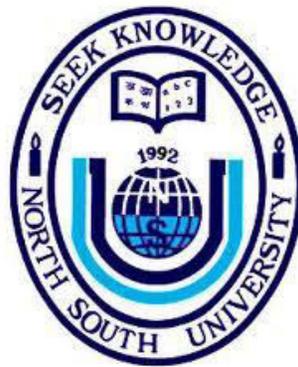# In-patients' Trust in Government Hospital:
A study at Bir Hospital, Nepal

By

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MPPG 4th Batch

December 2015

Master in Public Policy and Governance (MPPG)
Department of Political Science and Sociology
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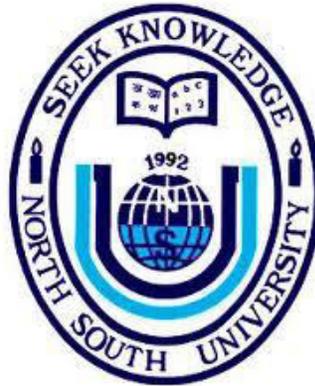# In-patients' Trust in Government Hospital:
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Thesis submitted to the
Public Policy and Governance (PPG) Program
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Dedicated to,

My respected parents, Lambodar Lamichhane and Anita Lamichhane for their unconditional love, guidance and support

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ABSTRACT

This study assess the level of inpatients' trust and factors determining the level of inpatients' trust towards doctors working in government hospital with special focus on central government hospital i.e. Bir hospital of Nepal. An integrative model of organizational trust has been taken as the theoretical basis of this research to assess the level of inpatients' trust and to identify the factors determining level of inpatient's trust.

This research has used mixed method approach and both primary and secondary sources of data were used to get comprehensive picture of reality. A questionnaire survey was conducted among patients admitted in medical and surgical wards. Data collection also included non-participatory observation and interview with doctors. Content analysis was conducted for observational notes, field notes and responses to opened-ended questionnaires by doctors. In addition, secondary sources were used to strengthen the research.

SPSS 16 was used to gather frequency, percentage and cross tabulation of the survey. Findings demonstrated that majority of admitted patients' has high level of positive trust in their doctor but 28% showed low trust level. Two sets of independent variables were used to find their influence in inpatients trust level; i) identity variables of the patients comprising age, gender, education level, length of stay at hospital, department of hospital, approaches to hospital and patients' responsiveness; and ii) factors of perceived trustworthiness consisting competence of doctors, compassionate care of doctors and communication skill of the doctors.

Among the seven identity variables, only length of stay at hospital, department of hospital and patients' responsiveness were found influential in determining the trust level in admitted patients. Patients who have stayed less days after admission showed high level of positive trust. This is surprising result in the way that continuous interaction leads to development of trust. But in this study those patients who have stayed longer days showed low level of trust. Similarly patient admitted in surgical ward showed high trust than those admitted in medical wards. This might be because patients admitted in surgical ward have gone through vulnerable situation than that of patients admitted in medical wards. In a similar vein, patients responsiveness was also found statistically significant determining factor that influence inpatients' trust level.

On the other hand, all three factors of trustworthiness were found influential in determining level of inpatients trust compared to identity variables. Respondents demonstrated high level of trust if they perceive that their doctors are competent enough to diagnose and treat their disease. Regarding compassionate care of the doctors, majority of patients' perceive that their doctors are kind and sympathetic towards their patient. But in case of patient perception regarding doctor's communication skill, 52% perceive that their doctors possess poor communication skill. Here doctors' communication skill was assess through patient's perception regarding doctor's way of communicating with patient, way of using simple language and way of involving patient in decision making.

The analysis of dependent and independent variables shows that higher percentage of respondents had positive level of inpatient's trust. Both patient and doctors were satisfied with treatment. In spite of this also, some patients had low trust towards their doctors. Bivariate analysis of dependent and independent variables showed that the age, gender, education and the approaches to hospital appears to have week relationship with dependent variable, I.e. inpatients' trust. Similarly the bivariate analysis of factors of perceived trustworthiness and inpatients trust showed significant relationship. It means the trust level of trustor is determined by the characteristics of trustor.

Pooja Lamichhane

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ACRONYMS

CHD	Child Health Division
DPHO	District Public Health Office
DHO	District Health Office
EPI	Expanded Programme on Immunization
EDCD	Epidemiology and Disease Control Division
FHD	Family Health Division
FCHV	Female Community Health Volunteer
GP	General Practice
LMD	Logistics Management Division
LCD	Leprosy Control Division
MD	Management Division
NHTC	National Health Training Centre
NHEICC	National Health Education, Information and Communication Centre
NTC	National Tuberculosis Centre
NCASC	National Centre for AIDS and STD Control
NPHL	Nepal Public Health Laboratory
OPD	Out Patient Department
PHC/ORC	Primary Health Care Outreach Clinic
VDC	Village Development Committee

CHAPTER 1

INTRODUCTION

This chapter deals with the introductory aspects of the study . It discusses the general background of the study, states the research problem, defines the scope of the study and specifies research objectives, and research questions. Further, it also sheds light on the significance of the study as well as limitations of the study and ends with the explanation of the structure of the study.

1.1 Background and Context

The term trust is used in a variety of ways; there is no any concise and universally accepted meaning of it. The word trust is derived from German word *Trost* meaning *Comfort* which implies natural, unquestioning belief in and reliance upon something (Hébert 2006:5). Similarly, Niklas Luhmann defines trust as a means to reduce the social complexity by highlighting the necessity of trust. Further he state that no one would be strong enough to leave his bed in the morning without trust. He also asserted that trust is mostly irrational and used to deal with situations where there is a deficit of information or knowledge (Luhmann, 2000).

Trust is an essential attribute of all human social interaction of which basic level is important for any transaction between human beings (Barber B, 1983). Generally, in the society, trust can be viewed as the source of minimizing the complexity and means of coping with the freedom of others. It is the feature of all social relationship that indicates some form of expectation about the future (Jones, 2002, p. 225). Trust can be defined depending on the characteristics of an object, or the occurrence of an event, or the behavior of a person to organize the desired but uncertain objectives in a risky situation (Giffin, 1967, p. 106). Because of the complexity of the notion of trust, it is generally conceptualized differently depending on the context and the field in which it is studied. For example, psychologist view trust as an internal cognitive process between trustor and trustees whereas Economists and some sociologists perceive trust as a calculative or rational expectation about outcomes generated by another party (Colman, 2003).

Trust in medical care contexts has been conceptualized as having two interrelated elements (Mechanic, 1996): social or institutional trust (trusts in collective institutions/bodies such as the health care system, the medical profession) and interpersonal trust (trusts in a particular individual). Interpersonal trust is defined as occurring in the context of an ongoing relationship. It is built over 'repeated interactions through which expectations about trustworthy behavior can be tested over time' (Pearson & Raeke, 2000, p. 510). Rowe & Calnan 2005 state that Trust in health care is generally seen as involving both beliefs about the medical competence or technical skills/ability and judgments about the motivation and intentions of the other (i.e. beliefs that the doctor will act in your best interests). Further they mention that interpersonal trust is related to the vulnerability associated with being ill, asymmetric information arising from the specialist nature of medical knowledge and the element of risk regarding the intentions of doctor on whom the patient is dependent. Hall and colleagues define interpersonal trust broadly as an 'optimistic acceptance of a vulnerable situation in which the truster believes the trustee will care for the truster's interests' (Hall et al., 2001, p. 615).

Traditionally trust is considered as cornerstone of effective doctor- patient relationships (Calnan & Rowe 2004 cited in Calnan & Rowe 2005). It is well known that health care involves uncertainty and vulnerability for patients, despite this also, there is some level of trust in patient that adhere them to consult with doctor and seek treatment (Hall et al., 2001). Trust can be characterized as a multi-layered concept primarily consisting of a cognitive element (grounded on rational and instrumental judgments) and an affective dimension (grounded on relationships and affective bonds generated through interaction, empathy and identification with others) (Gambetta 1998; Gilson 2003; Lewicki & Bunker 1996; Mayer, Davis, & Schoorman 1995). The uncertainty and vulnerability of medical care surrounding health and illness creates the imbalance of knowledge and expertise between patients and health professionals and this makes difficulty for patients to accurately judge how well they have been treated by the physician (Arrow 1963). It is important to note that trust arises from conditions of vulnerability and need reliance on others. Trust involves risk arising from uncertainty about another's intentions and likely actions. If there is absolute certainty about the future behavior of others, there is no need for trust (Mark Hall et al., 2001).

The focus of this study is to assess the level of inpatients trust and to determine the factors that influence the inpatients trust. It is confined to in-patient department of medical and surgical ward of Bir Hospital. Bir Hospital is the oldest and the busiest central hospital providing the tertiary care in Nepal. It was established in July 1889 by Bir Shamsher Jang Bahadur Rana. It is located at the center of Kathmandu city. The hospital is run by the National Academy of Medical Sciences, a government agency since 2003 (NAMS, 2014). The hospital provides medical and surgical treatments to people from all across the country. Many patients from different part of country come to this hospital for specialized and better treatment in subsidized government rate.

Every year it produces trained post graduates in different subjects of clinical medicine e.g. general surgery, internal medicine, orthopedic surgery, pathology etc. It has become an Internship centre for students who had passed MBBS from China and Russia and other parts of the world. Hundreds of nurses of different levels get nursing training in this hospital.

The yearly budget of this hospital is NRs 27 Crore (About US$ 4.1 million), two third of which is funded by the government. The hospital has been facing financial difficulties for many years now. The lack of adequate funding, non-functional equipment, and the administrative dispute pose significant challenges to the hospitals functioning. Moreover, inappropriate politicization of the administration seems to be the major contributor to the sorry state of affairs at the hospital (Kantipur, 2011/11/12).

1.2 Statement of the Problem

Health is highly sensitive sector surrounded by risk and vulnerability. In case of Nepal, government hospital has been highly politicized and has become the destination of poor only. People involved in health sector have become profit oriented instead of service oriented. Doctors are more involved in private practice. They are not giving quality and enough time to those patient visiting government hospitals because they are busy in their own private clinics (Kantipur, 2071/11/21). In such scenario how patient can develop trust toward doctors? Also the common problems of government hospital in Nepal are lack of availability of drugs, medical instruments and adequate staff necessary for the treatment. The resident doctors of Bir Hospital had launched an indefinite strike demanding reforms in the hospital. They have

claimed that the government failed to provide basic equipment such as MRI, CT-scan and X-ray machines at the hospital (Kathmandu-Post-2014/07/27). In such scenario, what will be the level of patients' trust in such public hospital?

Health service delivery today is not just affected by the accessibility, equitable allocation of resources, empowerment and inclusion in Nepal. It is also severely affected by doctor patient relationship. Interpersonal trust lies at the heart of doctor patient relationship and adherence of patients to the treatment (Kane et al, 1967 stated in Anderson FH., 1976). The study of trust and trustworthiness, in the context of healthcare, is crucial for several reasons. For example, trust in physician increases the likelihood of adhering to treatment recommendation; it means it enhances the efficacy of prescribed treatment (Pearson S.D and Racke L.H, 2000; 509-513). Similarly trust encourages use of services, facilitates disclosure of important medical information and also influences the health outcomes through patient's satisfaction and continuity of provider (Calnan & Rowe 2005). Also it promotes efficient use of both the patient's and the physician's time (Goold S.D, 2002).

The study of trust in health care is growing because of its imperative value (Goold S.D, 2002). Trust in health care is usually defined as a set of expectations that the patient has from doctor and the health care system to help them heal (Gopichandran V and Chetiapalli SK, 2013). Thus Trust in the healer is an essential to healing itself (Brody H, 1992). Patient's trust is one of the important goals of any health system but unfortunately in developing countries, it seems to have been largely ignored by health care managers (Sodani R.P, Kumar K.R, Srivastava J, & Sharma L, 2010; 52-56). It is said that trust is a part of norms and values which is exposed in behavior related to risk taking, information exchanging, decision making and goal setting (Gambetta, 1988; Mayer, Davis, & Schoorman, 1995). Many studies have shown that trust is highly correlated with patient satisfaction but it is conceptually distinct. It has been suggested that it is more sensitive indicator of performance than patient satisfaction. It is a forward looking that reflects the commitment to an ongoing relationship which can be used as potential marker to evaluate the quality of health care (Calnan M & Rowe R, 2005).

What quality care is considered can be ascertained in a number of ways from a number of perspectives. For doctors, it may be the number of remissions or successful treatments of

patients. For nurses, it may be the feeling that they provided care that improved the quality of their patient's lives. For patients and their families, quality may include efficient, timely, affordable, and equitable care as well as positive interpersonal relationship with the doctors. But Research that has been done in Least Developed Countries has indicated that health counseling and doctor patient communication is consistently weak (Nicholas, Highby & Hatzell 1991, cited in Roter, D., et al, 1998) in the efficacy of health care delivery systems (Loevinsohn 1990 cited in Roter,D., et al, 1998). Most of the communication focuses on the delivery of message and not interpersonal communication. In such scenario how patient can put faith towards doctors and the institution?

