PATIENT CRITERIA IN SELECTION OF DOCTORS: THE CASE OF PRIVATE DOCTOR PRACTITIONERS IN NAIROBI

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DECLARATION

This project is my original work and has not been submitted for a degree in any other university.

Signed.....

Githinji Kiumbura

Date.....15/3/2004.....

This project has been submitted for examination with my approval as the university supervisor.

Signed.....

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Date.....15/3/2004.....

DEDICATION

This study is dedicated to my mother and late father who saw the vision of education and sold it to me when I was young.

To my wife and children for their encouragement.

To my brothers and sisters for moral and material support.

ACKNOWLEDGEMENT

My sincere and special thanks go to God who is my enabler, and my supervisor Catherine Ngahu for her guidance and encouragement.

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ABSTRACT

The study was conducted in the period between August and September 2003. The objective of the study was to find out the criteria used by Nairobi residents in their selection of private doctor service.

Primary data for this study was gathered from 99 respondents selected from five middle-income estates in Nairobi. The respondents were selected through systematic random sampling.

The primary data was collected through a semi-structured questionnaire that contained several aspects that the researcher considered to be influential in the selection of doctors. This comprised of information sources, information types and factors considered in the selection of doctors.

The major findings of the study were as follows:

That; other doctors, other healthcare professionals, family members and friends are the most important sources of information when deciding on the doctor to consult.

The doctor's reputation both among other doctors and own patients, length and type of experience and fees charged are the important types of information that patients seek when evaluating whether the doctor meets their requirements.

The main factors that the patients consider identified by the survey were: Convenience, human touch, credentials, personality associations, keenness or alertness, freshness and peer (other doctors) approval.

The researcher suggested that future research could focus by doctor specialization, differences when selecting a doctor for self or for ones child and qualitative details about the criteria used by patients in the selection of doctors.

CHAPTER ONE
INTRODUCTION

1.1 Background

The power of information and technology, deregulation, globalization of markets and stiff competition (Capron and Hulland, 1999 as quoted by Mbau, 2000) has made consumers more educated, more inquisitive and demanding.

In the year 2002 Gallup Annual Optimism Poll rated Kenya as the most optimistic country among the sampled sixty-eight countries in the world at the time. This was followed by a historical political transition in which a new regime came into power. These are indicators of a consumer population that is spoilt for choice. It is therefore very important for anyone who is competing in this market to demystify his or her customer decision-making criteria.

The current environment has left a lot of choices to customers. Retaining a loyal customer becomes a challenge to the market players. This requires them to understand how customers make decisions. Customer care calls for bringing the voice of customers in-house so that you can design strategies and policies to meet your customer needs (Ngahu 2000).

According to Williams (2001), Our minds, like our bodies, have been shaped by evolution. We have inherited our ways of thinking from our ancestors whose mental tools were adapted for survival. Identifying some key cues quickly and making a good decision quickly is key to survival. In the real world, making a good decision is so much about choosing the best option. A good decision means choosing an option which works – and which lets you move quickly on to whatever you want to do next. (Williams, 2001).

Generally, the way customers chose between various alternatives varies from industry to industry. Consumer decision-making is guided by high order mental constructs such as customer satisfaction, perceived quality, value, trust and commitment (Mbau, 2000).

Consumer undertake more lengthy decision making process when the following conditions apply

i. Product/service price is high
ii. Product/service features are complex/new
iii. There are too many alternatives to choose from

(Churchill and Peter 1994)

In the case of medical services condition (ii) and (iii) apply in most cases, condition (i) applies in the case of major surgeries and diseases that require a rare type of specialist who are normally expensive. Since customers feel safer when they know the origin of a product or service, the institution or locality in which a doctor is trained becomes important.

Doctors' Operating Environment

By the end of year 2002 there were 4506 registered doctors and 746 dentists in Kenya, some of these were in employment while some were in private practice and a few are in both. (Economic Survey, 2002). Generally the population is growing at a faster rate than the growth in the number of doctors. (Economic Survey, 2002).

According to the Health Management Information System Report (MOH, 2002), the main causes of outpatient morbidity were as follows:

Malaria	32%
Diseases of the respiratory system (including pneumonia)	25%
Skin diseases	7%
Diarrhoea	5%
Intestinal worms	5%
Accidents	3%
Urinary tract Infection	2%
Eye infection	2%
Rheumatism	2%
Ear infection	1%
All Others	16%

Doctors operating in Kenya need to be well prepared to tackle patients who are suffering from the above diseases especially malaria and respiratory diseases. Besides there are many needs a patient may be seeking answers to in a doctor patient encounter.

Based on the AAR general practitioners guide (2002) and the authors experience the following outlines the current doctors operating environment and the patient needs:

- The real need is to heal the customers from disease; pain; discomfort; fear; anxiety or weakening. The doctor is a healer in this case.
- Availability at all reasonable times. When a doctor is not available he should arrange for suitable, qualified and competent replacement. (Medical Practitioners and Dentists Board: MPDB Code, 2002) Timing is important because often treatment is sought on urgent basis
- Grooming and etiquette represents the professional and there is a minimum expected standard often a high one.
- Communication skills for effective communication of personal disease and disease management information to the patient
- Interpersonal skills are important given the suspicion between the doctor and patient arising from the knowledge gap between the two. The field is least understood by others outside their profession
- Ambience, the environment where consultation and treatment takes place must represent hygiene standards that go with the profession.
- Access to the doctor is necessary for the practice. Some doctors have clinics in different locations.
- Affordability is a major issue due to the wide range of possible charges for similar or close to similar service. Also patients have a problem predetermining what would be the likely charges to the ailment they may suffer especially if the particular ailment is afflicting them for the first time. Budgeting becomes an issue and often the patient is caught off guard without enough money thus service is usually scaled down to money in pocket adversely affecting disease management and efficiency. The Medical Practitioners and Dentists Board (MPDB) code indicate that doctors should charge a reasonable fee proportionate to the services

rendered. The Board also advises doctors to raise the issue of fees at the earliest opportunity to minimize the risk of nonpayment by patients.

- Patients also look for convenience all under one roof. They dislike a situation where they are sent from one service providers to another because most of them are on tight time schedule, are weak and in pain thus would rather sleep or rest and save the little energy they can harness (NHSS, 1999).
- In some cases patient demands may complicate the treatment process. For example, if a patient has nursed a condition for five years then they become the specialist. Such patients may have preference for some medication and may only go to the doctor for prescription or self medicate.
- Overall, even in good health patients are looking for peace of mind often they are anxious of the possibility of disease and how easily it could harm them or their loved ones. A sudden cost may not be bearable. On this need Health Management Organizations (HMOs) have thrived.
- Selection may not often be based on specialization because doctors have the same qualifications in the eyes of the customer. This may mean that the selection decisions are perception based.
- Fraud – some clients whose medical expenses are paid by a third party may choose to go to a doctor who can 'deal' i.e. pay less but get inflated cash receipt for claiming.
- Price- patients are becoming more savvy consumers. They insist on shopping around for the best care at a competitive price (Bounds 1993). However, the MPDB code forbids the publication of the fee charged by its members. This may amount to advertising to gain advantage over other practitioners, which it disallows.
- Different doctors believe in different ways to handle a condition. E.g. one doctor may inject the patient while another one will prescribe some tablets for the same condition. Patients may also have their preferences. Professional ethics require patients to be presented with treatment options.

Health Marketing in Kenya

For a long time Kenyan government controlled the health care market. Nearly all hospitals were government funded and offered services for free. Nearly all doctors worked for the government institutions. These organizations were product driven given limited competition and lack of choice for patients. Patients were expected to be grateful for services offered and to put up with delays or other inadequacies because of resource shortages.

The market was transformed by the introduction of a cost-sharing program in the health sector in the 1984/88 Development plan. Cost sharing program coincided with the structural adjustment program (IEA, 1998). Since then the quality of health care delivery in the public sector has been on the decline. Patients continue to prefer non-governmental facilities (Deolaika, 1997). There is a tremendous growth of private clinic and upcoming hospitals. Most doctors who work in the government institutions are also practicing privately to increase their income. Therefore doctors are putting more effort to create a loyal customer base.

According to the National Health Sector Strategic Plan (NHSS): 1999-2004, (1999), during the planned period and beyond, the universities that are training doctors in Kenya will face a new challenge. This challenge will be to refocus their efforts towards strengthening the linkages between health manpower development and the health needs of the population. This is as opposed to the previous period where the main focus targeted clinical excellence and science based medicine. The introduction of parallel degree courses will help to increase the number of trained doctors beyond the limits of the government budget.

The Medical Practitioners and Dentist Board is concerned with the survival of its members. For a profession to retain its credibility, it needs to have stability. Lack of customers has been identified as the major cause of business failure (Timmons, 1994). Doctors need to understand their customers to guide strategies that are customer focused.

Health care marketing poses the greatest challenge for the medical practitioners. The product is intangible. Patients have to put faith in the skills of medical profession and take everything on trust. Therefore it is possible for a patient to leave a hospital dissatisfied with the service they have received even if their operation was performed to the very highest technical standards. Others factors include mismatch between customer expectations and actual delivery, the number of service providers in a service encounter, unpredictable demand and derived demand.

The increasing competitive environment necessitates the need for doctors to clearly differentiate their provisions from that available elsewhere in the market. Positioning on service quality is a key marketing strategy in achieving a sustainable competitive advantage (Sargeant, 1999). The way consumers evaluate services differs from the way they evaluate products (Kimonye, 1998).

