ed.), *Evaluation Studies Review Annual* (Vol. 1, pp. 140-157). Beverly Hills, CA: Sage.
- Perico, N., Plata, R., Anabaya, A., Codreanu, I., Schieppati, A., Ruggenenti, P., et al. (2005). Strategies for national health care systems in emerging countries: The case of screening and prevention of renal disease progression in Bolivia. *Kidney International Supplement*(97), S87-S94.
- Poe, S. S., & Brannan, D. (2006). Joint Commission International Center for patient safety web site. *Journal of Nursing Care Quality, 21*(2), 114-118.
- Pollock, A. M., & Price, D. (2002). Market forces in public health. *Lancet, 359*(9315), 1363.
- Prins, H., Kruisinga, F. H., Buller, H. A., & Zwetsloot-Sconk, J. H. M. (2002). Availability and usability of data for medical practice assessment. *International Society for Quality in Health Care, 14*(2), 127-137.
- Purohit, B. C. (2001). Private initiatives and policy options: Recent health system experience in India. *Health Policy and Planning, 16*(1), 87-97.

- Quinn, J. B., Anderson, P., & Finkelstein, S. (1996, Mar-Apr). Managing professional intellect: Making the most of the best. *Harvard Business Review*, 71-80.
- Qvist, P., Rasmussen, L., Bonnevie, B., & Gjorup, T. (2004). Repeated measurements of generic indicators: A Danish national program to benchmark and improve quality of care. *International Journal for Quality Health Care*, 16(2), 141-148.
- Rakich, J. S., & Wong, A. S. (2004). Medical Center of Southern Indiana: Community commitment and organizational revival. In J. S. Rakich, B. B. Longest Jr. & K. Darr (Eds.), *Cases in health services management* (4th ed., pp. 3-29). Baltimore: Health Professionals Press.
- Redshaw, M. E., & Harris, A. (1994). Training and education for nurses working in neonatal care. *Journal of Advanced Nursing*, 20(6), 1023-1029.
- Rodriguez-Vera, F. J. (2002). The AEP on the assessment of appropriate hospital stay. *International Journal for Quality Health Care*, 14(5) 429-430.
- Rowe, S. Y., Olewe, M. A., Kleinbaum, McGowan Jr., J. E., McFarland, D. A., & Rochat, R. (2006). The influence of observation and setting on community health workers' practices. *The International Journal for Quality in Health Care*, 18(4).
- Russo, G. (1994). The role of the private sector in health services: Lessons for ASEAN. *ASEAN Economic Bulletin*, 11(2), 190.
- Sanchez, E., Letona, J., Gonzalez, R., Garcia, M., Darpon, J., & Garay, J. I. (2005). A descriptive study of the implementation of the EFQM excellence model and underlying tools in the Basque Health Service. *International Journal for Quality Health Care*, 18(1), 58-65.

- Savage, G. T., Campbell, K. S., Ford, C. D., & van der Reis, L. (2004). International health care: A 12-country comparison. In L. F. Wolper (Ed.), *Health care administration: Planning, implementing, and managing organized delivery systems* (4th ed., pp. 3-54). Sudbury, MA: Jones and Bartlett Publishers.
- Schwandt, T. (2000). Three epistemological stances for qualitative inquiry: Interpretivism, hermeneutics, and social constructivist. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 189-213). Thousand Oaks, CA: Sage.
- Schwappach, D. L., Blaudszun, A., Conen, D., Ebner, H., Eichler, K., & Hochreutener, M.-A. (2003). 'Emerge': Benchmarking of clinical performance and patients' experiences with emergency care in Switzerland. *International Society for Quality in Health Care*, 15(6).
- Schyve, P. M. (2000). The evolution of external quality evaluation: Observations from the Joint Commission on Accreditation of Healthcare Organizations. *International Journal for Quality Health Care*, 12(3), 255-258.
- Seidman, I. (2006). *Interviewing as qualitative research: A guide for researchers in education and social sciences*. New York: Teachers College Press.
- Shipman, C., Burt, J., Ream, E., Beynon, T., Richardson, A., & Addington-Hall, J. (2008). Improving district nurses confidence and knowledge in the principles and practice of palliative care. *Journal of Advanced Nursing*, 63(5), 494-505.
- Siddiqi, S., Masud, T. I., & Sabri, B. (2006). Contracting but not without caution: Experience with outsourcing of health services in countries of the Eastern

Mediterranean Region. *Bulletin of the World Health Organization*, 84(11), 867-875.

Singer, N. (2008). As doctors cater to looks, skin patients wait [Electronic Version]. *New York Times*, July 28, 2008. Retrieved from

http://www.nytimes.com/2008/07/28/us/28beauty.html?_r=1&th=&oref=slogin&emc=th&pagewanted=print.

Singh, N. N., Wechsler, H. A., & Curtis, W. J. (2000). Family friendliness of inpatient services for children and adolescents with EBD and their families: Observational study of the treatment team process. *Journal of Emotional & Behavioral Disorders*, 8(1), 19.

Smeets, P. M. J. H., Verheggen, F. W. S. M., Pop, P., Lambert, J. G. G., Panis, L., J.G.G., & Carpay, J. J. (2000). Assessing the necessity of hospital stay by means of the Appropriateness Evaluation Protocol: How strong is the evidence to proceed. *International Journal for Quality Health Care*, 12(6).