Previously there was no such research regarding trust in public hospital in Nepal so it is important to assess the level of trust as Calnan and Rowe (2005) has mentioned that trust is more sensitive indicator of performance which can be used as potential marker to evaluate the quality of health care.

1.3 Significance of the Study

Though plenty of research has been carried out on interpersonal trust and institutional trust but in Nepal, very little work has been done specially from patient perspectives. As trust is psychological response so there are lots of factors that affect trust of people. There is no any specific factor that will make people to trust or distrust. Moreover, the studies on trust are either in public institution or interpersonal but there is less research in in-patients' trust. The government institutions like court, parliament, and hospitals are different by nature so the factors that enhance or decreases level of trust towards these institutions are different. Also the study carried out in Nepal about citizen trust in public institution shows that trust varied extensively among different public institution. So this study will help to explore the determinants and level of in-patients' trust towards their doctors.

In General there has been increased interest over the past couple of decades in the citizens' trust in the health system. Several studies have been carried about the factors influencing trust in healthcare but no such studies has been done in health sector in Nepal. So this study will provide the performance of government hospital from patient perspective because as we know trust is the qualitative indicator of performance. Further this study will also be useful to

the academics, scholars or researchers who are interested to work in the root level of trust. Besides this, findings of this study will help the policy maker to evaluate the quality of health care too.

1.4   Research Question

This study explores the patients' trust in public hospital. The main research questions based on specific objectives of this study are:

1. What is the level of In-patients' trust?
2. What are the factors determining In-patients' trust towards doctors?

1.5   Objectives of the study

The general objective of this study is to explore the patients' trust in public hospital. The specific objectives are:

1) To look at the level of In-patients' trust
2) To identify the factors determining In-patients' trust towards doctors

1.6   Limitation of the study

The main limitation of this study is that only one central government hospital has been selected for study. So the level of trust obtain from this hospital cannot be used to generalize the trusting nature of other government hospital. As this is renowned hospital situated in the centre of capital city. Therefore the research does not represent the status of trust of peripheral hospital. This hospital provided tertiary care from both out-patient department and in-patient department but for this study, only in-patient department has been selected. The patient to be interviewed is only from In-patient department so the inference drawn from in-patient department cannot be used for out-patient department. Due to time and financial constraint, this study has not covered all departments and administrative staff. Another limitation is the small number of sample that has been taken for questionnaire.

1.7 Structure of the Chapter

The thesis is presented in five chapters. The first chapter deals with the introductory aspects of the study. It discusses the general background of the study, states the research problem, defines the scope of the study, and specifies research objectives and research questions. Further, it also sheds light on the significance of the study and ends with the explanation of the structure of the study.

The Second chapter explains the theoretical and conceptual foundation of health system and trust. This chapter deals with theoretical and conceptual foundation of the trust. It is divided into two major parts; first part deals with theories and conceptualization of trust and second part with health system in Nepal. The first part deal the theoretical concept of trust along with special focus on its dimension, importance, the causative factors of trust and the consequences of trust. The first part ends with trust in health care services and the second part starts with brief introduction of health system in Nepal. It proceeds further describing the historical background of development and change in health system of Nepal and its present scenario along with its organogram. The second part ends with analytical framework which is developed on the basis of theoretical description of trust and an integrative model of organizational trust.

The third Chapter explains the methodology adopted for the study. This deals the research process, nature and type of data, sampling, data collection, data analysis plan. The Fourth chapter deals with data presentation and analysis. It tabulates, describes and analyses the data and findings. The final chapter winds up the study by giving the general summary of this study. It provides a brief discussion on to what extent identity variables of the patients and factors of trustworthiness affects the trust level.

CHAPTER- 2
REVIEW OF LITERATURE

This chapter deals with theoretical and conceptual foundation of the trust. It is divided into two major parts; first part deals with theories and conceptualization of trust and second part deals with health system in Nepal. The first part deal the theoretical concept of trust along with special focus on its dimension, importance, the causative factors of trust and the consequences of trust. The first part ends with trust in health care services and the second part starts with brief introduction of health system in Nepal. It proceeds further describing the historical background of development and change in health system of Nepal and its present scenario along with its organogram. The second part ends with analytical framework which is developed on the basis of theoretical description of trust and an integrative model of organizational trust.

2.1 Concept of trust:

The word trust is derived from German word *Trost* meaning *Comfort* which implies natural, unquestioning belief in and reliance upon something (Hébert 2006:5). In social sciences, the multidimensional concept of trust can be conceptualized with varied meaning and application (Kim; 2005). For explaining number of social phenomena, recently trust has been used as independent variables for economic growth (Fukuyama; 1995), democratic function (Putnam; 1995), electoral participation (Putnam; 1995), for citizen willingness to pay taxes (Yang and Holzer, 2006). A well functioning democratic system ensures citizen trust (Jamil et. al, 2015)

Similarly Calnan & Rowe (2005) has conceptualized trust as multidimensional which primarily consist cognitive element and an affective element. The cognitive dimension of trust has been grounded on rational and instrumental judgment where as affective dimension is grounded on relationships and affective bonds generated through interaction, empathy and identification with others (Gambetta 1998; Gilson 2003; Lewicki & Bunker 1996; Mayer, Davis, & Schoorman 1995cited in Calnan & Rowe; 2005). Due to its multidimensional nature, concept of its meaning and application varied in social sciences (Jamil et. al, 2015)

Comprehensive and universally approved definition has remained elusive though many scientists have attempted to define it from different dimension (Krammer 1999). Initially trust was conceptualized as moral entity where trustworthy person was equated with being honest, benevolent, friendly and highly predictable (Kim; 2005). Niklas Luhmann defines trust as a means to reduce the social complexity. Further he stated that trust is mostly irrational and used to deal with situations where there is a deficit of information or knowledge (Luhmann, 2000). So we can say that trust is the feature of all social relationship that indicates some form of expectation about the future (Jones, 2002, p. 225). Giffin has defined trust as dependent variable depending on the characteristics of an object, or the occurrence of an event, or the behavior of a person to organize the desired but uncertain objectives in a risky situation (Giffin, 1967, p. 106).

Because of the complexity of the notion of trust, it is generally conceptualized differently depending on the context and the field in which it is studied. For example, psychologist view trust as an internal cognitive process between trustor and trustees whereas Economists and some sociologists perceive trust as a calculative or rational expectation about outcomes generated by another party (Colman, 2003). Trust in health care is usually defined as a set of expectations that the patient has from doctor and the health care system to help them heal (Gopichandran, 2013). Thus Trust in the healer is an essential to healing itself (Brody H, 1992).

Tarrant (2006), in his study 'Continuity, trust and cooperation: a game theory Perspective on the GP-patient interaction' has conceptualized trust in medical care context where he mention that trust in medical care contexts has two interrelated elements (Mechanic, 1996): social or institutional trust (trusts in collective institutions/bodies such as the health care system, the medical profession) and interpersonal trust (trusts in a particular individual). His study was more focused on interpersonal trust where his survey findings showed that a history of positive interactions between a patient and a GP, and expectation of future interactions, were associated with higher trust. His analysis of patient interviews showed relatively high levels of initial trust. Another finding of his study was that the experience of consulting the same General Practice lead to a reduction of uncertainty and this was associated with increased willingness to disclose information, and to accept treatment or advice.

2.2 Dimension of trust

According to Mishra (1996), model of trust addressed four dimensions of both individual and organizational trust. As this study is more focused on interpersonal trust where the perception of "one party's willingness to be vulnerable to another party based on the belief that the latter party is: a) competent, b) open, c) concerned, and d) reliable" (Mishra, 1996). In a similar vein, Calnan and Rowe (2005) have framed the following trust relationship in health care:

Providers/practitioners

Trust (organizational)

Managers/commissioners/regulators
(interpersonal)

Trust

Trust (institutional)

Public/patients
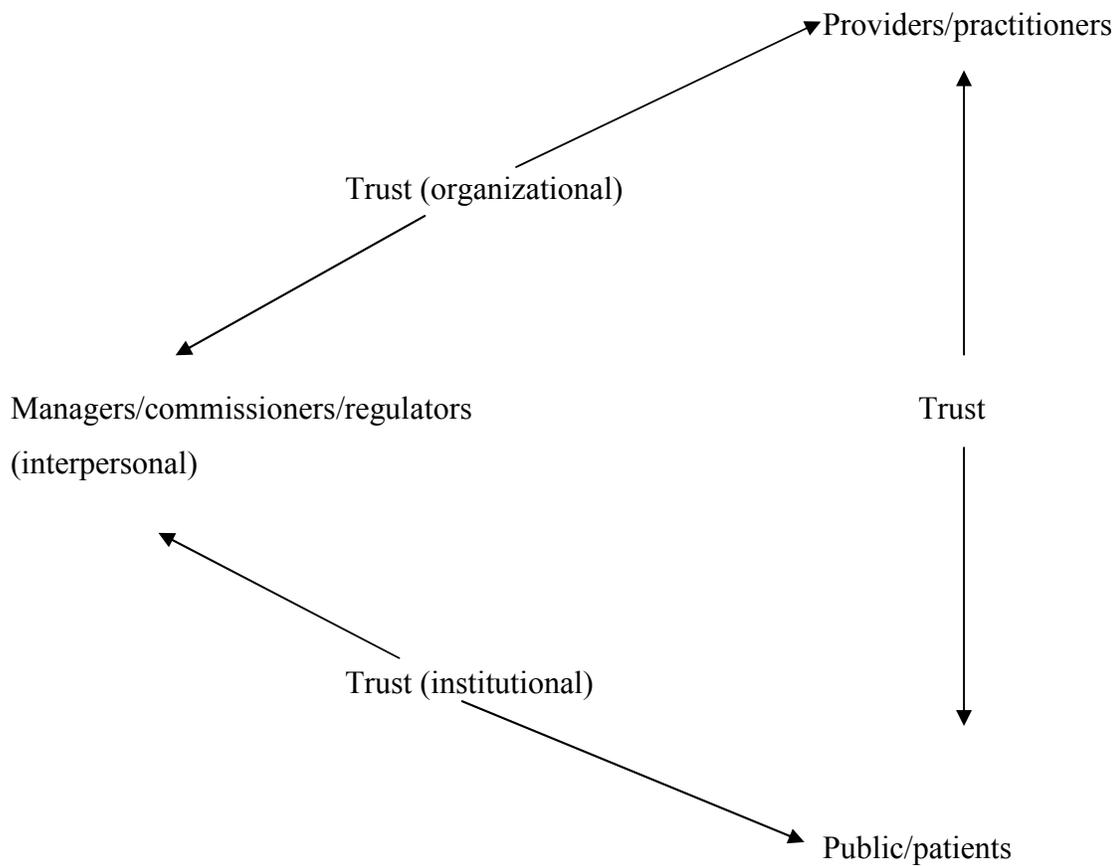
Fig 1: Trust relation in health care

In the above framework, it is shown that three types of trust exist in health care; i.e interpersonal trust, organizational trust and institutional trust. This interpersonal trust is related to the vulnerability associated with being ill and the element of risk regarding the intentions of doctor on whom the patient is dependent (Calnan & Rowe, 2005). It is well known that health care involves uncertainty and vulnerability for patients, despite this also there is some level of trust in patient that adhere them to consult with doctor and seek treatment (Mark Hall et al., 2001).

Lewicki and Bunker (1995) have stated three kinds of trust: calculus-based, knowledge-based and identification-based whilst McAllister (1995) identifies only two kinds: cognition-and affection based. The dimension of interpersonal trust is Affective where affect based trust involves a deep emotional investment in a relationship (Lewis and Weigert, 1985; McAllister, 1995). Zucker 1986 as cited by Hosmer, (1995) also suggest three but under the different names of: process-based, person-based and institution-based whilst in contrast Larzelere and Huston (1980) insist on a distinction between dyadic and generalized trust. Similarly many scholars have identified different types of trust but finally Kramer (1999) identified six types including: dispositional, history-based, third parties as conduits, category-based as well as role-and rule based trust.

By summarizing the concept and dimension of trust, we can say that interpersonal trust is a contractual social event where the trustor's decision to trust is based on various sources of information (as defined loosely) and a conscious weighing of the increases in risk, vulnerability and dependence (Ruotsalainen, 2003). It has been manifested that in case of interpersonal trust, a certain level of agreement needs to exist between the trustor and the trustee regarding the nature of the actions required of the latter and the time frame within which to execute them (Ruotsalainen, 2003).

2.3 Importance of trust

A well functioning democratic system is built on citizen trust because without trust people may feel estranged (Jamil et. al, 2015). Kim (2005) has asserted that citizen's higher trust in public institution ensures good governance and successful implementation of policies. Also he has mentioned the importance of trust as an important indicator for demonstrating how

public organizations are running and how officials are managing public affairs (Kim, 2005 cited in Jamil et. al, 2015). Fukuyama has highlighted the importance of trust as an efficient means for lowering transaction cost in any social, economic and political relationship (Fukuyama, 1995). Similarly other studies have shown that trust promotes civic engagement and community building and overcome the dilemmas of collective action (Fukuyama, 1995; Putnam, 1993 cited in Bahry et al 2005:2). Bahry et al 2005:2 has further highlighted that higher trust is associated with greater citizen involvement in politics, lower corruption, more effective public services, higher economic growth, and other benefits.

