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The Patients' Rights Charter and patient centered care in a South African hospital

Ipeleng Patience Nku

WITS Business School

Thesis presented in partial fulfilment for the degree of Master of Business Administration to the Faculty of Commerce, Law, and Management, University of the Witwatersrand

August 2021

DECLARATION

I Ipeleng Patience Nku declare that this research report entitled 'The Patients' Rights Charter and patient centered care in a South African hospital' is my own unaided work. I have acknowledged, attributed, and referenced all ideas sourced elsewhere. I am hereby submitting it in partial fulfilment of the requirements of the degree of Master of Business Administration at the University of the Witwatersrand, Johannesburg. I have not submitted this report before for any other degree or examination to any other institution.

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Signed at Johannesburg on 29th August 2021

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ABSTRACT

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Thesis title: The Patients' Rights Charter and patient centered care in a South African hospital

South Africa's historical context has resulted in significant disparities and challenges in its healthcare sector. The national Patients' Rights Charter was developed to counter these challenges by empowering patients and protecting their rights. Nevertheless, majority of patients attending hospitals remain unaware of their rights, and as a result face many frustrations associated with the quality of healthcare they receive.

This research seeks to assess patients' perceptions on the Patients' Rights Charter and the influence that it has on the concept of patient centered care in a public South African hospital. Making use of three components of the Patients' Rights Charter, namely confidentiality, informed consent and patient participation in decision making, the extent to which the rights are perceived by patients will be explored. The goal of this study is to assist hospitals in and around South Africa to improve patient centered care through use of the Patients' Rights Charter.

The study employed a quantitative research approach making use of fully structured questionnaires. With 200 participants observed from the medical and surgical out patients departments of the Tembisa Provincial Tertiary hospital, results revealed that 86% were aware that they have rights as patients, while only 31% were aware of existence of the Patients' Rights Charter. Overall the research found that patient perceptions of the Patients' Rights Charter were favourable. Correlation analysis revealed that all three constituents had a positive relationship with patient centered care, while multiple linear regression analysis found that only patient participation and informed consent directly influenced patient centered care. Thus laying focus on improving implementation of the Patients' Rights Charter can aid hospital management in enhancing patient centered care. Such improvement in implementation would best be achieved through collaborative efforts of different systems and areas of the hospital.

Key words: Patients' Rights Charter, patient centered care, confidentiality, informed consent, participation in decision making.

Johannesburg, August 2021

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DEFINITION OF KEY TERMS AND CONCEPTS

Acronym	Full description
PRC	Patients' Rights Charter
PCC	Patient Centered Care
NCS	National Core Standards
HPCSA	Health Professions Council of South Africa
EFA	Exploratory Factor Analysis
KMO	Kaiser-Meyer-Olkin
ICASA	Independent Communications Authority of SA
ANOVA	Analysis of variance

1 CHAPTER ONE – BACKGROUND AND INTRODUCTION

1.1 Background

This research seeks to assess the influence of the South African Patient Rights Charter (PRC) on the implementation of patient centered care (PCC) in a South African tertiary public healthcare facility. As the essence of patient centered care places patients at the centre of the health care system, healthcare organisations are increasingly focused on providing care which is patient-centered rather than disease-focused (Fix et al., 2018). As a result, public healthcare organisations are required to transform their culture of care and key managerial and organisational factors in a manner best suited for implementing patient centered care (Wolff & Jacobs, 2015). In this context, the primary role of the PRC is to promote and protect the rights of patients seeking proficient medical assistance, which must be provided economically and efficiently to provide citizens with the best possible value for money, in alignment with the principles of the PRC (The Department of Health, n.d.). As a result, this study will explore the extent to which attending patients recognise aspects of the PRC to evaluate their patient centered experiences in and around a South African public hospital.

1.1.1 The South African Healthcare Industry

The apartheid era in South Africa has left a legacy of inequality and poverty, with the discriminatory customs of the period causing lingering challenges in many sectors including the healthcare industry (Ramoroka, 2019). South Africa continues to face significant disparities in several healthcare areas that challenge the healthcare industry and provision of PCC, which in turn bears significant weight on society and the economy as a whole (Ataguba et al., 2011). These disparities impinge on the social and economic fabric of society through increasing direct medical costs and indirect costs to the economy that result from inadequate rendering of healthcare services (Benatar, 2013). Although there are multiple factors owing to healthcare disparities in South Africa, differing management models between the private and public healthcare services appears to play a significant role (Stewart & Wolvaardt, 2019), with institutions in the public sector generally known to suffer poor management, underfunding and deteriorating infrastructure, negatively impacting the rendering of patient-centered care (World Health Organization, 2017). As a result, a dichotomy appears to exist between what is stipulated in the Patient Rights Charter and the lack of effective service delivery

in the public healthcare sector (Tzelepis et al., 2015). Reports and results of investigations into the public healthcare system often describe it as collapsing with these results showing that several public hospitals are in a state of crisis with much of the public health care infrastructure in poor condition and vast sections of which are non-operational as a result of underfunding, mismanagement and neglect (Maphumulo & Bhengu, 2019).

1.1.2 Patient Centered Care (PCC)

Patient centered care is a critical aspect of health services, it represents a foundational shift from the traditional, provider-driven, disease-focused medical approach towards healthcare systems that ensure patients (along with their preferences, needs, desires and experiences) are fully integrated into every phase of health care services, including consultation, treatment and follow-up (Stewart & Wolvaardt, 2019). PCC is regarded as the foundational determinant of healthcare management and provision (Berghout et al., 2015). Therefore, all healthcare systems globally including South Africa, are designed to be centered around a proficient patient-healthcare worker relationship, in which it is imperative that concise attention be paid to patient interactions with healthcare providers (Jardien-Baboo et al., 2016). As a result, healthcare institutions are required to implement the necessary organisational changes required to transform from a traditionally provider-centric care system towards systems where patient preferences drive care and sustain the culture of PCC (Berghout et al., 2015). In contrast, research shows that patient experiences at public healthcare institutions in South Africa are often coupled with frustrations that occur as a direct result of the daily management challenges (Haskins et al., 2014). Facing staff shortages and overcrowding, healthcare providers often have great difficulty providing PCC which inadvertently leads to the negative experiences and frustrations faced by patients (Maphumulo & Bhengu, 2019). These experiences generally stem from poor management or implementation of the Patient Rights Charter (a fundamental constituent of PCC) that leaves patients with a lack of understanding regarding issues pivotal to PCC, such as confidentiality, informed consent and decision making (Effects of Poor Communication in Healthcare, n.d.).

1.1.3 The Patient Rights Charter (PRC)

In consultation with the Health Professions Council of South Africa (HPCSA) and several other bodies, the South African Department of Health established the national

Patients' Rights Charter to ensure the right to healthcare access as per the Constitution (Department of Health, n.d.). In this context, the concept of patient-centered care is endorsed in the Constitution of South Africa Second Amendment Act, no. 3 of 2003, where it is stated that all citizens have the right to health care that is caring, free from harm and as effective as possible with value for money (South Africa et al., 2015). This was done in response to the violation of basic human rights experienced by healthcare seekers making use of public health facilities during and post-apartheid (The Department of Health, n.d.): "The department of health is committed to upholding, promoting and protecting this right and therefore proclaims the Patients' Rights Charter as a common standard for achieving the realisation of this right" (The Department of Health, n.d., p. 1). The charter aims to promote deliverance of quality healthcare in South Africa's state hospitals by empowering patients and promoting ethical practices and equality within the sector (Health Professions Council Of South Africa, 2008). As a result, the Patients' Rights Charter paves way to establishing and sustaining patient centered care as its principles seek to introduce a new approach to service delivery that puts people first, and encapsulates the stated values of public service in South Africa, which directly relate to the concept of patient-centered care (Batho Pele White Paper, 1997). With successful implementation of the Patients' Rights Charter the intended outcomes are that patient autonomy is recognized, collaboration between patients and their healthcare workers is enhanced, patient treatment plans are improved and patient complaints and litigations are reduced, thus leading to overall improvement of healthcare services along with the positive impact thereof for organisational functions in public healthcare institutions and the economy as whole (Njuguna et al., 2019).

1.2 Research Conceptualisation

1.2.1 Research Problem Statement

Statista (2020) revealed that the national public healthcare sector remains the sole provider of health care for approximately 84% of the national population, thus it appears the majority of South Africans continue to receive inadequate health services that are largely lacking the foundation of patient centered care. Nkrumah and Abekah-Nkrumah (2019) corroborated this concept and established that the underlying barriers to patient centered care typically include resource constraints, resistance to change, poor staff commitment and unsupported policies, which are factors that appear to be pertinent to the South African context. This is supported by Lloyd et al. (2018) who

found that over and above the limited physical resources, staff shortage and poorly trained staff, management's role in policy implementation is a key barrier to the implementation of patient centered care.

Therefore, it appears healthcare management and service delivery in the public sector may not be executed in accordance with the principles espoused within the Patient Rights Charter (Tzelepis et al., 2015). As a result, the mission to transform healthcare to provide patient-centered care through the Patient Rights Charter, may fall short of its intended outcomes and instead appears to pose a heavy burden on patients and healthcare providers related to adverse outcomes both for the populace and overall economic development (Malakoane et al., 2020) .

Parsapoor et al. (2014) concurs that implementation of the Patient Rights Charter remains a serious challenge for the healthcare system. As the ultimate goal of the Patient Rights Charter is to strengthen the patient centered approach in health service management (Cohen & Ezer, 2013), rendering health care in the face of such challenges thus leads to the question of the extent to which patients are receiving patient-centered care in public hospitals. In this instance, the role of the patient is regarded as pivotal with a view to assessing outcomes in gauging understanding of patient centered care through the Patient Rights Charter (Cohen & Ezer, 2013).

1.2.2 The Research Aims and Objectives

In light of the research problem stated above, the purpose of this study is to assess the extent to which the Patients' Rights Charter has influence on patient centered care in patients attending a South African public hospital. The intention of the study is to assist public healthcare institutions in enforcing implementation of the Patients' Rights Charter and policies relating to patient centered care, in an attempt to enhance the quality of healthcare services provided. The research will look at the perceptions that patients have on constituents of the Patients' Rights Charter, namely confidentiality, informed consent and patient participation as well as their perceptions on the concept of patient cantered care. In addition, the study will seek to explore if a relationship exists between the Patients' Rights Charter constituents (confidentiality, informed consent, patient participation) and patient centered care and if so, do theses constituents of the Patients' Rights Charter influence patient centered care in any way.

1.2.3 The Research Questions and Hypotheses

1.2.3.1 Question 1:

What are the perceptions of patient experiences on constituents of the national Patient Rights Charter (confidentiality, informed consent, patient participation)?

H0: The perceptions of patient experiences on the PRC (confidentiality, informed consent, patient participation) are favourable.
H1: The perceptions of patient experiences on the PRC (confidentiality, informed consent, patient participation) are less than favourable.

1.2.3.2 Question 2:

What are the perceptions of patient experiences on Patient Centered Care?
H0: The perceptions of patient experiences on Patient Centered Care are favourable.
H1: The perceptions of patient experiences on Patient Centered Care are less than favourable.

1.2.3.3 Question 3:

What is the relationship between the Patient Rights Charter (confidentiality, informed consent, patient participation) and Patient Centered Care?

H0: There is no relationship between the Patients' Rights Charter (confidentiality, informed consent, patient participation) and patient centered care.
H1: There is a relationship between the Patients' Rights Charter (confidentiality, informed consent, patient participation) and patient centered care.

1.2.3.4 Question 4:

Does the Patient Rights Charter (confidentiality, informed consent, patient participation) have an influence on patient centered care?

H0: The Patients' Rights Charter (confidentiality, informed consent, patient participation) does not have a significant influence on patient centered care.
H1: The Patients' Rights Charter (confidentiality, informed consent, patient participation) has a significant influence on patient centered care.

1.3 Research Delimitations and Assumptions of the Research Study

Due to the scope of the study, the research only included one public hospital in the Gauteng Province of South Africa. Thus, research results cannot be generalised across all public hospitals. Further information could possibly have been obtained if a wider research population had been involved in the study.

Patient-centered care is a complex, multifaceted and long-term endeavour which occurs at multiple levels of the healthcare organisation. In this regard, assessment of all the relevant aspects was beyond the scope of the current study due to the diverse and broad nature. As a result, the scope of the study only allowed for particular aspects of patient centered care to be assessed. The study therefore focused solely on the challenges of incorporating patient-centered approaches through the Patient Rights Charter in the context of regulations concerning best practice for healthcare services. This was done using the fundamentals which underlie patient centered care in healthcare services, in particular confidentiality, informed consent and patient participation in decision making.

The study assumes participants provided truthful responses throughout. Discussed in more detail, the process and steps undertaken to ensure anonymity can be found in chapter three (methodology), serving the purpose of ensuring participant truthfulness is maximized. Making use of Linkert scale items to assess the perceptions that participants have on constituents of the PRC and PCC, the research assumed that the scale intensity of the attitudes was linear.

1.4 Research Significance

A consequence of poor patient centered care is the prolongation of patient disease and suffering, which ultimately bears long term economic and healthcare implications for the patient and the organisation (Dhai, 2015). Some direct and indirect implications of prolonged disease and dissatisfactory healthcare services have been described by World Health Organisation (2018) are as follows:

- Poor health outcomes contributing to individual and community suffering and the spreading of communicable disease, which in turn increases the burden on the public healthcare institution.
- Poor physical health leading to mental and emotional strain on patients.

- Dissatisfaction of patients resulting in litigations against the healthcare institution and its employees.
- Increased healthcare costs due to prolonged disease.
- Poor health outcomes resulting in reduced contribution to one's employment with further implications to the economy entirely.
- Poor health outcomes increasing access to social welfare and impacting the economy as a whole.

It is anticipated that the results of the study may assist in further evaluating outcomes of the Patient Rights Charter on patient centered care. This will in turn assist the hospital and possibly similar healthcare institutions to determine whether implementation of the Patient Rights Charter is an effective policy in terms of providing patient centered care and improving overall healthcare service delivery.

1.5 Preface to the research report

To this end, this research report consists of six chapters. Following this introductory chapter, chapter two will outline the literature review that covers the problem at hand, past studies relating to the research and the interpretive and conceptual frameworks. Chapter three will then discuss the research strategy, design, procedure & methods, reliability & validity measures as well as limitations. Chapter four and chapter five will present the research results and discussion findings respectively, while chapter six will deliver the summary, conclusions, and recommendations of the research.

2 CHAPTER TWO - LITERATURE REVIEW

This chapter explores literature relevant to the research to facilitate understanding of the problem and identify the knowledge gap. It explores literature from South Africa as well as other countries facing similar challenges and provides a theoretical framework for interpreting the research findings and identifying attributes that are key to the research.

2.1 Problem analysis

2.1.1 Societal Impact of Disease and Public Healthcare

While South Africa holds just over 58 million inhabitants, only 16.4% of its population is covered by medical aid schemes and makes use of private healthcare (Statista, 2020; Stats Sa, n.d.). Bradshaw (2019) predicts that the number of people that require health care is projected to increase in South Africa as a result of rising life expectancies, expanding HIV treatment, and a rapid increase of economy impacting diseases such as cardiovascular disease, diabetes and tuberculosis. He further adds that this burden is set to result in significant economic loss through mortality, treatment costs and effects on productivity (Bradshaw et al., 2019). This trend is prospectively expected to continue and has been compounded by the ongoing global Covid 19 pandemic, which is challenging healthcare service systems and organisations (Pillay et al., 2021). This shift in the burden of disease creates a need for people with multiple comorbidities to seek multiple medical consultations resulting in increasing healthcare costs across the public healthcare sector (Mbunge, 2020). In addition, South Africa is increasingly seeing the simultaneous coalescing of chronic diseases such as HIV with diabetes, which has resulted in an augmented burden on the healthcare system (Batho Pele White Paper, 1997).

The ongoing impact of South Africa's burden of disease requires patients to attend regular clinic and hospital appointments, adhere to ongoing diagnostic and therapeutic tests, remain compliant on chronic medications, and maintain an overall healthy lifestyle that includes healthy meals, self-care and taking responsibility of one's own health (Wolff & Jacobs, 2015). In order to assist patients to improve their health outcomes, healthcare systems are adopting patient-centered practices which aim to deliver quality care and value for money, while acknowledging the responsibilities that fall upon the patient (Adams, 2010). With the public healthcare system bearing much of this

healthcare burden, state hospitals face challenges that render them unable to accommodate and provide patients with the quality of care as required by South Africa's healthcare standards (Department of Health, 2011) .