Snook Jr., I. D. (2004). Hospital organization and management. In L. F. Wolper (Ed.), *Health care administration: Planning, implementing, and managing organized delivery systems* (4th ed., pp. 651-661). Sudbery, MA: Jones and Bartlett Publishers.

Sorlie, T., Sexton, H. C., Busund, R., & Sorlie, D. (2000). Predictors of satisfaction with surgical treatment. *International Journal for Quality Health Care*, 12(1), 31-40.

Spear, S. J. (2005). Fixing healthcare from the inside, today. *Harvard Business Review*, 83(9), 78-91, 158.

- Spiegel, J. M., Labonte, R., & Ostry, A. S. (2004). Understanding "Globalization" as a determinant of health determinants: A critical perspective. *International Journal of Occupational and Environmental Health*, 10(4), 360-367.
- Stake, R. E. (1995). *The art of case study research*. Thousand Oaks, CA: Sage Publications.
- Standing, M. (2007). Clinical decision-making skills on the developmental journey from student to registered nurse: A longitudinal inquiry. *Journal of Advanced Nursing*, 60(3), 257-269.
- Starfield, B. (1991). Primary care and health: A cross-national comparison. *Journal of the American Medical Association*, 266(16), 2268-2271.
- Stefl, M. E. (2004). The drivers of change. In A. R. Kovner & D. Neuhauser (Eds.), *Health services management: Readings, cases, and commentary* (8th ed., pp. 193-198). Washington D.C.: Health Administration Press.
- Stewart, L. J., & Lockamy III, A. (2001). Improving competitiveness through performance-measurement systems: An integrated performance-measurement system can improve competitiveness by meshing the organization's long-term goals with its day-to-day clinical and administrative functions. *Healthcare Financial Management*, 55(12), 46-50.
- Sweeney, J., Brooks, A. M., & Leahy, A. (2003). Development of the Irish national perception of quality of care survey. *International Journal of Quality in Health Care*, 15(2), 163-168.

- Taylor, D., Kennedy, M. P., Virtue, E., & McDonald, G. (2006). A multifaceted intervention improves patient satisfaction and perceptions of emergency department care. *International Journal for Quality Health Care*, 18(3), 238-245.
- Taylor, D., Wolfe, R. S., & Cameron, P. A. (2004). Analysis of complaints lodged by patients attending Victorian hospitals, 1997-2001. *Medical Journal Australia* 2004; 181: 31-35, 181, 31-35.
- Temkina, A., & Zdravomyslova, E. (2008). Patients in contemporary Russian reproductive health care institutions: Strategies of establishing trust. *Demokratizatsiya*, 16(3), 277-293.
- Ternov, S., & Akselsson, R. (2005). System weaknesses as contributing causes to accidents in health care. *International Journal for Quality Health Care*, 17(1).
- Tokunaga, J., & Imanaka, Y. (2002). Influence of length of stay on patient satisfaction with hospital care in Japan. *International Society for Quality in Health Care*, 14(6), 493-502.
- Tripoli Medical Center. (2008). Retrieved from <http://www.tmc.ly/>
- Turnock, B. J. (2004). *Public Health: What it is and how it works* (3rd ed.). Boston: Jones and Bartlett.
- Tway, D. C., Jr. . (1994). *A construct of trust*. (Unpublished doctoral dissertation). The University of Texas, Austin.
- Twigg, J. L. (2002). Health care reform in Russia: A survey of head doctors and insurance administrators. *Social Science & Medicine*, 55(2002), 2253-2265.

- UNDP. (2007/2008). Human Development Report Retrieved from
http://hdrstats.undp.org/countries/country_fact_sheets/cty_fs_LBY.html
- Upper Chesapeake Health: Mission, Vision, Values. (2005). Retrieved from
<http://www.uchs.org/aboutus/mission.cfm>
- Urassa, D. P., Carlstedt, A., Nystrom, L., Massawe, S. N., & Lindmark, G. (2002).
Quality assessment of the antenatal program for anaemia in rural Tanzania.
International Society for Quality in Health Care, 14(6), 441-448.
- van Herk, R., Klazinga, N. S., Schepers, R. M. J., & Casparie, A. F. (2001). Medical
audit: Threat or opportunity for the medical profession. A comparative study of
medical audit among medical specialists in general hospitals in the Netherlands
and England, 1970–1999. *Social Science & Medicine, 53*(12), 1721.
- Veillard, J., Champagne, F., Klazinga, N., Kazandjian, V., Arah, O. A., & A.-L., G.
(2005). A performance assessment framework for hospitals: The WHO regional
office for Europe PATH project. *International Journal for Quality Health Care,*
17(6), 487-496.
- Wagner, C., van Merode, G. G., & van Oort, M. (2003). Costs of quality management
systems in long-term care organizations: An exploration. *Quality Management in*
Health Care, 12(2), 106.
- Warming, S., Juul-Kristensen, B., Ebbelhøj, N. E., & Schibye, B. (2004). An observation
instrument for the description and evaluation of patient transfer technique.
Applied Ergonomics, 35(6), 603-614.