The study of trust and trustworthiness, in the context of healthcare, is crucial for several reasons. For example, trust in physician increases the likelihood of adhering to treatment recommendation; it means it enhances the efficacy of prescribed treatment (Pearson S.D and Racke L.H, 2000; 509-513). Similarly trust encourages use of services, facilitates disclosure of important medical information and also influences the health outcomes through patient's satisfaction and continuity of provider (Calnan & Rowe 2005). Also it promotes efficient use of both the patient's and the physician's time (Goold S.D, 2002). Brown (2009) has also highlighted trust as valuable and scarce commodity in late modernity which plays a major role in health care where environment is characterized by uncertainty.

In medical setting, trust is considered as cornerstone of effective doctor- patient relationships (Calnan & Rowe 2004 cited in Calnan & Rowe 2005). Many studies have shown that trust is highly correlated with patient satisfaction but it is conceptually distinct. It has been suggested that it is more sensitive indicator of performance than patient satisfaction. It is a forward looking that reflects the commitment to an ongoing relationship which can be used as potential marker to evaluate the quality of health care (Calnan M & Rowe R, 2005). Within health care, the concept of trust is considered fundamental to a supportive relationship between staff and managers (Rowe and Calnan, 2006), which is also linked to the development of professional and personal competence (Galvin and Timmins, 2010). Also trust reduces patient's costs of information for searching about the prices and alternative services and service provider. This ultimately strengthen a closer mutual relationship between the patient and service provider (Moliner, 2009).

The study on Physician Communication Behaviors that Elicit Patient Trust by Bambino (2006) highlighted the importance of trust in maintaining solid physician-patient relationship and for effective communication. Bambinos showed that the physician communication behaviors perceived to elicit trust are; comfort/caring agency, competence, compassion, and honesty. Thus trust leads to effective communication and vice versa.

2.4 Factors influencing trust

The study of trust in different setting shows that the level of trust and factor influencing trust varies with situation. A study on 'Dimension and determinants of trust in Health Care in Resource Poor Settings- a Qualitative Exploration' by (Gopichandran, 2013) found the difference in the dimension and determinants of trust in health care in resource poor settings and resource rich settings. They identified perceived competence, assurance of treatment, patient's willingness to accept drawbacks in health care, loyalty to physicians and respect for the physicians as key dimension of trust in health care. Similarly factor determining the levels of trust in health care were found to be associated with patient's comfort with physician and health facility, personal involvement of doctor with patient, behavior and approach of doctor, economic factors and health awareness.

The study on Trust within Field Bureaucracy by Anisuzzaman (2012) showed that within a bureaucratic organization old aged employees are more trusting than the middle aged employees, and less educated employee show high trust in coworkers and the highly educated employees show less trust in coworkers. Overall findings indicate that trust is influenced by country context, culture, and organization. Major finding of this study was that Horizontal trust is higher than the vertical trust in field administration. A survey on primary care patients in the US, showed that trust is associated with physician's qualities like being comforting and caring, demonstrating competency, and encouraging and answering questions and explaining (Thom and Stanford, 2001).

Trust is influenced by competence and reliability (Sellman 2007, Poortinga and Pidgeon, 2003). Along with this, beliefs regarding the good-will and benevolence of others also influenced trust (Baier, 1985, 1986, 1994; Robinson 1996). Similarly, Hupcey and Miller (2006) & Calnan and Rowe (2006) also mention that Trust arises from the perception of

another's competence, their technical and social skills, and the belief that the 'trustee' is working in the 'truster's' best interests. Also trust is influenced by previous experience based on perceived personality traits and qualities of others (Lewicki et al., 1998; Saunders and Thornhill, 2003; Mollering et al., 2004; Smith, 2005). Other factors that influence trust positively are communication, openness, listening to others and keeping them informed (Bowen and Lawler, 1995; Shaw, 1997; Weatherup, 1997; Randolph, 1995).

Many studies have shown inconsistent, low or no relationship of trust to demographic characteristics of patients except age (Anderson and Dedrick 1990; Kao, Green, Davis, et al. 1998b; Thom, Ribisl, Steward, et al. 1999; Meit, Williams, Mencken, et al. 1997; LaVeist, Nickerson, and Bowie 2000; Pescosolido, Tuch, and Martin 2001cited in Mark A. Hall et al. 2001). Age has found to be modest and positively correlated with trust in previous studies. But some other studies have found significant relationship between trust and education (Wholey and Sommers 2001). Similarly some studies have indicated that patient trust is consistently related to factors such as physicians' communication style and interpersonal skills (Safran, Kosinski, Tarlov, et al. 1998; Kao, Green, Davis, et al. 1998b; Thom, Ribisl, Steward, et al. 1999 cited at Mark A. Hall et al. 2001). Finally some study shows the relationship between trust and situational factor like the length of a doctor-patient relationship or the total number of visits (Kao, Green, Davis, et al. 1998b; Thom, Ribisl, Steward, et al. 1999; Safran, Kosinski, Tarlov, et al.1998 cited at Mark A. Hall et al. 2001).

Caterinicchio (1979) found a strong relationship between past successful treatment and trust, and concluded that positive physical and emotional outcomes in past treatment are critical for the development of trust. Hams (1997) mention the components of trustworthy behavior which involves willingness to engage in relationships. Along with this other components includes respect, care, honest and listening skills (Hupcey and Miller, 2006; Rowe and Calnan et al, 2006). Thom et al (2004) has asserted that trust is the basic and fundamental aspect to measure, physician attributes identified by patients which can be grouped into the domain of technical competency, interpersonal competency, and agency (also called fidelity, loyalty, or fiduciary duty) (Thom et al, 2004; Mark A. Hall et al. 2001).

The study of trust in different setting shows that the level of trust and factor influencing trust varies with situation. The characteristics of individual patient also influence their perception level (Haas, Phillips, Baker, Sonneborn, & McCulloch, 2003 Mark A. Hall et al. 2001). According to Izumi et al (2010), patient expectation and evaluation of quality nursing care also depend on patient characteristics such as age, sex, education and type and stage of illness. From this finding we can summarize that the characteristics of individual patient also influence the perception of them. As per the concept and definition of trust, it is also a psychological perception; it means trust is influence by individual characteristics.

2.5 Consequences of trust

Consequences of trust can be potentially divided between behavioral and attitudinal. Mark A. Hall et al (2001) has correlated trust in physician positively with adherence to treatment recommendations, not changing physicians, not seeking second opinions, willingness to recommend a physician to others, fewer disputes with the physician, perceived effectiveness of care, and improvement in self-reported health. Kiffen-Peterson and Cordery, 2003; Moye and Henkin, 2006 had shown the positive relationship of trust with efficiency, adjustment, communication, openness, organizational commitment, adaptability and survival. In addition Zand (1972) also showed the positive correlation of trust with problem solving. Similarly trust has positive correlation with individual and collective performance, citizenship behavior, cooperation, communication and satisfaction (Earley, 1986; McAllister, 1995; Fine and Holyfield, 1996; Roberts and O'Reilly, 1974; Dirks and Ferrin, 2002). This what trust leads to but conversely low trust leads to a 'greater amount of surveillance or monitoring of work in progress' (Mayer et al. 1995, p.728). Brann and Foddy, 1988 and Kramer, 1999 had shown that surveillance reduces the level of innovation and cooperation.

2.6   Trust in Health System

The core of functional and productive health system is based on trust raised by human decision, action and relationship (Topp and Chipukuma, 2015). Previous studies have shown the nexus between trust and health care objectives including access, utilization, satisfaction, information dissemination and effectiveness (Russell and Gilson 2006; Safran et al.1998; Hall et al.2001). Study carried out by Wang et al. (2009) has suggested that trust is associated

with improved self-reported health status. Most of the studies on trust carried out in developed countries are focused on patient–provider trust, factors of trustworthiness, and the role of institutions and structures such as ethical codes, training standards and regulatory mechanisms for improving patient–provider trust (Anderson and Dedrick 1990; Mechanic 1996; Thom and Campbell 1997; Campbell 1996; Rothstein 1998; Straten et al.2002). Trust in health system is studied under these constructions of concept, namely institutional, personal, interpersonal and impersonal to date (Taylor 1989; McKnight and Chervany 1996).

Gilson et al (2005b) has discussed that interpersonal trust is based on judgments of competency, assessments of a third party's reliability, sincerity, generosity and fairness. They have also examines the role of trust in South Africans primary health care centers concluding that 'patient–provider' trust are influenced by multiple and overlapping factors. Similarly Russell (2005) concluded the important role of patient–provider trust as a driver of health seeking behavior among patients in a hospital setting in Colombo, Sri Lanka. Also the study carried out by Topp and Chipukuma (2015) has highlighted the importance of trust as a mechanism influencing both health care workers' performance and patient responses, and its role in shaping health centre relationships central to generative and protective service delivery.

2.7 Health system in Nepal

 Every country has its own type of health system. Similarly Nepal has also a history long health system but it is very difficult to identify the exact date of its development due to missing history. Indigenous system of medicine remained mainstream health system till initial part of modern Nepal. This system remains less efficient system to solve the major health problems and the reason behind its poor efficiency is its inability to adopt scientific development in its diagnosis and treatment. This then paved the road for western medicine or allopathic system of medicine (Marasisni, 2003).

In ancient period, religion had the important role in developing and promoting health and education. Before establishment of today's modern allopathic medicine, in Nepal also, Ayurvedic medicine was in common. The so called modern or allopathic medicine was

introduced in Nepal in 16th century by Christian Missionaries (Marasisni, 2003). This is the short introduction of health system in Nepal. We will discuss in detail below.

2.7.1 Historical background

The Nepalese history has been divided into ancient (first century to 879 AD), medieval (879 AD to till control of the Kathmandu by King Prithvi Narayan Shah–1768 AD) and modern Nepal from 1769 AD onwards by Historians (Regmi, 1996). Similarly the history of health development can be divided in the same way. In 1889 A.D, Nepal government establish hospital to provide health services to common people as a state initiative, so this period is rather consider as landmark of modern health in Nepal (Marasisni, 2003).

The history of health system and hospital development dates back to Lichchhavi period. The health practices that were prevalent during this period were the safe motherhood practices (Regmi, 1996). Then during Malla period, medicine became family business rather than a state business. The current Singh Darbar Baidyakhana or Traditional Medicine Manufacturing Plant is believed to be the continuity of the dispensary established earlier by the King Pratap Malla (KC, 1998). In the same Malla period, Christian Missionaries working in Peking, China and Lhasa, Tibet introduce the modern medicine or allopathic system of medicine in Nepal (Gautam, 2001). But this allopathic system of medicine was discontinued during Nepal unification and Ayurvedic medicine continued to be the main health system of the country. In above session, we discuss a brief history of health system development in Nepal during ancient and medieval era, I.e. during Lichchhavi and Malla period. Now we will discuss about the development of hospital during modern era.

The expansion of modern medicine, reintroduction of modern services and institutionalization of Ayurvedic system of medicine occur in this period (Marasisni, 2003). The development of hospital in modern era can be divided into three phases namely; first phase (medical service from British resident doctor), second phase (Rana period) and third phase (post democracy period). In Nepal, the rana period, which lasted for 104 years, is considered as important era for the development of hospital and health system. Several hospitals and dispensaries were established both in the modern medicine and traditional medicine as a state initiative during this period (Dixit, 2002). The Bir hospital, which is the

today's central government hospital, was also established during the same period. Similarly cholera hospital and Leprosy hospital were also established in the same period (Dixit, 2002). National networks of hospitals and dispensaries developed during this Rana period. Not only in Kathmandu valley, but also outside valley, the then Rana prime ministers opened more than 18 hospitals and 14 dispensaries. Along with this, school health program was also initiated during this period (Sharma, 1990).

After Rana period, post democracy is also the important period in the history of Nepalese health system because during this period several new health programs were declared and secondary and tertiary care institution also were established (Sharma,1990). This period open opportunities to many non government organization and private sector to provide health care. This is the period when planned development process gets started in Nepal. During this period many reform and restructure took place, like many health institutions were established to increase the access of people to basic health care and many dispensaries established in Rana period were converted to health centers and upgraded to hospitals. Similarly to train the health care technicians and nurses, many health training institutions were also established within a country (Sharma 1990).

In 1958 AD ministry of health implemented new health policy- one health centre in each 105 electoral constituency. In the year 1964 AD, regionalization of health services started to provide comprehensive health services along with political and administrative division of the country into 75 districts and 14 zones (Dixit, 1996). During this period, ICU/CCU services were also opened for the first time in Bir Hospital and also for the first time in Nepal. Similarly, some health centers were converted into health posts and upgraded to district hospitals in this period. Along with this, another important health service initiative that took place during this period is the emergence of single specialty hospitals and implementation of primary health care system (Marasisni, 2003).