Parasuraman et al, (1988) developed a multiple-item scale, entitled SERVQUAL for measuring customer perceptions of service quality. The scale has been adapted to suit established industries to include health (Phipps 2000; Health and Cook 2000 and Wels-lips et.al, 1997). It has also been adopted locally to fit other industries including Airlines (Masinde, 1986) and Mobile phones (Mukiri, 2001) among others. Ware et al (1978) identified four service dimensions that affect service quality in a health setting: physician conduct, availability of services, continuity/confidence and efficiency/outcomes of care. Brown and Swartz (1989) identified physician interactions as the most important factor and also added convenience/access to be the fifth service dimension.

The physical environment can also affect customers' perceptions of quality and Lych and Schuler (1990) suggest that hospital patients in particular will evaluate the service quality received, in part by assessing their physical environment. Other studies conducted in the USA (Larsen and Rootman, 1976; Hall and Dornan, 1988; Singh, 1990) concluded that the following factors have a capacity to influence patient evaluation of service quality:

a) Physician's manners,
b) Quality of information,

c) Professional and technical competence of physician,

d) Nature of the patient's medical problems,

e) Demographic background of patient

1.2 Statement of the Problem

Many health care providers are monitoring the perceptions of their patients regarding the quality and delivery of services and their overall satisfaction. They use this feedback to improve the quality of the services provided. A study by Brown and Swartz (1989) on gap analysis of professional service quality found a significant gap between patient's expectations and their experiences with doctor services. This gap affected the patient's level of satisfaction with the services received. Interestingly enough, there was also a significant gap between the experiences reported by patients and the doctor's perceptions of those experiences. The study pointed out the need to identify gaps between patient expectations and provider perceptions in order to improve the health care service encounter.

Some research studies have been conducted outside Kenya to address the question of how consumers select doctors. A study by Crane and Lynch (1988) revealed that "personal referral" was the most important criterion while advertising was the least important. Whitehill and Haefner (1988) in their research found that the most important source of information in selecting a doctor is another doctor (particularly if the patient perceives the illness to be severe), followed by referrals from friends and relatives. Again advertising was the least important source of information used in selecting a doctor and the types of information sought.

A study that compared the importance of factors that consumers use in selecting a doctor for them versus selecting a doctor for their children found that families conduct very limited search in either case (Stewart and Hickson, et al 1988). They tend to rely primarily on word of mouth or personal experience. The patients often focus on factors of "care" rather than "cure" in evaluating a doctor.(Lovdal and Pearson 1989). The term 'care' refers to the doctor's personal manners, interest, attitude, listening behavior and the consumer's personal interaction with the doctor or staff.

How important are these factors in Kenya? Patients in Kenya are faced with a different social, economic, political environment from where these studies were conducted. Therefore, there was need for such a study to confirm whether patients in Kenya use the same factors as identified in other countries or they have other unique factors. Further, the studies were conducted some years ago and there was need to replicate them to check whether the findings are still relevant today. This study was designed to fill this knowledge gap. This proposed study sought to answer the questions: How do patients select their doctors? What are the important factors in choosing a doctor?

1.3 The Research Objectives

The objectives of this study were:

a) To establish how patients select their private doctors
b) To assess the importance of various sources of information in the doctor search
c) To establish the importance of various factors that patients put into consideration in choosing their doctor

1.4 Importance of the study

Research findings have provided important inputs to health care providers who use this information to generate clients and to improve the services they render. Astute hospital administrators have used research findings to develop new and innovative outpatient services to satisfy consumer needs and have helped them fill hospital beds at a time of stiff competition.

The information generated will be useful to practicing doctors, who will be able to understand their customers better thus deliver better service.

The doctors' and dentists' umbrella bodies; Kenya Medical Association (KMA), Kenya Dental Association (KDA) and Medical Practitioners and Dentists Board (MPDB) will find the findings useful while giving guidelines to their members.

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CHAPTER TWO
LITERATURE REVIEW

2.1 Introduction

This chapter is concerned with reviewing what other scholars say about consumer decision making in general and decision making in choosing healthcare service providers.

2.2 Models of Man

Sciffman & Kanuk (1997) noted that several models of man depict consumer decision-making in distinctively different ways. The following are consumer related models of man as explained by Sciffman & Kanuk:

I. Economic man
II. Passive man
III. Cognitive man
IV. Emotional man

Economic man

In the field of theoretical economics, which portrays a world of perfect competition, the consumer often is characterized as an economic man- that is one who makes rational decisions. The model has been criticized by a number of consumer researchers for a number of reasons. Consumers operate in an imperfect world in which they do not maximize their decisions in terms of economic considerations such as price-quantity relationships, marginal utility, or indifference curves. Sciffman & Kanuk (1997) added the consumer is generally unwilling to engage in extensive decision-making and will settle for a satisfactory decision, one that is "good enough". For this reason, the economic model is often rejected as too idealistic and simplistic.

Passive man

This model is quite the opposite of the economic model of man; it depicts the consumer as basically submissive to the self-serving interests and promotional efforts of marketers.

Consumers are perceived as impulsive and irrational purchasers. The principal limitation of the passive model is that it fails to recognize the fact that the consumer plays an equal, if not dominant role in buying situations by seeking information about alternatives and selecting the product that seems to offer the greatest satisfaction. Therefore this simple and single-minded field should be rejected as unrealistic.

Cognitive man

The third model portrays the consumer as a thinking problem solver. Within this framework, consumers are frequently pictured as either receptive to or actively seeking products and services that fulfill needs and satisfy their lives. The cognitive process focuses on processes by which consumers seek and evaluate information about selected brands and retail outlets. Within the context of the cognitive model, consumers may be viewed as information processing systems. Information processing leads to formation of preferences and ultimately purchase intention. Consumers may use preference formation strategy that is other based, in which case they allow another person maybe a trusted friend or an expert to establish preference for them. In contrast with the economic model, the cognitive man model more realistically portrays the consumer as unlikely to even attempt to obtain all available information about every choice. Instead the consumer information seeking efforts are likely to cease when what is perceived as sufficient information about some of the alternatives is obtained- enough information to enable an adequate decision to be made. As this information viewpoint suggests, consumers can develop short cut decisions rules (called heuristics) to ease decision-making process. They might use decision rules to cope with exposure to too much information (information overload).

The cognitive model seems to capture the essence of a well-educated and involved consumer who seek information on which to base consumption decisions.

Emotional man

Although the emotional or impulsive models of man have always been known, practitioners frequently prefer to think of consumers in terms of economic or passive

models. In reality however each of us is likely to associate deep feelings or emotions like joy, fear, love, hope, sexuality, fantasy or even a little 'magic' when it comes to certain purchases or possessions. An example is given where during World War II (1939-1944) some American soldiers attributed protective powers to their Zippo cigarette lighters. Some even credited it to saving their lives. When a consumer makes what is basically an emotional decision, less emphasis is placed on search for information. Instead more emphasis is placed on current mood and feeling 'go for it'. However, this does not mean that the emotional man does not make rational decision, Sciffman & Kanuk, also pointed out that buying anything that provides emotional satisfaction is a perfectly rational consumer decision.

2.3 Conventional models of decision-making

According to Tim Williams - Blue Chip Research (2001) conventional models of decision-making originated in the seventeenth century. He argued that there were two key developments around this time. Firstly religion and philosophy, which were the traditional sources of certainty, were coming under attack, and people now had to accept more readily the uncertainties of life on earth. Secondly, there were developments in the theory of probability that provided new tools with which to evaluate life's uncertainties.

These factors led to the rise of a pragmatic rationality to replace the old certainties and to cope with life's uncertainties. Rationality can be used to reduce uncertainty, using calculations involving probabilities, utilities and payoffs.

This is well illustrated by Pascal's famous wager: is it rational to believe in God? If you believe, the potential payoff is eternal bliss. If you do not believe, the potential payoff is eternal damnation. The size of these potential payoffs would, he argued, clearly outweigh the sacrifice of worldly pleasures as the price to pay. Therefore he concluded that it is rational to believe in God.

This probabilistic rationality has been used to build elegant and sophisticated models for decision analysis, particularly as computer power has dramatically increased in

availability and reduced in cost over recent decades. Two of the best-known approaches used in decision analysis are Expected utility theory and Bayes' theorem.

Fast and frugal heuristics

At the Max Planek Institute for Human Development in Berlin, a multi-disciplinary team has been investigating the concept that evolution has given us a set of mental short-cuts, a series of tools that we use in everyday life to make quick decisions. (Gigerenzer et al, 1999).

These mental short-cuts are termed "fast and frugal heuristics". They enable you make decisions quickly without complex mental processes. They are fast in the sense that they enable you to make quick decisions when time is pressing. They are frugal in the sense that they allow a decision to be taken based on limited information- much less information than is used in traditional models of decision-making.

According to Williams (2001), Our minds, like our bodies, have been shaped by evolution. We have inherited our ways of thinking from our ancestors whose mental tools were adapted for survival. Faced by a strange creature suddenly appearing before you, you have to make a quick decision on whether this is a predator or prey what would you do? Do you attack or flee? Identifying some key cues quickly and making a good decision quickly is key to survival.

In the real world, making a good decision is so much about choosing the best option. A good decision means choosing an option which works – and which lets you move quickly on to whatever you want to do next. We have a range of fast and frugal heuristics in our mental toolbox. Each of them has developed to solve a particular type of problem under certain circumstances. There is no universal " one size fits all" heuristic. We use different types of situations and decisions.