- Weiner, J. P. (1989). Primary health care systems in the United States, Denmark, Finland, and Sweden: Can the "corporatized" learn from the "socialized", or vice versa? *Scandinavian Studies*, 61(1989), 231-260.
- Weingart, S. N. (2005). Beyond Babel: Prospects for a universal patient safety taxonomy. *International Journal for Quality Health Care*, 17(2), 93-94.
- Wessen, A. F. (1999). *Health care systems in transition: An international perspective*. Thousand Oaks: Sage Publications.
- WHO. (2002). WHO Centre for Health Development, WHO Kobe Centre 2002 Annual Report. Retrieved from http://www.who.or.jp/reports/annual_report2002e.pdf
- WHO. (2003). A common agenda for partnership on poverty and health. *The Society for International Development. SAGE Publications (London, Thousand Oaks, CA and New Delhi)*, 10-13.
- WHO. (2006). Constitution of the World Health Organization. 45th Edition. Retrieved from http://www.who.int/governance/eb/who_constitution_en.pdf
- WHO. (2008). The World Health report 2008: Primary health care. Retrieved from http://www.who.int/whr/2008/whr08_en.pdf
- Wildman, S., Weale, A., Rodney, C., & Pritchard, J. (1999). The impact of higher education for post-registration nurses on their subsequent clinical practice: An exploration of students' views. *Journal of Advanced Nursing*, 29(1), 246-253.
- Williams, S. C., Watt, A., Schmaltz, S. P., & Koss, R. G. (2006). Assessing the reliability of standardized performance indicators. *International Journal for Quality Health Care*, 18(3), 246-255.

- Williams, S. J. (2005). *Essentials of health services* (3rd ed.). Clifton Park, New York: Thomson.
- Wolper, L. F., & Pena, J. J. (2004). The history of hospitals. In L. F. Wolper (Ed.), *Health care administration: Planning, implementing, and managing organized delivery systems* (4th ed., pp. 637-650). Sudbery, MA: Jones and Bartlett Publishers.
- Yin, R. K. (2003). *Case study research* (3rd ed. Vol. 5). Thousands Oaks, CA: Sage Publications.
- Zuckerman, A. M. (2000). Creating a vision for the twenty-first century healthcare organization. *Journal of Healthcare Management*, 45(5), 294.

Appendix A: Questionnaire Obtained from an Empirical Study¹

KNOWING YOUR OPINION...

IN OSAKIDETZA WE WANT TO KNOW YOUR OPINION ABOUT YOUR RECENT ADMITTED EXPERIENCE IN THE HOSPITAL, IN A MANNER THAT HELPS US DETECT POSSIBLE ERRORS.

WITH THE INFORMATION THAT YOU AND OTHER PERSONS PROVIDE, IT MAKES IT EASIER FOR US TO IMPROVE THE QUALITY OF SERVICE GIVEN TO PERSONS WHO ARE ADMITTED TO THE VARIOUS HOSPITALS IN THE AREA OF OSAKIDETZA.

INSTRUCTIONS FOR COMPLETION: ON EACH QUESTION, SELECT THE OPTION THAT IS CLOSEST TO HOW YOU FEEL OR WHAT YOU THINK. THERE ARE NO CORRECT OR INCORRECT ANSWERS; WHAT IS IMPORTANT IS THAT YOU PROVIDE US WITH YOUR OPINION. PLEASE KEEP IN MIND THAT THERE ARE QUESTIONS ON BOTH SIDES OF THE SHEETS. PLEASE, ANSWER ALL OF THE QUESTIONS IN THE SURVEY.

ALL THE ANSWERS WILL BE TREATED IN A CONFIDENTIAL MANNER.

THANK YOU VERY MUCH FOR YOUR COLLABORATION.

¹ Gonzalez, N., Quintana, J. M., Bilbao, A., Escobar, A., Aizpuru, F., Thompson, A., et al. (2005). Development and validation of an in-patient satisfaction questionnaire. *International Journal for Quality Health Care*, 17(6), 465-472.

DURING ADMITTANCE

THE QUESTIONS THAT APPEAR BELOW REFER TO WHAT OCCURRED DURING ADMITTANCE.

IN REGARDS TO THE NURSES...

- 1.- REGARDING THE MEDICAL PROBLEM THAT I HAD AND WHAT THEY WERE DOING TO ME, THE NURSES...
 - THEY TOLD ME VERY LITTLE, ALMOST NOTHING
 - THEY ATTEMPTED TO EXPLAIN SOME THINGS TO ME, ALTHOUGH SOME THINGS WERE UNCLEAR
 - THEY MADE EVERYTHING CLEAR FOR ME
- 2.- WHEN I ASKED THE NURSES A QUESTION...
 - THEY RESPONDED WITH INTEREST TO MY QUESTIONS
 - THEY RESPONDED, SOMETIMES WITH INTEREST, OTHER TIMES NO
 - THEY RESPONDED, BUT WITHOUT BEING INTERESTED
 - THEY DID NO RESPOND AT ALL
- 3.- DID YOU HAVE THE IMPRESSION THAT THE NURSE PERSONNEL WAS PENDING ON YOUR CASE AND THE MEDICAL PROBLEMS THAT COULD ARISE?
 - AT EVERY MOMENT, WITHOUT EXCEPTION
 - HABITUALLY
 - SOMETIMES
 - NEVER
- 4.- DO YOU BELIEVE THAT THE NURSES REALIZED HOW YOU WERE FEELING ABOUT BEING SICK AND ADMITTED TO THE HOSPITAL?
 - ONLY SOME OF THEM
 - QUITE A FEW OF THEM
 - ALL OF THEM
- 5.- THE TREATMENT THAT THE NURSES GAVE YOU WAS
 - FRIENDLY, WARM
 - CORRECT, ALTHOUGH SOMEWHAT SERIOUS
 - DRY, SOMETIMES VERY CURT
- 6.- APART FROM HOW THEY TREATED YOU, DID IT APPEAR TO YOU THAT THE NURSES WHO TENDED TO YOU WERE WELL PREPARED AND WERE ABLE TO COMPLETE THEIR JOB?
 - YES, ALL OF THEM
 - YES, ALMOST ALL OF THEM
 - ONLY SOME OF THEM
 - ALMOST NONE OF THEM