2.7.2 The present health system

Though the Christian missionaries were introduced in 16th century, the history of modern health services is not long in Nepal. Due to ineffective system of traditional health system to provide health services, Non government organization and private sectors started putting

effort for the effective delivery of health services. These efforts later seem more satisfactory than previous one. In spite of this also, there seems lack of policy on hospital establishment and management (Marasisni, 2003).

The development of present health system of Nepal dates back to 1990s along with emergence of tertiary care centers and expansion of primary health care and growth of private health institutions. Today's health system started along with the establishment of tertiary care services in neurosurgery, cardiac surgery and cancer. Polio eradication health programs, DOTS strategy to control tuberculosis were also initiated in present health system (Das, 1996; Marasisni, 2003). The present health status of people is the result of efforts to end the 104 years of Rana feudal rule in February of 1951. With the people's movement 1st, April 1990, new health policy had been put forward and later the official documents of the Ninth and Tenth Plans and the second Long Term Health Plan were introduced. The last decade of 20th century saw the setting up of many medical colleges across the length and breadth of the country (Dixit, 1995).

The hospital those were prevalent till mid-fifties were under the government and most of them were under the Ministry of Health (MoH). Later, opening of hospitals by missionaries and NGOs, semi-private hospital come into being. Similarly, another category of hospital, name private medical colleges was also introduced in Pokhara, Bharatpur, Nepalgunj, Bhairahawa and Kathmandu. In this way following category of hospitals are in existence in present in Nepal:

1. Governmental
    a) Civil
    b) For service personnel
    c) Educational
2. Non- governmental (mission hospital and private medical school)
3. Private (nursing homes/hospitals)

(Source: Dixit, 1995)

On the civil side, Bir hospital is the first institution of western medicine type for providing tertiary health care with in a country. It was established in 1889 AD during Rana period but after the fall of Rana rule, this hospital was renovated, surgical block and nurses' residence were constructed with the help of USAID in 1965. OPD facilities started in this hospital in 1985 AD. In-patient services started in Nepal in 1986 AD (Dixit, 1995). This is the brief introduction and historical background of present health system in Nepal. As we already discussed about tertiary care and types of hospital in Nepal. So to the concept clearer, let's see the recent organogram of department of Health services which give the facts and figure of government hospitals at different levels and government health institutions of Nepal.

CENTRAL LEVEL

Ministry of health and

Department of Health services

D I V I S I O N S						
P F A D	F H D	C H D	E D C D	L M D	H M I D	L C D

C E N T E R S				
N T C	N H T C	N P H L	N C A S C	N H E I C C

Central hospitals – 8

REGIONAL LEVEL

Regional Health Directorate-5				
Regional hospital	Regional training centers	Regional health laboratory	Regional medical store	Regional TB center

ZONAL LEVEL

Zonal hospital-11

DISTRICT LEVEL

DPHO   14 | District hospital- 74 | DHO   61

ELECTORAL CONSTITUENCY- 205

PHCC- 17

VDC LEVEL – 3995

Health post-754

Sub-Health post-3187

COMMUNITY LEVEL

FCHV (42,427)	TBA (12,682)	PHC Outreach (11,862)	EPI outreach

Source: Administration section, HMIS/MD, DOHS

Fig 2: Organizational Framework of DOHS

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2.8   An Integrative Model of Organizational Trust

This model was proposed by Roger C. Mayer et al. (1995). This model suggests that three major factors determine trust and they are characteristics of the trustor, characteristic of the trustee, and the perceived risk. The propensity of the trustor and the element of trustworthiness that the trustee possesses influence the level of trust. This model clearly differentiates trust from factors that contribute to it and also differentiates trust form its outcomes of risk taking in the relationship. Likewise, the critical role of risk is clearly specified in this model (Kramer, 2006).

In this model the characteristics of trustor are presented as the propensity of the trustor to trust, means some individual do more trust than others. Similarly characteristics of the trustee are presented as trustworthiness. An author has highlighted three elements of trustworthiness in this model. First element is an ability which is the competence the trustee possesses in the specific domain; second element of trustworthiness is the benevolence which implies the willingness of the trustee to do good for the trustor; and the final one is the integrity which means whether the trustee has a core set of values to guide behavior.

Factors of Perceived Trustworthiness

```
┌─────────────┐          ┌──────────┐
│ Ability     │          │ Perceived│
│ Benevolence │          │ risk     │
│ Integrity   │          └────┬─────┘
└─────────────┘               │
       │        ┌───────┐     ▼    ┌──────────────┐      ┌─────────┐
       └───────►│ Trust ├──────────►│ Risk taking  ├─────►│ Outcome │
       ▲        └───────┘           │ in           │      └─────────┘
       │            ▲               │ relationship │
       │            │               └──────────────┘
       │      ┌───────────┐
       │      │ Trustor's │
       └──────│ propensity│
              └───────────┘
```
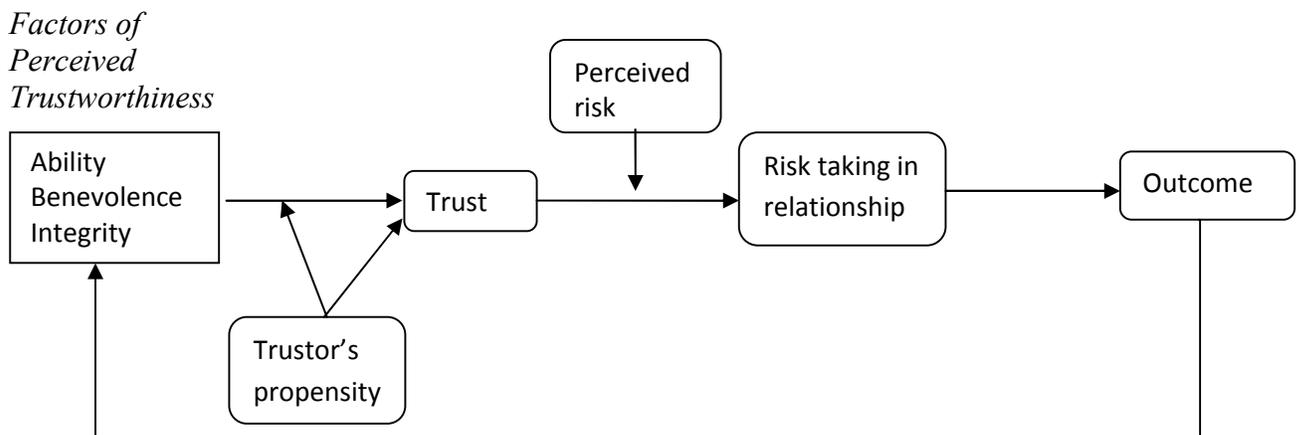
Fig 3: Model of organizational trust   *Source: Kramer, 2006*

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Ability in this model is similar to competence, interpersonal competence, business sense, and judgment. Here ability highlights the task and situation- specific nature of the construct in the current model (Kramer, 2006). Similarly benevolence suggests that the trustee has some specific attachment to the trustor. Here author used the idea of benevolence for the assessment of trustworthiness i.e. high benevolence in a relationship would be inversely related to motivation to lie. Benevolence connotes a personal orientation that is integral to this model (Kramer, 2006). Here the relationship between integrity and trust involves the trustor's perception that the trustee adheres to a set of principles that the trustor find acceptable (Kramer, 2006). These three factors appear to explain concisely the within trustor variation in trust for others. Colquitt, Scott, and Lepine found strong correlation between trust propensity, trustworthiness and trust in their meta- analysis of this model. Hence from above model we can sum up as, the trust for a trustee is the trustee's perceived ability, benevolence and integrity and of the trustor's propensity to trust.

2.9 Analytical framework

By analyzing the definitions of trust and reviewing trust literature extensively and evaluating relevant trust theory, following dependant and independent variables have been identified for this research purpose. From the literature review, it is found that **characteristics of individual patient** influence their perception level (Haas, Phillips, Baker, Sonneborn, & McCulloch, 2003). Similarly, **Izumi et al (2010)** also mention that **patient expectation depend on patient characteristics such as age, sex, education and type and stage of illness.** A number of studies showed that for the development of trust clinician's communication skills, their technical competence also plays important role (Burkitt Wright et al, 2004; Cooper-Patrick et al, 1997; Gibson, 1990; Gilson et al, in press; Goold and Klipp, 2002, Henman et al, 2002; Lee-Treweek, 2002; Lings et al, 2003; McKneally et al, 2001; Thom et al, 2002 cited at Calnan and Rowe, 2004). From this finding we can summarize that the characteristics of individual patient influence their own perception. As per the concept and definition of trust, it is a psychological perception; it means trust is influence by characteristics of trustor and trustee. The main objective behind framing this framework is to first to conceptualize what this research is about and to show the significance of relationship between independent and dependent variables

┌─────────────────────────┐
│ **Identity variables** │
│   │
│ Age, gender, education, │
│ Length of stay at hospital, │
│ Department of hospital, │
│ Approaches to hospital, │
│ Patient responsiveness │
└─────────────────────────┘

┌─────────────────────────┐
│ **Factors of perceived**│
│ **Trustworthiness**   │
│   │
│ Competence   │
│ Compassionate care   │
│ Communication skill   │
└─────────────────────────┘

In-Patients' Trust

Dependent variable
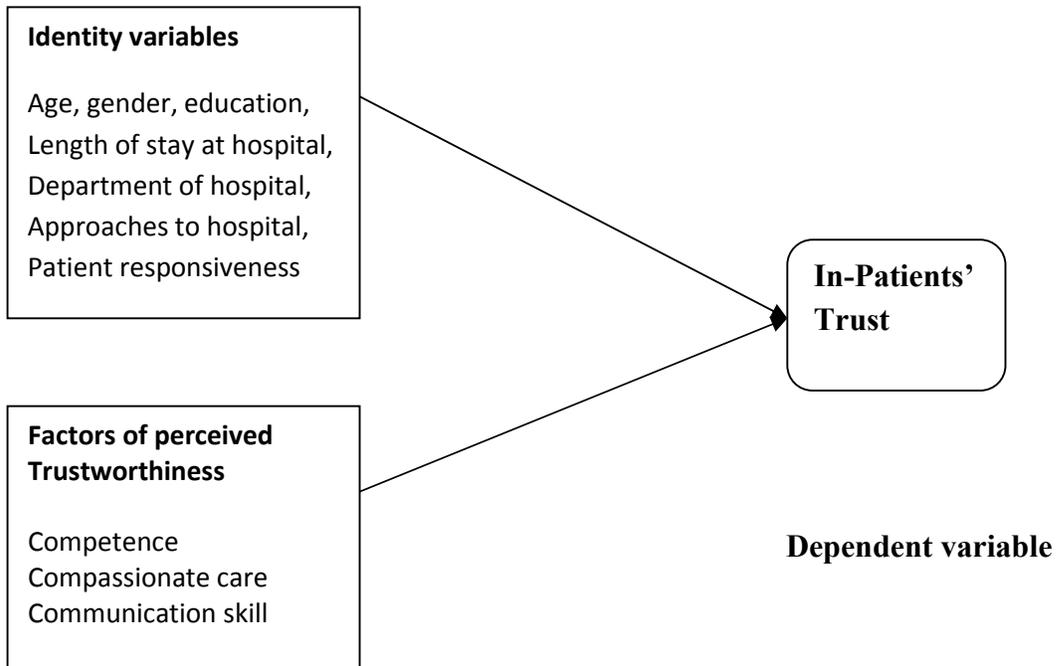
In-dependent Variables

Fig 4: Analytical Framework

1. **In-patient's Trust:**

In the integrative model of organizational trust, Rogers Mayer et. Al (1995) has define trust as "*the willingness of a party to be vulnerable to the actions of another party based on the expectation that the other will perform a particular action important to the trustor, irrespective of the ability to monitor or control that other party.*"

Rousseau *et al.* (1998) has defined trust in their cross disciplinary review as "*a psychological state comprising the intention to accept vulnerability based upon positive expectations of the intentions or behavior of others*".

Here in-patients trust is a psychological state of admitted patient of Bir Hospital where patient has belief and expectation that doctors of the same hospital will treat them according to their interest.

2. Identity Variable:

Here the identity variable means the individual characteristics of the patients only admitted in the hospital which consist of the patients' age, gender, education level, length of stay at hospital, department of the hospital where patient are admitted, approaches to hospital and patient responsiveness.

Patient Responsiveness

Here patient responsiveness means the response of the patient based on the impression created to the patients depending upon how they are welcomed at the hospital.

3. Factors of perceived trustworthiness:

Reviews of literature on trust have shown that characteristics and actions of the trustee will lead that person to be more or less trusted. Here the factors of trustworthiness are the characteristics of doctors that influence the perception of patients' towards them. In this study, only three characteristics of doctors are taken into consideration because of their unique perceptual perspective which are operationalize below.

Competence:

Competence means avoiding mistakes and producing the best achievable results. Mistakes can be cognitive, which are errors in judgment, or technical, which are errors in execution. Most patients have difficulty assessing technical competence directly, so their views of competence are heavily influenced by a doctor's competence. In this study competence dimension will be limited to Patient perception on doctors' competence of proper diagnosing, treating and curing.