Basic Heuristics

The basic heuristics include: 'recognition, minimalist, take the last and take the best. (Williams, 2001). Following is a discussion of each of these heuristics.

Recognition

The simplest heuristics is the recognition heuristics. If you have to choose between options, one of which you recognize and the other not, then you probably select the one that you recognize. This is a very basic heuristic that underpins the whole concept of branding, but it applies in many situations. There is a clear benefit in choosing the familiar, the safe choice, rather than the unknown option.

In most situations recognition alone is not enough to enable you to make a choice but in unfamiliar situations with limited options it is a very effective strategy. For example categories that are bought infrequently, or where there are few brands available, or where there are few heavy advertised brands, or where you are buying in an unfamiliar environment.

Minimalist

This heuristic is very basic, one level up from recognition

It applies in situations where there are a number of criteria that you could use to make a decision between the options available but you have no strong view of their relative importance. You start with the recognition heuristic. If recognition differentiates between the options, then you decide on that basis. If recognition does not enable you to choose, then you select a criterion at random if that discriminates, and you select on that basis. If it does not discriminate, then you select another criterion and see if that enables you to choose, you continue until you take a decision at random if needed. This may sound a really basic approach. But consumers do not have the same level of interest and involvement in their categories as brand managers (who usually take it quite personally when they come across such a disinterested attitude towards their category). This strategy is used in categories where consumers lack involvement, are confused about the differences between alternatives or do not know much about the criteria. Often the

decision is found frustrating and there is evident irritation with the choice process when they try to explain it.

Take the last

"Take the last" is similar to the minimalist in that it applies in a situation where the consumer does not have clear view on the relevance of the criterion that could be used to make a decision. But rather than selecting criteria on a random basis, the consumer looks for a past similar looking situation and applies the criteria that were used to make the choice in that past situation. There are parallels to the search and reapply philosophy in management. Again this applies mainly to categories where there is low involvement and a lack of clear choice criteria in consumers mind.

Take the best

Take the best differs from the above heuristics in that consumers have views on the relevance of the criteria which differentiate between options and what is most important to look for when choosing between options. The consumer will assess the options in order of perceived importance of criteria, until a criterion is reached which differentiates between the options and identifies the one to choose.

2.4 Factors considered by patients when selecting doctors

The following factors were used in a research to assess the patient doctor selection criteria (Stewart et al, 1989):

- Doctors formal qualification
- Length of time doctor has practiced
- Doctor has recently completed residency
- Recommended by another doctor
- Recommended by a friend
- Doctor has sense of humor
- Doctor does not appear in a hurry
- Doctor is a good listener
- Doctor has warm personality
- Doctor can treat whole family
- Doctor has evening and Sunday official hours
- Doctor will prescribe medicine without an office visit

- Could get an appointment quickly
- Practice was convenient to home and work
- Practice has a short waiting time
- Doctor returns calls quickly
- Doctor has low fees schedule
- Does not request payment on day of service/treats on credit
- The practice has more than one doctor
- Doctor is willing to go to emergency room
- Doctor willing to talk about adult stress
- Doctor is female
- Neat, attractive office
- Doctor is male
- Doctor's office has an X ray machine
- Doctor provides information on health promotion (ways to avoid illness, promote physical well-being)
- Doctor willing to discuss a treatment alternatives
- Doctors promotes periodic check ups
- Doctor tries to avoid hospitalization
- Doctors tribe (in Kenyan context)

2.5 Levels of decision-making

Not all consumer decision situations receive (or require) the same degree of information search. (Kotler,1999; Sciffman & Kanuk, 1997). On a continuum of effort ranging from very high to very low levels of decision making the Howard-Sheth model identifies three levels of decision-making:

- Extensive problem solving
- Limited problem solving
- Routinized response behavior

Extensive problem solving

When consumers have no established criteria for evaluating a category or have not narrowed the number of alternatives to a manageable sub set. Their decision-making can be classified as extensive problem solving. This level is mainly characterized by a great information need.

Limited Problem Solving

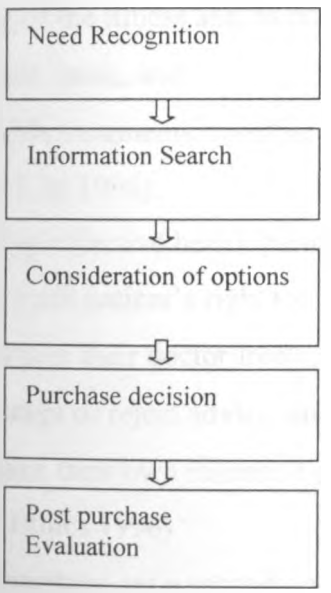
At this level of problem solving, consumers already have established the basic criteria for evaluating the category. However they have not fully established preferences concerning a selected group of alternatives. The search for additional information is more like 'fine tuning' they must gather additional information to discriminate among the available alternatives.

Routinized response behaviour

At this level consumers have experience with the category and a well-established criteria with which to evaluate the alternatives in their evoked sets. In some cases they may go for a small amount of additional information; in others they simply review what they already know.

2.6 Consumer decision-making process

The process of consumer decision-making consists of five stages.



2.7 Patients' Rights- Doctors' Perspectives

Good interpersonal relationships and communication are the pillars of high quality medical care.

The Australian Medical Association (AMA) position on patients' rights regarding various levels of doctor-patient interaction states;

> "Effective communication is essential for the provision of high quality medical care and is the basis for a good working relationship between medical practitioners and their patients"

This statement is also in line with the Kenyan MPDB Code, 2002.

Communication Between a Medical Practitioner And the Patient

Consultations

Practitioners require accurate information from the patient to enable the practitioner to provide appropriate advice and care. Patients can expect to be informed and advised about the:

- Nature of the illness and its possible consequence,
- Probable cause, and
- Available treatments, together with their likely benefits and risks (AMA code of Ethics 1.3c 1996).

As part of an effective health partnership, practitioners recognize patient autonomy by respecting each patient's right to:

- Choose their doctor freely,
- Accept or reject advice, and
- Make their own informed decisions about treatment or procedures (AMA code of Ethics 1996)
- Complain; get a second opinion; get a copy of their records and right to information about the complaint procedure (MPDB Code section 4.5, 2002)

Patient autonomy entails responsibility for the consequences of the patient's decision to follow or reject the advice of the practitioner.

Referrals

Practitioners referring patients for consultations or diagnostic investigations should clearly inform the patient of the reasons why the referral is recommended and the potential consequences of not proceeding. Practitioners should also make reasonable inquiries to ascertain that it is feasible for the patient to attend the recommended referral. Where a doctor has close family relationship with the practitioner they are referring the patient to, doctors should always give an alternative for the patient to choose. (MPDB Code 2.22, 2002)

Follow-up

Practitioners may request patients to return for a consultation which may involve further examination, diagnosis or treatment. Practitioners should clearly inform the patient why the follow-up consultation is recommended and the potential consequences of not proceeding.

Follow-up arrangements, such as the means of contact between the practitioner and patient, should be clarified during the consultation at which follow-up is recommended. (In appropriate cases follow-up consultations need not be in person). Recommendations and agreed arrangements for follow-up should be documented accurately in the medical record.

As part of the health care partnership, patients who reject their practitioner's advice or to contact the practitioner following a referral need to be aware of their responsibility for that decision.

However, if a practitioner is advised of a clinically significant result or diagnosis, the practitioner has an ethical obligation to make reasonable attempts to ensure the patient becomes informed.

Communication Between Medical Practitioners

Practitioners should explain to patients how personal information collected about them will be used and disclosed to others in the treating team and ensure that theirs and the patient's expectations are aligned. (MPDB code of a practice section 2, 2002) Subject to compliance with privacy legislation the referring practitioner should make all clinically relevant patient information available to the other clinician. The other clinician should inform the referring practitioner of the results of the referred consultation whether or not the other clinician assumes continuing care of the patient. Unless the appointment is cancelled by a patient, the referring practitioner should be informed if the patient fails to keep an arranged appointment.

Record Keeping

A practitioner should clearly note in the medical record all requests for investigations and referred consultations, results, any agreed follow-up arrangements and any refusal by a patient to attend a referral or follow-up. When known, non-attendance for a booked appointment should be noted.

2.8 Consumer protection perspectives of patients rights

Patients' right issues are sometimes viewed to be a reserve for the activists. However, they are all about doctors duty to protect life, prevent or reduce suffering and they even apply to animals in veterinary medicine like they apply to humans. (Tannenbaum, 1998)

Choosing a Doctor

Choosing a doctor is a very difficult and important task, because the body is the most valuable asset we have. As in all professionals, there are doctors, between the hands of which, it is hazardous to be, and other doctors who deserve the full confidence of the patients. There are very few relationships as those, which bind a doctor with a patient. To find a qualified doctor worthy of ones confidence requires time and effort. It is worthwhile, since this will result to years of quality life, or even sometimes save life. (Patient Protect, 2003; KCO, 1995). In addition to a great integrity, several factors and qualities must be joined together so that one will be completely satisfied with their

choice. Here are the principle parameters among sixty-six that Patient Protect, a consumer protection body index analyzed.

a) Communication

The patient-doctor relationship should be built on a foundation of communication, trust and mutual respect. The patient is the most important partner in medical care. (Tannenbaum, 1998;) He or she must feel confident. The doctor must listen to the patient, answer their questions and give them comprehensible explanations. This feeling and confidence are the key elements. It is with contact, during the first consultation, that the patient will carve out their opinion. They must feel relaxed with his or her choice of doctor. (MPDB Code section 4.3)

The doctor should welcome questions from the patients. They help him to make a correct diagnosis. The more communication there is between the patient and the doctor, the better the service encounter. The more the patient prepares him/herself, the more effectively they can communicate.

b) Warning (Caveat)

Patients should be wary of the trendy doctors who impose a commercial vocabulary: they do not speak to a patient like he or she is a patient but like customer or consumer. Against wind and tide, one should behave like a patient. It is also important to make the decision on what does not have a price in particular the relationship between doctor and patient, to act in a manner that expresses a free and critical behavior.

c) Availability.