WITH REGARDS TO THE DOCTORS...

- 7.- HOW WOULD YOU RATE THE MANNER IN WHICH THE DOCTORS INFORMED YOU?
 - IT SEEMED GOOD TO ME
 - NEITHER GOOD OR BAD
 - IT SEEMED BAD TO ME
- 8.- REGARDING THE PROBLEM THAT I HAD AND WHAT THEY WERE GOING TO DO TO ME, THE DOCTORS...
 - TOLD ME VERY LITTLE, ALMOST NOTHING
 - ATTEMPTED TO EXPLAIN SOME THINGS TO ME, ALTHOUGH SOME THINGS WERE UNCLEAR
 - THEY MADE SURE THAT EVERYTHING WAS CLEAR
- 9.- DID THE DOCTORS SPEAK TO YOU IN WORDS THAT YOU DID NOT UNDERSTAND...
 - MANY TIMES
 - SOMETIMES
 - VERY FEW TIMES
 - NEVER

- 10.- WHEN I ASKED THE DOCTORS A QUESTION...
- THEY RESPONDED WITH INTEREST TO MY QUESTIONS
 - THEY RESPONDED, SOMETIMES WITH INTEREST, OTHER TIMES NO
 - THEY RESPONDED, BUT WITHOUT BEING INTERESTED
- 11.- ON SOME OCCASION, IT IS POSSIBLE THAT YOU HAD TO UNDRESS FOR A MEDICAL EXAMINATION AND/OR TEST; HOW DID YOU FEEL?
- I FELT RATHER UNCOMFORTABLE
 - I FELT SOMEWHAT UNCOMFORTABLE
 - IT ABSOLUTELY DID NOT MATTER TO ME
 - I DID NOT HAVE TO GET UNDRESSED
- 12.- WHEN THEY TOOK ME FROM MY ROOM IN MY PAJAMAS TO PERFORM SOME EXAM ON ME OR TO TAKE ME FOR CONSULTATION, IN THE PRESENCE OF PEOPLE THAT CAME FROM OUTSIDE (THE HOSPITAL)...
- I FELT RATHER UNCOMFORTABLE
 - I FELT SOMEWHAT UNCOMFORTABLE
 - IT ABSOLUTELY DID NOT MATTER TO ME
 - THEY DID NOT HAVE TO TAKE ME FROM MY ROOM FOR ANY TEST OR CONSULTATION
- 13.- THE TREATMENT THAT THE DOCTORS GAVE ME WAS...
- FRIENDLY, WARM
 - CORRECT, ALTHOUGH SOMEWHAT SERIOUS
 - DRY, SOMETIMES CURT
- 14.- APART FROM HOW THEY TREATED YOU, DID IT APPEAR TO YOU THAT THE DOCTORS WHO TENDED TO YOU WERE WELL PREPARED AND WERE ABLE TO COMPLETE THEIR JOB?
- YES, ALL OF THEM
 - YES, ALMOST ALL OF THEM
 - ONLY SOME OF THEM
 - ALMOST NONE OF THEM
- 15.- DID THE DOCTORS TEND AND LISTEN TO YOU WHEN YOU CALLED THEM?
- YES, ALWAYS
 - REGULARLY
 - SOMETIMES YES, OTHER TIMES NO
 - ALMOST NEVER OR NEVER
- IN RELATION TO ALL THE PERSONNEL** (DOCTORS, NURSES, ASSISTANTS, ETC.)
- 16.- DID THEY SOMETIMES NOT KNOW WHAT TO DO BECAUSE SOME PERSONS FROM THE HOSPITAL TOLD THEM TO DO ONE THING AND OTHERS TOLD THEM TO DO SOMETHING ELSE?
- YES, VERY OFTEN
 - SOMETIMES
 - NO, NEVER
- 17.- SO THAT THEY GAVE ME INFORMATION ABOUT MY TREATMENT...
- I ALWAYS HAD TO REQUEST IT FROM THEM
 - I REGULARLY HAD TO REQUEST IT FROM THEM
 - I RARELY HAD TO REQUEST IT FROM THEM
 - THEY KEPT ME INFORMED WITHOUT ME HAVING TO REQUEST INFORMATION
- 18.- DID THEY EXPLAIN TO YOU WHY THEY WERE GIVING YOU MEDICATION IN A MANNER THAT YOU COULD UNDERSTAND?
- YES, WITHOUT HAVING TO ASK
 - YES, BUT I HAD TO ASK WHY
 - NO, THEY DID NOT TELL ME ANYTHING