Compassionate care:

According to the Merriam-Webster dictionary the word compassion is defined as sympathetic consciousness of others' suffering together with a desire to alleviate it. Consciousness is the state of being aware. Here the compassionate care is that moral dimension of care which will be limited to Patient perception that doctor is sympathetic.

Communication skill:

It is all about being able to convey information to patient clearly and simply, in a way that means things are understood and get done. It's about transmitting and receiving messages clearly between doctor and patient.

2.10   Conclusion

From above literature review, the importance of communication in building interpersonal trust i.e. relationship between interpersonal skills (communication and interpersonal care) and trust is shown. Similarly the findings of above mention studies showed that the factor determining the level of trust in health care are comfort with physician and health facility, personal involvement of doctor with patient, behavior and approach of doctor, economic factors and health awareness. Also some studies show the strong relationship between past successful treatment and trust. These studies were done in different setting, some are looking trust from citizen perspectives to government institution like parliament and judiciary, and some looked at the level of trust between employee within field bureaucracy, and other looked at factor influencing level of patients' trust from different perspectives. They have highlighted doctor's qualities that influence trust of patient. But these studies are done in different place in different setting. So does the same factor influent the trust of in-patient in the context of Nepal is the main question to researched in this study.

CHAPTER- 3
RESEARCH METHODOLOGY

The major objective of this chapter is to present the methodology used in this study. Research method provides a planned and systematic approach of investigation that denotes the detail framework of the unit of analysis, data gathering techniques, sampling focus and interpretation strategy and analysis plan. The chapter begins by discussing the approach of the study. The details of the methodology which is carried out prior, during and after field work have been described in this chapter.

3.1 Research Approach: The research methodology comprises of three parts which is explained below:

• Pre-field work phase which comprises of problem identification, literature review, development of variables and indicators etc

• Field work phase which comprises of data collection in identified variables and indicators

• Post field work phase was focused on analysis and interpretation of data

3.2 Pre-Field Work Phase

This phase comprises of problem identification and set the research objectives based on relevant scientific literatures, text books, papers, articles and internet sources. According to analytical framework designed in chapter two, the questionnaire has been designed for carrying out survey with in-patient of hospital. The questionnaires were designed according to the research objectives and analytical framework.

3.3 Field Work Phase

This is data collection phase and involves the collection of primary data. The purpose of conducting the field work is to collect the required data in order to assess the factor influencing interpersonal trust between admitted patient and doctors.

3.3.1 Research Design:

This study was mainly based on micro study of in-patients' trust in government hospital with special focus on Bir Hospital. This study has tried to analyze the relationship between level of in-patients' trust and demographic factors of the in-patient as well as skill and behavior of doctors. So descriptive cum analytical research design have been used. The descriptive research design has been used to describe the citizens' trust in doctors. Further, the analytical research design has enabled to establish relationship between different independent and dependent variables used in this research.

3.3.2 Research Method:

Scientific study follows a certain research approach; either qualitative approach, quantitative approach or mixed approach in nature. Qualitative research emphasizes the "study of things in their natural settings, attempting to make sense of, or to interpret, (an event or experience) in terms of the meanings people bring to them." (Denzin, NK., Lincoln YS., 2000:3). Typically qualitative study designs use research questions and semi-structured methods such as open-ended and in-depth interviews, ethnographic field notes, focus groups, open-ended questions on surveys, and participant observation. Quantitative research, on the other hand, emphasizes "the measurement and analysis of causal relationships between variables, not processes" (Denzin, NK. Lincoln YS. 2000:8). Quantitative study design states a hypothesis and collects data through highly structured methods such as questionnaires, surveys, and structured observation and uses closed-ended format for questions and interviews.

Using both qualitative and quantitative elements in research is known as mixed method research. Mixed methods research is formally defined here as " the class of research where the researcher mixes or combines quantitative and qualitative research techniques, methods, approaches, concepts or language into a single study" (Johnson, RB., Onwuegbuzie, AJ., 2004). A combination of Questionnaire Survey, Interview, and Observation methods has been used to take advantage of their respective strengths and overcome the limitations of others. The combination of the stated methods also helps to reduce bias of any single method.

3.3.3 Study population and sampling:

The study population encompasses the admitted patient of Bir hospital. So patient from medical and surgical ward were chosen randomly, 25 from each ward respectively. A total sample size was 50 with equal representation of male and female. Efforts have been made to make the sample representative in terms of gender, age, education, length of stay at hospital, department wise and approach to the hospital which is given in the following table.

Table 1: Tabular presentation of respondents according to Identity Variables

Identity Variables		Sample size (%)
Gender	Male	50
	Female	50
Age (years)	11-20	6.0
	21-30	28.0
	31-40	22.0
	41-50	26.0
	51-60	10.0
	61-70	6.0
	71-80	2.0
Length of stay at hospital (days)	2-4	50.0
	5-7	38.0
	8-10	12.0
Department of hospital	Surgery	50
	Medicine	50
Literacy	Illiterate	14.0
	under SLC	36.0
	Undergraduate	40.0
	Masters	10.0
Approaches	self addressed	70.0
	Referred	30.0

Source: Field Study, 2015

The above table shows the characteristics of admitted patient. The data for this study were collected from only those patients who are 11 years or above who has been admitted for more than one day. Regarding the age, high percentage of 28, 26, 22 belong to 21-30, 41-50 and 31-40 age group respectively. Only 2% of respondents were from 71-80 age groups. 6 percent of respondent were from 11-20 and 61-70 age group and remaining 10 percent were from 51-60 age group. This proves that majority of respondents were from middle age group. Among 50 respondents, 14 percent were illiterate, 36 percent were under SLC, 40 percent were under graduate and remaining 10 percent were master's degree holder. Similarly majority of respondents were self addressed while remaining 30 percent respondents were referred from other hospitals.

3.3.4 Data Collection Tools and Sources

The data for the study were obtained from various sources including documents, questionnaire survey, observation checklist and interview checklist. Data and information were obtained from both primary sources and secondary sources.

A. Primary Data:

Hardin (2006) has mention that the survey is the most common way of measuring trust, at least at societal level. This study has also used questionnaire survey method as a chief method of primary data collection. Along with questionnaire, interview checklist and observation checklist were also used for collecting primary data. Questionnaire administered to patient were closed ended where as interview checklist administered to doctors were open type. The logic behind using questionnaire is that it is a very effective instrument that facilitates in collecting data from a large, diverse and widely scattered group of people (Aminuzzaman 1991). A pilot study was done at Rapti Zonal Hospital, Dang, before administering questionnaire to the respondent to make it more precise, simple, clear and patient friendly.

Questionnaire:

Open ended or structured questionnaire was used in this study. In Structured questionnaire, there are definite, concrete and pre-determined questions, and are presented with exactly the same wording and in the same order to all respondents (Kothari, CR., 2004:101). Questions were grouped to focus on patient's characteristics, patient responsiveness, doctor's competence, doctor's compassionate care, doctor's communication skills and patient's trust. Designed questionnaires were patient friendly with descent options.

During pilot study, some questions were found repetitive and some options to be re-considered. So those questions and options were modified. It was then discussed with the supervisor and final questionnaire were prepare. After this, the finalized questions were administered to 50 patient admitted in Bir hospital. The questionnaires were comfortably welcomed by the study group. It allowed them to talk about their good and bad experiences in the hospital. The respondents enjoyed the questions pattern and its options. The questions were asked them in Nepali to make the interview patient friendly. In most of the questionnaires, the patient options were scaled in 4-point scale, with high number indicating good satisfaction level.

Interview

Interviewing is one of the most common tools for naturalistic data - collection because of its interactional nature. The purpose of interviews is to find out those things which cannot be observed directly; a representation of what someone else is thinking. An open ended structured interview (interviewer asking predetermined questions) was conducted to 10 consultants but only six of them participated. Doctors who participated in interview were all male consultants.

Observation

Observation is essentially naturalistic and occurs in the natural setting under study where the observer is unobtrusive and inconspicuous, neither manipulating nor controlling the situation (Mays, N., Pope, C., 1995). Observational research can vary widely with the researcher assuming a role that can range anywhere between the hidden, or absent observer, who watch

from outside or with a passive presence, to the active participant who is involved in the setting and who acts as a member rather than a researcher (ibid). Since there was no natural role that could be assumed, it was not possible for the researcher to assume a role of participant in the context of the medical setting being observed in this study. Observation was therefore carried out in a non-participatory, unobtrusive and inconspicuous manner as possible.

The observations were performed at the medical and surgical IPD of Bir hospital. For observant to observe or notice everything which occurs in a natural setting is not possible, even within the context of attempting to achieve a holistic sense of the situation. Social researchers (Glaser, 1978; Padgett, 2004; Patton, 2002 cited in Bowen, GA., 2006) recommend using what they call 'sensitizing concepts' to help make the situation manageable and to determine those aspects which becomes focus of each observation. Sensitizing concepts can provide a framework and give the analyst a "general sense of reference" (Blumer (1954) cited in Bowen, GA., 2006). Some sensitizing concepts were initially identified by the researcher. These concepts are as such: doctors' behavior, language used by doctors, time given by doctor to patient during rounds and patients' conversational skills. Observation was performed simultaneously during questionnaire survey. Researchers kept a log of events and descriptions of the events, specially focusing on the sensitized concepts.

B. Secondary Data:

Secondary sources are also major sources of data for this research. For secondary data, this study mainly relied on review of previous studies on health system and trust. To understand the development of health system in Nepal, various books, policy documents, and research articles were reviewed. Similarly, different books, journals, research articles, dissertation reports were mainly used to understand the concept of trust by analyzing definitions offered by various scholars. Further secondary sources have been used to review the existing literature regarding previous studies on citizens' trust in public institutions in different countries, and studies in the context of Nepal. Moreover, the literatures review facilitated in chalking out the theoretical framework for this study.

Content Analysis

Qualitative content analysis is a technique for systematic text analysis which can be defined as the use of a replicable and valid method for making specific inferences from text (Krippendorff, 2004; Mayring, 2000). It can be used either alone or in conjunction with other methods. All sorts of recorded notes like field notes of observations, transcripts from interviews and documents such as books can be used (Krippendorff, 2004). The goal of qualitative content analysis is to reduce the material into the smallest parts, textual units. The rules of analysis are that the material is to be analyzed step by step and to organize the material into content analytical units.

Observational notes, field notes and responses to opened – ended questionnaires by doctors are measured using content analysis. The researcher has tried to find common ground for the observed interaction, leading to more general conclusions. Content analysis was gauged by doctor's reaction to patient satisfaction with their treatment and factors affecting their satisfaction level.

3.4 Post Work Field Phase

In this phase, data entry, analysis and interpretation of information collected from questionnaire survey was done. The data collected through the use of different techniques have been organized, processed, and analyzed by using different statistical tools with the help of SPSS. Then finally interpersonal trust has been assessed in terms of characteristics of the patients and factors of trustworthiness.

3.4.1   Data Analysis and Interpretation Plan

The dependent variable under examination here is Inpatient's trust in government hospital with special focus on Bir hospital. Similarly the independent variables are the characteristics of admitted patient and the factors of perceived trustworthiness like compassionate care, communication skill and competence. This study has measured trust directly using a scale approach. Questions were of 4 point scale option with higher number (4) indicating good option and lower number (1) indicating poor option. Once survey was completed, then options were broken into two options with high and low option only.

Cross tabulation has been used to show the relationship between different independent and dependent variables. Data are presented in percentage and mean. Further bivariate analysis has been done to show the degree of relationship between dependent and independent variables.

3.5 Reliability and Validity of the data and Ethical concern

Researcher tried to take utmost care on various identity variables such as age, gender, education, department and responses of the respondents to ensure the true representation. The field work was administered by the researcher personally. Researcher took the letter of permission from central department of Public administration to get the permission for data collection also. Consent of participant was taken before administering the questionnaire. Confidentiality of the information and identity was ensured to respondent and they were encouraged to provide true and real experiences. Data gathered were rechecked and crossed checked with the secondary data and records where possible. Sometimes discussions and informal talk have been made on the research topic with the respondents by the researcher to know their views on the issue, and that has been checked whether their views are reflected on the questionnaires.

3.6 Generalization

This study has not included all the patients of the hospital. The findings of this study cannot be generalized in case of outpatient department and other private hospital. This study was carried after massive earthquake. During such situation even a small help to anybody can satisfy their expectation which can influence the level of satisfaction and trust level. So, the result from this finding cannot be generalized in other normal situation.

CHAPTER 4

DATA PRESENTATION, ANALYSIS AND INTERPRETATION

This chapter presents the data, findings and results, which were collected by the survey. It analyses the factors that determines the interpersonal trust in government hospital. On the basis of these factors, this chapter shows the level of trust exist in inpatient. It outlines the general results of the questions regarding trust in government hospital, with special focus on interpersonal trust between admitted patients and doctors. This chapter also explains how the interpersonal trust is affected by characteristics of the patient and factors the perceived trustworthiness. It also goes into depth to see the variation of the level of trust on the basis of age, gender, education, length of stay at hospital, department of hospital, approaches to hospital and finally personal characteristics of the doctors. Finally, this chapter seeks the answer about the relationship of interpersonal trust on the hospital based on the performance of doctors.