In an emergency, can the doctor be reached with ease? Is it easy to get an appointment? Is it always necessary to wait in his waiting room? He should schedule an adequate time for surgery visit to make a diagnosis and answer questions. It is important to remember that, even with careful scheduling, appointment can back up and one may have to wait. Once a patient is in the examination room, it may take longer than expected if the

diagnosis is more complicated than could be foreseen. Patients are advised to expect the same care and diligence from the doctor when it is their turn.

d) Does he devote the time that he invoices?

Is it easy to obtain a second meeting before an operation or an invasive investigation? Patients are also advised to disapprove haste operation, investigation or hospitalization. This is mainly because except in a vital emergency, a good doctor must always leave a long time for consideration.

e) Word of Mouth

Word of mouth is not enough to certify professional qualities of a doctor.

f) Competences

For how many years has this doctor been practicing? What reputation does he have? Does he also give preventive medical advice? A good doctor is personally concerned with the patients and their health. This is why he should give regular advice on preventive medicine. Did the consultation include anamnesis (personal history) i.e. patient's medical history, a physical examination and done with respect? A doctor who prescribes para - clinical examinations (laboratory tests, radiology…) , without having initially made the patients anamnesis and physical examination . Need for a Para clinical examination always depends on the medical condition discovered at the time of the anamnesis and the physical examination.

g) Gender of the doctor

The gender of a doctor should be a matter of personal preference, because research shows that, on average, female doctors spend more time with their patients than male doctors (Courtney McGrath: in Kiplingers Personal Finance).

h) The doctor must have only one master: The patient

A doctor is partner in the care of his patients: his duty to the patient comes first. He works for the good of the patient, not that of the government, an insurance company, or a managed health care bureaucrat.

Generally, any doctor, officially agreed or not, knows extremely well that he is not a recipient in the contract which binds the policyholder and the insurer and he is not a co-signatory. In fact the doctor does have and can have only one master: his patient. Nobody can serve two masters neither can a doctor. An old proverb of Bourrignon in the *Swiss jura* points this out extremely well: he who serves two masters misleads one of them, very often the two. The acceptance of the presence an all-powerful third party in the patient-doctor relation is the privilege of the veterinary surgeon. Only in this precise situation, the animal is property of its master; the parties involved here are itself, the owner and the veterinary surgeon.

If the doctor won't agree to the basic patient rights, it is advisable to consider finding another doctor.

i) Hospital or private clinic where the doctor practice

Does the doctor practice in a respected and financially solid hospital? A hospital with financial problems, or subsidized like most public hospitals are, is more likely to save on care and qualified personnel recruitment. A hospital, whose majority of nurses and doctors are on training, (interns)', have only a foreign qualification, probably suffer from big problems. It is consequently unreasonable to trust it. Even its existence should be called in question as fast as possible. If it is one doctor {primary care doctor, family practitioner, general practitioner etc...} who chooses a second doctor for the patient, for example a surgeon, or even imposes this doctor to the patient, {which he should above all not do}, he then takes the responsibility for this choice and will have to also insure the consequences of them. Be wary of such a doctor. He could be that he has even a financial interest to advise that way. Indeed cases of dichotomy are more and more often reported.

j) What distinguishes the very qualified doctor?

Mastery of complex problems, improvement and update of knowledge, skills with which data are used, analyzed and applied, adaptability to stress, emotional stability, manual skills, quick-wittedness, real clinical flair, conscientious and solid ethics, these are qualities which distinguish the very qualified doctor from the average doctors.

k) A surgeon should also well be chosen

Each doctor knows that a surgeon's experience and skill are very significant for an operation success. Too many, primary doctors are simply confident with the surgeon on turn in the nearby public hospital or, worse, address their patients to the surgeon who pay them, whereas the law on the sickness insurance too require them to recommend to the patient a surgeon whose operational qualities remains a medical act of the highest importance. The rates of the late post-operative complications, in particular the frequency of stenos is based on the numbers operated in each hospital and the surgeon's experience. (Patient Protect)

l) Choosing a Doctor that's right

Generally patients are advised that it is important:

- To look for a doctor when one is well and not distracted by an illness.
- To choose the doctor whose sex or age suits them best.
- To consider what matters to them; if a warm bedside manner is important, then they should look for that trait in the doctor.
- To choose a doctor or practice that can admit them to their preferred hospital. This also ensures that the doctor has been accepted by an accredited hospital.

m) Is the doctor a good potential health partner?

Other issues to consider when choosing a doctor include

- Well organized office
- Available after hours
- Reasonable waiting time

- Explains diagnosis, treatment.
- Consults with other doctors
- Whenever possible suggests choices for treatments
- Provides information on drugs side effects
- Good listener
- The doctor/patient relationship takes time to build

2.9 Doctor Patient Relationship

Changes in patients may be undermining the doctor –patient relationship, said Dana Gelb Safran, SCD, the lead author of the study and director of the Health Institute at New England Medical Center in Boston. Many patients take a more active role in their treatment, prompted in part by direct to consumer drug communication and better access to medical information. Researchers studied eight aspects of medical care as defined by the Institute of Medicine Committee on the future of primary care.

Four of these categories involved doctors/patient relationship

- Personal interaction (patience, friendliness, caring, respect and time spent with patient)
- Confirmation of information (a doctor's questions and clarity of his or her explanation)
- Trust (integrity, competence and role as the patients agent)
- Doctors knowledge of the patient.

Four more involved other aspects of the practice:

- Access to care (including the ability to get through by phone or make appointments)
- Visit based continuity
- Patient's out of pocket costs
- Integration (synthesizing caring from the specialists and hospitals).

Problems between doctors and patients

Most problems between patients and their doctors are not about bad advice or treatment but about poor communication. This is becoming an increasingly difficult problem for doctors {both general practitioners and specialists} because they are being asked to see more and more patients. There is therefore less and less time that they give to you as an individual when you go for help. Further, patients have been encouraged by recent government and the media to expect more and more from modern medicine. Patients are increasingly demanding for more comprehensive computer usage in clinical medicine and in their interaction with doctors. (Slack 1997). Sometimes these expectations are not realistic. Patients are more aware of new treatments through newspapers and magazines articles and televisions and radio programs. However the journalists who produce this information are interested in what is new. They will often try to hype up a new treatment to encourage people to read their article or listen to their programs. The doctors whose research they are reporting are usually much more cautious about what it can achieve. Furthermore, issues of affordability are ignored or given little attention in such articles.

A further new problem for doctors is information about treatments that patient or their relatives can get from the Internet. Patients are warned to be aware that anyone can write anything, about any disease or treatment on the Internet. Normally no authority has checked that this information is correct. They do not have to be medically valid or to have done any research. They do not have to have had their work published in a peer-reviewed journal. (Patient Protect, 2003)

2.10 What the Society Expects of Doctors

After holding consultation with various healthcare interest groups, MPDB came up with the societal expectations as the key characteristics of doctors (MPDB code of practice section 4.2):

i.) Availability- at all reasonable times, when a doctor is not available he or she should arrange for a suitable replacement. Patients should always be informed of the absence.

ii.) Affability: The doctor should always be pleasant, cheerful and adopt an optimistic, friendly and caring attitude to the patient.

iii.) Ability: He should be efficient and keep up to date in his work and specialty by regularly attending continuing medical or dental education. He should recognize the limits of his ability and refer patients to other specialists or inform patients of alternatives.

iv.) Be trustworthy and honest: a doctor should be able to explain treatment in terms the patient can understand. If a medic makes a mistake, the patient should be told and an apology be made in a friendly way to avoid litigation.

v.) Confidentiality should be maintained at all times

vi.) Be patient with patients and his/her staff

vii.) Charge reasonable fee commensurate to services offered

viii.) Be distinguishable from quacks and other nonqualified persons by displaying professionalism and only engaging in scientifically acceptable practice.

ix.) Be fair and dispense service fairly without discrimination or prejudice of any form.

x.) Have adequate equipment and competent ancillary staff in his/her office, nursing home or hospital

xi.) Doctors should be smartly dressed and practice hygiene so as to give an overall impression of a responsible person with dignity and decorum respecting local sensibilities.

xii.) Be well grounded in medical ethics and behavioral sciences

xiii.) Give certificates that are honest and not get involved in fraudulent claims, use due care in filing insurance forms.

xiv.) Learn, respect and tailor his management to the customs of the community in which he or she serves

xv.) A chaperon of the same sex as the patient should always be available when an intimate examination of the patient is by a doctor of the opposite sex. This mainly applies to female patients being examined by male doctors

xvi.) Not to press his religious practices onto the patient without the patients agreement. For example, ask for God's help by both praying together as part of the management without the patients consent. The patient may be an atheist.

xvii.) Avoid improper relation with the patient

2.11 Other current issues

The need to look beyond a patients immediate clinical symptoms and search intensively for deeper meaning has been and must always be the defining quality of the medical profession. As doctors are compelled to see more patients in less time and are encouraged to order minimal testing, there is a pressure to treat patients rather than understand them. (Shaywitz –2003) Shaywitz gives the following examples of how doctors 'treat and street' patients:

- Low potassium Level- Give potassium supplements
- Belly hurts- gives an anti-acid
- Depressed- Try Prozac

He notes that more often than not, the medications prescribed work but it just illustrates how doctors have become good at alleviating symptoms and correcting laboratory abnormalities. He stresses that doctors feel good when this happens and their patients are often grateful. Indeed, this is what patients want when they see a doctor- a couple of lab tests and a prescription to fix whatever their problem is.