ENVIRONMENT CONDITIONS / COMFORT

THE QUESTIONS THAT APPEAR BELOW REFER TO ALL ASPECTS RELATED TO THE PHYSICAL ENVIRONMENT, THE INSTALLATIONS OF THE HOSPITAL

- 19.- WHILE YOU WERE ADMITTED, DID YOU HAVE PROBLEMS SLEEPING DUE TO NOISE, THE TEMPERATURE, OR OTHER ENVIRONMENTAL CONDITIONS?
- YES, ALWAYS
 - MANY TIMES
 - SOMETIMES
 - NO, NEVER
- 20.- IN RESPECT TO THE TIME IN WHICH THEY WOKE YOU UP IN THE MORNING, DID YOU CONSIDER IT TO BE
- TOO EARLY
 - VERY EARLY
 - A GOOD TIME
- 21.- IN RELATION TO THE BATHROOM...
- IT WAS ALWAYS CLEAN
 - IT WAS CLEAN, ALTHOUGH IT COULD BE BETTER
 - SOMETIMES IT WAS NOT CLEAN
 - IN GENERAL, IT WAS DIRTY
- 22.- IN REGARDS TO THE ROOM...
- IT WAS ALWAYS CLEAN
 - IT WAS CLEAN, BUT IT COULD BE BETTER
 - SOMETIMES IT WAS NOT CLEAN
 - IN GENERAL, IT WAS DIRTY
- 23.- THE CONDITIONS OF THE ROOM TO WHICH YOU WERE ADMITTED APPEARED TO BE...
- EXCELLENT
 - GOOD
 - ACCEPTABLE, BUT COULD BE BETTER
 - SUBPAR
- 24.- RATE THE LEVEL OF COMFORT OF THE ROOM FOR YOUR FAMILY MEMBERS OR VISITORS
- RATHER UNCOMFORTABLE
 - SOMEWHAT UNCOMFORTABLE
 - COMFORTABLE, BUT COULD BE BETTER
 - RATHER COMFORTABLE
- 25.- IN GENERAL, THE QUALITY FO THE FOOD THAT THEY GAVE YOU WAS
- GREAT AND DIVERSE
 - GOOD
 - BAD

VISITORS

IN THE FOLLOWING QUESTIONS WE WANT TO KNOW YOUR OPINION ABOUT THE VISITS THAT YOU AS A PATIENT OR YOUR ROOMMATES RECEIVED DURING YOUR STAY IN THE HOSPITAL.

- 26.- DID THE TIMES AT WHICH VISITORS CAME INTO THE ROOM BOTHER YOU?
- YES, ALWAYS
 - SOMETIMES
 - NO, NEVER

- 27.- THE AMOUNT OF TIME IN WHICH THE VISITORS WERE IN YOUR ROOM APPEARED TO BE...
- TOO LONG
 - A LITTLE TOO LONG
 - SUFFICIENT
 - SHORT
- 28.- WITH RESPECT TO THE VISITORS THAT WENT TO YOUR ROOM, YOU WOULD SAY...
- THERE WERE TOO MANY
 - ON OCCASION THERE WERE QUITE A FEW
 - THERE WERE SUFFICIENT NUMBER OF THEM
 - THERE WERE FEW PEOPLE
- 29.- IN GENERAL, WOULD YOU SAY THAT THE VISITORS WERE BOTHERED WITH YOU?
- NEVER
 - VERY FEW TIMES
 - SOMETIMES
 - ALWAYS
- 30.- IN GENERAL, THE PHYSICAL CONDITIONS AND OVERALL COMFORT LEVEL (TEMPERATURE, CLEANLINESS, COMFORT, NOISE, ETC.) OF THE HOSPITAL APPEARED TO BE...
- EXCELLENT
 - VERY GOOD
 - GOOD
 - AVERAGE
 - BAD

DISCHARGE

ON THESE QUESTIONS WE ASK YOU TO REMEMBER MOMENTS IN WHICH THE HOSPITAL DISCHARGED YOU

- 31.- BEFORE LEAVING THE HOSPITAL, WHO EXPLAINED TO YOU WHAT YOU SHOULD (TREATMENTS, MEDICATION, SPECIAL CARE,...) AND SHOULD NOT DO ONCE AT HOME?
- YES, AND THE INSTRUCTIONS WERE VERY CLEAR
 - YES, BUT SOME INSTRUCTIONS WERE UNCLEAR
 - NO, THEY DID NOT EXPLAIN ANYTHING TO ME
- 32.- IN ORDER TO REMEMBER WHAT I SHOULD AND SHOULD NOT DO AT HOME, UPON BEING DISCHARGED
- THEY GAVE ME DETAILED INFORMATION IN WRITING
 - THEY GAVE ME VERY LITTLE INFORMATION IN WRITING
 - THEY DID NOT GIVE ME ANY INFORMATION IN WRITING

GENERAL RATING

IN THIS SECTION, WE ASK YOU TO GIVE US YOUR GENERAL OPINION ABOUT YOUR STAY IN THE HOSPITAL.