Maphumulo and Bhengu (2019) found that the underperformance within these facilities can be linked to inadequately trained staff, erratic supply of medication, frequent lack of stock, poor allocation of resources and a lack of essential equipment. In addition they state that staff shortages significantly hinder the ability of public hospitals to develop relationships with patients, which inevitably hampers the long term care required for the effective treatment of chronic diseases (Maphumulo & Bhengu, 2019). Thus, a need exists to improve the patient's public healthcare experience, reduce the cost of care and improve the patient-provider relationship (Adams, 2010). In support of this concept, Richards and Wicks (2015) successfully demonstrated the effectiveness of PCC innovations in improving patient experiences, trust, care, quality, chronic disease management and outcomes.

2.1.2 Patient Centered Care Defined

Patient centered care is defined as "care that is respectful of, and responsive to individual patient preferences, needs and values, and ensures that patient values guide all clinical decisions" (Wolff & Jacobs, 2015, p. 79). It therefore broadens the conventional medical approach to include the patient as an active participant in care. It is built around the needs of the individual and is contingent upon the interpersonal relationship between patient and health service provider (Mapes et al., 2019).

According to De Man et al. (2016) patient centered care assists patients to become active participants in their own healthcare, which is essential to the delivery of effective medical care systems. As a result, patients are also required to understand their role as partners in their own care and be willing to collaborate with healthcare providers to improve their self-care experiences and concerns (De Man et al., 2016).

To this end, as part of the movement towards patient-centered care, several countries have adopted charters of rights for patients, and South Africa is no exception, having formulated the National Patient Rights Charter to ensure the realisation of the right to

access healthcare services as per the Constitution (Act No 108 0f 1996) of South Africa (South Africa et al., 2015).

2.1.3 Patient Rights Charter Defined

According to The Department of Health (n.d.) the Patient Rights Charter typically includes rights that already exist in law, as well as a variety of statutes that are applicable to the rendering of healthcare services. Three distinct sources of legal and ethical principles inform the Patient Rights Charter, these are the Constitution (and all statutes and regulations stemming from it that embody its principles), medical case law and the Health Professions Council of South Africa (HPCSA) (South Africa et al., 2015). The HPCSA is mandated to set and maintain healthcare standards, with the primary role of protecting the public and guiding the profession, it is guided by a formal regulatory framework that includes the Health Professions Act 56 of 1974 (HPCSA, n.d.) Every institution which provides healthcare services is required to operate in a manner compliant with regulations and requirements as set out by the HPCSA (HPCSA, n.d.).

The 'Batho Pele' principles translating to 'people first' are principles developed in line with the PRC to transform public service delivery in South Africa (Batho Pele White Paper, 1997). These principles align with the Constitution (Act No 108 0f 1996) of South Africa in that they seek to respond to people's needs, thus all healthcare conduct must support and reflect its values and aims. Under the Constitution, all citizens enjoy certain rights, and healthcare organisations have the responsibility to ensure those rights are respected. In addition to these rights, patients also have responsibilities which are also set out in the PRC. These rights and responsibilities are presented below (The Department of Health, n.d.) .

The patient rights as presented in the PRC include:

A healthy and safe environment; Participation in decision-making; Access to health care services which includes receiving timely emergency care and being treated patient with dignity and respect; Knowledge of one's health; Information and freedom to utilize medical insurance; Choice of healthcare services; Treated by a named healthcare provider; Confidentiality and privacy; Informed consent; Right to refusal of treatment; Right to referral for a second opinion; Continuity of care; Complain about health services.

Patient responsibilities as presented in the PRC include:

Taking care of the records in their possession; Taking care of one's health ; Not abusing the healthcare system; Providing healthcare providers with relevant and accurate information for diagnostic, treatment, rehabilitation or counselling purposes; Advising healthcare providers of their wishes in treatment and in the event of death; Complying with treatment; Enquiring about healthcare related costs; Caring for and protecting the environment; Respecting the rights of other patients and healthcare providers; Knowing your local healthcare services and what they provide

2.1.4 Implementation of the PRC and PCC

Implementing a patient centered model of care which embraces the rights and principles set forth in the PRC has profound implications for the way health services are managed, planned, delivered, and evaluated. Four main components are considered essential in the performance of PCC (Fix et al., 2018), these components are: The professional skills of healthcare providers (relating to the training and development of healthcare professionals); The care environment and whether this is conducive for PCC (relating to the environment being conducive for privacy and confidentiality); The person-centered processes (relating to effective communication pertaining issues such as obtaining informed consent); The expected outcome (being measured from the patients perspective and not particularly the therapeutic outcome as perceived by the health professional).

At the heart of these components and their implementation are health care management and leadership, defined as the ability to inspire individual and organisational excellence in healthcare service delivery, to create a shared vision and successfully manage change to attain strategic health service goals and successful outcomes (National Health Act, 2003). Healthcare management and leadership is the driving force behind decision making and communication and is responsible for guiding the vision of a healthcare organisation (National Health Act, 2003). Thus, it forms a critical aspect in any change initiative toward patient centered care.

2.1.5 Healthcare management

Maphumulo and Bhengu (2019) state that public hospital management is in crisis. The national policy on healthcare management identified the challenges that hamper the

delivery of effective and efficient healthcare services, these stem from the lack of appropriate legislation and policies. While in other cases the challenges related to capacity constraints, such as the competency levels of hospital CEOs, lack of proper training, lack of strategic support, and lacking the capacity to deal with small operational issues (National Health Act, 2003). This national policy on management of hospitals was thus derived to ensure that the management of hospitals is underpinned by principles of effectiveness, efficiency and transparency (National Health Act 2003). The objectives set out in this policy specifically for management teams are as follows:

- Promoting applicable legislations and policies to improve hospital functions
- Ensuring the appointment of highly skilled managers
- To move towards decentralisation of management
- To develop frameworks that promote accountability
- To provide the training and development of managers in leadership, management and governance

2.1.6 Institutional theory

As described by Greve and Argote (2015) " The institutional theory focuses on the roles of social, political and economic systems in which companies operate and gain legitimacy"(Greve & Argote, 2015, p. 3). This theory within the management context describes how the institution provides the 'rules of the game' and defines the available ways to work by encouraging or discouraging given behavioural patterns (Debroux, 2010). While the hospital is an entity on its own with its own structures and policies, it cannot operate much of its desired functions solely without the intervention of The Department of health. The Department of Health provides policies and regulations to the institution in an attempt to manage the different operational functions effectively. These inherited policies and guidelines were developed to serve all healthcare institutions, based on research of a broad nature rather than from a focus on an individual institution (Debroux, 2010). This is turn bears significance with regards to how effective and efficient these policies will be in individualized institutions. This thought is further refined by Zucker (1987) who mentions that organisations are generally influenced by normative pressures, that occasionally arise from external sources such as the state, whose involvement is of a broad nature. Zucker (1987) further goes to state that often times these pressures can also arise from the organisation itself. To counter these pressures, public healthcare institutions make use of committees and

general audits whose role is to ensure that the incorporated policies and regulations are being implemented efficiently and effectively (Zadeh et al., 2016).

2.1.7 Implementation Theory

A series of constructs within five structural areas interact to influence implementation, these include intervention characteristics, inner setting and outer setting of the organisation, individual characteristics, and the process to be implemented. The five structural areas also include pertinent factors such as strength of evidence for the implementation (linked to knowledge about what is being implemented), implementation fit within the organisation's practices (adaptability), organisational readiness to implement the change (priority, climate, training), role of leadership (engagement, management and resource allocation) and engagement of staff (Schein, 1992).

The implementation theory provides a conceptual framework for understanding how healthcare leadership can typically implement PCC and PRC practices as 'implementation' describes the aggregation of processes needed to get an intervention into use within an organisation on a daily basis (Sinclair, 2001). It is a social process defined by the context in which it takes place and requires engagement of all the team members who are involved in the process, alongside a leadership strategy to accomplish the intended outcome (Sinclair, 2001). In addition, implementation requires creation of structures within the organisation that will facilitate the process (Schein, 1992).

Asumeng and Osae-Larbi (2015) describe the implementation of organisational change in healthcare organisations in terms of bridging (integration of different facets of the organisation), redesigning (integration among professionals) and engaging (directing and leading behaviours towards the core values and goals) the relevant tools and frameworks. The Department of Health (n.d.) developed the National Core Standards (NCS) in line with the Office of Occupational Health Standards as a tool to guide healthcare institutions with the implementation of different domains within the organisation. This NCS framework is discussed further in section 2.4 as the interpretive framework.

2.1.8 Systems Theory

The systems management theory proposes that an organisation consists of multiple components that work together for the greater outcome. The theory emphasizes the concept of collaboration of all the functions of the organisation (Chikere & Nwoka, 2015). The key elements pertinent to the success of the organisation are Synergy, interdependence and the interrelations between various subsystems. Furthermore, the theory describes how that over and above employees, other crucial elements in the organisation include departments, workgroups and business units (Kessler, 2013).

2.1.9 Overall Economic Impact on Healthcare Services

In addition to facing a civil claim in negligence, healthcare service providers or organisations whose practice falls short of acceptable standards may face disciplinary action by the Health Professions Council with possible suspension of duties or revoking of a medical licence entirely (Department of health, n.d). The number and value of clinical negligence claims brought in South Africa has been rising rapidly in recent years, which has had drastic financial implications on the public healthcare sector (Dhai, 2015).

A large number of these litigations result from dissatisfaction with services and interactions with public healthcare institutions (Pienaar, 2016). Raveesh et al. (2016) found that some of the common grounds for majority of South African medico legal challenges are: healthcare workers avoid showing compassion, failure to communicate clearly and effectively, and insufficient information provided for patient follow ups, all of which pertain to patient centered care (Raveesh et al., 2016).

Although it is the duty of the attending healthcare worker to assure dignified efficient care of high quality is delivered to a patient, the institution bears the weight of responsibility for the overall operations and can therefore be held responsible and bear direct liability for failing to provide a safe environment that can provide quality treatment (Raveesh et al., 2016). As a consequence, these litigations come attached with significant cost implications for public healthcare institutions, which is transferred to the state thus resulting in dire economic drawbacks. Zikali (2019) estimated that the medico-legal claims in 2019 amounted to at least R20 billion for South African state hospitals. In addition, the World Health Organization (2017) mentioned that the long-standing consequences of poor delivery of patient centered care incur additional

healthcare expenditures for both the patient and the state. This is over and above poor health outcomes whose long-term implications (and associated cost) can result in ongoing economic impact disease, disability and in most cases death. The report states that the economic costs attached to health outcomes resulting from poor quality of care, is said to amount to trillions of dollars yearly at an international level (World Health Organization, 2017).

The PRC affords the opportunity for communication between patient and provider so any areas of concern can be clarified in advance, thus circumventing the prospect of litigation entirely (Pienaar, 2016). In this context what a PRC is intended to add is a catalyst through which to resolve individual patient concerns quickly and economically. It details expectations for how a patient experiences care within the present offerings of the health care system, known as rights "in" healthcare (Pienaar, 2016).

2.2 Research knowledge gap analysis

With the intention of adding significant value to the existing body of knowledge, this section focuses on existing literature to explore similar studies, methods, procedures, findings and conclusions in Sub Saharan Africa and similar countries in order to contextualise the South African scenario and the current study.

A critical analysis conducted by Nevhutalu (2016) following an ethics audit at the Chris Hani Baragwanath Academic Hospital in South Africa, revealed no correlation exits between the theory and the practice of the Patient Rights Charter. The study explores various case reports that highlight various violations of patient rights at the Chris Hani Baragwanath Academic Hospital, emphasizing poor implementation of the Patient Rights Charter. The results of this study are especially significant as the hospital is one of the prominent tertiary training institutions for healthcare services in South Africa and is thus reasonably expected to create appropriate benchmarks for provision of services in line with PCC and PRC (Nevhutalu, 2016).

Njuguna et al. (2019) looked at the influence of the Patients' Rights Charter on health systems responsiveness in Kenya. Making use of a cross sectional descriptive study, qualitative data was obtained from healthcare workers using questionnaires. The study found that "the awareness and knowledge of the Patients' Rights Charter was significant

and had an influence on the responsiveness of health systems"(Njuguna et al., 2019, p. 4663). As successful implementation of the Patients' Rights Charter relies on both the patient and healthcare provider, the current study in contrast to Njuguna et al. (2019) focuses solely on the patient perspective.

Dadashi et al. (2019); Mastaneh and Mouseli (2013); Razavi et al. (2006) all looked at awareness of Patient Rights Charters in various regions in Iran among patients and healthcare workers, and came to the conclusion that awareness and practicing of patient rights is limited and in need of intervention. Agrawal et al. (2017) also focusing on patient awareness in Egypt came to the conclusion that patient rights awareness was low among patients, families and healthcare workers, with much needed attention to educating healthcare workers on the contents and importance of the Patient Rights Charter. Furthermore a recommendation was made of forming a committee to monitor appropriate implementation of the Patient Rights Charter (Agrawal et al., 2017).

These challenges are not uncommon in other African hospitals. Kagoya et al. (2013) focusing on patient rights practice and awareness in a national hospital in Uganda found that over 80% of patients and healthcare providers had never heard of a Patient Rights Charter, although awareness was higher amongst the healthcare providers. Zeina et al. (2013) looked at the manner in which patient rights are perceived and exercised in Egypt among patients, their companions and staff members. While three quarters of the patients were not familiar with existence of a Patient Rights Charter, about half of the healthcare workers were also unaware of it. Majority of the respondents reported having learnt of the charter through mass media, followed by posters displayed on the hospital walls (Zeina et al., 2013).

A vast amount of research looking at patient rights has focused on awareness among patients and healthcare workers. Although this is of vital importance to the fundamental concept of the charter, it is equally as important to establish if the charter has effectively influence desired outcomes (Fix et al., 2018). Whilst it is noted that the charter components have positive effects on health outcomes in general, there is not much evidence to suggest that these outcomes are specifically of a patient centric nature (De Man et al., 2016). Together with all the research conducted in third world countries similar to South Africa, Nevhutalu (2016) added knowledge specific to South Africa on

the importance of patient awareness of the Patient Rights Charter. As a result, it has become evident that the relationship and influence of the Patients' Rights Charter on patient centered care is of utmost importance and thus there is room for research to establish this influence.

2.3 Quantitative variables key to research

Strategies for the clinical delivery of PCC include the incorporation of knowledge of the patient history, the conduct of consultation sessions, providing validation, prioritizing well-being ahead of routines and care tasks, simplifying and personalizing the environment and performing activities that promote well-being and comfort. Consequently, these strategies which are central to the concept of patient centered care and most representative of the patient-doctor relationship are confidentiality, informed consent and patient participation which form part of patient rights in the PRC and have been used as the key independent variables for the research.

2.3.1 Patient centered care

PCC consists of five key dimensions (Mead & Bower, 2000), these dimensions have been describes as follows:

i) Patient as a person - describes the physician getting to know the patient in a comprehensive manner. This begins by the physician conducting a full patient history, making sure to listen carefully to all the aspects of the patient history (includes main complaint, medical and surgical history, social history), followed by appropriate examination and assessment in a private setting.

ii) Bio psychosocial perspective - relates to the physician getting to know all the aspects pertaining to the patient, including their biological, psychological and social issues.

iii) Sharing power and responsibility - relates to patient autonomy, requiring that the physician respects the patient's autonomy and affords them the opportunity to be involved in the decision-making process.

iv) Therapeutic alliance - describes the partnership formed between the physician and the patient that works to benefit the patient.

v) Physician as a person - relates to active self-awareness and self-control of the physician as all emotion and biases displayed by the physician play a role in the recovery journey of the patient.

2.3.2 Confidentiality

In healthcare services confidentiality is defined as "the law whereby a doctor or medical practitioner cannot reveal anything said to them by their patients during consultation or treatment" (Dyban, 2015). It is thought to be a key feature of patient centered care and ethical medical practice and is understood to be guaranteed in order for patients to trust in the interaction with the healthcare provider (Jones, 2003). Failure to guarantee confidentiality can result in legal implications, inaccurate diagnosis and poor health outcomes (Jones, 2003). Merideth (2007) describes five legally accepted parameters that are recognized as an exception to a physician fulfilling the duty of confidentiality as follows:

1. Confidential information may be released if given consent to do so by the patient.
2. A physician may release confidential information if granted a court order to do so.
3. Confidential information may be released in order to assist a patient with continuing their treatment.
4. Confidential information may be released in order to comply with the law.
5. The clinician has a duty to protect people facing danger, and when faced with such a situation they may release confidential information.