CHAPTER THREE
RESEARCH DESIGN AND METHODOLOGY

3.1 Introduction

This is a descriptive study of the criteria used by patients in the selection of doctors. A descriptive study presupposes much prior knowledge about the phenomenon being studied (Churchill 1987).

3.2 Research Setting

This research was carried out in Nairobi. Nairobi was representative of all provinces in Kenya due to its cosmopolitan nature.

3.3 Population

The target population was composed of the users of private doctor services in Nairobi. These are typically middle class (in social economic terms) in Nairobi. Since there was no known list of patients in Nairobi a list of the residential estates in the city were used as the sampling point (see Appendix 3). In order to draw the sampling frame, the researcher adopted the classification done by Mburu (2001) on the consumers in Nairobi in terms of the socio-economic classes. In this classification, Mburu developed a simple model of identifying the middle class estates in Nairobi. He developed the model in consultation with the Central Bureau of Statistics. In the model, information about spending patterns of various income groups derived from the Economic Survey (2001) was used to delineate middle-income estates by considering how much they spent on rent and housing per annum. This was also used by Kisese (2002), the researcher also validated the list with the classification that is currently used by the Marketing and Social Research Association (MSRA 2002) in Kenya.

3.4 Sample Size

The researcher achieved an effective sample of 99 respondents who were selected by use of systematic random sampling. Five residential estates were selected from the list of all middle class estates identified as being the population of interest. After the estates are selected, every 10^{th} house was picked after a random start (Depending on how large the estate is aiming at 20 houses per estate). The Estates covered were: Buruburu, Langata Southlands, Woodleys, Zimmerman and Komarok.

3.5 Data Collection

Primary data were collected by use of a questionnaire (See Appendix 2). The researcher personally administered the questionnaires to the respondents on face to face basis. This method was preferred because the target is literate- can understand English without difficulties. Also the subject of the research (doctors) is technical to some respondents hence the need for face-to-face interview. This method also helped in addressing the time constraint problem, as once contacted there was no need to go back to the respondent. The questionnaire is divided into two major parts. Part one is an introductory part that sought personal details about the respondent. Part two is the main questionnaire covering patient behaviour, information search and criteria used in doctor selection.

3.6 Data Analysis

The response categories were assigned values of 1-5 to correspond with the least important and the most important sentiments. These scores have been aggregated for each statement and then averaged to obtain a mean score. Other simple descriptives like frequency distributions and percentages have also be used. In the analysis two adjacent categories on the extremes of the five-point scale were combined to reduce responses to important, neutral and not important categories only to ensure that interpretations can be more meaningful. Ming'ala, 2002 argues that frequencies can be suppressed if a variable has many distinct values. Factor analysis using the principle component method was performed for the purpose of identifying and naming the underlying dimensions of the criteria used by the respondents. This helped to reduce the data into identifiable small

number of factors that explains most of the variance observed in a much larger number of manifest variables.

CHAPTER FOUR

DATA PRESENTATION AND ANALYSIS

4.1 Introduction

This chapter sets out to present in summary and statistically analyze the primary data that was gathered from the study.

A total of 99 questionnaires were completed from 5 estates (as stated in chapter three). Summaries of the collected data in each aspect are presented in percentage and mean scores (as set out in chapter three). Later data reduction using factor analysis was applied to the data to combine related factors into fewer factors. This enabled the researcher to identify the most important factors.

4.2 Descriptive Summaries of the Data Collected

This section summarizes the data collected by use of percentages and mean scores. This summary shows from the variable with the highest score to the variable with the least score. Percentages have been used to show the proportion of respondents who perceived various aspects as important, neutral or not important.

4.2.1 General Information

Many (60%) of the respondents said they have a personal doctor (the one they always consult for doctor services) compared to those who don't have (40%). Most (82%) had consulted a doctor within last one year compared to 15% for 2-3 years before, and 3% for 4 years or more.

The main reasons for consulting a doctor were: health check ups (23%), malaria (14%), sick family members (14%) and feeling unwell (9%) among others. (*See table 1 below)*

Table 1: Reasons for consulting a doctor

BASE	93	
Reason	**Frequency**	**%**
Check up for maintaining good health	21	23%
Had Malaria	13	14%
The daughter/son/I was sick/husband/my mother was sick	12	12%
Treatment/my body was unwell	8	9%
Has a terrible cold/common cold	4	4%
Eye problem	4	4%
Accident/had broken a leg/had knee injury	4	4%
Was pregnant/had gone for clinic	3	3%
Sick with typhoid/had typhoid fever	3	3%
Tooth problem/dental fillings	3	3%
Stomach problem	3	3%
Headaches/severe headaches	4	4%
Has tonsils/throat infection	2	2%
I was feeling nausea	2	2%
Difficulty in breathing/pneumonia	2	2%
Chest problems	2	2%
Has skin allergy/acne	2	2%
Had gout/ kidney/ liver problem	3	3%
High blood pressure	1	1%
Had a growth that needed surgery	1	1%

4.2.2 What was Liked or Disliked about Doctors and their Clinics

Doctors were liked for their understanding and caring (20%), their good sense of humour (14%) quick services/treatment (16%), and giving hope and advice (12%) among other reasons (see table 2a). They were disliked for charging a high consultation fee (14%) and being too confidential to a point of not disclosing illnesses to the patient (7%). 20% said they disliked nothing about their doctors while 25% did not respond to this question. Generally, the patients gave more likes than dislikes about doctors indicating a general positive appeal.

Table 2a) What is liked about Doctors

BASE	99	100%
Non response	14	14%
Understanding/Concerned caring/they have fatherly love	20	20%
Attended us quickly/treated quickly/ Efficient in handling patients issues	16	16%
Had a good sense of humour/was very friendly	14	14%
The doctor gave advice/hope/counsels	12	12%
Kind/gentle/humble and courteous	9	9%
They rely on their opinions because they are knowledgeable/ Confident in what he was doing/knew how to deal with patient	8	8%
They are keen to listen to what you are saying/they are open	5	5%
They had good services/everything went well	3	3%
They knew my problem immediately/they cured it/ The treatment was effective/he followed me up	5	5%
They are patient	3	3%
Will tell you what your are suffering from/straightforward	3	3%
They spend enough time with their patients and give them the	3	3%
Trustworthy/honest	2	2%
Was available/always available in emergencies/ flexible	3	3%
Polite/helpful/committed	2	2%
They are cooperative and dedicated	2	2%
Accurate/works very hard	2	2%
Others Recommended two types of drugs – generic and original, They are confidential, Authentic, They do a very through test before they treat you, Low cost	8	8%

Table 2b: What is disliked about Doctors

BASE	99	100%
Non response	25	25%
Nothing/none	20	20%
High consultations fees charged/expensive/ they value money than life	14	14%
They won't disclose your illness to you	7	7%
Going for consultation and finding other doctors standing in	4	4%
Some are very rude	4	4%
They are very serious/not jovial	4	4%
Not punctual/was sometimes late for our appointments	5	5%
Failure to take my views into consideration/dismissed my explanation/ Writing in a hurry and not noting everything	4	4%
Sometimes they give the wrong prescription/ drugs not available They disperse very expensive drugs/expensive chemists/ Insists that you have to buy medicine from their pharmacy	6	6%
Some offer treatment instead of diagnosing the ailment	3	3%
Sometimes they ask too many personal questions	2	2%
Contacted my father to discuss my illness and my insurance/ untrustworthy	3	3%
Gives no alternative but stopped me from my habits	1	1%
Was too aggressive with my wounds	1	1%
Had many patients and appeared to be in a hurry to finish	1	1%
He couldn't remember that he had asked me to return / Some give you a late date for consultation	2	2%
Slow response from other recommended doctors	1	1%
Some are untidy	1	1%
Ignorant	1	1%
They lack expertise in all fields	1	1%

Table 2c: What is liked about Doctors Clinics

BASE	99	100%
Non response	25	25%
Clean and neat	19	19%
Was attended quickly/no waiting	9	9%
Was well equipped/had all the facilities needed/it was well	7	7%
Found in residential areas	7	7%
Conveniently located/strategic proximity	6	6%
People were very friendly and the nurses helpful	6	6%
Well organized/good records	5	5%
Are alternatives to health cares/quick medical providers	5	5%
Nice reception/TV, magazines, and newspapers in the waiting	4	4%
Cheap/affordable fee to their regular clients	3	3%
Availability of drugs	3	3%
Small	2	2%
Didn't ask for money first	2	2%
Attendance by the general staff was good	2	2%
Specialized in certain areas	2	2%
Good ventilation/good standards	2	2%
Less bureaucracy	1	1%
Discreet	1	1%
Quiet and cool	1	1%
Nothing	1	1%
Gives a sense of well being	1	1%
Humility of the nurses	1	1%
They have a policy of 'First come first served basis'	1	1%
Have informative posters on the walls	1	1%
Easily accessible	1	1%