- 33.- IN GENERAL, THE INFORMATION THAT I RECEIVED DURING ADMITTANCE
- WAS ALWAYS DETAILED
 - APPEARED SUFFICIENT, ALTHOUGH IT COULD BE BETTER
 - WAS INSUFFICIENT
 - I RECEIVED VERY LITTLE INFORMATION
- 34.- WOULD YOU SAY THAT THE TREATMENT FROM THE HOSPITAL PERSONNEL WAS RESPECTFUL?
- YES, AT ALL TIMES
 - YES, IN GENERAL
 - ON SOME OCCASIONS I FELT THAT THEY DISRESPECTED ME

Appendix B: Patient Survey

Consent Form acknowledgement: Yes No

Audiotaping approved: Yes No

Patient Number _____

Interviewer Number _____

Date _____

Interview start time _____

Interview end time _____

Patient's Residency (City/Municipality) _____

Self-referred: Yes No

Inpatient Outpatient

Date/Time of admission _____

1. Why did you come to Tripoli Medical Center?
2. Describe your interaction with nurses during admission.
3. How did the nurses respond to your questions?
4. How would you describe the level of caring of the nursing staff?
5. What was your impression of how attentive nurses were to you?
6. What do you think about the nurses' ability to understand the patient's feelings when admitted?
7. What do you think about the nurses overall treatment?
8. Describe the nurses' preparation to handle your case.
9. Describe the skills of the nursing staff.
10. Describe the nursing team for your case.
11. Describe the how the doctors communicated with you.
12. How would you describe the manner in which doctors kept you informed?

13. How would you describe the level of understanding you had of the doctors' explanation?
14. How would you describe the answers the doctor gave to your questions?
15. How would you describe your overall interaction with the doctors?
16. Describe the doctors' preparation to handle your case.
17. How attentive were the doctors?
18. How well was the patient's pain managed?
19. Describe the communication among nurses, doctors, and administrators regarding your case?
20. How would you describe the availability of the staff?
21. Overall, how well informed were you about the patient's treatment?
22. How well informed were you about the patient's medicine?
23. How informed were you about side-effects of any medicine prescribed or dispensed?
24. How would you describe the physical environment such as noise or temperature?
25. How comfortable was the patient at night? (for inpatients only).
26. Describe the cleanliness of the bathroom.
27. Describe the cleanliness of the room.
28. Describe the overall condition of the room. (for inpatients only).
29. Describe the level of comfort for family and other visitors.
30. Describe the quality of the food.
31. How was the accessibility of visitors?
32. How would you describe the overall conditions and comfort of the hospital (temperature, cleanliness, comfort, noise, etc.).
33. Overall, describe the adequacy of information received at time of arrival.
34. How do you think hospital personnel showed respect for the patient and family?
35. How do you think hospital personnel showed respect for the beliefs and values of the patient and family?
36. How satisfied are you with the treatment?
37. Describe how the treatment addresses the patient's condition.
38. To what degree did the medical treatment meet your expectations?
39. Describe the adequacy of the information you received about the results of examinations, operations, and/or tests.
40. Describe the adequacy of the information you received about how examinations were to be done.
41. Describe the adequacy of the information you received about home care?
42. Describe the adequacy of the information you received about preventive care? (for illnesses, injuries, or disease) .
43. How are you satisfied with the quality of healthcare in the region you live?
44. What are the advantages and disadvantages of public hospitals and clinics?
45. What are the advantages and disadvantages of having more private clinics and hospitals?

46. What is the affect on the quality of care if there were more private healthcare institutions?
47. What would be the affect on the quality of care of doctors receiving?
48. How would giving doctors financial incentives affect the fairness of the healthcare system?
49. How does spending more money on healthcare affect the quality of healthcare?
50. How would you describe the differences or similarities in healthcare across the region you reside in?
51. How would you describe the changes, if any, of healthcare where you reside?
52. What is your opinion on healthcare providers receiving payments directly from patients?
53. What do you think the affect of more private practices would be on healthcare?
54. Where do you think the emphasis on training of healthcare professionals and administrators should be?
55. What do you think is the optimum administrative structure for the Libyan system of healthcare?
56. Describe the level of understanding of Secretariat of Health to the specific problems in my region.

Interview 2 of 3:

Date_____

Interview start time _____

Interview end time_____

69. How would you describe the level of caring of the medical staff?
 70. How would you describe the level of caring of the administrative staff?
 71. Describe the skills of the medical staff.
 72. Describe the skills of the administrative staff.
 73. Describe the skills of the pharmacy staff.
 74. Describe the communication among nurses, doctors, and administrators?
 75. How would you describe the availability of the staff?
 76. How would you describe the physical environment for patients?
-

Interview 3 of 3:

Date_____

Interview start time _____

Interview end time_____

77. What are the biggest obstacles to providing quality healthcare?
78. What are the advantages and disadvantages of public hospitals and clinics?
79. What are the advantages and disadvantages of having more private clinics and hospitals?
80. What is the affect on the quality of care if there were more private healthcare institutions?
81. What would be the affect on the quality of care of doctors receiving?
82. How would giving doctors financial incentives affect the fairness of the healthcare system?
83. How does spending more money on healthcare affect the quality of healthcare?
84. How would you describe the differences or similarities in healthcare across the region you reside in?

85. How would you describe the changes, if any, of healthcare over the last 10 years you reside?
86. What is your opinion on healthcare providers receiving payments directly from patients?
87. What do you think the affect of more private practices would be on healthcare?
88. Where do you think the emphasis on training of healthcare professionals and administrators should be?
89. What is the role of Medical associations?
90. What do you think is the optimum administrative structure for the Libyan system of healthcare?
91. Describe the level of understanding of Secretariat of Health to the specific problems in my region.
92. To what degree does Libya [U.S] have unified standards for healthcare?