4.1 Analysis and Discussion of Dependent Variable

In-Patient Trust

In this study, the dependent variable under examination is inpatients trust. Here, In-patient trust refers to psychological state of admitted patients where patient has belief and expectation that doctors will treat them according to their interest. It means this study assess the trust level of admitted patient of Bir hospital. The trust which is assessed here is interpersonal trust because only the trust of admitted patient on the government doctor is researched in this study.

Inpatients' trust on doctor was assessed directly using scale approach. To find this inpatients trust level, other questions were developed and analyzed in 4 point scale option. After analyzing those questions of dependent variable (trust), respondents were broken into those who had high level of trust (3, 4) and those who had low level of trust (1, 2). The following table illustrates the general scenario of inpatients trust.

Table 2: Inpatients' Trust Level

Level of trust	Number of respondents	Percentage of respondents
High	36	72%
Low	14	28%
Total	50	100%

Source: Field study, 2015

(Q. Do you feel assured that you will be treated well by your doctor in this hospital? What level of trust you have on your doctor? What was the reason that you trust your doctor? Will you come back to your doctor for follow up? Would you like to recommend your doctor to others too?)

The above table illustrates the result of inpatient's trust in their doctor of Bir hospital. Within the overall sample collected, 72 percent of respondents showed high level of trust in their doctors while 28 percent had still low level of trust. Result showed good level of inpatient trust but still 28% of respondent showed low trust. Question arouse here, why all respondents did not show high trust? Although majority of patient expressed high degree of trust in their doctor but what are those factors that determine their trust level and undermined their trust level.

From content analysis of interview taken from doctors based on trust and factors of trustworthiness, one thing was clear from their opinion that both doctors and patients were satisfied with each other regarding treatment. This shows the positive signs of trust in the medical fraternity. In a similar vein, they added that there can be some differences in views of some patients regarding the services and behavior. All doctors concluded that their patients carry medium level of trust on them. This means according to doctor's opinion, expectation and perception of patient differs so might be their satisfaction and trust level. From the literature review also, it was found that characteristics of individual patient influence their perception level (Haas, Phillips, Baker, Sonneborn, & McCulloch, 2003).

Similarly, Izumi et al (2010) has also mentioned that patient expectation depend on patient characteristics such as age, sex, education and type and stage of illness.

Trust doesn't develop when doctor sees his patient but starts even before he enters the hospital. There can be pre-existing trust among patient about the hospital or the doctor as Review of literature also has shown that interpersonal trust is related to the vulnerability associated with being ill and the element of risk regarding the intentions of doctor on whom the patient is dependent (Calnan & Rowe, 2005). It is well known that health care involves uncertainty and vulnerability for patients, despite this also there is some level of trust in patient that adhere them to consult with doctor and seek treatment (Hall et al., 2001).

Researcher found varied responses of the in-patients during interview. Many of them had good thought about the Bir Hospital, the central government hospital of Nepal. Hence, they did visit the hospital by their own, trusting the better experienced doctor and the fame of the hospital. Some were referred from inside the country as a tertiary centre but they too did carry positive trust of getting cured at the better and specialized centre on the hands of experienced doctor. So it can be said that patient comes with the positive attitude to the hospital with an expectation that the doctor will treat their disease. It shows the presence of blind faith in patients towards doctor and hospital.

From the literature review, it has been clear that patients' level of trust is influenced by different factors like age, gender of the patient, their education level. This research has also considered identity variables and factors of perceived trustworthiness as the factors affecting the patients' trust level. In order to analyze the factor that had an impact on this interpersonal trust, following section deals with independent variables and their relationship with dependent variables through bivariate analysis.

4.2 Analysis and discussion of identity variables of patients:

This section explains how the identity variables of the patient admitted in the Bir hospital play role in building interpersonal trust with doctors. Though there might be many other factors related to identity variables of the patients that might affect level of trust but this study has considered only seven variables: gender, age, education, length of stay at hospital,

department of hospital, approaches to hospital and patient responsiveness. The relationship between identity variables with trust is presented in following table.

Table 3: Cross Tabulation of Identity Variables and Inpatient Trust Level

Identity Variables		Number of respondent	(%) within trust		Chi square test	
			High	Low	Value	Sig. Level
Gender	Male	25	50	50	.000	1
	Female	25	50	50		
Age (years)	11-40	28	61	43	5.875	0.437
	41-80	22	39	57		
Length of stay at hospital (days)	2-4	25.0	64	14	10.763	.005
	5-7	19.0	25	72		
	8-10	6.0	11	14		
Department of hospital	Surgery	25	64	13	9.921	.002
	Medicine	25	36	86		
Education	Uneducated	25	40	71	4.995	.172
	Educated	25	60	29		
Approaches	self addressed	35.0	72	64	.302	.582
	Referred	15.0	28	36		

Source: Field Study, 2015

Gender

The first identity variable under consideration to test interpersonal trust was gender of the respondents. Above table shows the relationship between gender and trust. Out of 50 respondents, 25 male and 25 female were selected for survey. When level if inpatient trust was crosstab between male and female, then same level of trust was observed. This study has

falsified the assumption that females in developing countries are comparatively less educated and less interested to the outer world. So they have less expectations and hence high level of trust.

Previous studies about citizen's trust in local government carried by Bhakta (2010) in Nepal yielded the evidence to support the assertion that the female has a higher level of trust in local government compared to males. But the findings of this study do not support the assumption that female put higher trust than male. These two contradictory results showed that trust is situational.

Age

Another identity variable under consideration to test the level of interpersonal trust in doctors was age of the patients. The level of trust might differ based on the age of the people because their needs, wants and expectations also differ. If we see the above table then we can observe that the level of trust has decreases as the age of respondent has increased. Again here this result falsified the assumption that "the more the age of the people, the higher the level of trust".

Previous studies about citizen's trust in local government carried by Bhakta (2010) in Nepal yielded the evidence to support the assertion that "the more the age of the people, the higher the level of trust on local government. Others studies have reported that higher trust levels were found among older (Balkrishnan et al, 2003, Anderson, 1990, Freburger et al, 2003; Mainous et al, 2001, Tarrant et al, 2003; Kraetscher et al, in press). But the findings of this study do not support this assumption.

Reasons behind this might be young people are more immune than old one and they might get well faster than that of old aged one. So soon recovery of disease might lead to higher satisfaction. As we know satisfaction is positively related to high trust.

Length of stay at hospital

Another independent variable considered in this study was the length of stay at hospital of the respondent. The reason behind taking this into consideration as a factor for the analysis of

trust level is that patient with longer length of stay at hospital might get more chance to communicate with their doctor which might help to build the bonding between them.

Above table showed that, out of 50 respondents, 25 respondents have admitted for less than 5 days. Among them, 64 percent showed higher level of trust in their doctor. Other 19 respondent have admitted longer than 5 days and less than 8 days and among them, 71 percent showed lower level of trust. Only 6 respondents have admitted longer than 7 days and among these also, majority showed lower level of trust. The correlation analysis of these two variables indicates that the relationship between length of patient stay at hospital and inpatients trust is highly significant at significant level 0.005. Form this finding we can analyze that there is strong and significant association between length of stay at hospital and level of interpersonal trust.

Department of hospital

The fourth identity variable was the department of hospital where respondent were admitted. In this study two department were chosen for the study; medicine department and surgery department. The assumption was set as the level of trust is higher among the patient admitted in surgery department. The reason behind taking this into consideration was that the patient admitted in surgery department are more prone to vulnerable situation than that of patient admitted in medicine ward.

Above table showed that among 50 respondents, 25 were from medicine department and 25 from surgery department. Above table showed, among 25 respondents from surgery department, 64 percent had higher level of trust whereas 14 percent had low trust. Similarly among 25 respondents from medicine department, 36 had higher level of trust whereas 86 percent had low trust level. From this result we can analyze that level of trust differ according to department of hospital.

It's clear from the table that trust is higher among patient admitted in surgery than in medicine department. This might be because of the nature of their disease. Surgery patients have definitive treatment towards their diagnosis and most of them get cured and discharged timely. Hence the trust also increases towards their treating surgeon. But the scenario is

different with patient with medical problems. It's difficult to get to the diagnosis and had to go different level of investigations during their hospital stay. This creates a dilemma in their mind. Because of this dilemma, patients from medical ward might have low trust.

Statistically also chi square test also showed significant difference between these two variables with Pearson Chi-square value 9.921 at the significant level 0.002. This test and finding gives us strong evidence to conclude that the relationship between the two variables is significant.

Education

Educational attainment of the respondents was another identity variable. The level of trust might differ based on the level of education a respondent completed. The rationale behind considering educational background of people in analyzing the level of trust was that education matters in many ways in determining the level of trust. Education can change the way of perception so it was considered as an independent variable. Previous studies have reported that higher trust levels were found among less educated patients (Balkrishnan et al, 2003, Anderson, 1990, Freburger et al, 2003; Mainous et al, 2001, Tarrant et al, 2003; Kraetscher et al, in press). But the findings of this study did not support this assumption.

People with low education might have no knowledge regarding the duties and function of doctors. They might get confused of actual consultant who is treating them with other paramedics of the same hospital who assist their consultant. Because of their little knowledge, they will listen to outsider and might have lots of complain. If we see the people with low education background, they are especially from low economic background. People with low economic background don't want to get admitted in hospital, and they want to get treated with drugs only as soon as possible. Because of their little knowledge about the method of treatment, they have more complains than satisfaction with the medication.

On the other hand, more educated people may have knowledge about the roles and responsibilities of the doctors and they are aware of their duties. Further they can analyze the performance of the hospital and duty of doctors critically. They are aware of their consultant and other paramedics. Also they are aware of the competence of the doctor so they don't

have complained regarding their doctor though they may have complained towards the services of hospital.

The above table illustrates that, out of 50 respondents, 20 were undergraduates and 5 were at master level. Among these educated respondent majority has higher trust where as 18 respondents were under SLC and 7 were illiterate. Among these less educated respondents, majority showed low trust in their doctors. This bivariate analysis of trust and education shows that more educated people have high trust and less educated people have low trust. From this result we can make an inference that trust and education are positively related.

Approaches

The sixth identity variable under consideration to test the level of trust was approaches to hospital of the respondents. The above table illustrates that among total respondents, 35 were self addressed and 15 were referred. Among self addressed respondent, majority showed the higher level of trust where as among referred, majority showed low trust.

The positive trust level is seen in self addressed patients. This might be because of their blind positive trust towards their doctor or hospital but sometimes they don't meet their expectations so few showed low level of trust. Referred patient carried medium level of trust because they might have thought they were referred to higher centre with better health facilities. This thought might create higher expectation and if referred patient felt uncomfortable with the facilities then in that case, low level of trust does exist.

Patient's Responsiveness

In this study, patient responsiveness has been operationalized as the response of the patient based on the impression created to the patients depending upon how they are welcomed at the hospital.

The underlying assumption made here was that trust level differs with the impression created to the patients depending upon how they were welcomed at the hospital and how smoothly they went through the hospital process. It can differ in between patients too with same care and facilities. This independent variable was supported with five more questions which

indirectly showed patients responsiveness. The following section will deal with the individual result of each question followed by cross tabulation of patient responsiveness and trust level.

Table 4: Cross Tabulation of Patients' Responsiveness and Trust Level

Patient's Responsiveness	Trust		Total	Chi square test	
	Low	High		Value	Sig Level
Negative	64%	25%	36%		
Positive	36%	75%	64%	6.752	.009
Total	100.0%	100.0%	100.0%		

Source: Field study, 2015

(Q. Why you choose Bir Hospital for treatment? How quick your concern doctor examined you? How you find the admission procedure? How long you have to wait for bed? How you found doctor services in the hospital?)

The trust level of the patients differs with the impression created in their mind with the name and fame of the hospital and doctors working there. The patient coming with good hospital reputation and impression of good experienced doctor had high level of trust. This is very true because doctors may be good to the patients but government hospital facilities may not be up to the expectations. Most of the government hospitals are running with poor and disorganized facilities. The poor patient with blind trust towards hospital and doctor showed high to low level of trust. They think they can't afford private hospital costs and they get low level of care from their doctor because they belong to low socio-economic group. This may not be the actual scenario. Hence they could not develop high level of trust on their doctor.

How fast your doctor examines you after you reach the hospital plays major determining factor in developing future trust on them because it is the phase of pain and uncertainty and its cumbersome to keep waiting them. It's clear from the table that those patients who were

seen immediately after they reached the hospital had high level of trust as compared to those who have to wait for a day. Surprisingly, those who have to wait for full day also had some level of trust, may be they knew the reasons for late like busy hospital or doctors or they got good care later on during their hospital stay. The patient who had to wait for a day had mostly low level of trust, might be because they were frustrated with the services and care. Hence it's very important to see the patient as soon as possible to develop a good rapport between patient and doctor.

Though the study showed varied level of trust among both the groups but those patients who found the admission procedures to be comfortable to them had more level of positive trust as compared to those who found it to be complex. The admission procedures should always be patient friendly and comfortable to the patient. Though record keeping is as important, it must be less and easy going as much as possible because both the patient and patient attendants are in stress at that moments. Hence this patient response can be improved by the hospital administration to improve the level of trust among them.