Table 2d: What is disliked about Doctors Clinics

BASE	99	100%
Non response	32	32%
None/nothing	13	13%
Very expensive	12	12%
Rude nurses/arrogant/nurses lacked sense of urgency	6	6%
Long and slow queues to see the doctor	6	6%
Untidy healthcares/no water	4	4%
Sometimes they lack drugs people require	3	3%
Too much antiseptic smell/smell of drugs /bad odours	3	3%
Some are bogus/not trustworthy	2	2%
Specialists of certain fields	2	2%
Some of the medical equipments are outdated/some clinics are	2	2%
Some sell cheap medicines	2	2%
Congestion in wards	2	2%
Poor management i.e. receptionists	2	2%
They took time before they admitted us	1	1%
Shabby looking nurses	1	1%
Long questions	1	1%
The protocol is too long	1	1%
Excessive bureaucracy	1	1%
Had some bad scenes of sick people at the reception	1	1%
Some don't listen to patients. They start prescribing	1	1%
They won't tell you the truth even if they fail to diagnose	1	1%
Keeps referring one to another doctor	1	1%
Lack of ample space	1	1%
Mixing of patients with different diseases	1	1%
Referring patients to go out for many tests	1	1%
Uncomfortable seats	1	1%
Treatment without proper tests	1	1%
They don't do enough tests	1	1%
Poor disposal of used needles, cotton wool and blades	1	1%
They despise your ailments	1	1%
Being open to anybody (businessmen)	1	1%
Lack privacy	1	1%

Table 3 Decision makers in previous doctor consulted

BASE	97	100%
Self	67	69%
Parent	11	11%
Employer	9	9%
Insurance provider	9	9%
Friend/colleague	4	4%
My wife/family	3	3%

4.2.3 Sources of Information

Other doctors (92%), other healthcare professionals (87%), other family members (84%) and friends (81%) were considered as the most important information sources in doctor selection. Yellow pages (32%) and News stories (39%) were only considered important by less than 50% of the respondents.

Table 4a: Sources of Information

	Important		Neutral		Not Important		Mean
Information Source	Freq	%	Freq	%	Freq	%	
Other doctors	91	92%	1	1%	7	7%	4.6
Friends	80	81%	6	6%	13	13%	4.1
Spouses or children	75	76%	6	6%	83	84%	4.0
Nurse	79	80%	8	8%	12	12%	4.0
Other family Members	83	84%	6	6%	10	10%	4.2
Other healthcare professionals	86	87%	5	5%	8	8%	4.4
Pharmacists	79	80%	8	8%	12	12%	4.1
Yellow pages	32	32%	17	17%	50	50%	2.6
News story or article	39	39%	9	9%	51	51%	2.9
Media e.g. TV, radio or newspaper	51	52%	12	12%	36	36%	3.2

Other important sources of information include: Disease specialists, insurance providers, experienced patients, hospital image, church pastors and personal experiences.

The most important sources of information were other doctors (45%) other healthcare professionals (14%) and family members (10%).

4.2.4 Types of Information

When selecting a doctor the information types were rated at the tops of the list in terms of importance were: Length and type of experience (98%), reputation among patients (97%), reputation among doctors (96%) and fees charged (91%). The doctors sex was considered least important with 70% rating it as not important.

Table 4b: Importance of information types

	Important		Neutral		Not important		Mean
Information Type	Freq	%	Freq	%	Freq	%	
Reputation among other doctors	93	94%	1	1%	5	5%	4.7
Reputation among patients	96	97%	0	0%	3	3%	4.8
Length and type of experience	97	98%	2	2%	0	0%	4.8
Hospitals with which the doctor is associated	89	90%	2	2%	8	8%	4.5
Doctor is willing to take calls from patients with questions –gives cell phone number	85	86%	4	4%	10	10%	4.4
Personality or 'bedside manner'	80	81%	5	5%	14	14%	4.3
Length of waiting time before you get an appointment	89	90%	5	5%	5	5%	4.6
Convenience of official hours	89	90%	4	4%	6	6%	4.6
Convenience of office location	85	86%	4	4%	10	10%	4.4
Time taken in the waiting room	87	88%	1	1%	11	11%	4.5
Fees charged	90	91%	2	2%	7	7%	4.5
Whether the doctor is male or female	25	25%	5	5%	69	70%	2.4

4.2.5 Factors considered in doctor selection.

Doctors formal qualification (100%), willingness to discuss treatment alternatives (96%) length of time practiced (99%) and promotion of regular check ups (94%) were considered as important in doctor selection by over 90% of the respondents. Doctor's tribe was considered as not important by 93%, whether doctor is male (80%) or female (82%) was also unimportant to most

Table 4c: Importance of factors considered in doctor selection

	Important		Neutral		Not important		Mean
Factor	Freq	%	Freq	%	Freq	%	
Doctors formal qualification	99	100%	0	0%	0	0%	5.0
Length of time doctor has practiced	95	96%	2	2%	2	2%	5.0
Doctor is willing to discuss treatment alternatives	98	99%	0	0%	1	1%	5.0
Doctor promotes periodic check ups	93	94%	4	4%	2	2%	4.9
Doctor tries to avoid hospitalization	70	71%	8	8%	21	21%	4.3
Doctor has recently qualified	67	68%	13	13%	19	19%	3.9
Recommended by another doctor	89	90%	3	3%	7	7%	4.5
Recommended by a friend	75	76%	7	7%	17	17%	3.7
Doctor has sense of humor/ is jovial	85	86%	0	0%	14	14%	4.2
Doctor does not appear in a hurry	82	83%	4	4%	13	13%	4.3
Doctor has warm personality	91	92%	0	0%	8	8%	4.4
Doctor can treat the whole family	78	79%	5	5%	16	16%	4.1
Doctor understands you	94	95%	1	1%	4	4%	4.6
Doctor will prescribe medicine without an office visit	74	75%	6	6%	19	19%	3.8
Could get an appointment quickly	90	91%	1	1%	8	8%	4.4
Practice is near your home, work etc	60	61%	3	3%	36	36%	3.6
Willing to go to emergency room	65	66%	8	8%	26	26%	4.0
Doctor willing to talk about adult stress	80	81%	4	4%	15	15%	4.0
Doctor is female	10	10%	8	8%	81	82%	2.5
Neat, attractive office	71	72%	2	2%	26	26%	3.8
Doctor is male	12	12%	8	8%	79	80%	2.3
Doctor's office has an X ray machine	42	42%	10	10%	47	47%	3.3
Doctor provides information on health promotion (ways to avoid illness, promote physical well-being)	89	90%	1	1%	9	9%	4.3
Doctor avoids injections	50	51%	9	9%	40	40%	3.3
Doctor s tribe	1	1%	6	6%	92	93%	1.5

4.2.6 Preferred training environments

The most popular training institutions were those in United Kingdom, USA and Nairobi University. These were rated among the top three by 73%, 66% and 55% of the patients respectively.

Table 5: Credibility of Medical Schools/ Country

	% Ranking in Top three	Rank
Training Institution/country	%	
UK	73%	1
Kenya - Nairobi university	55%	3
USA	66%	2
India	36%	6
South Africa	41%	4
Kenya - Moi University	28%6	5
Total	100%	

4.2.7 Time of selecting a doctor

Most (78%) select their doctors when they fall sick or when they see signs of sickness. Only a few (24%) select their doctor when they are healthy just in case they fall sick.

4.3 Factor Analysis- data reduction

This section seeks to carry out secondary analysis of the collected data to meet research objectives. Data reduction through factor analysis was used to achieve this. The first step in this analysis is to obtain communalities between the variables under each of the aspects in each aspect considered in doctor selection. The variables are then factored out using the principle component analysis method. In this case two or more correlated variables are combined into one factor. Kaiser Normalization criterion of selecting variables with an Eigen value that is greater than one has also been applied in this analysis.

Table 6a Communalities

Communalities		
Variable	Initial	Extraction
Q6A	1	0.647
Q6B	1	0.509
Q6C	1	0.536
Q6D	1	0.407
Q6E	1	0.713
Q6F	1	0.568
Q6G	1	0.537
Q6H	1	0.432
Q6I	1	0.53
Q6J	1	0.587
Q6K	1	0.766
Q6L	1	0.307
Q6M	1	0.669
Q6N	1	0.565
Q6O	1	0.69
Q6P	1	0.706
Q6Q	1	0.686
Q6R	1	0.67
Q6S	1	0.824
Q6T	1	0.524
Q6U	1	0.756
Q6V	1	0.523
Q6W	1	0.568
Q6X	1	0.475
Q6Y	1	0.518
Extraction Method: Principal Component Analysis.		

Table 6a above estimates the communalities for each variable. These communalities represent the proportion of variance that each variable has in common with others. For instance, Variable Q6s (doctor is female) has 82.4% communality or shared relationships with other variables. Same case applies to Q6k (warm personality), which has 76.6% shared relationships with other variables.