Appendix D: Letter of Cooperation

Prof. Ali M Mgadmi

Head of Paediatric Respiratory division

Tripoli Medical Centre/ University Road

Tripoli/Libya

Date : Sept/24/2008

Dear Ms. Osborne

Based on my review of your research proposal, as I am authorized by the general director of Tripoli Medical Centre Prof. Omran Shamam to give you permission for you to conduct the study entitled " Managing healthcare in a Libyan public hospital; A case study " within Tripoli Medical Centre. As part of this study, I authorize you to invite members of my organization, Whose names and contact informations I will provide. To participate in the study as interview subjects. Their participation will be voluntary and at their own discretion. We reserve the right to withdraw from the study at any time if our circumstances change.

I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the research team without permission from the

Walden University IRB .

Sincerely

Prof. Ali M Mgadmi

E-mail: amgadmi@lbmlibya.org

Telefax office : +218 21 4623701 ext 2804

Cell phone: +218 91 2130167

Appendix E: Employee Qualification Report

**Employee's Qualification
Report**

**Great Socialist People's Libyan Arab Jamahiriya
Peoples' General Committee of Health & Environment**

Tripoli's Medical Center

Employee's Efficiency Report

Total of deduction letters with notification ()

**Salary of the last contract () Libyan Dinars Maximum salary of the
position () L.D.**

**Signature of the concerned employee
division**

**To be used
Chief of the employees' affairs**

.....
.....

Second Section: Performance efficiency & personal traits		Final Maximum Grade	Employee's Efficiency Grade (Immediate supervisor)	Modified Efficiency Grade (General Manager)	Grounds for Assessment's Modification of employee's qualification given by the General Manager	
<u>Duty Performance</u> Work Load. Work quality. Compliance with using work's tools & materials. Coordination of work performance.		45%				
<u>Persistence at work</u> Compliance with the official work time schedule. Respect of working schedules.		15%				
<u>Capabilities & self preparation</u> Extent of accepting criticism and direction. Ability to progress and invent. Ability to perform the position's obligations. Alertness and good action. Keeping good appearance.		20%				
<u>Human Relations:</u> Relations with colleagues and supervisors. Public Relations General work.		20%				
TOTAL	In figures	100%			Assessment	Modified Assessment
	In letters	One hundred				

Third Section: The immediate supervisor's opinion

Efficiency grade assessment Justifications (Excellent – Very Good – Good – Average – Weak)

.....
.....

Any other remarks seen by him:

.....

To be designated

The immediate supervisor /	The General Manager /
The signature /	The signature /
Date / / / 20 A.D.	Date / / / 20 A.D.
The position /	The position /

Directions for the report preparers

- 1- This report's sections should be filled-in according to its layout, so the (First) clause is filled-in by the concerned employee and the (Second) clause by the management or the employees' affairs division which the employee belongs to.**
- 2- The immediate supervisor puts the assessed grade that he sees appropriate before every member, and the General Manager may modify the report's grade, with the supervisors each signing in the appropriate place for him.**
- 3- The efficiency reports are not the goals in themselves, but a method aiming to direct the subordinates and support their capabilities and correct their mistakes before it is too late, that's why the efficiency reports are generally open, no matter what these assessments are.**
- 4- The immediate supervisor assumes completing the efficiency report of his subordinates since he is the responsible person for reviewing their work and observing and directing them and he is the best one able to sense their qualifications.**
- 5- Leaving five grade points between each assessment and the next..... and that serves two purposes:
 - A- Creating clear and controlled separations between the various levels of the position.**
 - B- Giving the immediate supervisor an opportunity to analyze the assessment elements and their weights in order to arrive to a just evaluation in specifying and placing the report's grade in the mentioned five categories.****
- 6- Clarifying the understanding of the general work of comprehensive works and voluntary work.**
- 7- Coordinating the work performance. That the work performance should be on a high level of organizing, cleanliness, right planning and coordination between the elements, so the more important work comes before the less important.**
- 8- The employee's assessment is graded on the following basis:**

- **(Excellent) if the general total is between 90 and 100**
- **(Very Good) if the general total is between 75 and 85**
- **(Good) if the general total is between 60 and 70**
- **(Average) if the general total is between 45 and 55**
- **(Weak) if the general total is 40 and less**

Curriculum Vitae

Alexandria K. Osborne, PMP

EDUCATION:

Bachelors of Science in Chemistry with highest honors, 1978

Pratt Institute, Brooklyn, New York

Honors: National Dean's List

Masters of Business Administration in Management, 2005

Western Michigan University, Kalamazoo, Michigan

GPA 3.8

PhD Candidate, Applied Management and Decision Sciences, 2009 anticipated

Specialization: Leadership and Organizational Change

Walden University

Dissertation Topic: Managing family care in a Libyan Public Hospital: A Case Study

CERTIFICATIONS:

- Project Management professional, Project Management Institute (PMP Number: 427528)
- Information Technology Infrastructure Library Foundation (EXIN ID: EXIN007713)
- Social/Behavioral Human Subjects Research (CITI Collaborative Institutional Initiative, Ref # 2047615)
- Human Research (CITI Collaborative Institutional Initiative, Ref # 2047604)