2.3.3 Informed Consent

Informed consent is defined as "the process in which a health care provider educates a patient about the risks, benefits, and alternatives of a given procedure or intervention" (Shah et al., 2020). In order to fully comply with the concept of informed consent, its legal, ethical and administrative standards are to be fulfilled (Hall et al., 2012). The factors described in the acquiring of informed consent are: patient comprehension, patients' use of disclosed information, patient autonomy, demands on providers and physicians meeting of standards (Hall et al., 2012), all of which form fundamental components of patient centered care.

2.3.4 Patient Participation

Patient Participation is described as "the involvement of the patient in decision making or expressing opinions about different treatment methods, which includes sharing information, feelings and signs and accepting health team instructions" (Vahdat et al., 2014). The encouragement of participation of patients in their healthcare has been shown to result in better outcomes, in addition to improved voluntary active

participation which is key to patient centered care and resulting long term health maintenance (Vahdat et al., 2014). The key factors that influence patient participation in the decision-making process are described as follows:

- Patient related factors: demographics; personal characteristics; cultural knowledge; beliefs/ values; knowledge
- Diseases related factors: symptoms; stage; illness severity; health outcomes; health expectations
- Healthcare worker related factors: interpersonal communication skills; beliefs; values; knowledge
- Healthcare setting factors: -cultural appropriateness; competency of the system; location; type of institution
- Health provider task factors: cultural appropriateness; competence; behaviours

2.4 Framework for interpreting research findings

2.4.1. National Core Standards

The efforts being pursued by the PRC to improve on the quality of health care services is proving to have many difficulties. In order to strengthen these efforts, the National Core Standards (NCS) were established by the Department of health. The primary objectives of the NCS are to develop criteria and indicators for the assessment of health establishments; to set a benchmark of standards for health establishments; and to establish a baseline for hospitals and communities to inform their development (Department of Health, 2011).

The NCS tool is structured into seven domains. Each domain has sub-domains, within which are a set of standards. Each standard has a number of criteria that are achievable and measurable as per a provided description. The first three domains are directly involved with the core business of the health system of delivering health care to patients and relate specifically to patient rights, safety, clinical governance, clinical care, and clinical support services. The remaining domains form the support structures which ensure the system can deliver its core business, these include public health, leadership and corporate governance, operational management, facilities and infrastructure (Department of Health, 2011).

The tool is intended as a quality assurance mechanism that sets the benchmark against which delivery of healthcare services in health care organisations can be monitored by the Office of Health Standards Compliance (OHSC). It describes what is mandatory for implementation in all health establishments in South Africa to obtain national accreditation and certification of compliance in terms of mandated standards. The standards also provide details to managers of health organisations about what the definition of 'adequate' service delivery means in practical terms. In addition, it provides a means of measuring performance and success of implementation. As a result, healthcare managers in South Africa are significantly and continuously engaged with the NCS (Department of Health, 2011).

When a healthcare facility generates an inspection report that shows non-compliance (score less than 50% on an NCS rating scale), the facility leadership is issued with a non-compliance notice attached to the inspection report, along with a quality improvement (QIP) template. The facility leadership is then required to implement the QIP template (with relevant support) to correct areas of non-compliance, followed by facility self-assessment within a stipulated time period for rectification. A follow-up re-inspection of implementation and compliance is then verified by the OHSC. Should the follow up inspection reveal persistent noncompliance, further action for enforcement or shut down may occur in terms of the National Health Amendment Act 12 of 2013. The NCS tool acknowledges that staff are key in achieving the core business of the healthcare system and in this regard, internal members (health care providers) play a pivotal role in enforcing the standards (Department of Health, 2011).

It is a requirement for all health facilities to achieve a pre-determined level of compliance with the NCS tool in order to permit and maintain healthcare operations. This is enforced and monitored via internal self-assessment audits and external audits conducted by a quality assurance sub-directorate of the OHSC & quality assurance managers at the various levels and districts (Department of Health, 2011).

The internal assessments done to assess the Patient's Rights Domain of the NCS makes use of multiple tools to assess the different patient rights. Reports and patient files are analysed, internal audits are conducted, and interviews are conducted with patients and healthcare workers. Pertaining to the three patient rights studied in this research, namely

confidentiality, informed consent and patient participation, the most appropriate tool is that of interviews. Following the use of the mentioned tools, the organisation is then rated based on the results obtained. This rating consists of four categories that correspond with the type of intervention required in connection with the results. These categories are as follows: extreme (X); vital (V): essential (E); developmental (D). Institutional interventions are made accordingly based on the overall outcome of each component (Department of Health, 2011).

3 CHAPTER THREE - RESEARCH METHODOLOGY

3.1 Introduction

This chapter identifies and describes the research methodology in terms of approach, design, procedure and methods. It also introduces the procedure employed to collect, process and analyse relevant data. Reliability and validity measures applied as well as the ethical considerations are also described in this chapter.

3.2 Research Strategy

Saunders et al. (2006) define the research strategy as the general plan of how the researcher will go about answering the research questions. The three general strategies one can employ when undertaking research are quantitative, qualitative, and the mixed approach which makes use of both quantitative and qualitative research approaches.

In order to fulfil the research questions and objectives posed in chapter one, this investigation made use of a quantitative research approach. Creswell and Creswell (2018) define the quantitative research approach as follows: "Quantitative research is an approach for testing objective theories by examining the relationship among variables. These variables, in turn, can be measured, typically on instruments, so that numbered data can be analysed using statistical procedures" (Creswell & Creswell, 2018, p. 32). This approach was deemed appropriate as this research seeks to ultimately identify and assess if there is a significant relationship between the PRC constituents and PCC in the hospital setting. In this context, fully structured questionnaires including Linkert scale type questions and closed ended questions were appropriately used to fulfil the research purpose. The use of these questions in this research is described below in the research instrument section. Furthermore, to expand on variable relationships, this strategy would allow for the research to assess the influence that these PRC constituents have on PCC if indeed a relationship does exist between the variables. The quantitative research approach permitted the investigation to collect, analyse and process data from a large sample all while minimizing bias and improving credibility of the research.

3.3 Research Design

The research design is described as "Representing the framework for data collection and data analysis and comprises the following five types: experimental design, cross-sectional

or social survey design, longitudinal design, case study design and comparative design" (Saunders et al., 2006, p. 160).

A cross-sectional design was regarded as suitable for the current study as it involves assessing data from a specific population (patients) who are selected based on particular interest (patient perspectives of patient centered care and the specific constituents of the patients' rights charter) at one specific point in time and in a specific setting. The cross-sectional study design in this instance is descriptive in nature as it seeks to describe the characteristics of the chosen variables. The descriptive research design further allows for correlations between the variables to be made as well as to determine the degree of association between the variables (Saunders et al., 2006).

The chosen research methodology permits for analysis of the patients' perceptions of the patients' rights charter from their hospital experiences, and whether this influences their perception of patient centered care provided within the hospital setting.

3.4 Research Procedure and Methods

3.4.1 Research setting

As the purpose of the study was to investigate patient perceptions of the PRC and PCC in a South African public hospital, the Tembisa Provincial Tertiary Hospital was selected as a suitable locality. According to the South African Doctors Hospital (n.d) information page, the hospital provides healthcare services to a vast and wide catchment area. As a Provincial Tertiary hospital, it receives health care users from, and provides specialist support to other regional hospitals and thus requires the expertise of clinicians working as specialists. The hospital is located in the township of Tembisa within the Ekurhuleni municipality of Gauteng Province. The immediate communities serviced by the hospital are Midrand and Diepsloot (including their local township and suburb areas). It is also a referral hospital for approximately twenty smaller clinics and two community healthcare centres in the region spanning across three municipalities. As a tertiary hospital, the facility is also used to provide health education at a tertiary level to train future medical professionals (South African Doctors Hospitals, n.d). With approximately 840 approved and usable beds, the hospital serves a catchment population of close to 2 million people according to 2011 Census (Census, 2011).

3.4.2 Research target population

The target population for the study included the patient collective who make use of the medical and surgical outpatient departments of the Tembisa Provincial Tertiary Hospital. The medical and surgical outpatient departments were specifically selected as the target population as they consist of patients who attend the hospital for treatment without overnight stay or undergoing critical care. As a result, medical services provided on an outpatient or non-hospitalized basis include those of relevance to PCC and the PRC, namely consultation, diagnosis, treatment and rehabilitation.

3.4.3 Sample population

The sample population for the study included two hundred patients from the medical and surgical outpatient departments of the Tembisa Provincial Tertiary Hospital. The sample size was considered appropriate in terms of the limited scope of the study. Sample participants were randomly selected from the waiting area based on availability (i.e. attending the hospital by appointment) and were not selected on the basis of their clinical status (severity of disease or symptoms). Patients were enrolled in the study if they consented to participate and if they met the inclusion and exclusion criteria. This included adult male or female patients over the age of 18, who were able to read, write and communicate in English, Tswana or Zulu (researcher acting as translator). Due to concerns on consent, vulnerable patients (minors, etc) and those with psychiatric conditions were excluded from the study.

3.4.4 Research data collection instrument

The study made use of a structured questionnaire with discrete sections to accommodate the aspects under investigation, namely confidentiality, informed consent, patient participation and patient centered care (Appendix 2). The questions were designed for relevancy of the investigation, using the frameworks of PCC, PRC and NCS tool. The structured questionnaire was considered an ideal quantitative data tool for use in this cross sectional study as it made use of closed ended questions and Linkert scale type questions. Linkert scales are used to determine the perspectives and views that individuals have towards a particular element (Jamieson, 2005).

A comprehensive and analytical review by Joshi et al. (2015) describes how one can combine the items of a Linkert scale in order to generate a composite score for different

participants, rendering the assigned scale an interval scale, thus permitting the data to be statistically treated with Pearson's correlation coefficient (r) and regression analysis (Joshi et al., 2015). Analysis of the Linkert scale items in this regard facilitated determination of patient perceptions of three specific constituents of the PRC (namely confidentiality, informed consent, patient participation), and establishing if a relationship exists between these three PRC constituents and PCC. A brief description of each of the applicable sections of the structured questionnaire is provided below:

Section A – included **demographic details** of patients such as age, gender, education level, employment status, place of residence and home language.
Section B – assessed patient knowledge of rights and aspects of the **Patient Rights Charter** using closed ended questions.
Section C – investigated **confidentiality** via closed ended questions and a five item Likert scale.
Section D – explored **informed consent** through closed ended questions and a seven item Likert scale.
Section E – assessed **patient participation** by asking closed ended questions and a seven item Likert scale.
Section F – evaluated **patient centered care** using a ten item Likert scale.

3.4.5 Research ethical considerations

Participants entered the study voluntarily and were free to withdraw at any time. Anonymity was maintained by omitting participant names from the questionnaire and final report. In addition, completed questionnaires were only accessible to the researcher, whilst all data derived was saved in a password protected file that could only be accessed by the researcher. All results and records pertaining to the study were securely maintained, for a mandatory period of five years. The study was clarified to participants both verbally and via a written participant information sheet, through which written informed consent was obtained prior to the completion of the questionnaire (Appendix 3). Ethical clearance to proceed with the study was obtained from Wits Business School Ethics Committee (Appendix 4), whilst permission to conduct the study at the Tembisa Provincial Tertiary Hospital was obtained from the Gauteng Department of Health (Appendix 6), in addition, staff in the medical and surgical out

patient departments of the hospital were duly informed about the research prior to the data collection process.

3.4.6 Research Data collection process

The study utilised hard copy questionnaires as opposed to electronic platforms, in order to ensure ease of accessibility and eliminate the need for participants to own a device in order to participate. As the study was conducted during the global Covid 19 pandemic, all relevant precautions were executed to ensure health and safety during the data collection process. Data was collected for a period of five days from consenting patients over a single hospital visit whilst in the waiting area, prior to their consultation. As the medical and surgical department of the hospital operates by appointment only at least one month in advance, repeat visits (and repeat questionnaires) were not possible during the period of data collection.

The following procedures were applicable to data collection process:

- Patients were randomly approached in the waiting area to ascertain their interest in participation, their eligibility for the study, and to obtain their consent to participate.
- After the researcher fully explained the study to the patient, an information and consent form was provided to them, which disclosed the details relevant to the study. The forms were signed by each participant acknowledging their understanding and consent to participate.
- The participant then immediately completed the questionnaire while the researcher was available for assistance.
- Completed questionnaires were then collected in a locked box at the end of each day, and the box was kept in a safe and secure location, accessible only to the researcher.

3.4.7 Research data processing and analysis

The data gathered from participant questionnaires was analysed using descriptive statistics (frequencies and percentages) via IBM SPSS Statistics®. In order to fully address the research aim and objectives, further statistical analyses were used to describe the relationship between the variables of confidentiality, informed consent, patient participation and patient centered care. This was performed using Pearson's Correlation Analysis to determine the relationship between the variables, whilst Multiple Linear

Regression was used to determine how the variables influence each other. Results of the data analysis are presented in both graphical and tabular form in chapter four to follow.

3.5 Research Reliability and Validity

Reliability and validity of the research were articulated by the fact that the questions posed in the participant questionnaire were specifically tailored to assess confidentiality, informed consent, patient centered care and patient rights in accordance with criteria outlined in the PRC and NCS tool. In addition, all participants were required to complete the same questions. The descriptions of the sample, procedure and design are also sufficiently comprehensive to allow for transferability to other settings in a similar context.

4 CHAPTER FOUR - RESULTS

4.1 Introduction

This chapter provides the presentation of results from the data collected. Data analysis was performed in line with the questionnaire responses received from participants. Whilst two hundred and thirty (230) patients were approached for participation, responses were received from two hundred (200) participants in total. In the process of analysis, participant responses were categorized to coincide with the particular sections of the questionnaire (namely demographic information, patient rights, confidentiality, informed consent, patient participation and patient centered care). The responses were assessed using frequencies, percentages (rounded off where applicable) as well as Pearson's Correlation and Multiple Linear Regression analytical tools.

4.2. Patient Demographic Details

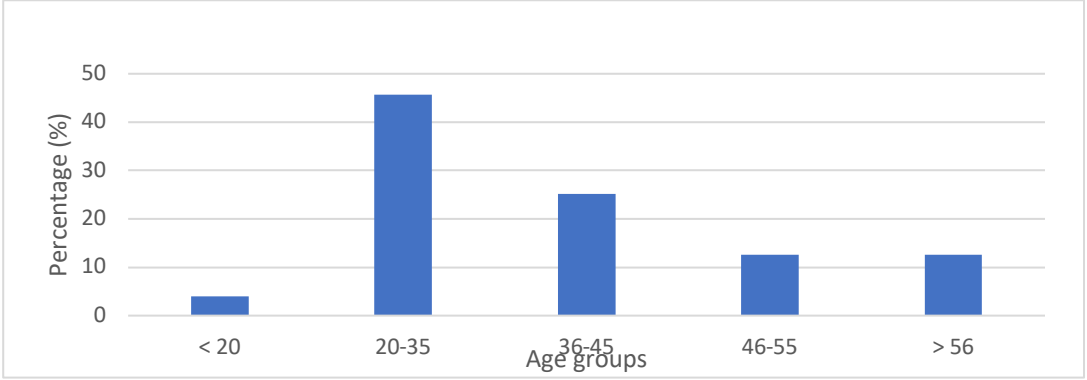
4.2.1 Age

Results obtained from the respondents regarding age are represented in Table 1 and Figure 1 below:

Table 1: Percentage of Participant Age

Age	Frequency	Percent
< 20	9	4%
20-35	91	45%
36-45	50	25%
46-55	25	13%
> 56	25	13%
Total	200	100%

Figure 1: Participant Age Groups



As shown in Table 1 and Figure 1 above, of the sampled participants:

- The majority at forty five percent (45%, n = 91) were between 20 and 35 years.
- Twenty five percent (25%, n= 50) were between 36 and 45 years.
- Thirteen percent (13%, n=25) were aged between 46 and 55 years and (13%, n=25) over 56 years, respectively.
- The minority at four percent (4%, n = 9) were under 20 years of age.