Table 6b:Total variance explained

		Component					
		1	2	3	4	5	6
Initial Eigenvalues	Total	4.536	3.575	2.055	1.714	1.339	1.339
	% of Variance	18.144	14.299	8.222	6.856	5.354	5.354
	Cumulative %	18.144	32.443	40.665	47.522	58.849	58.849
Extraction Sums of Squared Loadings	Total	4.536	3.575	2.055	1.714	1.339	5.354
	% of Variance	18.144	14.299	8.222	6.856	5.354	58.849
	Cumulative %	18.144	32.443	40.665	47.522	58.849	5.354
Rotation Sums of Squared Loadings	Total	3.21	3.21	2.272	2.21	1.747	58.849
	% of Variance	12.841	12.839	9.088	8.839	6.986	58.849
	Cumulative %	12.841	25.68	34.768	43.607		58.849

Through the use of Kaiser Normalization Criterion we extract components that have an Eigen value that is greater than one. This way the researcher extracted 6 major Components. Table 6 b above indicates that those 6 components accounted for 58.849% of the total variance.

Table 6 c: Rotated Component Matrix

Rotated Component Matrix(a)

Variables	Component					
	1	2	3	4	5	6
Doctors formal qualification	0.43	-0.01	0.56	-0.10	-0.13	-0.36
Length of time doctor has practiced	0.02	0.19	0.68	0.03	0.04	0.12
Doctor is willing to discuss treatment alternatives	0.13	0.03	0.69	-0.14	0.10	0.08
Doctor promotes periodic check ups	0.51	-0.09	0.27	-0.10	0.23	-0.02
Doctor tries to avoid hospitalization	0.67	0.03	0.44	0.11	-0.23	0.07
Doctor has recently qualified	0.08	0.01	0.04	0.07	0.00	0.75
Recommended by another doctor	0.07	-0.21	0.30	0.02	0.16	0.61
Recommended by a friend	0.07	0.12	0.47	0.19	-0.17	0.36
Doctor has sense of humor/ is jovial	0.13	0.63	0.29	-0.05	0.14	-0.06
Doctor does not appear in a hurry	-0.06	0.68	0.20	-0.10	0.26	-0.09
Doctor has warm personality	0.05	0.78	0.28	-0.20	0.16	-0.10
Doctor can treat the whole family	0.36	0.42	-0.05	0.04	0.03	-0.04
Doctor understands you	0.04	0.72	-0.27	0.10	-0.19	0.18
Doctor prescribe medicine without an office visit	0.74	0.08	-0.01	-0.05	0.04	0.07
Could get an appointment quickly	0.50	0.21	-0.11	-0.09	-0.22	0.58
Practice is near your home, work etc	0.74	0.03	0.18	0.00	0.32	0.17
Willing to go to emergency room	0.26	0.43	0.05	0.02	0.66	-0.09
Doctor willing to talk about adult stress	0.47	0.41	-0.31	-0.11	0.42	0.03
Doctor is female	-0.16	-0.14	0.00	0.88	0.03	-0.04
Neat, attractive office	-0.13	0.63	-0.01	-0.16	0.27	0.10
Doctor is male	-0.06	-0.12	-0.02	0.85	0.11	0.03
Doctor's office has an X ray machine	0.08	0.12	0.05	0.12	0.69	0.07
Doctor provides information on health promotion (ways to avoid illness, promote physical well-being)	-0.29	0.31	-0.08	-0.29	0.54	-0.04
Doctor avoids injections	0.50	-0.04	0.09	0.29	-0.28	0.22
Doctor s tribe	0.35	0.03	-0.08	0.57	-0.19	0.18

Extraction Method: Principal Component Analysis.
Rotation Method: Varimax with Kaiser Normalization.
a Rotation converged in 11 iterations.

Through component rotation by use of Varimax (Variance Maximization) method. The researcher generated the above component matrix. This matrix made it possible to identify the variables that fall under each of the extracted factors. In this case a variable is said to belong to the factor to which it explains most of the variation than any other factor.

Table 6d: Constituent Variable

Component /Factor name	Constituent Variable	Variance Explained
1 Convinience	Doctor promotes periodic check ups Doctor tries to avoid hospitalization Doctor will prescribe medicine without an office visit Practice is near your home, work etc Doctor willing to talk about adult stress Doctor avoids injections	18.1%
2 Human touch/bonding	Doctor has sense of humor/ is jovial Doctor does not appear in a hurry Doctor has warm personality Doctor can treat the whole family Doctor understands you Neat, attractive office	14.3%
3 Credentials	Doctors formal qualification Length of time doctor has practiced Doctor is willing to discuss treatment alternatives Recommended by a friend	8.2%
4 Personality Associations	Doctor is female Doctor is male Doctor s tribe	6.8%
5 Keenness	Doctor provides information on health promotion (ways to avoid illness, promote physical well-being) Willing to go to emergency room Doctor's office has an X ray machine	5.4%
6 Freshness	Could get an appointment quickly Doctor has recently qualified Recommended by another doctor	5.3%
Total variance explained= 58.8%		

This analysis indicates that the 6 extracted factors absorb all the 25 variables in the criteria used in the selection of doctors.

CHAPTER FIVE
CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter sets out to draw conclusions that will seek to answer the research questions as outlined in chapter one. The question sought to know the criteria used by patients in selecting doctors.

5.2 Summary of Findings

In this section the researcher seeks to answer the research question as stated in chapter one. What are the criteria used by patients in their selection of doctors in Nairobi? The answer to this question is guided by the output from the previous data analysis chapter. Since the selection of doctors is a rather wide concept comprising of many aspects the researcher mainly used the factors that enhance each of the constituent aspects of the bigger picture.

The researcher extracted various component/factors and considered the constituent variables under each component. These were used to come up with simple service marketing concepts that summarize the variables. These concepts were considered the important factors that enhance each aspect of concern. The analysis in chapter four about aspects considered in selection of doctors extracted 6 components/factors from all the initial variables considered.

Out of the factors extracted the most important customers were convenience and human touch. These two factors combined explain 32% of the reason why a customer may select the services of one doctor and not the other. The important aspects for convenience are promotion of periodic checkups and willingness to talk about stress. The important aspects for human touch are the doctor's understanding of patients, warm personality and a sense of humor. It is important to note that patients seem to value preventive care than implied in the literature review. Since, all doctors are qualified and experienced the patients seem to base their choice of a doctor using more care aspects than cure aspects. To a patient a doctor is supposed to provide curative services, being caring is an added advantage which most patients seem to seek in a treatment/consultation service

encounter. The recent increase in demand for 'safe' products like mineral water may be an indicator of a paradigm shift where Kenyans are seeking for more preventative measures rather than firefighting when it's too late. Doctors who care may be viewed as having the interest of their patients at heart; hence they are likely take all the necessary caution to ensure the safety of their patients.

The other important factors were credentials this includes: doctors formal qualification, experience and willing ness to discuss treatment alternatives. These explain 8% of the reason why a customer may choose a specific doctor.

Personality associations were also identified as factors influencing the patients' choice of a doctor. These were mainly related to the sex of a doctor and their tribe. The tribe is less important than the sex of a doctor. These personality associations can closely be related with the need for the doctor to build rapport with the patients in all service encounters.

Doctor's keenness and freshness were also important factors in the patient criteria in selection of doctors. Doctors who provide information on health promotion are likely to be rated higher than those who don't, here the doctor is required to be willing to help and educate. The presence of hi-tech equipments in a doctor's office is viewed as a statement of readiness to assist. Freshness relates with the doctor being in touch with the latest developments in the field of medicine, such doctors are likely to be available for quick appointments, young and recently qualified. Recommendation by other doctors is very important for fresh graduates. Still, there is a lot of room for synergy between experienced and fresh graduates.

5.3 Recommendations

As set out in chapter one, due to the continuously changing marketing environment in Kenya today characterized by informed consumers, technology, stiff competition, deregulation and globalization, there is need for the health sector and especially the medical profession to adopt the marketing concept. This is the only way to enhance customer retention ensure long term business survival and brace up for increasing deregulation of the key service sectors. Understanding how customers make decisions and how they select their doctors is important to any private doctor in Nairobi or any other part of the country.

The findings of this study indicate that other doctors, other healthcare professionals, family members and friends are the most important sources of information when deciding on the doctor to consult. This implies that a doctor must manage his or her relationship with these information providers in order to enhance positive word of mouth and recruit more customers. Any marketing strategy adopted by a private doctor practice must consider these as key players in reputation building.

The doctor's reputation both among other doctors and own patients, length and type of experience and fees charged are the important types of information that patients seek when evaluating whether the doctor meets their requirements. The implication of this finding is that doctors must manage their affairs in a manner that create a positive image among peers and patients. Any action taken that taints a doctor's reputation is likely to reduce the patient (customers) inflows. Although in private practice, doctors are viewed as community workers and they should not carry out themselves as too commercial to forget their community roles as lifesavers and role models. Community and charity services in the social environment such as schools, church and neighborhood associations is also recommended for doctors.

Convenience has come out as an important factor in the selection of doctors. To provide convenience to their patients doctors should package their services to make them hassle free for the patients. Approaches such as reminding the patient to go for health check ups, prescribing medicine on the phone / Internet, giving unsolicited health advice and practicing near the target market areas would help enhance convenience. Avoiding unnecessary medication or hospitalization and providing alternatives to patients are also recommended.

Human touch has been identified as an important factor. This affects how a doctor is perceived. Doctors should cultivate a sense of humor, listening skills and general positive body language. It is also important to make patients feel appreciated and relaxed by creating a pleasant/ neat work environment, getting them into normal conversations (not medical) and showing genuine concern. The front office staff in a doctor's clinic should be friendly, have a genuine liking for people and have a pleasant personality.

Credentials were also identified as an important factor. This implies that the current practice of displaying certificates in the clinics and indicating the qualifications in the signage are useful. Doctors should showcase their experience to patients by involving the patients in the treatment process and asking questions that are relevant to the patients situation. Ensuring customer longevity by developing strong bonds with current patients would help the patients to become the doctor's advocate for referrals.