The respondents, who got the bed immediately in their respective wards, after admission was decided, showed high level of positive trust. Those who have to wait for long hours to a day for the bed in the ward showed the low level of trust. The availability of bed in the government hospital is always in scare and getting bed immediately or sooner takes away the tension and hence increases the trust development.

From the table 4 above, it is clear that those patients who thought that doctors are punctual and patient oriented mostly have high level of trust. Positive thought leads to positive trust. The government hospital are always in rush with patients hence the number of doctor always get less there. Patient who have negative impression of doctors coming late for work, mostly showed low level of trust. Sometimes, hospital environment are so cumbersome and disorganized to work that it delays the routine daily work which can hamper patient level of satisfaction and hence the trust also decreases. Hence the hospital working environment should both patient and doctor friendly.

When chi-square test was applied to this bivariate analysis, result of the test showed that the relationship is significant at the level of 0.009. Thus the relationship between patient's responsiveness and inpatient's trust level is statistically significant.

4.3 Analysis of factors of Perceived Trustworthiness

This section explains how the cues of trustworthiness; ability/competence, compassionate care and communication skill possess by doctors affect the inpatient trust level. Though there might be many other factors of perceived trustworthiness that might affect inpatients' level of trust, this study has considered only three variables which are analyzed in detail as following.

4.3.1 Competence of the Doctor

This is an attempt to examine whether the competence perceived by admitted patient influences their level of trust or not. Here the competence of the doctor refers to patient perception on doctors' competence of proper diagnosing, treating and curing. The underlying assumption was that patient put blind faith towards more able or competent doctor if they perceive that he/she is competent or able to treat them. In this study, patients' perception of doctors' ability has been assessed through five questions.

Table 5: Cross Tabulation of doctor's Competence and Trust Level

Ability/ Competence	Trust		Total	Chi square test	
	Low	High		Value	Sig Level
Absence	93%	3%	28%		
Presence	7%	97%	72%	40.571	0.000
Total	100.0%	100.0%	100.0%		

Source: Field study, 2015

(Q. Are you aware of your disease? Who is treating you? Do you think your doctor correctly diagnosed your disease? How well are you recovering with the treatment? Are you satisfied with the management and advice of your doctor?)

Above table 5 shows the relation between patient's perception of doctor's Competence and trust. Above tabular result shows that out of 50 respondents, 42 respondents perceived that they were aware of their disease. But the positive level of trust was equals among aware and unaware respondent though level of low trust was higher among unaware respondents. Similarly, 86% of respondents perceive that they knew who is treating those and showed positive trust than that of those who don't know.

Regarding correct diagnosis of disease, out of 50 respondent, 64% perceived that their doctor correctly diagnose their disease and showed higher degree of positive trust (97%) whereas those respondent who perceived that their doctor had not correctly diagnose their disease showed low trust (86%). In a similar way, 78% of respondents perceived that they are recovering excellently with the treatment and showed 100% positive trust. It means the level of inpatient trust is highly influenced by the perception of the patient about how fast they are recovering.

Among 50 respondents, 74% perceived that they are satisfied with the management and advice of their doctor and showed 100% positive trust. It means the satisfaction level of the patient with their doctor's advice is positively related to trust.

Thus the finding shows that, majority of patients put higher level of trust because they perceived that the doctors were competent enough to diagnose and treat their disease. But still those who perceived that their doctors are not enough competent shows higher level of low trust and lower level of high trust. It means competence of the doctor's is the contributing factor of trustees trustworthiness that helps to built trust in trustor but not the sole determining factor of inpatients trust. Chi-square test also provides value 40.571 with p value 0.000. This test provides strong evidences to conclude that the relationship between patients' perception of doctors' competence and inpatients' trust is statistically significant.

4.3.2 Compassionate care

Here in this study compassionate care refers to patient perception that doctor is sympathetic, caring and reassuring that the patient feels comfort. Here the underlying assumption was that when doctor shows caring behavior then patients feel pampered and comfort, this comfort feeling lead to built interpersonal trust between patient and doctors. Here the compassionate care of doctors has been assessed through patient's perception regarding doctor's behavior, care, and time given by doctors during rounds. Following table present the relationship between result of patient's perception on compassionate care and trust level.

Table 6: Cross Tabulation of doctor's Compassionate Care and Trust Level

Compassionate Care	Trust		Total	Chi square test	
	Low	High		Value	Sig Level
Absence	93%	14%	36%		
Presence	7%	86%	64%	27.282	0.000
Total	100.0%	100.0%	100.0%		

Source: Field Study, 2015

(Q. How you found your doctor behavior during your hospital stay? Did the doctor showed sympathy and care? Does your doctor give you enough time during rounds (listen to you and allowed you to talk)? What is your assessment about doctor in treating you?)

Above table 6 shows the result of patient's perception regarding doctor's compassionate care and it relationship with trust level. Above table illustrate that out of 50 respondents, 37 respondents found their doctors behavior excellent and rest of other respondents found poor. High level of positive trust was present among the respondents who found their doctor's behavior excellent and majority of respondents who perceive that their doctor's behavior was poor during their stay showed low level of trust. It means doctors 'behavior is positively related to inpatient's trust level.

Similarly 38 respondents perceive that their doctors were sympathetic and caring and among them, 94% showed high level of positive trust. 86% of respondents showed low trust after they perceive that their doctors' behavior is poor. In a same way, 35 respondents perceive that often their doctors give enough time to them during round. Also they perceive that doctors allowed them to talk freely and listen to while rest of others feel just opposite. When we see their level of trust, it is seen that majority (89%) of respondents who perceive positive showed high level of positive trust and vice versa.

Finally to assess the compassionate care, question regarding patients' assessment about doctor's treatment was asked. Among 50 respondents, 28 perceived kind towards them whereas 22 perceived unwelcoming. All the respondents who perceived kind showed high level of positive trust and no low trust at all. But those who perceived unwelcoming treatment of doctors toward them showed 100% low trust. From this relationship, it is clear that the inpatient's trust level is positively related to above mention patient's perception.

Bivariate analysis of compassionate care and trust showed that high level of trust was present among them who perceive positive feelings. And majority of respondents who did not perceive compassionate care of doctors towards them showed high percentage of low trust. From this result it is clear that there is positive relationship between compassionate care and trust. Chi-square test also provides value 27.282 with p value 0.000. This test provides strong evidences to conclude that the relationship between patients' perception of doctors' compassionate care and inpatients' trust is statistically significant.

4.3.3   Communication skill

Here in this study, communication skill of the doctor refers to patient perception that doctors convey message clearly and simply, doctors encourage patient to involve in decision making. Here the underlying assumption is that when doctor explain clearly about disease using simple language to patients and involve patient in decision making then patient feels comfort and intimate. This comfort feeling lead to built interpersonal trust between patient and doctors. Here the communication skill of doctors has been assessed through patient's perception regarding doctor's way of communicating with patient, way of using simple language and way of involving patient in decision making. Following table present the

relationship between result of patient's perception on doctor's communication skill and trust level.

Table 7: Cross Tabulation of doctor's Communication skill and Trust Level

Communication Skill	Trust		Total	Chi square test	
	Low	High		Value	Sig Level
No	100.0%	33%	52%		
Yes	0.0%	67%	48%	17.949	0.000
Total	100.0%	100.0%	100.0%		

Source: Field study, 2015

(Q. Did the doctor greet you and gave a friendly look? Does your doctor explain you clearly about your disease? Does your doctor ask your opinion on decision making? Do you feel comfortable asking your quarries to your doctor?)

Above table 7 shows the relationship between patient's perception of doctor's communication skill and inpatient's level of trust. Question regarding did doctor's greet and gave friendly look to their patient or not, out of 50 respondents, 18 perceived yes and 22 perceived no, the level of high trust was equal among both respondents. Only those respondents who perceive that their doctor did not greet them and gave friendly look showed 100% low trust. It means unfriendly behavior lead to low level of trust in patients.

Similarly when patients were asked about does their doctors explains clearly about diseases then 27 respondents perceive yes and 23 perceive no. When trust level were checked among these two respondents who perceive yes and no, majority of yes perceiving respondents showed high trust where as 100% of those respondent who perceive that their doctor did not explain clearly about their disease showed low trust.

When questions regarding inclusion of patient's opinion in decision making by their doctors were asked with respondents, majority of respondents (36) replied no. Rest of others only

perceives that their doctors ask their opinion in decision making. When level of trust was cross tab with this finding, it is found that 100% of respondents who perceive that their doctors did not ask their opinion in decision making shows low trust though few of them have shown positive trust too. It means if doctors do not involve patient in decision making then definitely it will lead to decrease of trust level.

In a same way, when respondents were asked how they feel, either comfortable or uncomfortable, asking quarries. Result was 50-50. Half of the respondents feel comfortable and half of others feel uncomfortable. When the result was cross tabulated with level of trust, then majority of respondents who feel comfortable shows high trust whereas majority of respondents who feel uncomfortable shows low level of trust. It means, from this figure we can make an interpretation that inpatients trust level is positively related to their perception regarding doctors communication skill.

Doctor thought that they explain well to their patient about the disease and its progress but only minority of patients thinks so. Many patients thought that their doctor give instruction to nursing staffs rather than explaining them. About 70-80% of doctors thought that they have given enough time to their patients to talk freely and ask their quarries and consider patient's opinion regarding their disease during rounds. Half of patients also had similar view and rest of the half thinks that their doctors have no time and they are in hurry.

After analyzing individual patient's perception regarding doctors' communication skill, above table shows to what extent communication skill affect the inpatient's trust level. Result showed that communication skill is the determinant of inpatient trust. Chi-square test also provides value 17.949 with p value 0.000. This test provides strong evidences to conclude that the relationship between patients' perception of doctors' competence and inpatients' trust is statistically significant. Here result showed that poor communication skill is factor of distrust. It is very important that doctors explain clearly to their patient during rounds to develop a good trust in between them. As many research has also shown that trust is built better in the presence of clear interpersonal communication.

4.4 Conclusion

The analysis of dependent and independent variables shows that higher percentage of respondents had positive level of inpatient's trust. Both patient and doctors were satisfied with treatment. In spite of this also, some patients had low trust towards their doctors. Bivariate analysis of dependent and independent variables showed that the age, gender, education and the approaches to hospital has no any significant relationship with dependent variable, I.e. inpatients' trust. Previous study of trust in local governance carried by Bhakta (2010) has shown the significant relationship of age, gender and education of respondent with trust. But this study has falsified this assumption. In this support, Mark Hall et al (2001) has mentioned that except age, the demographic factors of patients have no relation with trust at all. Similarly the bivariate analysis of factors of perceived trustworthiness and inpatients trust showed significant relationship. It means the trust level of trustor is determined by the characteristics of trustor.

CHAPTER 5

SUMMARY AND CONCLUSION

This concluding chapter is mainly devoted to summaries of the study. First, a recap of main issues of this study is highlighted. Second, an overview of the results is presented. It also underlines which are most influential factors in determining the trust level. Suggestions for future areas of study are also outlined.

This study is mainly built on two issues: to uncover the level of inpatient trust and to identify the determining factors that affects the inpatients' trust towards doctor. To emphasize these issues, inpatient's trust is taken as the dependent variable and independent variables consists of identity variables (age, gender, education, length of stay at hospital, department of hospital, approaches to hospital and patients' responsiveness) and factors of perceived trustworthiness (competence, compassionate care, communication skill). For this study, individual patients are examined through identity variables and doctors are examined through factors of trustworthiness. Empirical studies conducted on doctor patient interface, in relation to inpatients' trust is deficient in Nepal. In this sense, the present research initiative marks a milestone in the analysis of inpatients' trust in health system.

The recognition of the importance of trust in health care context has particular relevance for patient to mediate therapeutic processes as higher levels of trust is associated with acceptance of recommended treatment and adherence to it. The theoretical aspect of this study concentrates on An Integrative Model of Organizational Trust proposed by Roger C. Mayer et al. (2006). The study was carried out through mixed methods approach. It has tried to analyze the relationship between the level of inpatients' trust and identity variables of the admitted patient, and factors of perceived trustworthiness of doctors. The data were collected through close-ended questionnaire survey, interview and non-participatory observation. Besides, secondary resources were utilized to review the literature and to ensure reliability and validity. The data were presented both through tabulation and description.