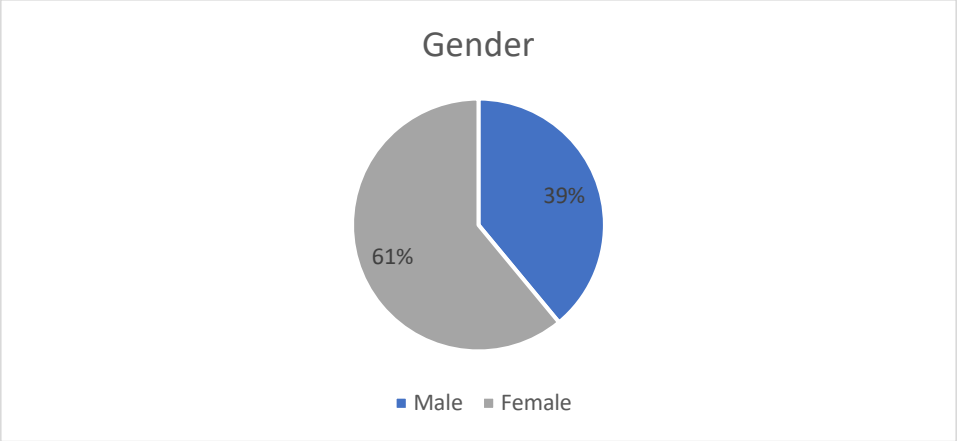
4.2.2. Gender

The number of males versus females comprising the participants is thirty nine percent (39%, n = 78) and sixty one percent (61%, n = 122) respectively. This is depicted in Table 2 and Figure 2 below:

Table 2: Percentage of Participant Gender

	Frequency	Percentage
Male	78	39%
Female	122	61%
Total	200	100%

Figure 2: Participant Gender



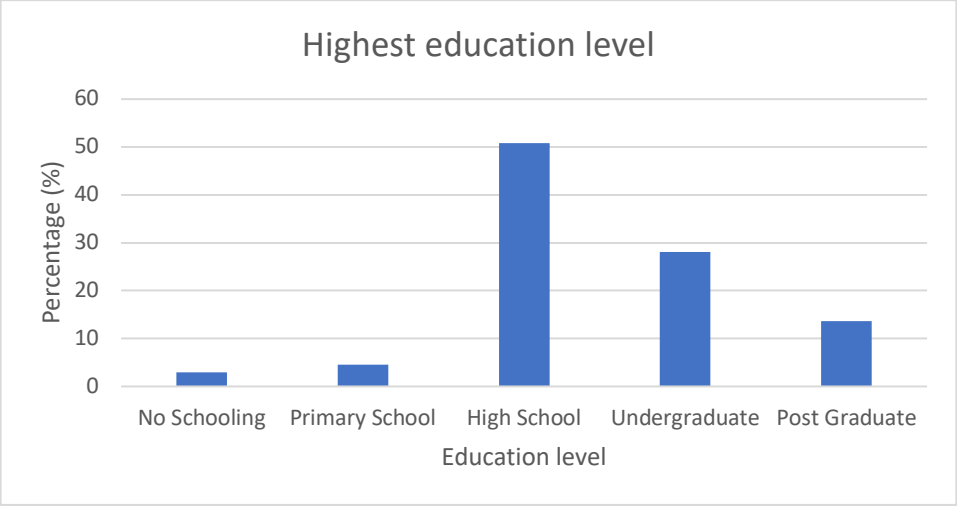
4.2.3 Education level

Results pertaining to the highest level of education attained by participants is shown in Table 3 and Figure 3 below:

Table 3: Percentage Education Level of Participants

	Frequency	Percentage
No Schooling	7	3%
Primary School	9	5%
High School	101	51%
Undergraduate	56	28%
Postgraduate	27	13%
Total	200	100%

Figure 3: Participant Education Level



According to the results in the Table 4.3 and Figure 4.3 above, of the sampled participants who provided information about their education:

- The highest number at fifty one percent (51%, n= 101) attained high school level education.
- Twenty-eight (28%, n= 56) had undergraduate education.
- Thirteen percent (13%, n= 27) attained postgraduate education.
- Five percent (5%, n= 9) had primary school as the highest level of education.
- The lowest number at three percent (3%, n=7) had no formal education.

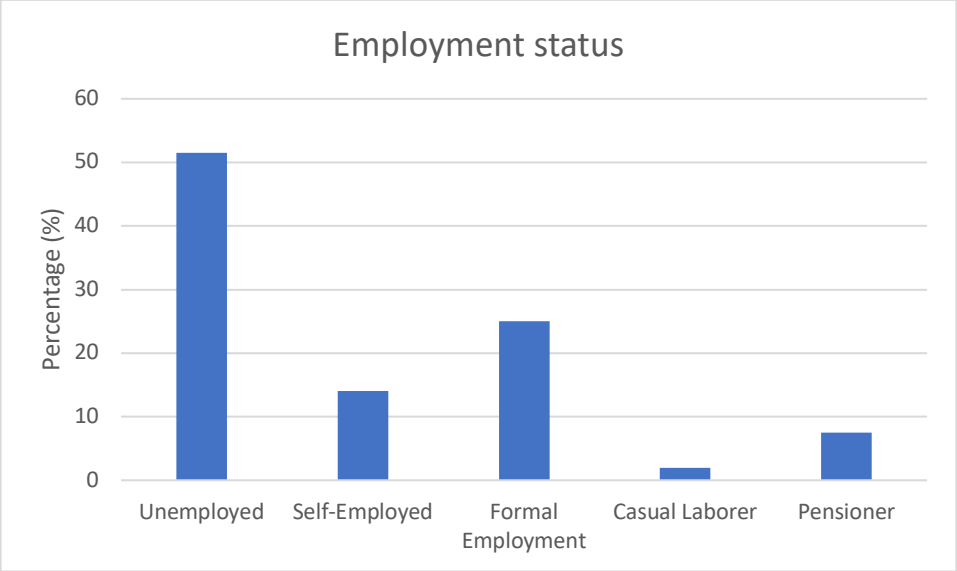
4.2.4 Employment status

The employment status of participants is reflected in Table 4 and Figure 4 as follows:

Table 4: Percentage of Participant Employment Status

	Frequency	Percentage
Unemployed	103	52%
Self-Employed	28	14%
Formal Employment	50	25%
Casual Labourer	4	2%
Pensioner	15	7%
Total	200	100%

Figure 4: Employment Status of Participants



From Table 4 and Figure 4 above, the employment status of participants is categorised as follows:

- The majority of participants at fifty two percent (52%, n=103) are unemployed.
- Twenty-five percent (25%, n=50) have formal employment.
- Fourteen percent (14%, n=28) are self-employed.
- Seven percent (7%, n=15) are pensioners.
- The least number of participants at two percent (2%, n=4), perform casual labour.

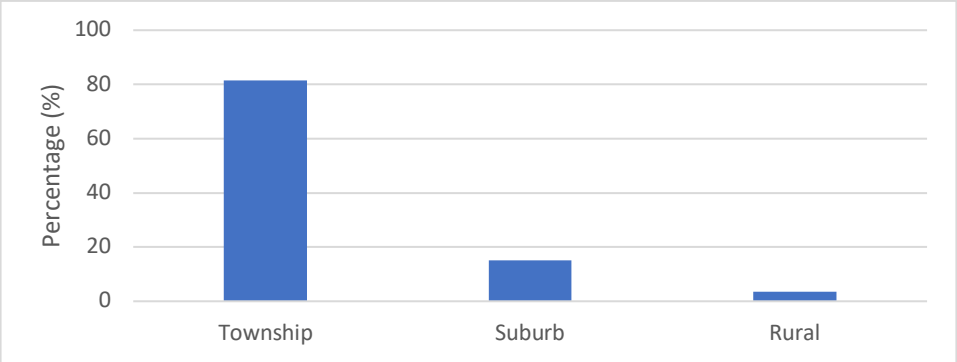
4.2.5 Place of residence

Results for place of participant residence illustrate the majority of respondents (81%, n=163) reside in a township, fifteen percent (15%, n=30) reside in a suburb, while the minority at four percent (4%, n=7), reside in a rural area as seen in Table 5 and Figure 5 below:

Table 5: Percentage of Participant Place of Residence

	Frequency	Percentage
Township	163	81%
Suburb	30	15%
Rural	7	4%
Total	200	100%

Figure 5: Participant Place of Residence



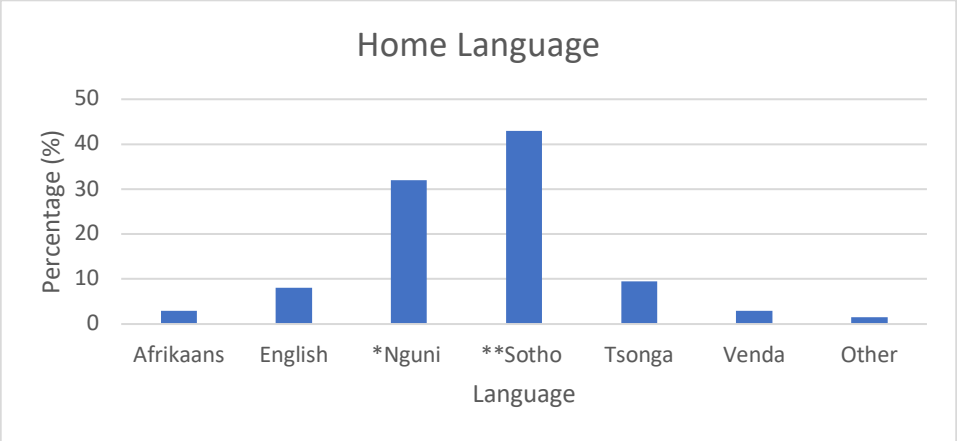
4.2.6 Home language

Results reflect the participants' home language as shown in Table 6 and Figure 6 as follows:

Table 6: Percentage of Participant Home Language

	Frequency	**Percentage**
Afrikaans	6	3%
English	16	8%
Nguni (Zulu, Xhosa, Swati, Ndebele)	64	32%
Sotho (Sepedi, Sesotho, Setswana)	86	43%
Tsonga	19	9%
Venda	6	3%
Other, please specify	3	2%
Total	200	100%

Figure 6: Participant Home Language



*Nguni: Zulu/ Xhosa/ Swati/ Ndebele

**Sotho: Sepedi/ Sesotho/ Setswana

As reflected in Table 6 and Figure 6 above:

- Sotho is the home language for most of the participants (43%, n=86).
- This is followed closely by thirty-two percent (32%, n=64) of participants with Nguni as the home language.
- Nine percent (9%, n=19) have their home language as Tsonga, followed by eight percent (8%, n=16) whose native language is English.
- Both Afrikaans and Venda are spoken by three percent (3%, n=6) of participants, respectively.
- The least number of participants (2%, n=3) have other native languages which did not form part of the options on the questionnaire.

4.3 Research question 1: What are the perceptions of patient experiences on constituents of the national Patient Rights Charter (confidentiality, informed consent, patient participation)?

4.3.1 Patient rights

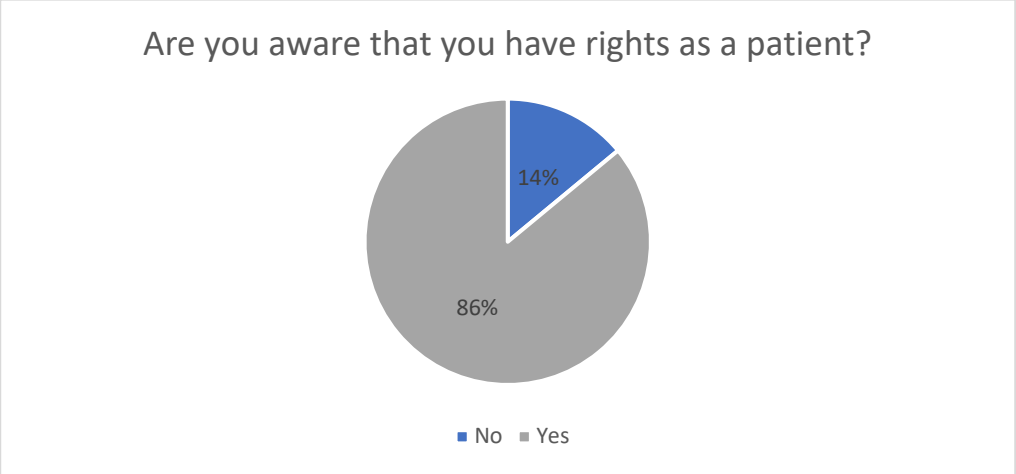
4.3.1.1. Awareness of patient rights

Results illustrate that the majority of patients at eighty six percent (86%, n=172) were aware they have rights whilst, the minority at fourteen percent (14%, n=28) were not aware of this. These results are depicted in Table 7. and Figure 7 below:

Table 7: Awareness of patient rights

	Frequency	Percentage
No	28	14%
Yes	172	86%
Total	200	100%

Figure 7: Awareness of patient rights



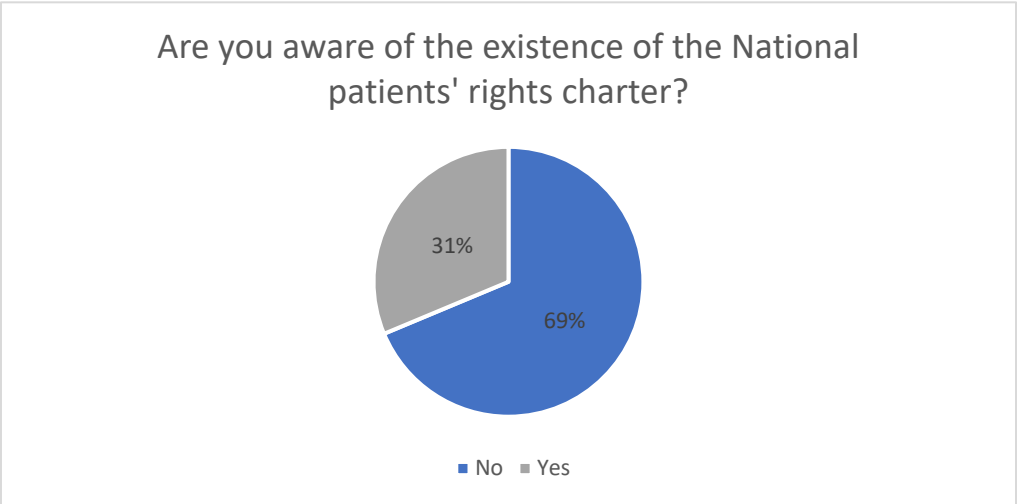
4.3.1.2 Awareness of the patient rights charter

In accordance with the results pertaining to participant awareness of the Patient Rights Charter, the majority of patients at sixty nine percent (69%, n=138) indicated they were not aware of the PRC whilst, the minority at thirty one percent (31%, n=62) were aware of existence of the charter, as reflected in Table 8 and Figure 8 below:

Table 8: Awareness of the patient rights charter

	Frequency	Percentage
No	138	69%
Yes	62	31%
Total	200	100.0

Figure 8: Awareness of the patient rights charter

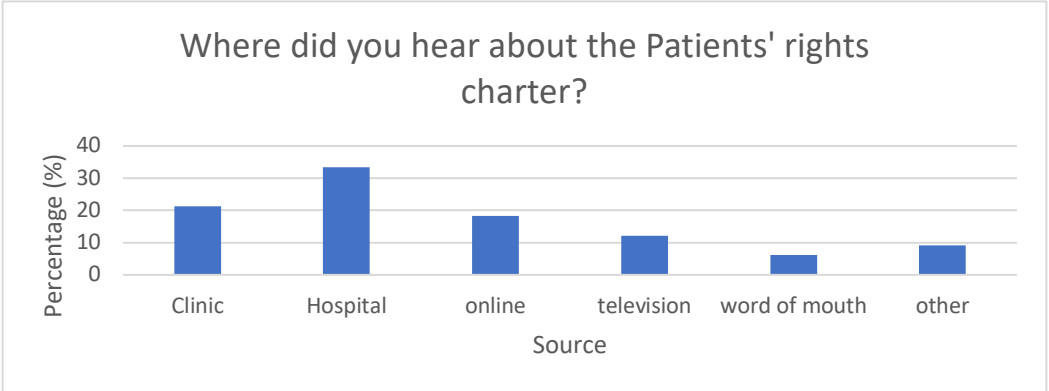


The sixty nine percent (69%) of participants who indicated they were aware of the PRC were further asked where they had heard about the charter. The results indicating how participants became informed of the charter are reflected in Table 9 and Figure 9 below:

Table 9: Information Source for Patients' Rights Charter

	Frequency	Percentage
Clinic	7	21%
Hospital	11	33%
online	6	19%
television	4	12%
word of mouth	2	6%
other	3	9%
Total	33	100%

Figure 9: Information Source for Patients' Rights Charter



As shown in Table 9 and Figure 9 above, the 69% of participants who knew about the PRC, indicated they heard about it from the following sources:

- Thirty three percent (33%, n=11), forming majority of responses, heard about the PRC from the hospital.
- Twenty one percent (21%, n= 7), said they found information about the PRC from the clinic, whilst nineteen percent (19%, n= 6) were informed online.
- Six percent (6%, n=2), of participants heard of the PRC from sources such as television and by word of mouth respectively while nine percent (9%, n=3) stated other miscellaneous sources.

4.3.2 Confidentiality

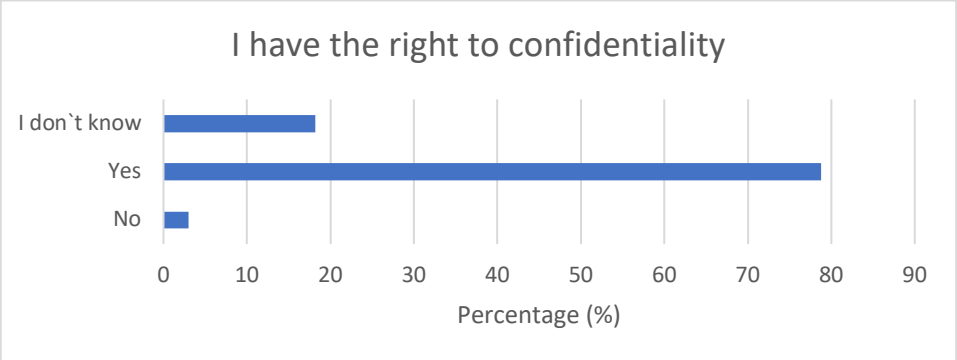
4.3.3.1 Awareness of confidentiality

Results illustrate that the majority of patients at seventy nine percent (79%, n= 156) were aware they had the right to confidentiality, whilst eighteen percent (18%, n= 37) seemed unsure and the minority at three percent (3%, n = 7) were not aware of this patient right. These results are shown in Table 10 and Figure 10 below:

Table 10: Participant Awareness of Confidentiality

	Frequency	Percentage
No	7	3%
Yes	156	79%
I don`t know	37	18%
Total	200	100%

Figure 10: Participant Awareness of Confidentiality



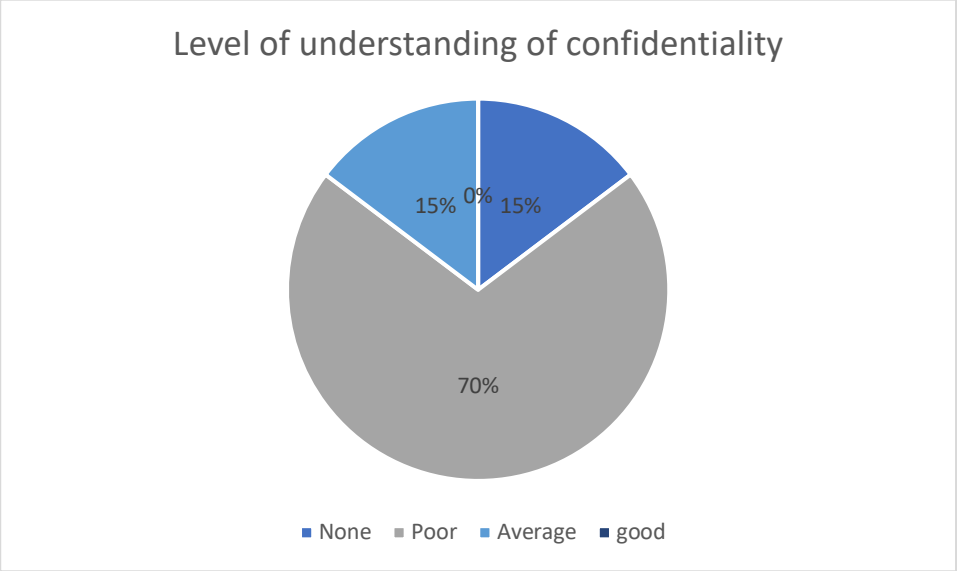
4.3.3.2 General understanding of confidentiality

The seventy nine percent (79%, n=156) of participants who indicated they were aware of confidentiality as a patient right, were further required to indicate how they would best describe and define their right to confidentiality. The descriptions of confidentiality were divided into four categories using the definition of confidentially as stated in the PRC, "Information concerning one's health, including information concerning treatment may only be disclosed with informed consent, except when required in terms of any law or an order of the court" (The Department of Health, n.d.). The four categories were as follows:

- None (no understanding): where all the pertinent parameters of confidentiality were omitted.
- Poor understanding: where most of the pertinent parameters of confidentiality were omitted.
- Average understanding: where some parameters of confidentiality were included.
- Good understanding: where all the parameters of confidentiality were included.

The results pertaining to the above categories are reflected in Figure 11 below:

Figure 11: General understanding of Confidentiality



As shown in Figure 11 above, the 79% of participants who affirmed their right to confidentiality, were found to have a level of understanding as follows:

- In accordance with the definition stated in the PRC, most participants at seventy percent (70%), displayed a poor understanding of the parameters of this right.

- Fifteen percent (15%) demonstrated average correlation with the definition of confidentiality, with understanding of some of the parameters.
- Fifteen percent (15 %) displayed a poor understanding of its parameters overall.
- There were no participants (0%) who had a good understanding of confidentiality and all the parameters that pertain to it.

4.3.3.3. Patient perception of confidentiality specific parameters

The participant perceptions were assessed in relation to specific parameters of confidentiality, where they were required to indicate to what extent they agree or disagree with predetermined statements describing these parameters. For ease of interpretation, responses which reflect 'agree' and 'strongly agree' have been aggregated, the same applies to responses reflecting 'disagree' and 'strongly disagree.' Results are portrayed in Table 11 below:

Table 11: Percentage Perception of Confidentiality Specific Parameters

			Disagree/ Strongly disagree	Unsure	Agree/ Strongly agree	Mean	Standard deviation
C1	The hospital makes sure my information is kept in a safe and secure place	Count	14	36	149	4.02	0.992
		Row N %	7%	18,10%	74,90%		
C2	The hospital makes sure my information is not seen by other people	Count	18	44	136	3.90	1.064
		Row N %	9,10%	22,20%	68,60%		
C3	The doctor makes sure our conversations are only between the two of us	Count	21	25	151	4.00	1.055
		Row N %	10,70%	12,70%	76,70%		
C4	In some instances, the doctor can share my information if necessary	Count	66	33	98	3.14	1.374
		Row N %	33,50%	16,80%	49,80%		
C5	In some instances, the hospital can release my information if necessary	Count	91	36	70	2.79	1.326
		Row N %	46,20%	18,30%	35,60%		
	Overall					3.9715	0.90873

As shown in Table 11 above, the participant perceptions of confidentiality specific parameters are described as follows:

- C1: The majority of participants (75%, n=149) felt the hospital ensures information is kept safe and secure, whilst eighteen percent (18%, n=36) were unsure and the least number at seven percent (7%, n=14) did not agree.
- C2: Most participants (69%, n=136) agreed that the hospital ensures their information is not seen by others. Twenty two percent (22%, n=44) were unsure of this aspect while the minority (9%, n=18) disagreed.

- C3: The least number of participants (n=21) at eleven percent (11%) disagreed that the doctor ensures conversations remain between doctor and patient only, thirteen percent were unsure of this whilst the majority of participants at seventy seven percent (77%, n=151) felt assured of this aspect.
- C4: Almost half the number of patients (50%, n=98) agreed that the doctor could share their information if necessary, while thirty four percent (34%, n=66) did not agree. Seventeen percent (17%, n=33) were unsure of this.
- C5: Less than half the number of patients (46%, n=91) felt the hospital could not release their information if necessary, eighteen percent (18%, n=36) were unsure of this and more than half (36%, n=70) agreed this was acceptable.

4.3.2 Informed Consent

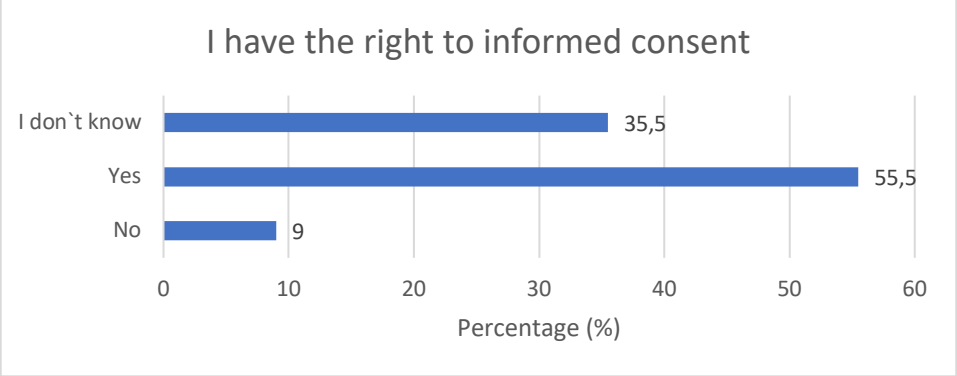
4.3.2.1 Awareness of informed consent

In accordance with the results, most patients at fifty six percent (56%, n= 111) were aware they had the right to informed consent, whilst thirty five percent (35%, n=71) were unsure and the minority at nine percent (9%, n=18) were not aware of this right. These results are shown in Table 12 and Figure 12 below:

Table 12: Awareness of Informed Consent

	Frequency	Percentage
No	18	9%
Yes	111	56%
I don`t know	71	35%
Total	200	100%

Figure 12: Awareness of Informed Consent



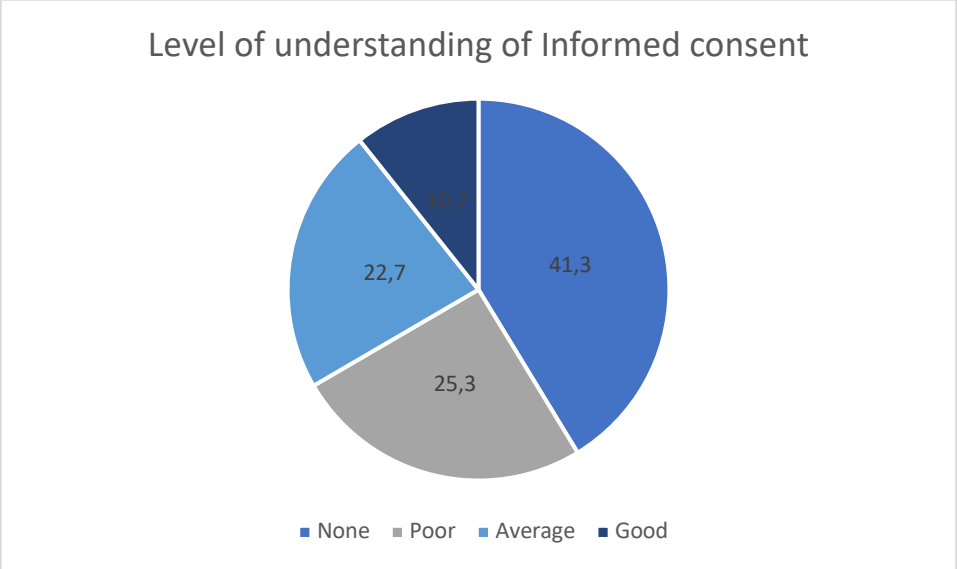
4.3.2.2 General understanding of informed consent

The fifty six percent (56%, n=111) participants who indicated they were aware of informed consent as a patient right, were requested to indicate how they would best describe and define their right to informed consent. The descriptions of informed consent were divided into four categories using the definition of informed consent as stipulated in the Patients' Rights Charter "Everyone has the right to be given full and accurate information about the nature of ones illnesses, diagnostic procedures, the proposed treatment and the costs involved, for one to make a decision that affects any one of these elements" (The Department of Health, n.d.). These categories were as follows:

- None (no understanding): where all the pertinent parameters of informed consent were omitted.
- Poor understanding: where most of the pertinent parameters of informed consent were omitted.
- Average understanding: where some parameters of informed consent were included.
- Good understanding: where all the parameters of informed consent were included

The results pertaining to the above categories are reflected in Figure 13 below:

Figure 13: General Understanding of Informed Consent



As shown in Figure 13 above, the 56% of participants who affirmed their right to informed consent, were found to have the following understanding of the patient right:

- Most participants at forty one percent (41%), were noted to have no understanding of the full correct definition including all its parameters.
- A further twenty five percent (25%) demonstrated a poor understanding of the parameters pertaining to informed consent.
- In contrast, twenty three percent (23%) were found to display an average understanding of informed consent and its parameters.
- The least number of responses at eleven percent (11%) indicated a good understanding of the parameters of this right.

4.3.2.3 Perception of informed consent specific parameters

Similar to confidentiality, participant perceptions were further assessed regarding specific parameters of informed consent. Participants were required to indicate to what extent they agree or disagree with predetermined statements describing these parameters. For ease of interpretation, responses once again reflect aggregated 'agree' and 'strongly agree' or 'disagree' and 'strongly disagree' as shown in Table 13 below:

Table 13: Percentage Perception of Participant Informed Consent Specific Parameters

			Disagree/ Strongly disagree	Unsure	Agree/ Strongly agree	Mean	Standard deviation
IC1	The doctor fully explains what is wrong with me	Count	21	16	163	4.04	1.067
		Row N %	10,50%	8,00%	81,50%		
IC2	The doctor explains the treatment and procedures needed for my illness	Count	22	11	166	4.06	0.993
		Row N %	11%	5,50%	83,40%		
IC3	The doctor explains other options for my treatment	Count	42	19	135	3.67	1.300
		Row N %	21,40%	9,70%	68,90%		
IC4	I am able to ask the doctor as many questions as I need to understand	Count	23	18	155	3.98	1.086
		Row N %	11,70%	9,20%	79,10%		
IC5	I am given the opportunity to make a choice of my own about my treatment	Count	60	32	106	3.28	1.363
		Row N %	30,30%	16,20%	53,50%		
IC6	I can say no to the treatment my doctor wants to give me	Count	58	33	107	3.37	1.334
		Row N %	29,30%	16,70%	54%		
IC7	I can ask about costs regarding my treatment	Count	38	42	119	3.54	1.274
		Row N %	19,10%	21,10%	59,80%		
	Overall					3.396961	1.03100

From Table 13 above, the participant perceptions of informed consent specific parameters are clarified as follows:

- IC1: Eighty one percent (81%, n=163), forming the majority of participants agreed that the doctor provided a full explanation of their condition, eleven percent (11%, n=21) were unsure and the least number (n=16) at eight percent (8%) did not agree.
- IC2: Most participants eighty four (84%, n=166) agreed that the doctor explained the required treatment and procedures. Eleven percent (11%, n=22) were unsure of this aspect while the minority (6%, n=11) disagreed.
- IC3: The least number of participants (n=19) at 10 percent (10%) felt unsure whether other options for treatment were provided. Twenty one percent (21%, n=42) felt certain this was not provided, while the majority of participants at sixty nine percent (69%, n=135) felt assured this was provided.
- IC4: Most patients (79%, n=155) agreed they were able to ask questions to obtain clarity, twelve percent (12%, n=23) did not agree. Nine percent (9%, n=18) were unsure of this.
- IC5: Approximately half the number of patients (54%, n=106) felt they could make their own choice regarding treatment, sixteen percent (16%, n=32) were unsure of this and less than half (30%, n=60) disagreed.
- IC6: A little over half of the participants (54%, n=107), indicated agreement that they could reject the proposed treatment, seventeen percent (17%, n=33) were unsure and the least number (n=38) at twenty nine percent (29%) did not agree.
- IC7: The least number of participants (n=38) at nineteen percent (19%) felt they could not ask about treatment costs. Twenty one percent (n=42) felt unsure of this, while the bulk of the participants at sixty percent (60%, n=119) felt this was acceptable.

4.3.4 Patient Participation

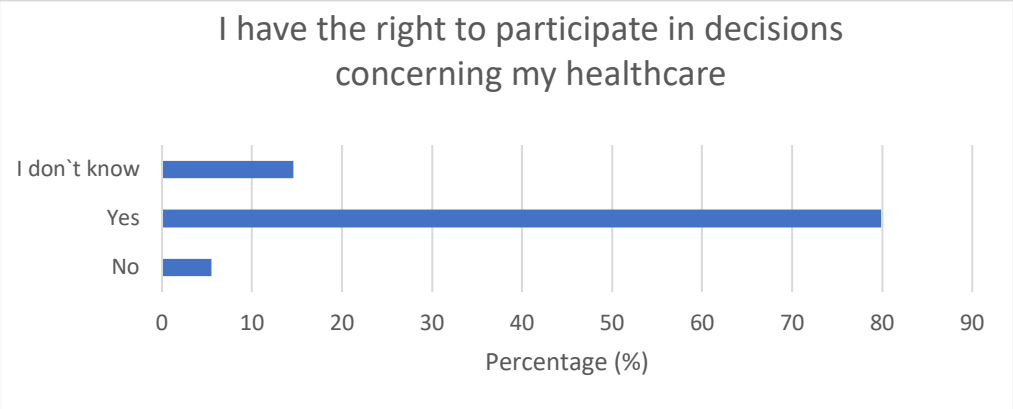
4.3.4.1 Awareness of patient participation

The results showed that the majority of patients eighty percent (80%) were aware they had the right to participate in their healthcare decisions, whilst fourteen percent (14%) seemed unsure and the minority at six percent (6%) were not aware of this right. The results are portrayed in Table 14 and Figure 14 below:

Table 14: Awareness of Patient Participation

	Frequency	Percentage
No	12	6%
Yes	159	80%
I don`t know	29	14%
Total	200	100%

Figure 14: Awareness of Patient Participation



4.3.4.2 Perception of patient participation specific parameters

The participant perceptions were explored regarding specific parameters of participation where they were required to indicate to what extent they agree or disagree with predetermined statements describing these parameters. For ease of interpretation, responses once more reflect aggregated 'agree' and 'strongly agree' or 'disagree' and 'strongly disagree' as shown in Table 15 below:

Table 15: Percentage Perception of Patient Participation Specific Parameters

			Disagree/ Strongly disagree	Unsure	Agree/ Strongly agree	Mean	Standard deviation
PP1	I can ask about my symptoms/ diagnosis/ treatment	Count	17	7	175	4.23	1.017
		Row N %	8,50%	3,50%	87,90%		
PP2	I make sure I understand my illness before I leave	Count	28	10	160	4.06	1.184
		Row N %	14,20%	5,10%	80,90%		
PP3	I know and understand what is planned for managing my case	Count	40	21	134	3.70	1.208
		Row N %	20,50%	10,80%	68,70%		
PP4	The doctor/ nurse listens to me	Count	43	19	134	3.64	1.283
		Row N %	21,90%	9,70%	68,40%		
PP5	I can decide treatment goals with the doctor	Count	54	32	110	3.41	1.335
		Row N %	27,50%	16,30%	56,10%		

PP6	I can help the doctor make decisions about my healthcare	Count	60	38	99	3.31	1.302
		Row N %	30,50%	19,30%	50,20%		
PP7	I can help with developing health policies	Count	63	51	83	3.12	1.314
		Row N %	31,90%	25,90%	42,20%		
	Overall					3.9075	0.91090

According to Table 15 above, the perceptions of patient participation specific parameters are clarified as follows:

- PP1: The majority of participants (88%, n=175) felt they could ask about aspects of their health and care; however, nine percent (9%, n=17) did not agree, whilst the minority (n=7) at four percent (4%) were unsure.
- PP2: Most participants (81%, n=160) also ensured they did not leave without understanding their condition, whereas fourteen percent (14%, n=28) did leave without this understanding and the least number of patients at five percent (5%, n=10) were unsure.
- PP3: The least number of participants (n=21) at eleven percent (11%) felt unsure whether they knew and understood what was planned for their case management. Twenty one percent (n=40) felt they did not know or understand this information, while the greater number of participants at sixty nine percent (69%, n=134) felt assured of this.
- PP4: Most patients (68%, n=134) felt the doctor/nurse listens to them, twenty two percent (22%, n=43) did not agree, and ten percent (10%, n=19) were unsure.
- PP5: A little over half of the patients (56%, n=110) concurred they were able to decide treatment goals with the doctor, sixteen percent (16%, n=32) were unsure of this, and twenty eight percent (28%, n=54) disagreed.
- PP6: Approximately half of the participants (50%, n=99) indicated agreement that they could assist the doctor with their own healthcare decisions. The minority (n=38) at nineteen percent (19%) were unsure and thirty one percent (31%, n=60) disagreed.
- PP7: The smallest number of participants (n=51) at twenty six percent (26%) felt unsure whether they could assist in developing health policies. Thirty two percent (n=63) did not feel this was possible, while the bulk of the participants at forty two percent (42%, n=83) were in agreement.

4.4 Research Question 2: What are the perceptions of patient experiences on Patient Centered Care?

4.4.1 Perception of patient centered care specific parameters

In order to describe the overall participant perceptions of patient centered care, specific parameters of PCC were explored, in which participants were required to indicate to what extent they felt satisfied, unsatisfied or neutral regarding predetermined statements describing these parameters. For ease of interpretation, responses reflect aggregated 'satisfied' and 'extremely satisfied' or 'unsatisfied' and 'extremely unsatisfied' as shown in Table 16 below:

Table 16: Percentage Perception of Patient Centered Care Parameters

			Extremely unsatisfied/ Unsatisfied	Neutral	Extremely satisfied/ Satisfied	Mean	Standard deviation
PCC1	I am satisfied with the questions the doctor asked me	Count	14	32	150	3.86	0.904
		Row N %	7,20%	16,30%	76,50%		
PCC2	I am satisfied that the doctor listened to me	Count	20	34	141	3.80	0.988
		Row N %	10,30%	17,40%	72,40%		
PCC3	I am satisfied that the doctor treated me with respect	Count	10	26	159	4.06	0.904
		Row N %	5,20%	13,30%	81,50%		
PCC4	I am satisfied with the way that the doctor considered my emotions	Count	13	30	152	3.94	0.898
		Row N %	6,70%	15,40%	77,90%		
PCC5	I am satisfied with the way the doctor explained everything to me	Count	20	35	141	3.86	0.985
		Row N %	10,30%	17,90%	71,90%		
PCC6	I am satisfied with the way the doctor involved me in the treatment process	Count	23	41	130	3.75	0.989
		Row N %	11,90%	21,10%	67%		
PCC7	I am satisfied with the partnership between the doctor and I	Count	19	49	127	3.74	0.977
		Row N %	9,80%	25,10%	65,20%		
PCC8	I am satisfied with the fact that the treatment is to my benefit	Count	10	34	151	3.96	0.864
		Row N %	5,20%	17,40%	77,50%		
PCC9	I am satisfied with the attitude of the doctor	Count	18	34	144	3.87	1.017
		Row N %	9,20%	17,30%	73,50%		
PCC10	I am satisfied with the emotional state displayed by the doctor	Count	18	41	137	3.81	0.978
		Row N %	9,20%	20,90%	69,90%		
	Overall					3.8678	0.76290

Table 16 above describes the perceptions of PCC specific parameters as below:

- PCC1: The bulk of participants (77%, n=150) felt satisfied with the questions posed by the doctor. Sixteen percent (9%, n=32) were neutral and the minority (n=14) at seven percent (7%) were unsatisfied.
- PCC2: Most participants (72%, n=141) were satisfied the doctor listened to them, whereas seventeen percent (14%, n=28) felt neutral and the least number of patients at ten percent (10%, n=20) were unsatisfied.
- PCC3: Eighty two percent (82%, n=159) of patients expressed satisfaction on being treated with respect by the doctor, while thirteen percent (13%, n=26) felt neutral, and a minimum of five percent (5%, n=10) felt unsatisfied.
- PCC4: The majority of patients (78%, n=152) felt satisfied that the doctor considered their emotions, fifteen percent (15%, n=30) were neutral, and seven percent (7%, n=13) were unsatisfied.
- PCC5: Seventy two percent (72%, n=141) of patients, forming the majority, were satisfied with the explanation from the doctor, eighteen percent (18%, n=35) were neutral, and ten percent (10%, n=20) felt unsatisfied.
- PCC6: Sixty seven percent (67%, n=130) participants (12%, n=23) expressed satisfaction with their involvement in the treatment process, twenty one percent (21%, n=41) were neutral on this aspect and twelve percent (12%, n=23) were unsatisfied.
- PCC7: The smallest number of participants (n=19) at ten percent (10%) felt dissatisfied with their partnership with the doctor. Twenty five percent (n=49) were neutral, while the bulk of the participants at sixty five percent (65%, n=127) were satisfied.
- PCC8: The majority of patients (78%, n=151) felt satisfied that the treatment was beneficial for them, seventeen percent (17%, n=34) were neutral, and five percent (5%, n=13) were unsatisfied.
- PCC9: Most participants (74%, n=144) were satisfied with the attitude of the doctor, whereas seventeen percent (17%, n=34) felt neutral and the least number of patients at nine percent (9%, n=18) were unsatisfied.
- PCC10: The bulk of participants (70%, n=137) felt satisfied with the emotional state displayed by the doctor. Twenty one percent (21%, n=41) were neutral and the minority (n=18) at nine percent (9%) were unsatisfied.

4.5 Research Question 3: What is the relationship between the Patient Rights Charter (confidentiality, informed consent, patient participation) and Patient Centered Care?

4.5.1 Correlation Analysis

Correlation analysis was carried out to assess the relationship between patient centered care and the variables associated with the Patients' Rights Charter (confidentiality, informed consent, patient participation). In this instance the analysis was interpreted through Pearson's correlation coefficient (r) to measure the strength of the linear relationship, which ranges from -1 to +1, where -1 indicates a negative correlation (one variable increases while the other decreases), +1 indicates a positive correlation (variables will increase together and decrease together) and 0 indicates no relationship (Schober et al., 2018). However, different authors have suggested varying interpretations to interpret values between 0 and 1, and Cohen (1988) suggests the following guidelines:

Strength of correlation:	Small (Weak)	r = 0.10 to 0.29
	Medium (Moderate)	r = 0.30 to 0.49
	Large (Strong)	r = 0.50 to 1.0

In light of this interpretation, table 18 below depicts the results of the correlation analysis:

Table 17: Correlation Analysis

		Confidentiality	Informed Consent	Patient Participation	Patient Centered Care
Confidentiality	Pearson Correlation	1			
	Sig. (2-tailed)				
	N	199			
Informed Consent	Pearson Correlation	.121	1		
	Sig. (2-tailed)	.090			
	N	198	199		
Patient Participation	Pearson Correlation	.468**	.372**	1	
	Sig. (2-tailed)	.000	.000		
	N	198	198	199	
Patient Centered Care	Pearson Correlation	.322**	.302**	.504**	1
	Sig. (2-tailed)	.000	.000	.000	
	N	196	196	197	197

**. Correlation is significant at the 0.01 level (2-tailed).

From Table 17 above, the results of the Pearson correlation analysis are as follows:

- A relationship exists between confidentiality and PCC, which has a positive correlation that is statistically significant (p value< 0.05).

- A relationship exists between informed consent and PCC, which has a positive correlation that is statistically significant (p value< 0.05).
- A relationship exists between patient participation and PCC, which has a positive correlation that is statistically significant (p value< 0.05).
- In accordance with the interpretation by Cohen (1988), the strength of correlation between PCC and confidentiality (0.322) and informed consent (0.302) are both denoted as moderate, while the correlation between PCC and patient participation is strong (0.504).

4.6 Research Question 4: Does the Patient Rights Charter (confidentiality, informed consent, patient participation) have an influence on patient centered care?

4.6.1 Regression Analysis

Since the correlation analysis determined that a relationship exists between PCC and the variables of the Patient Rights Charter (confidentiality, informed consent, patient participation), further analysis was used to assess how these variables affect each other through Multiple Linear Regression (MLR) analysis. MLR is a statistical technique that uses a linear approach to model the relationship between a scaler response and several explanatory models (Hayes, 2021). This analysis is used as a measure to evaluate how strongly each independent variable (confidentiality, informed consent, patient participation) is associated with the dependent variable (PCC). This is done by assessing whether the coefficients on the independent variables (confidentiality, informed consent, patient participation) are different from 0, measured as a P-value (significant=p<0.05), which indicates they have a genuine effect on the dependent variable (PCC) as shown in Tables 18 and 19 below:

Table 18: ANOVA

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	32.218	3	10.739	25.167	0.000[b]
	Residual	81.506	191	.427		
	Total	113.724	194			

a. Dependent Variable: Patient Centered Care
b. Predictors: (Constant), Patient Participation, Informed Consent, Confidentiality

It is apparent from Table 18 above that the MLR is statistically significant (p-value <0.05). This indicates that overall, one or more of the independent variables is/are significant predictors of PCC.

It is ideal to check the MLR assumptions before interpretations of the regression coefficients so as to verify that the model is robust. These MLR coefficients are: independence, linearity, normality, and homoskedasticity.

Independence assumes that the independent variables do not cause or influence each other in any way, Multicollinearity is the term used if the independence assumption is violated (Pallant, 2010). This MLR model found the following:

1. According to the correlations table 17 above, there are no strong correlations (>0.8) between any two independent variables in the captured results.

2. As noted from table 19 below, the VIF values for the independent variables are 1.282, 1.160 and 1.461 which are all well below the value of 10.
3. Table 20 below, clearly shows the condition index values for each of the variables. It can be seen that all of them fall below the threshold value of 100.

According to the three diagnostics presented, it can be seen that the MLR assumption of independence has not been violated by this model.

Table 19: Coefficients for MLR

Model		Unstandardized Coefficients		Standardized Coefficients			95.0% Confidence Interval for B		Collinearity Statistics	
		B	Std. Error	Beta	t	Sig.	Lower Bound	Upper Bound	Tolerance	VIF
1	(Constant)	1.800	0.259		6.951	0.000	1.289	2.311		
	Confidentiality	0.102	0.058	0.122	1.753	0.081	-0.013	0.216	0.780	1.282
	Informed Consent	0.109	0.049	0.147	2.222	0.027	0.012	0.206	0.862	1.160
	Patient Participation	0.329	0.062	0.395	5.331	0.000	0.208	0.451	0.684	1.461

a. Dependent Variable: Patient Centered Care

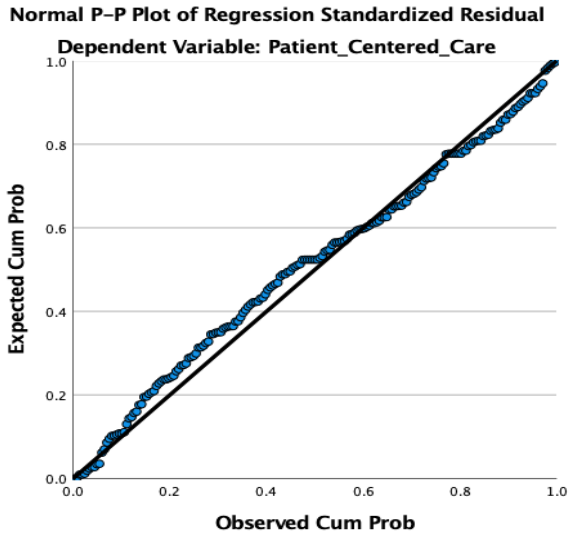
Table 20: Collinearity diagnostics

Model	Dimension	Eigenvalue	Condition Index	Variance Proportions (Constant)	Confidentiality	Informed Consent	Patient Participation
1	1	3.888	1.000	0.00	0.00	0.00	0.00
	2	0.063	7.852	0.01	0.17	0.78	0.01
	3	0.027	12.082	0.37	0.05	0.01	0.88
	4	0.022	13.171	0.62	0.78	0.20	0.11

a. Dependent Variable: Patient Centered Care

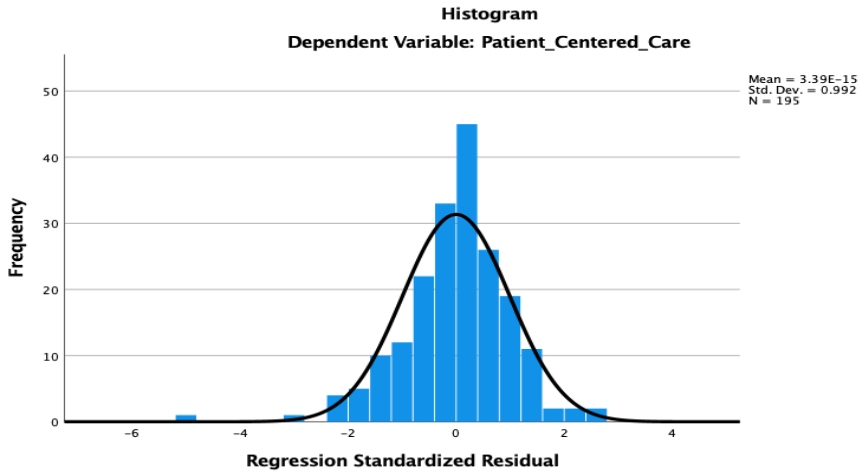
Linearity assumption of MLR states that the relationship between the outcome variable and the predictor variable should be linear (Pallant, 2010). In order to check this assumption, the P-P plot is used to check if all the residuals fall on a diagonal. Our model's P-P plot is presented below as figure 15 and as can be seen from it, the residuals lie on the diagonal thus we can safely say that the linearity assumption is not violated by this MLR model.

Figure 15: P-P Plot



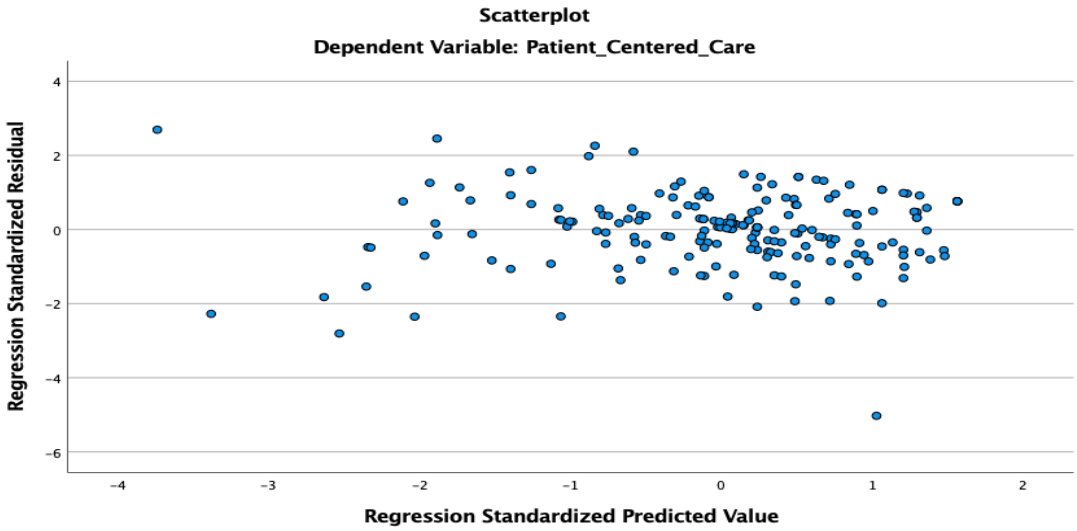
Normality assumption makes reference to whether or not the residuals are normally distributed (Pallant, 2010). This can be confirmed by the shape that the plotted histogram takes. A normal distribution histogram will take on a bell shaped curve. Figure 16 below demonstrates how the normality assumption has not been violated for this MLR model as it follows a bell shaped curve.

Figure 16: Histogram



Homoskedasticity is the instance where residuals are equally distributed on the scatterplot, where there is no apparent pattern and the random variables have the same finite variance. Figure 17 below shows our model's scatterplot where it can be seen that the equally distributed residuals indicate that this assumption is not violated by the MLR model.

Figure 17: Scatterplot



While all the assumptions discussed above indicate that our MLR model is robust, when the MLR model is conducted, the coefficient of determination and the Dublin Watson are also presented. The coefficient of determination is used to evaluate the model and is displayed below:

Table 21: Model Summary[b]

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Durbin-Watson
1	0.532[a]	0.283	0.272	0.65325	1.852

a. Predictors: (Constant), Patient Participation, Informed Consent, Confidentiality
b. Dependent Variable: Patient Centered Care

Table 21 above shows that this study's coefficient of determination is 0.283 or 28.3%. This suggests that 28.3% of the variance in patient centered care is explained or predicated by our model. The Dublin Watson value of 1.852 suggests that the variables are working in real time and none of them are either leading or lagging, thus there is no autocorrelation.

The beta coefficient shown in table 19 above is the degree of change in the outcome variable (PCC) for every one unit of change in the predictor variables (confidentiality, informed consent, patient participation). If the beta coefficient is negative or positive, the interpretation is that for every one unit increase in the predictor variables, PCC will correspondingly decrease or increase by the beta coefficient value. The t-value measures the size of difference relative to the variation, therefore the greater the magnitude of the t-value, the greater the evidence of a genuine effect on the dependent variable (PCC). In light of this, the results of Table 19 above show that the most significant predictors of PCC are patient participation (t -5.331, P-value 0.000, Beta 0.395) and informed consent (t-2.222, P-value 0.027, Beta-0.147). Confidentiality, on the other hand does not appear to be a significant predictor of patient centered care (t-1.753, P-value 0.081, Beta-0.122). Using the unstandardized coefficients from table 19 above, the linear equation depicting the independent variables (informed consent and patient participation) that predict patient centered care is as follows:

$$PCC = 1.8 + 0.109\ IC + 0.329\ PP$$

5 CHAPTER FIVE - DISCUSSION

5.1 Introduction

This study set out to investigate and describe patient perceptions of patient centered care in one of the major public hospital settings in South Africa (Tembisa Provincial Tertiary Hospital), using specific constituents of the Patient Rights Charter. The results presented in the previous chapter, with relevance to the aims and objectives of the study, are discussed in this chapter.

5.2 Demographics

Demographic information was obtained from the sample population of the study to ascertain their characteristics and generalise this to the greater target population. The results indicated that the 20-45 year old age groups (46%, 25%) made up the majority of participants, which seems consistent with the hospital reported age statistics of patient visits from the region in which it is situated. Results of the study also showed more females (61%) than males (39%) among participants. However, gender statistics of the area locality of the hospital by contrast show 54% males and 46% females (Census, 2011). While the average is not significantly divergent, the results appear to be in accordance with research indicating that females tend to seek out healthcare services more than males (Thompson et al., 2016). It was established from the results that most participants' highest level of education was high school (51%) or undergraduate education (30%), while this may not necessarily equate to the completion of matric/grade 12, it would denote that most participants were in a position to effectively read, articulate and understand information on the PRC and the presented questionnaire itself. Results also showed that most participants were unemployed (52%), while the place of participant residence illustrate that the majority of respondents (80%) reside in a township, showing consistency of patient demographics with the hospital located in Tembisa township and servicing the Deipsloot township area. In terms of home language, while English is the medium of instruction in the South African schooling system (Uys et al., 2007), it appears that it was the native language for a minority of participants (8%), raising concern as the PRC displays are presented in English within the hospital.

5.3 Research question 1

What are the perceptions of patients on the national Patient Rights Charter and its parameters (confidentiality, informed consent, patient participation)?

5.3.1 Patient rights

The results illustrate that the vast majority of the sample population (86%) were aware they have patient rights, suggesting some efficacy of the manner in which the educational promotion of this concept has been implemented. Although participants indicated that they are aware they have patient rights, the results pertaining to participant awareness of the Patient Rights Charter, indicated that most patients (69%) were not aware of existence of the charter, suggesting that specific components of the charter itself wouldn't be prevalent among the sample. Similarly, Halawany et al. (2016) in Saudi Arabia found that a majority of their study participants were aware that they had rights but had not observed specific rights such as providing the hospital with suggestions and participating in medical research. Majority of the participants (33%) who were aware of the PRC indicated that their awareness of it was derived from the hospital itself suggesting that the internal measures implemented to create PRC awareness is relatively satisfactory with room for improvement.

5.3.2 Confidentiality

The results illustrate that the majority of patients in the sample population (79%) were aware they had the right to confidentiality. Although, most of these patients (71%) displayed poor understanding of the patient right as they could not identify all the parameters relating to it as per the definition in the PRC. By contrast, the participants perception of the hospital implementation of confidentiality specific parameters appears satisfactory overall, with the majority of participants indicating agreement on various aspects such as information is kept safe and secure (75% agree), information is not seen by others (69% agree) and doctors ensure conversations remain between doctor and patient only (77% agree). This draws a parallel with similar research which found that patients experienced better quality care when privacy and confidentiality were ensured for the patient doctor consultation (Toomey et al., 2016). It appears overall however, that participants were not aware of the parameters of confidentiality enabling the doctor (50%) or the hospital (46%) to share their information if required by the court of law. This specific parameter afforded the sample group a very low result regarding a good understanding of confidentiality. Pertinent to this discovery is the basis that medicolegal

claims in negligence have occurred and rewards granted with respect to confidentiality being breached, however no criminal convictions occur as a result (Blightman et al., 2014). Thus, these implications are not only important for healthcare workers, but are just as important for patients themselves to understand.

5.3.3 Informed Consent

In accordance with the results, a little more than half of the sample group (56%) were aware they had the right to informed consent, while the understanding of informed consent appeared to depict a surprisingly high amount of participants with poor to no understanding (25%) and (41%) respectively. These results are consistent with those of other studies and suggest that South African patients are aware of the right to informed consent, but many are vulnerable due to indigence (Chima, 2015).

In contrast, the assessment of the overall specific parameters on informed consent saw the majority of participants indicating agreement that they could inquire about cost (60% agree), that the doctor provided a full explanation of their condition (81% agree), explanation of the required treatment and procedures (84% agree), information on other options for treatment provided (69% agree), and affording them the opportunity to ask questions to obtain clarity (79% agree). In accordance with specifications in the HPSCA and the NCS tool, physicians are required to inform patients about all parameters of informed consent (National Patients' Rights Charter, 1999). As approximately half of the participants felt they could make their own choice regarding treatment (54% agree) or could reject the proposed treatment entirely (54% agree), suggesting much required room for improvement with the PRC implementation. These findings are consistent with those by Purcaru et al. (2014) where the results portrayed a lack of interest, awareness and understanding of the information regarding informed consent. While 23% of the participants displayed an average understanding of informed consent, there remains concern regarding the notion that participants are not aware that all parameters need to be understood before consent is provided.

5.3.4 Patient Participation

The results showed that the majority of the sample population (80%) were aware they had the right to participate in their own healthcare decisions and this result appeared to draw a parallel to perceptions of patient participation specific parameters, where most

participants agreed they could ask about aspects of their health and care (88%), take the responsibility to understand their condition (81%), and what was planned for their case management (69%), feeling comfortable because they felt the doctor/nurse listens to them (68%). This aspect of patient participation thus speaks directly to the rights and responsibilities as detailed in the PRC and NHS tool. Based on the participant responses, implementation appears to have been sufficient contributing positively towards the quality of healthcare services provided. However, aspects which approximately half the participants agreed on, were related to the ability to decide treatment goals with the doctor (56%), assisting the doctor with their own healthcare decisions (50%) and assisting in developing health policies (42%), suggesting these parameters of patient participation, and in particular the concept of patient autonomy which is central to PCC, may be lacking in the implementation process.

Overall, the results of patient perceptions on the PRC suggest that patients perceive their experiences with regards to confidentiality, informed consent and patient participation as favourable. It is in this regard that the research favours the null hypothesis, **the perceptions of patient experiences on the PRC (confidentiality, informed consent, patient participation) are favourable.** However, although the patients' perceptions were satisfactory, they displayed an overall poor understanding of the patient rights. This is in relation to the specific parameters contained in each patient right. This brings to light that communication regarding patient rights is substandard. As per the NCS, management's role is this aspect is to ensure that the rights are effectively communicated to patients. Whilst evidence suggests this occurs to some extent, it would appear that the communication of the charter as per the NCS standards is not effective. Effective communication relating to areas of the PRC does not just occur at the point of the patient-doctor consultation but rather at every step of the patients journey within the institution. Ensuring that these components of the PRC are effectively related to all patients would require all the different parties who interact with the patient to play a role in the communication process. In this manner, a culture of communicating rights with patients need be established within the organisation. For this to occur, the collaboration of the different departments (ie. Allied health/ administrators/ pharmacists/ radiographers) needs to be established as per the system theory of management.

5.4 Research question 2

What are the perceptions of patients on Patient Centered Care?

5.4.1 Patients Centered Care

The results of the specific parameters of patient centered care appear to indicate overall satisfaction of this aspect from the participant perspective. In this instance, the research favours the null hypothesis, **the perceptions of patient experiences on Patient Centered Care are favourable.** Most participants indicated adequate implementation of PCC factors such as the questions posed (77% satisfied) and explanation received (72% satisfied) from the doctor, the doctor's attitude (74% satisfied), emotional state (70% satisfied) and ability to listen (72% satisfaction), being treated with respect (82% satisfied), having their emotions considered (78% satisfied), their level of involvement in the treatment process (67% satisfied), believing the treatment to be beneficial (78%, satisfied) and their partnership with the doctor (65% satisfied). Although the framework used to interpret PCC assesses its key dimensions, it lays focus on the specific patient doctor consultation which limits the applicability of the study to other factors affecting patient centered care. The systems management theory clearly stipulates the importance of synergy, interdependence and the interrelations between various subsystems. With this, the application of all the other factors that relate to patient centered care is crucial to maintain the level of satisfaction as perceived by patients.

5.5 Research question 3

What is the relationship between the Patient Rights Charter (confidentiality, informed consent, patient participation) and Patient Centered Care?

Results of the correlation analysis to assess the relationship between patient centered care and the parameters of the Patients' Rights Charter (confidentiality, informed consent, patient participation) revealed a significant relationship indeed does exist between the PRC variables and PCC. Thus, the results of the correlation analysis favoured the alternative hypothesis, **there is a relationship between the Patients' Rights Charter (confidentiality, informed consent, patient participation) and Patient Centered Care.** In addition, each variable showed a statistically significant positive correlation suggesting that the variables move in tandem – as confidentiality, informed consent, patient participation are enhanced, so too is PCC enhanced.

The correlation between PCC and confidentiality was found to be positive, with a moderate correlation of 0.322 that was statistically significant (p value< 0.05). Similar to findings by Toomey et al. (2016) where the relationship between the adolescent reports of PCC and the quality of primary healthcare was evaluated. The research revealed that PCC was positively correlated with high quality care measures including privacy and confidentiality.

The research found that the strongest correlation was found to be between PCC and patient participation where a statistically significant correlation of 0.504 was established (p value<0.05). Corroborated by the findings by Sidani (2008),where not only were the medical and surgical patients studied reported that they perceived the hospital care as patient centric, but also that this was driven by their involvement in their own care. The research furthermore showed that there is a positive association between elements of PPC and the level of satisfaction derived from the ability to provide oneself with care (Sidani, 2008).

The weakest correlation between PCC and the independent variables was found to be with informed consent, where a positive correlation of moderate strength was established. These two variables had a correlation of 0.302 that was found to be statistically significant with (p value <0.05), thus suggesting that there is a lower likelihood of there being a relationship between these two variables.

5.6 Research question 4

Does the Patient Rights Charter (confidentiality, informed consent, patient participation) have an influence patient centered care?

The main objective of performing the MLR was to determine if the Patients' Rights Charter (confidentiality, informed consent, patient participation) can predict patient centered care. Results of this regression model came to show that the most significant specific predictive PRC variables for PCC are patient participation and informed consent with (t -5.331, P-value 0.000, Beta 0.395) and (t-2.222, P-value 0.027, Beta-0.147) respectively. Lending support to the concept of reliance on clinical consultation settings for PCC and PRC implementation. The MLR analysis was in favour of the alterative hypothesis finding that, **The Patients' Rights Charter (informed consent, patient participation) has a significant influence on patient centered care**.

However, according to this predictive model, confidentiality did not appear to be a significant predictor of patient centered care (P-value 0.027).

In contrast, Brann (2006) studied the influence that illness factors have on a doctors likelihood to disclose patient information. This research found that factors such as a patients prognosis play a significant role in influencing doctors to disclose the information of a severely ill patient. They tend to view the patient in the context of their family suggesting that a holistic patient centric approach is taken, resulting in an overall positive impact. This manifests the influential potential that confidentiality has on PCC (Brann, 2006).

The linear equation depicting the independent variables (informed consent and patient participation) that predict patient centered care was reported as follows:

$$PCC = 1.8 + 0.109\ IC + 0.329\ PP$$

It is noted from this equation that patient participation has higher predictive ability on patient centered care then informed consent. In order to accurately compare the two, the standardized coefficients are used, where results further verified this predictive ability with patient participation having a standardized coefficient of 0.395 and that of informed consent being 0.147. Using these standardized coefficients a deduction can be made that patient participation has more influence on PCC than informed consent.

The research findings draw similarity to the findings of Cegala et al. (2007) who found that a patient's style of participation during a medical consult has significant influence on the type and amount of information provided to them by their doctor. In parallel experimental research by Greenfield et al. (1985) established that the active and increased involvement of patients with their physician not only resulted in fewer limitations imposed by their disease, but significantly increased their preference for active involvement in decision making.

In this context, it can be said that enhancement of PCC within the hospital setting can occur by laying focus on specific areas pertaining to the doctor-patient consultation. In light of this research, these areas specifically include enhancing the participation of patients and improving the concept of informed consent. This can be done by improving the implementation of enforcing the PRC and ensuring collaboration of

departments in improving aspects of the PRC. While studies have assessed interventions to promote patient-centered clinical consultations, the evidence base on how to achieve PCC at the organisational level is very limited. There is a widespread understanding that becoming patient centered requires not merely the adoption of various interventions, but rather an organisational 'culture change' (Fix et al., 2018). Thus it is necessary for management to not only develop policies, but rather lay focus on implementation and collaboration among departments, in order enhance PCC and recognize overall organisational improvement.

6 CHAPTER SIX – SUMMARY, CONCLUSIONS, LIMITATIONS AND RECOMMENDATIONS

This chapter provides a summary of the key research findings, the conclusions drawn from the research as well as the study limitations. Lastly, the research recommendations for the healthcare organisation and for future research are presented.

6.1 Summary

Looking at combatting the South African healthcare challenges faced by public hospitals, this research looked at the perceptions that patients have on the Patients' Rights Charter to use it towards the improvement of patient centered care. The study employed a quantitative research approach using fully structured questionnaires. Descriptive analysis was run on the data collected and provided insight into the perceptions of participants regarding confidentiality, informed consent, patient participation and patient centered care. With majority of these findings indicating relatively satisfactory perception, the research further used these variables to establish if relationships exist between patient centered care and confidentiality, informed consent and patient participation. Correlation analysis was performed on the data, it revealed positive correlations between the three Patients' Rights Charter constituents (confidentiality, informed consent, patient participation) and patient centered care. Over and above this, Multiple Linear Regression analysis was also conducted in order to fulfil the fourth research question that explored cause and effect. This analysis revealed that patient participation and informed consent positively influence the concept of patient centered care. This notion can be used by the hospital management to improve patient centered care through use of the Patients' Rights Charter, this can be done through use of the implementation and systems theories focusing on implementation of the PRC.

6.2 Conclusion

This study has brought to light that patient participation and informed consent positively influence patient centered care, thus we can conclude that improving awareness and understanding of the Patients' Rights Charter can have much needed impact on healthcare delivery in the public sector. This improvement rests with hospital management as a policy such as the PRC requires implementation on multiple

platforms. Although some perceptions of the PRC are positive and satisfactory, there appears to be much required room for improvement with respect to specific parameters of patient rights. With patients more aware of their rights and their specific parameters, healthcare workers will be persuaded to enforce and improve on aspects of the Patients' Rights Charter, in turn enhancing other care aspects including patient centered care. In this aspect, healthcare outcomes can be improved, and the broader impact on the healthcare organisation, society and economic fabric of the country can be realized.

6.3 Limitations

The limitations in this research outline the characteristics that have influenced the interpretation of the results discussed in the previous chapter. This is done in order to address any uncertainties that one may still be left with.

A random simple strategy was used to select research participants. Although this was the case, there is likelihood that researcher bias played a role in the selection of participants.

The participants were selected from the two main outpatient departments of the hospital which limited the patient population and thus limits the generalizability of the study.

6.4 Recommendations

The findings show that the Patients' Rights Charter has significant use within the South African healthcare system. Furthermore, although there is positive correlation, it is unclear whether this is utilized to its maximum ability in implementation. Hospitals leadership and management in South Africa can use the Patients' Rights Charter as part of the NCS tool to improve service delivery and overall business functions. In addition, hospital management can reinforce, educate its staff and promote collaboration on the Patients' Rights Charter and its contents to ensure its implementation at a broad level. Additionally, presenting the PRC in the native language of majority of the population would prove beneficial to communicating its contents. A Patients' Rights Charter committee consisting of patients and healthcare workers who not only monitor and test awareness and understanding of the charter, but focus on ensuring implementation of each of its components through collaboration of all hospital departments.

The broad and complex nature of the studied variables leaves room for future research in various directions. Having looked at relationship and predictability of the PRC

constituents on PCC, there is much required room to explore the reasoning behind the results found in this study. On the backbone of this research, future studies can lay focus on the reasoning behind the relationships found, thus introducing a qualitative component. While this research analysed the demographics studied, no corelations were made with the PRC constituents. Future research on the topic would benefit from exploring these correlations and their impacts.

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APPENDIX 1: CONSENT FORM

The Patients' Rights Charter and patient centered care in a South African hospital

By Ipeleng Patience Nku

I, ……., agree to participate in this research project. The research has been explained to me and I understand what my participation will involve. I agree to the following:

(Please circle the relevant options below).

I agree that my participation will remain anonymous	YES	NO
I agree that the researcher may use anonymous quotes in his / her research report	YES	NO
I agree that the information I provide may be used anonymously after this project has ended, for academic purposes by other researchers, subject to their own ethics clearance being obtained.	YES	NO

(signature)……
(name of participant)……
(date)……

(signature)……
(name of researcher)…Ipeleng Patience Nku…….
(date)…… ……...

Appendix 2: Research Instrument

The Patients' Rights Charter and patient centered care in a South African hospital

By Dr Ipeleng Nku

Instructions

a) Please complete all the sections in this questionnaire
b) Place a mark (X) next to the item that matches your view
c) Choose only one answer from the listed items
d) Your responses are anonymous and confidential
e) You must be at least 18 years old to participate
f) This questionnaire consists of closed-ended questions.

Section A: Demographic details

1. Age

<20	1
20 - 35	2
36 - 45	3
46 - 55	4
>56	5

2. Gender

Male	1
Female	2

3. Education level (highest level obtained)

No schooling	1
Primary school	2
High school	3
Graduate	4
Higher than graduate	5

4. Employment status

Unemployed	1
Self- employed	2
Formal employment	3
Casual laborer	4
Pensioner	5

5. Place of Residence

Township	1
Suburb	2
Rural	3

6. Home language

Afrikaans	1
English	2
Nguni (Zulu, Xhosa, Swati, Ndebele)	3
Sotho (Sepedi, Sesotho, Setswana)	4
Tsonga	5

Venda	6
Other	7

Section B: Knowledge of patients' rights

7. Are you aware that you have rights as a patient?

No	0
Yes	1

8. Are you aware of the existence of the National Patients' Rights Charter (PRC)?

No	0
Yes	1

9. If yes to 9 above, where did you hear about it?

Clinic	0
Hospital	1
Online	2
Television	3
Word of mouth	4
Other	5

Section C: Confidentiality

10. I have the right to confidentiality

No	0
Yes	1
I don't know	2

11. If yes to 11 above, what is your understanding of confidentiality? (Please choose ONE of the following statements below)

The doctor can discuss information regarding my healthcare with someone else at any time that they need to	0
Information regarding my healthcare should always just stay between the doctor and I	1
Information regarding my healthcare should remain between the doctor and I and can only be disclosed if I give them permission to do so.	2
Information regarding my healthcare should remain between the doctor and I and should only be disclosed if I give permission or it is required and requested by the court of law	3

12.

		Strongly Disagree	Disagree	Unsure	Agree	Strongly agree
		1	2	3	4	5
C1	The hospital makes sure my information is kept in a safe and secure place					
C2	The hospital makes sure my information is not seen by other people					
C3	The doctor makes sure our conversations are only between the two of us					
C4	In some instances, the doctor can share my information if necessary					
C5	In some instances, the hospital can release my information if necessary					

13. Do you believe that you can have a better experience in the hospital with confidentiality?

No	0
Yes	1
I don't know	2

Section D: Informed Consent

14. I have the right to informed consent

No	0
Yes	1
I don't know	2

15. If yes to 16 above, what is your understanding of informed consent? (Please choose ONE of the following statements below)

The doctor doesn't always have to provide me with full information for me to make decisions regarding my healthcare	0
I should always be given the opportunity to make decisions affecting my healthcare	1
I should be able to make decisions affecting my healthcare following some information provided by the doctor	2
Decisions affecting my healthcare should be made after I have full and correct information about my illness, procedures, treatments and costs if the decisions affect any of these elements	3

16

		Strongly Disagree	Disagree	Unsure	Agree	Strongly Agree
		1	2	3	4	5
IC1	The doctor fully explains what is wrong with me					
IC2	The doctor explains the treatment and procedures needed for my illness					
IC3	The doctor explains other options for my treatment					
IC4	I am able to ask the doctor as many questions as I need to understand					
IC5	I am given the opportunity to make a choice of my own about my treatment					
IC6	I can say no to the treatment my doctor wants to give me					
IC7	I can ask about costs regarding my treatment					

17. Do you believe that you can have a better experience in the hospital with informed consent?

No	0
Yes	1
I don't know	2

Section E: Patient Participation

18. I have the right to participate in decisions concerning my healthcare

No	0
Yes	1
I don't know	2

19.

		Strongly disagree	Disagree	Neutral	Agree	Strongly agree
		1	2	3	4	5
PP1	I can ask about my symptoms/diagnosis/treatment					
PP2	I make sure I understand my illness before I leave					
PP3	I know and understand what is planned for managing my case					
PP4	The doctor/nurse listens to me					
PP5	I can decide treatment goals with the doctor					
PP6	I can help the doctor make decisions about my healthcare					
PP7	I can help with developing health policies					

20. Do you believe that you can have a better experience in the hospital if you are able to participate in your healthcare and treatment?

No	0

Yes	1
I don’t know	2

Section F: Patient Centered Care

21.

		Extremely unsatisfied	unsatisfied	Neutral	satisfied	Extremely satisfied
		1	2	3	4	5
PCC1	I am satisfied with the questions the doctor asked me					
PCC2	I am satisfied that the doctor listened to me					
PCC3	I am satisfied that the doctor treated me with respect					
PCC4	I am satisfied with the way the doctor considered my emotions					
PCC5	I am satisfied with the way the doctor explained everything to me					
PCC6	I am satisfied with the way the doctor involved me in the treatment process					
PCC7	I am satisfied with the partnership between the doctor and I					
PCC8	I am satisfied with the fact that the treatment is to my benefit					
PCC9	I am satisfied with the attitude of the doctor					
PCC10	I am satisfied with the emotional state displayed by the doctor					

Thank you.

Appendix 3: Participation Information Sheet

Wits Business School

Dear Sir / Madam,

My name is Ipeleng Patience Nku and I am a Master of Business Administration student at the University of the Witwatersrand, Johannesburg. As part of my studies, I have to undertake a research project, under the supervision of Samukelo Ngubane. The research project is titled "The Patients' Rights Charter and patient centered care in a South African hospital".

As part of this project, I would like to invite you to take part in answering a questionnaire. This activity will involve answering 35 questions and will take roughly 10 minutes.

There will be no personal costs to you if you participate in this project, you will not receive any direct benefits from participation but there are no disadvantages or penalties if you do not choose to participate or if you withdraw from the study. You may withdraw at any time or not answer any question if you do not want to. The questionnaire will be completely confidential and anonymous as I will not be asking for your name or any identifying information, and the information you give to me will be held securely and not disclosed to anyone else.

If you have any questions during or afterwards about this research, feel free to contact me on the details listed below. This study will be written up as a research report which will be available online through the university library website. If you have any concerns or complaints regarding the ethical procedures of this study, you are welcome to contact the University Human Research Ethics Committee (Non-Medical), telephone +27(0)117171408, email hrec-medical.researchoffice@wits.ac.za

Yours sincerely,
Ipeleng Patience Nku

Researcher:
Ipeleng Patience Nku
306444@students.wits.ac.za

Supervisor:
Samukelo Ngubane

Appendix 4: Ethics Documentation

Graduate School of Business Administration
University of the Witwatersrand, Johannesburg

Wits Business School Ethics Committee
Constituted under the University Human Research Ethics Committee (Non-Medical)

Ethics Clearance Certificate

Ethics protocol number: WBS/BA306444/821
This certificate is only valid with a legitimate ethics protocol number and signed by the Researcher (below).

This certificate is only valid if accompanied by formal permission from the relevant stakeholder(s).

Project title	The patients right charter and patients centered care in a South African hospital
Investigator / Researcher	Dr Ipeleng Nku
Nature of Project	MBA (Research Article)
Decision of the Committee	Approved unconditionally
Issue Date of Certificate	2021-02-19
Expiry date	Date of submission of the project report
Chairperson	Prof Anthony Stacey ☎ +27 11 717 3587 +27 82 880 4531 Anthony.Stacey@wits.ac.za

Declaration by Researcher

One copy must be signed by the Researcher and returned to the Chairperson of the Wits Business School Ethics Committee.

I fully understand the conditions under which I am authorized to carry out the abovementioned research and I guarantee to ensure compliance with these conditions. Should any departure to be contemplated from the research procedure as approved I undertake to resubmit the protocol to the Committee.

Signature

22/02/2021
Date:

Appendix 5: Bio of Researcher

Ipeleng is a Medical Doctor with 6 years of medical experience in the public healthcare sector. Vast challenges in the field have helped her gravitate towards operational management and strategy alignment. She is driven by great interest in collaborating South African healthcare and management, while maintaining positive societal impact.

Ipeleng holds a Bachelor of Medicine and Bachelor of Surgery degree from the University of Witwatersrand, she also holds a Postgraduate Diploma in Business Administration (PDBA) from Wits Business School. She is currently enrolled in a Master of Business Administration (MBA) at Wits Business School.

Ipeleng works at Tembisa Provincial Tertiary Hospital as a medical officer, where the study was carried out. She is not based in either of the departments where the research was conducted.

Appendix 6: Permission Letter

GAUTENG PROVINCE
HEALTH
REPUBLIC OF SOUTH AFRICA

TEMBISA PROVINCIAL TERTIARY HOSPITAL
PR NO: 5602793
Cnr Flint Mazibuko Dr & Rev Namane, Olifantsfontein, 1665
Private Bag X 07, Olifantsfontein, 1665
Tel: 011 923 2320 | Fax: 011 926 2719
Enquiries: Dr. L.M. Mogaladi
E-mail: Lekopane.Mogaladi@gauteng.gov.za

To : **Dr Ipeleng Nku**

Subject : **Permission to Conduct Research at Tembisa Provincial Tertiary Hospital Research Committee**

From : **Ms G. Bogoshi Interim CEO, Tembisa Provincial Tertiary Hospital**

Date : **05 March 2021**

Dear Dr Nku

This is to notify you that you have been granted permission to conduct research in our institution for the following study:

Study Title: The Patients' Rights Charter and patient centered care in a South African hospital

NHRD Reference Number: GP_202103_001

Permission to conduct research as per study protocol
Please note the institution requires for all data collection and interaction with staff; patients or records to be as outlined in the study protocol and within the constraints of ethics approval obtained for this study. Should any of these parameters or professional conduct be violated at any stage then the Tembisa Research Committee reserves the right to review and change the decision to allow the researcher to conduct research at the institution.

Recommended by:
Dr M. J. Matnabatne
Rotating Chair of Tembisa Provincial Tertiary Hospital Research Committee
Signature:
Date: 05/03/2021

Approved by:
Ms Gladys Bogoshi
Interim CEO, Tembisa Provincial Tertiary Hospital
Signature: Bogoshi
Date: 05.03.2021