Personality associations also came out as important. In this case doctors can use their sex or tribe as business strengths. For instance, female doctors are known to spend more time with their patients than their male counterparts. Also a patient who is illiterate or semiliterate is likely to be more comfortable with a doctor from the same tribe. Doctors should learn local languages especially if working in the rural areas.

Keenness and alertness was also identified as an important factor. The implication here is that patients appreciate doctors who are ready to serve them, is well equipped to make

several examinations before making conclusions and one who is generally concerned about wellness. Doctor should provide some physical evidence about why they prescribe various treatments to avoid looking like they are guessing. Use and presence of computers and other modern equipments in the clinics is also recommended.

Freshness and peer approval are also important factors. Doctors who have qualified recently are viewed as more informed about 'modern medicine' and flexible. Doctors practicing in a group should have a mixture of old and new graduates. To remain competitive in a changing environment doctors should also undertake continuous professional education.

5.4 Limitations of the Study

Like many other studies this study faced several limitations. The major limitations were time and financial resources. For this reason the study was narrowed to Nairobi only. The researcher was also limited in terms of sample size, a larger sample would not have been achieved with the resources available.

Another limitation though not major was the understanding of medical issues by the respondents. The researcher tried to put these issues into an easy to understand language for the respondents. The researcher also administered the questionnaire on a face-to-face basis to ensure uniformity of results. This limitation may have lessened the accuracy of measuring what the researcher intended to measure.

5.5 Suggestion for Further Research

The study focused on a rather wide category of doctors. This made the study a bit too wide as it put a dentist, pediatrician, optician, general practitioner and all other specializations in one class. Future research could be more focused by doctor specialization.

Future research could also focus other differences selecting a doctor for self or for ones child. This difference was ignored in this study. Rural-urban differences were also ignored.

This research was quantitative in nature, it only help us to identify the aggregate nature of the situation without considering the quality of individual responses. Future research could consider qualitative aspects to dig into deeper details about the criteria used in the selection of doctors.

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Appendix 1: Introduction Letter

Data Collection Instrument

Department of Business Administration,
Faculty of commerce
University of Nairobi
Po Box 30197
Nairobi

15th August 2003

Dear Respondent,

My name is Kimbura Githinji. I am a postgraduate student in the University of Nairobi doing a research project as part of the requirements of the degree of Masters of Business Administration. I am doing a survey to establish how people select doctors and the kind of information they need to evaluate their healthcare providers. (Patients Criteria in The Selection of Doctors). The information collected will be treated confidentially; your opinion will be combined with those of others to give an overall understanding of subject. In case there are any issues you require clarification, Kindly contact me (Kiumbura Githinji at University of Nairobi, Box 30197 Nairobi, telephone 2715319 or Cell 0722-511065) A copy of the research will be made available to you on request. I highly appreciate your kind assistance.

Yours Sincerely

Kiumbura Githinji

MBA Student

C W Ngahu
Department Of Business Administration
Faculty of Commerce
University of Nairobi

Appendix 2
Questionnaire

Section A: General Information

Sex: Male ( ) Female ( )

Marital Status: Married...( ) Single.....( )

Age: 18-30 years ( ) 31-40 years ( ) 45 years and above ( )

Highest Education Level: Primary...( ) Secondary....( ) College certificate...( )

College Diploma( ) University degree and above...( )

Size of the family (number of members):_____

Occupation_____

Section B Main Questionnaire

1. Do you have a personal doctor ? (*That is, the one you would go to most of the times if you are sick)* Yes ( ) No ( ) *Please Indicate by tick (✓)*

2. When was the last time you consulted a doctor. *Please Indicate by tick (✓)*

Less than one year ago ( ) 2 or 3 years ago ( ) 4 or more years ago ( ) Never ( )

3. (i) What was your reason for consulting your doctor?

_____

3(ii) What did you like and dislike about the doctors and their clinics?

Likes (Doctors)	Dislikes (Doctors)
Likes (Clinics)	Dislikes (Clinics)

3 iii) Who decided on the doctor you last consulted? (*You can tick more than one answer)*

Self ( ) Parent ( ) Employer( ) Insurance provider ( ) Others _____

4. (i) When making a choice of the doctor to visit, how important is each of the following sources of information? (*Please circle the number that fits your opinion for each source of information)*

		Very Important	Somehow important	Not sure	Not Important	Not Important at all
a	Other doctors	5	4	3	2	1
b	Friends	5	4	3	2	1
c	Spouses or children	5	4	3	2	1
d	Nurse	5	4	3	2	1
e	Other family members	5	4	3	2	1
f	Other healthcare profession	5	4	3	2	1
g	Pharmacists	5	4	3	2	1
h	Yellow pages	5	4	3	2	1
i	News story or article	5	4	3	2	1
j	Media e.g. TV, radio or newspaper	5	4	3	2	1

Any other source that you think is important_____

4ii) Of all the above sources of information which one would be the most important to you?

5. When making a choice of the doctor to visit, how important is each of the following types of information? (*Please circle the number that fits your opinion for each type of information*

	Very Important	Somehow important	Not sure	Not Important	Not Important at all
i.) Reputation among other doctors	5	4	3	2	1
ii.) Reputation among patients	5	4	3	2	1
iii.) Length and type of experience	5	4	3	2	1
iv.) Hospitals with which the doctor is associated	5	4	3	2	1
v.) Doctor is willing to take calls from patients with questions –gives cell phone number	5	4	3	2	1
vi.) Personality or 'bedside manner'	5	4	3	2	1
vii.) Length of waiting time before you get an appointment	5	4	3	2	1
viii.) Convenience of official hours	5	4	3	2	1
ix.) Convenience of office location	5	4	3	2	1
x.) Time taken in the waiting room	5	4	3	2	1
xi.) Fees charged	5	4	3	2	1
xii.) Whether the doctor is male or female	5	4	3	2	1

5 And how important to you is each of the following factors when you are selecting a doctor? (*Please circle the number that fits your opinion for each factor)*

		Very Important	Somehow important	Not sure	Not Important	Not Important at all
a	Doctors formal qualification	5	4	3	2	1
b	Length of time doctor has practiced	5	4	3	2	1
c	Doctor is willing to discuss treatment alternatives	5	4	3	2	1
d	Doctor promotes periodic check ups	5	4	3	2	1
e	Doctor tries to avoid hospitalization	5	4	3	2	1
f	Doctor has recently qualified	5	4	3	2	1
g	Recommended by another doctor	5	4	3	2	1
h	Recommended by a friend	5	4	3	2	1
i	Doctor has sense of humor/ is jovial	5	4	3	2	1
j	Doctor does not appear in a hurry	5	4	3	2	1
k	Doctor has warm personality	5	4	3	2	1
l	Doctor can treat the whole family	5	4	3	2	1
m	Doctor understands you	5	4	3	2	1
n	Doctor will prescribe medicine without an office visit	5	4	3	2	1
o	Could get an appointment quickly	5	4	3	2	1
p	Practice is near your home, work etc	5	4	3	2	1
q	Willing to go to emergency room	5	4	3	2	1
r	Doctor willing to talk about adult stress	5	4	3	2	1
s	Doctor is female	5	4	3	2	1
t	Neat, attractive office	5	4	3	2	1
u	Doctor is male	5	4	3	2	1
v	Doctor's office has an X ray machine	5	4	3	2	1
w	Doctor provides information on health promotion (ways to avoid illness, promote physical well-being)	5	4	3	2	1
x	Doctor avoids injections	5	4	3	2	1
y	Doctor s tribe	5	4	3	2	1

6 Please rank the following institutions/ countries in which you prefer your doctor to have been trained? (*indicate the rank e.g 1st , 2nd , 3rd*)

	Rank
South Africa	
Kenya- Moi University	
Kenya- Nairobi University	
India	
USA	
UK	

7 Which of the following statements best describes the point at which you select your doctor? *Please Indicate by tick (✓)*

When I see the signs of sickness ( )
When I fall sick ( )
When am healthy just in case I get sick ( )
Others (specify)_____

8 Any other Comment about how people choose their personal doctor?

Thank you Very Much for your Cooperation

APPENDIX 3
LIST OF MIDDLE CLASS ESTATES IN NAIROBI

Air Port View
Akiba (Langata)
Akiba (South C)
Ayany
Buru Buru Phase 1,2,3,4,5
Donholm
Eastleigh
Embakasi high Rise
Golden Gat
Golf Course
Harambee
Highway Estate Phase 1, 2
High View
Imara Daima
Jamhuri
Kariobangi Civil Servants
Kariokor
Kibera High rise
Komarock Infill B
Komarock Phase 2
Komarock Phase 2 Infill A
Komarock phase 3
Langata Civil servants
Maasai Estate
Madaraka
Magiwa
Mariakania
Mvuli Avenue
Nairobi west
New Pumwani (California)
Ngara
Ngei Phase 2
Ngumo
NSSF Complex (Sololo/Hazina)
Onyonka
Otiende
Outering Estate
Pangani
Park View
Pioneer
Plains View
Pumwani High Rise
Reality (Nairobi South C)

River Bank (south B/Kariba Estate)
Rubia
Saika
Savannah
South Lands Phase 1,2
Sun View
Tena
Thika Road Site Estate
Thome
Ufunguo
Uhuru Gardens
Ushirika
Villa Franca
Woodley (Joseph Kangethe)
Zimmerman