GENERAL BACKGROUND:

<u>IT Compliance Manager</u>	Pfizer Corp., Kalamazoo, Michigan 2006 - Present
<u>Manager IT Systems/Sr. Systems Analyst</u>	Pfizer Corp., Kalamazoo, Michigan 2003 - 2006
<u>IT Service Manager</u>	Pharmacia Corp., Kalamazoo, Michigan 2000 - 2003
<u>IT Project Manager</u>	Pharmacia Corp., Kalamazoo, Michigan 1998 - 2000
<u>Quality Assurance Specialist</u>	Pharmacia & Upjohn Co., Kalamazoo, Michigan 1984 - 1998
<u>Laboratory Analyst</u>	The Upjohn Co., Kalamazoo, Michigan 1980 - 1984
<u>Research Chemist</u>	International Paper Co., Tuxedo Park, N.Y. 1979-1980

Cooperative Education

Summer 1978
 Summer 1977 & Jan.- Aug. 1976
 Summer 1975

International Paper Co., Tuxedo Park, N.Y.
 Grumman Aerospace Corp., Bethpage, N.Y.
 Union Carbide, Charleston, and W. VA

SPECIFIC EXPERIENCE:

Manager, IT Compliance – Responsible for developing and ensuring consistency of Good IT practices across Business Systems in the US/Canada region. Serves as the compliance lead on IT information system quality projects.

Manager IT Systems/IT Service Manager/Sr Systems Analyst - Responsible for the management, development, and delivery of PGM Quality Operations Information Systems. Serves as the functional lead for eight Systems Analysts .Services and Systems currently supported but are not limited to include GALAXIE, IDARS, LABUMC, IDB, ECC, HPLIMS, Trackwise, and web services. Successfully completed several integration projects including the migration legacy Searle and Pharmacia Product Recall data to Pfizer’s Recall System and the migration of the legacy Searle Corporate Stability Database from Skokie to Kalamazoo.

IT Project Manager - Responsible for planning, monitoring, and fiscal control of the development and implementation of two top '99 Projects: PREMIER and The Site Chromatography Project. The latter was a current top 2000 Project.

- Worked directly with the Office of Program Management for PREMIER (corporate finance program) identifying synergies and dependencies between projects. Served as the IT Project Manager for the PREMIER Y2K initiative, which was comprised of 9 Corporate Accounting and Reporting Systems, assuring that PREMIER systems were Y2K compliant by December 1998. As the IT Project Manager for the Intercompany Royalties project managed a global team and applied Project Management best practices through the development and implementation phases.
- As the IT Project Manager, led an interdivisional project team through the establishment of initial requirements and selection of a replacement for both the Access*Chrom and HP-LAS Chromatography Data Systems. Assured that the process met the Corporate Validation Standards, Procurement policy and the IT Work Process. The project also came in within budget.
- As the IDARS (Instrument Data Archiving and Retrieval System) IT Project Manager, led an interdivisional and global project team through the Product Selection/Evaluation Phase and the Implementation Phase. Project was delivered within budget.
- As the IT Project Manager for the DIAMIR to GALAXIE Chromatography Upgrade Project (including server consolidation) , managed a project team of team of eight. The project was delivered on-time and within budget.
- Aligned across Pfizer by serving as project manager for design and implementation of a financial system, BERT (Budget, Expense, Reporting, and Tracking).

System Responsible for Lot Release System - Assured SQL*LIMS/SQL*QA (LAS) is GMP. Responsibilities included maintaining system configuration; granting users access; training of users, performing validations for enhancements, new software releases, and upgrades; maintaining validation documentation; reviewing audit and error reports, maintaining applicable User Guides, SOPs and other supporting documentation. Also responsible for identifying and coordinating changes QC systems driven by other projects changes (i.e. IRIS).

Master Document Control - Responsible for the maintenance of procedures on several information systems which support testing and lot release. Performed validations and wrote specifications for a new database which maintains the master specifications and test plans. As the Data Manager for the database, developed

the guidelines for the loading of the database to ensure that information was loaded consistently and meets customer needs. Responsible for planning and tracking of the loading effort to ensure that the project is completed on time. Directed activities of several clerical and technician staff.

Lot Release and Vendor Quality - Audited material suppliers to ensure that they meet Good Manufacturing Practices and meet Upjohn standards. Supported manufacturing for material problems and follow-up with vendors. Review of all incoming packaging material inspectors' records. Directed activities of Inspectors. Wrote quality reports on vendor quality leading to recommendations and certification of the vendor site.

Analytical Chemistry - Developed and conducted bioavailability and dissolution studies for drug candidates using HPLC. Validated changes to production processes. Performed polymer characterization using thermal analysis and gel permeation chromatography with low angle laser light scattering. Used various other laboratory techniques such as GC, AA, UV, IR, X-ray fluorescence, and X-ray diffraction.

ACTIVITIES:

- Chairperson of Community Relations Board City of Kalamazoo
- 2004 Member of Citizens Police Review and Appeal Board, City of Kalamazoo
- Secretary and Executive Board member of the American-Arab Anti-Discrimination Committee (ADC) of Greater Kalamazoo. 2002-2004
- Junior Achievement volunteer 2003, 2004, 2006, 2007, 2008
- Loaves and Fishes Pantry Coordinator 2008

REFERENCES: Furnished upon request.