5.1 <u>Level of Inpatients' Trust</u>

Trust is the most important factor in the management of the disease of the patient. It is the factor which increases adherence to treatment and the likeliness of getting well soon. Results from the questionnaire survey shows that more than half of the respondents had a positive reaction regarding trust on their doctors. They were satisfied with the care, the consultation, and the allocated time by the doctors and the attention they received. Majority of respondents felt assured that their doctor treats them well and they will come back to the doctor for follow up and if needed, they will recommend others patient to see the same doctors also. There is no doubt about the doctor ability and competence among the health seekers. Our patients treat doctor as god. They have the positive trust towards their treating doctor. Researcher also gathered the same information here, where most patients believed they were treated by the experienced and specialized doctor and would get better soon with treatment. The in-patients were happy to see the good behavior of their doctor during rounds and found almost equal level of sympathy and care. Though, patient assessed their doctor differently as kind, professional, friendly, unwelcoming and hurried, doctor found their patient respecting and showing good behavior towards them. This was the natural response of the patient with the positive trust towards doctor. Doctors also thought that their patients were satisfied with the treatment. So, researcher found same level of positive trust in patient toward their doctors. But important things to note here is that 28% of respondent still had low level inpatients' trust. Many factors like patient education, doctors' behavior, language, etc play role here. Overall, study shows the presence of good positive level of trust in most of the in-patients. Many patient thought doctor's competence, his care and good behavior were collectively reason for their trust.

5.2 Identity variables of the Patients affecting Inpatient's trust and their relationship

The present study has considered age, gender, education, and length of stay at hospital, department of hospital, and approaches of hospital as the identity variables of the patient influencing the inpatient's trust.

Gender: This study has falsified the assumption that female put higher trust than male. It means in the context of hospital, male and female are treated equally thus both genders carry same level of trust.

Age: In the case of age also, this study did not support the assumption that older people carry higher level of trust. As this study was carried among admitted patient and what researcher has concluded is, younger patient are physically immune and get well sooner than that of old aged one. This sooner recovery might have lead to built higher trust among young patient than old one.

Length of stay at hospital: The assumption for this independent variable was that lesser the days of hospital stay, higher the levels of inpatients trust. The result showed that 25 respondents had 4 days hospital stay and remaining stayed more than that. Level of inpatients trust found high among those who had less of hospital stay and low level of trust found among those who had stayed more than 4 days. It was also proved by Chi-square test showing the difference between the two groups significant at level of 0.005. Thus the proposed assumption has accepted.

Department of hospital: Findings of research showed that the level of inpatients trust was high among respondent admitted in surgery department. Chi-square test also showed the difference between two groups with value 9.921 significance at the level 0.002. This test also proved that the relationship between department of hospital and inpatients trust is highly significant.

Education: Study showed that level of inpatients trust was higher among those whose education level was high but chi- square test showed that the relationship is not statistically significant.

Approaches to hospital: Result of the study showed that level of low and high trust was higher among self addressed patient. Even chi-square test also showed no significant difference. It means there is no relationship between patients approaches to hospital and inpatients' level of trust.

Patient's responsiveness: The underlying assumption made here was that the inpatients' trust level differs with the impression created to the patients depending upon how they were welcomed at the hospital and how smoothly they went through the hospital process. Findings of the study showed that trust level of the admitted patients differs with the impression created in their mind with the name and fame of the hospital and doctors working there.

Result of Chi-square test applied to this bivariate analysis showed that the relationship is significant at the level of 0.009. Thus, this test yielded evidence to support the assertion that the inpatient's trust level increases with the positive patient responsiveness.

5.3   Relationship between factors of Perceived Trustworthiness and Inpatients' Trust

The present study has considered competence, compassionate care and communication skill of the doctors as the factor of trustworthiness, influencing the level of inpatients trust, possessed by doctor and perceived by patient.

Competence: Here the competence of the doctor refers to patient perception on doctors' competence of proper diagnosing, treating and curing. The underlying assumption was that patient put blind faith towards more able or competent doctor if they perceive that he/she is competent or able to treat them. In this study, patients' perception of doctors' ability has been assessed through five questions.

Result showed that level of inpatients' trust was higher among those who perceived that their doctors are competent. Chi-square test also provides value 40.571 with p value 0.000. This test provides strong evidences to conclude that the relationship between patients' perception of doctors' competence and inpatients' trust is statistically significant.

Compassionate care: In this study compassionate care refers to patient perception that doctor is sympathetic, caring and reassuring that the patient feels comfort. Here the underlying assumption was that when doctor shows caring behavior then patients feel pampered and comfort, this comfort feeling lead to built interpersonal trust between patient and doctors. Here the compassionate care of doctors has been assessed through patient's perception regarding doctor's behavior, care, and time given by doctors during rounds.

Result showed that level of inpatients' trust was higher among those who perceive that their doctors are compassionate towards them. Chi-square test also provides value 27.282 with p value 0.000. This test provides strong evidences to conclude that the relationship between patients' perception of doctors' compassionate care and inpatients' trust is statistically significant.

Communication skill: Here in this study, communication skill of the doctor refers to patient perception that doctors convey message clearly and simply, doctors encourage patient to involve in decision making. Here the underlying assumption was that when doctor explain clearly about disease using simple language to patients and involve patient in decision making then patient feels comfort and intimate. This comfort feeling lead to built interpersonal trust between patient and doctors. Here the communication skill of doctors has been assessed through patient's perception regarding doctor's way of communicating with patient, way of using simple language and way of involving patient in decision making.

Result showed that majority of respondents perceived that their doctors have poor communication skill and showed lower inpatient trust. But level of inpatients trust was high among those respondents who perceive that their doctors have good communication skill. Chi-square test also provides value 17.949 with p value 0.000. This test provides strong evidences to conclude that the relationship between patients' perception of doctors' communication skill and inpatients' trust is statistically significant.

5.4 Implications for Future Research

This research was conducted with limited scope, time and resources. This endeavor is only for fulfilling the researcher's academic requirement. In this research inpatient's level of trust towards their doctors and factors determining that inpatients' level of trust has been assessed against only two independent variables; identity variables of the admitted patients and factors of perceived trustworthiness with regard to doctors' competence, compassionate care and communication skill. Not only the doctor but also the other hospital departments and services do play the vital role in affecting the trust of that in-patient. This research could not address the nursing services, patients from OPD, administrative services and hospital administrative culture. For that the future researchers can explore the relationship of those variables in

assessing and identifying the factors determining the trust level of citizen's towards government hospital. There is a need for further empirical research. As Boucka et al. (2002) notes, trust is never absolute; it is always conditional and contextual.

5.5 Conclusion:

Trust is the most important factor in the management of the disease of the patient. It is the factor which increases the likeliness of getting well soon. Trust bring the faith in treating doctor, to clearly describe his disease and expect to get excellent care and treatment by the patient. In other hand, if doctor gain trust of his patient, can satisfy them easily with his treatment plan. This study has explored the main factors that have been affecting the level of inpatients' trust.

Result has showed that the age, gender and education of the patients has no relationship with their trust level. Length of stay at hospital, department of hospital where the respondents were admitted play role in determining the inpatients' trust level. Similarly the perception of patient regarding doctors' competence, compassionate care and communication skill were also found to be significant determining factors of inpatients trust level. Hence trust can't be measured in one scale. There are many factors affecting them. It is very difficult to gain 100% trust with doctor's care and treatment but number of other hospital facilities do play role. It should try to overcome the lagging corners so the trust level increases.

> *It is interesting to note that a speaker's ethos is based on the listener's perception of three things: intelligence; character (reliability, honesty); and goodwill (favorable intentions toward the listener). - Aristotle*

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ANNEXURE

Annex: 1

Questionnaire for admitted patients

Thesis title; In-patients' Trust in Government Hospital: A study at Bir Hospital, Nepal

Disclaimer: *The data gathered through this questionnaire would be used exclusively for the purpose of research only. Your name is strictly optional and information you have provided will not used in other than the research purpose.*

Informed Consent *of patient:*   **Yes / No**

Section A: Patient's Characteristics

Q.N.	Questions	Options	Coding	Remark
A1.	Name of the patient			
A2.	Age of the patient	_____ Years		
A3.	Sex of the patient	a) Male b) Female c) Third Gender	3 2 1	
A4.	Literacy	a) Master b) Undergraduate c) Under SLC d) Illiterate	4 3 2 1	
A5.	Approach to the hospital	a) Referred b) Self addressed	2 1	
A6.	Length of the hospital stay	_____ Days		
A7.	Department of hospital			

Section B: Patient's Responsiveness

Q.N.	Questions	Options	Coding	Remark
B1.	Why you choose Bir Hospital for treatment?	a) Hospital reputation b) Doctors are good and experience c) Cheap d) All of the above	4 3 2 1	
B2.	How quick your concern doctor examined you?	a) Immediately b) 2-4 hours c) Half a day d) Full day	4 3 2 1	
B3.	How you find the admission procedure?	a) Comfortable b) Complex	2 1	
B4.	How long you have to wait for bed?	a) Immediately b) Few hours c) Same day d) More than a day	4 3 2 1	
B5.	How you found doctor services in the hospital?	a) They are punctual and patient oriented b) Number of doctors on duty are less compared to patients c) Doctors usually come late for work d) Disorganized hospital environment delays the doctor services	4 3 2 1	

Section C: Ability/ Competence

Q.N.	Questions	Options	Coding	Remark
C1.	Are you aware of your disease?	a) Very well known b) Have some information c) After doctor diagnosis d) I don't know	4 3 2 1	
C2.	Who is treating you?	a) Consultant Physician b) Resident Doctor c) Medical Officer d) I don't know	4 3 2 1	
C3.	Do you think your doctor correctly diagnosed your disease?	a) Yes, I think b) May be c) Not sure d) I don't know	4 3 2 1	

Q.N.	Questions	Options	Coding	Remark
C4.	How well are you recovering with the treatment?	a) Excellent b) Better than admission c) No recovery d) Deteriorating	4 3 2 1	
C5.	Are you satisfied with the management and advice of your doctor?	a) Very much b) Somewhat c) Unsatisfied d) Want to see other doctor	4 3 2 1	

Section D: Compassionate Care

Q.N.	Questions	Options	Coding	Remark
D1.	How you found your doctor behaviour during your hospital stay?	a) Excellent b) Good c) Poor d) Bad	4 3 2 1	
D2.	Did the doctor showed sympathy and care?	a) Yes b) Not exactly c) Not at all d) I did not notice	4 3 2 1	
D3.	Does your doctor give you enough time during rounds (listen to you and allowed you to talk)?	a) Often b) Sometimes c) Not at all d) He is always in hurry	4 3 2 1	
D4.	What is your assessment about doctor in treating you?	a) Kind and Professional b) Friendly c) Unwelcoming d) Professional but hurried	4 3 2 1	

Section E: Communication Skill

Q.N.	Questions	Options	Coding	Remark
E1.	Did the doctor greet you and gave a friendly look?	a) Yes b) No c) I did not notice	3 2 1	
E2.	Does your doctor explain you clearly about your disease?	a) He clearly explains me b) He does not convey full information c) He does not explain at all d) He examined and left instructing the nurse	4 3 2 1	

Q.N.	Questions	Options	Coding	Remark
E3.	Does your doctor ask your opinion on decision making?	a) Always b) Sometimes c) I always agree to his decision d) Never	4 3 2 1	
E4.	Do you feel comfortable asking your quarries to your doctor?	a) Always b) Sometimes c) I hesitate d) He does not listen	4 3 2 1	

Section F: Trust

Q.N.	Questions	Options	Coding	Remark
F1.	Do you feel assured that you will be treated well by your doctor in this hospital?	a) Yes, I am comfortable because of its reputation b) Not yet assured as there is no signs of improvement c) Feel like going to private hospital for better treatment d) It is early to tell	4 3 2 1	
F2.	What level of trust you have on your doctor?	e) Excellent f) Good g) Poor h) Bad	4 3 2 1	
F3.	What was the reason that you trust your doctor?	a) Competence b) Care and Treatment c) Friendly Behaviour d) All of the above	4 3 2 1	
F4.	Will you come back to your doctor for follow up?	a) Definitely b) Will think c) Never d) I don't know	4 3 2 1	
F5.	Would you like to recommend your doctor to others too?	a) Yes b) No	2 1	

Interviewed by:

Date:

Annex: 2

<u>**Interview Checklist of Doctors**</u>

   Thesis title; In-patients' Trust in Government Hospital: A study at Bir Hospital, Nepal

Disclaimer: *The data gathered through this questionnaire would be used exclusively for the purpose of research only. Your name is strictly optional and information you have provided will not used in other than the research purpose.*

Informed Consent *of doctor:*   **Yes / No**

1   To what extent your patients are satisfied with your treatment and advice?

      _____
      _____
      _____
      _____

2   Do you explain clearly about the disease and its progression to your patient?

a) Usually	4
b) Sometimes	3
c) Never	2
d) They don't understand	1

3   Are you able to give enough time always to your patient during rounds?

      _____
      _____
      _____
      _____

4   Do you feel overworked having too many patients?

a) Yes, usually b) Sometimes c) No, I am comfortable	3 2 1

5   Does your patient feel comfortable talking and asking queries with you?

_____
_____
_____
_____

6   Do you involve patient opinion in decision making?

a) Always	4
b) Sometimes	3
c) They agree to me	2
d) Never	1

7   How do you find your patient behavior towards you?

_____
_____
_____
_____

8   Do your patient follow up to you?

a) Many do	4
b) Only few	3
c) They are lost	2
d) I don't remember	1

9   What level of trust your patient have on you?

_____
_____
_____
_____

10   What do you think the reason of the patients' trust on you?

_____
_____
_____
_____

Doctor's Name: **Signature:**

Designation: **Date:**

Department: