The Influence of Social Identity and Communication on Healthcare Delivery in Thailand

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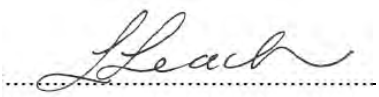

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Abstract

Existing literature on healthcare communication research using Social Identity Theory (SIT) and Communication Accommodation Theory (CAT) frameworks have shown that social identity affects communication and collaboration between hospital staffs at different levels of the power hierarchy. Little, however, is known about how communication and intergroup relations affect healthcare delivery in Thailand. In this study, we used convenience sampling and one to one semi-structured interviews to qualitatively explore hospital staff perspectives on the healthcare communication dynamic in Thai healthcare. As a collectivistic society, Thailand has unique cultural values such as seniority, harmony, duty towards nation and hospitality. We found that these values interacted with healthcare staff's social identity and communication methods, in a way that makes healthcare communication in Thailand different to existing healthcare communication research in the West. Our study highlighted the need for additional research and further development of communication theories for application to future communication research in Eastern healthcare contexts.

Keywords: Social identity, Communication, Thailand, Healthcare

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Chapter 1: Introduction

Rationale

Hospitals are dynamic systems made up of a complex hierarchy of different health professionals, from doctors to nurses to administrative officials, working together with the aim of delivering good quality patient care. However, patients often go into hospitals with unrealistic expectations that the service they will receive is systematic, unquestionable and void of potential error, foregoing that there are a number of human factors that come into play (Reid, Compton, Grossman, & Fanjiang, 2005). One of the main human factors in healthcare delivery is fluid communication between hospital staff, which determines how effectively staff can collaborate in delivering good patient care (Hewett, Watson, Gallois & Leggett, 2009a). A substantial amount of evidence shows that 75-80% of all medical errors are caused by systematic errors that occur due to miscommunication amongst hospital staff (Helmreich & Merritt, 1998). Research using Social Identity Theory (SIT) (Tajfel, 1974) and Communication Accommodation Theory (CAT) (Gallois & Giles, 2015) has shown that social identity affects communication and collaboration between hospital staff at different levels of the power hierarchy; between clinicians, nurses and administrators, and between senior or junior staff (Watson, Hewett & Gallois, 2012).

However, most of the communication in healthcare research has been conducted in Western individualistic societies. Many studies have established the cultural differences in Western and Eastern societies based on the individualistic and collectivistic dimension (Triandis, 1988). Thailand is considered a collectivistic culture where the emphasis is put on interrelations and social harmony, which may influence the interactions and communications amongst its people. It is important to account for the cultural distinctiveness of each context. Thus, our research aims to extend the study of SIT and CAT from Western healthcare to the context of

Thai healthcare while also taking into consideration Thai cultural values and norms in influencing healthcare communication patterns in Thai hospitals. We hope that our research findings will reveal key aspects that contribute to or hinder effective communication in Thai healthcare in order for future research to develop novel communication theories based on collectivistic cultures and find ways to enhance healthcare communication and improve patient care. The paper will now review previous literature regarding human factors in healthcare, including the components of healthcare and overview of Thai healthcare, social identity theory, and communication accommodation theory.

Human Factors in Healthcare

A number of recent reports have identified the importance of patient safety in healthcare system (Duncan et al., 2012). One of these reports concluded that there are three technical factors that negatively affect patient care that are important to consider when exploring healthcare in Thailand, namely poor use of technology, insufficient resources, and inadequate training (Yang, Kelley, & Darzi, 2011). Firstly, they found that despite the benefits of technology in improving patient care, lack of knowledge and skills in health professionals about the use of these technologies actually increased harm to patients. Secondly, the problem of insufficient resources has also been one of the main problems in healthcare especially in developing countries. These problems include inadequate sanitation care and health facilities, over-populated hospitals, lack of clean water, unreliable access to electrical power, and inaccessibility of technologies due to limited funding. Thirdly, inadequate training was also identified as an important factor that can affect patient care. However, they concluded that the implementations developed in many reports were not certain to improve patient safety (Yang, Kelley, & Darzi, 2011). Therefore, human factors analysis tools, which analyze the root cause of problems related to human aspects, were

specifically designed as major engineering tools to create effective healthcare and improve patient safety (Reid, Compton, Grossman, & Fanjiang, 2005).

Human factors researchers study humans as an element within a complex system. In hospitals, they explore human errors in a dynamic system, such as checking procedures, transcription, medicine prescription, computational errors, and misunderstanding in written communication. Overall, these communication errors amongst staff have been found to adversely affect the quality of patient care (Safren & Chapanis, 1960; Kohn, Corrigan, & Donaldson, 2000).

Recent research further found that human factors, especially social factors, also play a very important role in ensuring patient safety. The examination of patient safety perceptions in primary care settings by Daker-White and colleagues (2015) claimed that previous research in healthcare focusing on technical factors in improving patient safety may not have addressed the issues that arise from the complexity of medical culture, hierarchical organization, and the interaction between medical staff and teams. As a result, Daker-White and colleagues (2015) conducted a meta-analysis on the characteristics of health professionals, patients, the organizational system, and their interactions in contributing to the quality of patient care in primary care settings. Specifically, they found that the effectiveness and quality of communication, namely face-to-face communication between patients and medical staffs or staff to staff, is central to the ability to take care of patients, even in smaller groups such as primary care settings.

A study conducted in the United States and Japan validated the importance of communication in treating patients (Miyasaka, Kiyota, & Fetters, 2006). They found that the main errors in treating patients occurred through misdiagnosis stemming from

miscommunication between hospital staff. Other research has tried to improve these communication problems by using a systematic structured approach to communication (Leonard, Graham & Bonacum, 2004), which has led to some improvements (Randmaa, Martensson, Swenne, & Engstrom, 2014). Additionally, improvements have been attempted through technological systems, for instance the use of electronic medical records to avoid misreading of handwriting and to create a record that can be revisited in the future (Schaffer & Munyer, 2015; Daker-White et al., 2015). Altogether the present literature shows that communication is central to effective delivery of patient care within the healthcare context. Thus, it is important to try to improve communication in healthcare in order to minimize any medical errors, which could bring harm to patients both physically and emotionally (Van Vorst et al., 2007).

Components of Healthcare

In order to improve communication amongst healthcare professionals and efficiency and quality of patients' care, social skills such as communication, team-work, and leadership of health professionals should be improved (Van Vorst et al., 2007; Leach, Watson, Hewett, Schwarz, & Gallois, in press). To address this, understanding the mechanisms of the healthcare system and the interaction of healthcare professionals is crucial. The nature of the healthcare context can be divided into two parts: system and working procedure (Hewett, Watson, & Gallois, 2015). However, a review by Odell (2011) in the Australian Critical Care Journal also identified human interaction as another important component within the healthcare system. This component is directly related to the communication mentioned above. The following section briefly discusses the first two components of system and working procedure before focusing on the quality of human interaction as the pivotal source of communication issue. Moreover, it will address the current studies that study effective communication between hospital staff.

System

Within the system, Duckett and Ward (2008) found that patients, clinicians, and financial interests are the three foci in healthcare. However, the roles taken by hospital staff are inappropriately distributed, as important medical decisions are made based on financial interests by the hospital administration sector rather than clinicians. In order to produce effective healthcare, these three foci have to be in balance. For example, investing resources into improving patients' well-being might be beneficial for patients themselves as well as the clinicians' reputation; however, it might conflict with the interest of the financial sector since this may increase costs from purchasing medical devices and medicines for patients. Thus, effective communication and collaboration between patients, clinicians, and financial administrators is needed to ensure the needs of patients are met according to the expertise of clinicians, whilst ensuring these decisions are economically viable without compromising the safety of patients (Hewett et al., 2015).

Working procedure

Previous research established two models that represent the working procedure of healthcare professionals: the traditional model of healthcare and the shared ownership model (Hewett et al., 2015). The first model involves one doctor and several nurses that work together to care for one particular patient until he or she is fully recovered. This model is no longer effective due to the complexity and changing nature of patients and their needs, number of permanent staff, and resources in hospitals. The new model, 'shared ownership', was introduced to improve a more effective working procedure within the healthcare system (Hewett et al., 2015). In this model, the care of a patient is determined by doctors or nurses who are on duty during a particular shift. However, researchers commented that this shared-ownership model

might be worse than the traditional model because it can create confusion amongst health professions in determining who is responsible for a particular patient (Hewett et al., 2015). Issues such as these highlight the importance of efficient communication in hospitals.

Human Interaction

The basis of human interaction directly relates to the communication issues mentioned above. Communication can be described as the exchange of information from one individual to another, thus in the context of healthcare, poor communication can lead to potential harm to patients.

The healthcare context is made up of different teams and departments, such as emergency and intensive care, working together to provide optimal patient care. These teams are made up of members of different medical professions including doctors and nurses of different genders and levels of experience. Research shows that social identity can lead to a number of stereotypes, which then contributes to human errors, such as communication error (Duncan et al., 2012). Stereotypes between doctors and nurses are prevalent in healthcare (Stein, Watts, & Howell, 1990), such as the assumption that a nurse's role is one of performing feminine tasks such as tending and caring for patients whereas doctors presume more masculine roles in performing practical tasks, such as surgical operation, and making final decisions (Sweet & Norman, 1995). These stereotypes in healthcare can potentially affect how health professionals collaborate and communicate. However, there have been some changes in western contexts (Stein et al., 1990), for instance, nurses usually play the role of a subordinate and are expected to obey a doctor's orders without question Thus, they are not empowered to speak up when doctors might be wrong (Sweet & Norman, 1995).

This can be explained through social identity theory. For instance, healthcare staff may try to classify themselves and others based on their department or group identity in order to create more salient boundaries for their responsibilities (Duncan et al., 2012; Hewett et al., 2015). Crucially, developing a strong social identity with one's own department might hinder individuals' ability to effectively cross-communicate and collaborate with individuals from other departments (Walshe & Shortell, 2004; Lingard, Espin, Evans, and Hawryluck, 2004).

Additionally, social identity in healthcare may be reinforced by the hierarchy, gender differences, and the trainings and tasks that differ from one medical profession to another. For example, the unequal power status between professions such as nurses and doctors as well as junior and senior positions can influence how individuals within these differing roles interact with one another (Reader, Flin, Mearns, & Cuthbertson, 2007). Similar work by other researchers concluded that social identity is a significant contributor to poor communication (Duncan et al., 2012; Odell, 2011). Therefore, to improve patient safety the communication issues in regard of social identity must be addressed (Odell, 2011).

Improving Inter-Professional Collaboration

Several reports provide suggestions and interventions to address communication problems between hospital staff. The model Inter-Professional Collaborative Practice (IPCP) by Pilon et al. (2015) is an example of a current intervention program that has been developed to help clinicians and medical staff work together smoothly. It focuses on establishing excellent collaboration amongst healthcare professionals. The experts under IPCP paradigm classify themselves as 'having collective identity and shared responsibility for a patient or group of patients'. The education and practice of healthcare professionals has been conducted in a

collaborative and interactive healthcare environment. Results from a study of the intervention show that this model provides good outcomes for patients and hospital staff (Pilon et al., 2015).

Overview of Thai healthcare

Health Institutes

Currently in the Thai healthcare system, both public and private hospitals are under the care of the Ministry of Public Health (MOPH). Most health professionals work in both private and public hospitals, while some of them also establish their own private practices. In 2004, the Thai hospital to bed ratio was 1:469, while the doctor to bed ratio was 1:15.3 in 1991 and 1:7 in 2004. The decrease in number of beds per doctor resulted from the increase in number of graduates who trained to become qualified clinicians (Sakunphanit, 2008). However, distribution of healthcare providers is still an issue in Thailand. It is evident that there are an unequal proportion of health professionals in Bangkok, the capital metropolitan city, compared to other provinces of Thailand (Jariyanuwat, 2014). As a consequence, staff that work at provincial health centers may undertake more responsibilities and workload than their metropolitan peers. Possibly, this could have adverse effects on the quality of patient care. Another issue in the Thai healthcare system is the allocation of budgets from the MOPH, where a bias favoring larger health facilities for the allocation of resources is observed, while many small centres remain overlooked (Sakunphanit, 2008).

Staff

According to Sakunphanit (2008), since 1932, health institutes in Thailand have aimed to provide prevention and curation services to control communicable diseases and take care of sick patients. The services were mainly provided by doctors, nurses, midwives and sanitarians. At present, the focus has shifted to disease prevention, health promotion, curation of illness, and

rehabilitation wellness rather than only treating diseases. In rural areas, these tasks fall under the responsibility of the nursing department, which forces nurses to become all-rounders even if they are not trained for this (Sakunphanit, 2008). To date, the Thai education system and the medical field have strived to increase the number of qualified clinicians and health professionals in order to improve the quality of the healthcare system. The Thai government has also intervened by establishing a policy to keep fresh graduates in the healthcare service for a minimum 3 years, where those who discontinue may have to pay a fine of 400,000 Thai baht, which is equivalent to roughly 11,186 American dollars (Chokewiwat, 1999).

Human Errors in Thai healthcare

The following paragraphs briefly summarize how cultures affect patient care and lead to communication problems present in Australia and Thai healthcare centers.

Hospitals consist of a complex system where hierarchy is emphasized, such that doctors are placed at a higher status compared to nurses or other health professionals (Burnard & Naiyapatana, 2004). Hierarchy and professional status are also found in cross-cultural contexts such as in an Eastern country, Thailand. In Thailand, the concept of hierarchy and seniority is also evident in hospitals, where junior nurses are viewed with the Thai concept of ‘small person,’ and are expected hold a more inferior ranking, while doctors or a head of nurse are regarded as a ‘big person,’ or someone with a more superior ranking (Burnard & Naiyapatana, 2004). This distinction between professional identity and power hierarchy can affect the effectiveness of healthcare communication, which then affects the quality of patient treatment.

In line with the study by Burnard and Naiyapatana (2004), Srismith (2010) published research on the organizational culture and communication in Thai healthcare. 36 Thai non-medical staffs were recruited from one Thai hospital, including staffs from the hospital’s back

office such as executives, management, human resources, marketing, education and training staffs and the front office, such as customer service, support service, and international center staffs. The results from the study showed that there were two types of organizational structures that were most prevalent: clan and hierarchical. Clan structures were characterized by a 'culture based on norms and values associated with affiliation and teamwork' whereas hierarchical structures were characterized by 'culture reflecting the values and norms associated with bureaucracy such as control, stability, and security' (Quinn, 1999 in Srismith, 2010). The majority of front officers in this study valued clan structures in hospital management. Interestingly, they agreed on the idea that managerial staffs should act as helpful mentors, rather than feared authority, to the subordinates. This may be because they perceived managerial staffs to be helpful, supportive and good listeners to the subordinates in the training sessions they received. Contrastingly, those in managerial positions in the hospital preferred the hierarchical structure, which is based on top-down authority. However, findings suggest that even though the hospital staffs prefer clan structure, they were not resentful with these authoritative orders; instead they appreciated the organizational structure, which clearly instructed them how to proceed with their work and communicate in the hospital.

In 2006, Thai researchers Jirapaet, Jirapaet, and Sopajaree (2006) conducted a qualitative study on healthcare errors when there was no national report based on errors in healthcare systems in Thailand. The results were in line with those mentioned above from Sakunphanit (2008). Understaffing caused nurses to perform many tasks and rotate to different jobs, so they were unable to fully respond to all medical cases. As a result, patient safety was threatened. Moreover, there were many interruptions in the hospital which depleted nurses' cognitive attention and increased errors. Significantly, these error events were accelerated through

misleading and poor team communication amongst staff (Jirapaet et al. 2006). These researchers also found issues such as the misuse of verbal and nonverbal expression in communicating and poor handwriting in medical prescriptions. To illustrate the latter point, nurses tended to misinterpret information from doctors' and poor handwritings. Moreover, they hesitated to ask any questions to confirm their understanding when they found that the prescriptions were unclear. Jirapaet et al. (2006) suggested the Thai healthcare system can be improved when these obstacles are addressed.

Currently, the implementation for improving the communications amongst nurses in Thai hospital focuses on building up the relationships between hospital staffs and patients as well as between hospital staffs themselves (Jariyanuwat, 2014).

Social Identity Theory

Tajfel and Turner (1979) developed the Social Identity Theory (SIT) to explain intergroup behavior. They defined social identity as the part of an individual's self-concept that is derived from their knowledge of their membership of a group, where the membership is valuable to the person or holds some emotional significance. Each individual is viewed as having a binary self: which is made up of their personal and social identities. According to Tajfel and Turner's (1979) SIT, people categorized themselves and others as either ingroup members, who are part of their own group, or outgroup members, who are part of the others' group. This "us" and "them" categorization is done for two main reasons: one, the categorization provides a meaningful way of organizing the social world and two, identifying oneself with a highly valued group augments one's self-esteem. In fact, people are so inclined to enhance their self-esteem that often these comparisons are made to highlight the positive distinctiveness of their group compared to others.

Furthermore, SIT theorists (Turner et al., 1986) propose that when one's membership is particularly prominent, people tend to focus on the similar characteristics that group them together with other members rather than on the individual characteristics that differentiate between them. When facing conflict, social identity is more salient than personal identity. Perceptions resulting from these categorizations incline people to behave in certain ways, such as getting involved with ingroup behavior. This occurs due to the internalization of group norms. According to SIT, intergroup dynamics are influenced by one's group membership, because the group identity extracted from this membership guides one's interactions with others.

SIT and Intergroup Studies in Healthcare Contexts

The SIT framework has also been applied to hospital settings (Grol, Bosch, Hulscher, Eccles, & Wensing, 2007), and research suggests that social identity plays a significant role in the interactions amongst healthcare professionals (Hewett, Watson, & Gallois, 2015). Earlier research found that hospital procedures often lack explicit rules and thus the interaction between hospital staff usually evolved around implicit and unspoken rules, which were determined by the perceived social identity groups of the hospital staff (Strauss, Schatzman, Ehrlich, Bucher, & Sabshin, 1963; Lingard, Espin, Evans, and Hawryluck 2004). These implicit rules have led to miscommunication amongst hospital staff, even in acute life-threatening contexts (Coupland, Wiemann, & Giles, 1991). Group behavior can have both positive and negative outcomes: identification with one's own group can encourage camaraderie with ingroup members, but can also lead to discriminatory attitudes towards outgroup members (Kreindler, Dowd, Star, & Gottschalk, 2012).

Furthermore, the health communication literature reports that conflicts amongst healthcare providers tend to occur mainly due to the rigid hierarchical structure, desire for

professional autonomy, and sociocultural factors (Poole & Real, 2003; Ray & Miller, 1990). These conflicts were found within and between the emergency department, operating theatres, and intensive care units, as well as other hospital units. For instance, Eisenberg et al. (2005) found that admission of patients into the emergency department varied based on the quality of inter-departmental relationships, communication and conflict that occurs in that specific context. Lingard, Reznick, Espin, Regehr and DeVito (2002) and Lingard et al. (2004) similarly found that staff in operating theatres and intensive care units experience substantial role-based conflicts and described the culture as "tribal".

Related research has concluded that within the healthcare context, people manage and maintain their social identities by using power, status, control, and competition in guiding their social interactions with other people in different professions and departments within the hospitals (Haslam, 2004). Unfortunately, a need to maintain social identities often leads to intergroup rivalry, evasion of responsibility, and blaming of outgroup departments or members of other hierarchical levels. When neither group compromises, their conflicts take foreground over the delivery of effective patient care (Hewett et al., 2009a).

SIT provides the framework to understand the phenomenon of identity threat (Turner & Oakes, 1986). Recently, Setchell, Leach, Watson, and Hewett (2015) conducted research on the attitudes of endoscopy practicing doctors regarding the expansion of nurses' roles, which would involve nurses performing gastrointestinal endoscopies. Findings suggested that the more doctors reported a sense of identification with endoscopy, the more likely they were to have a negative attitude towards nurses carrying out the procedure. Furthermore, the results suggested that a sense of threatened identity contributed to this resistance, since if performing endoscopies were

no longer exclusively a doctor' role, their social position would be lowered and they would face more competition in employment.

In a hospital based project, Hewett and colleagues (2009a) conducted an interview study framed by SIT that explored intergroup relations and communication amongst Australian doctors. Their findings showed that doctors categorized specialists from other departments as outgroup members and specialists from their own departments as ingroup members, and when making comparisons between these two groups, they showed a tendency to distinguish a greater importance of the role their department plays in patient care in comparison to others. These doctors had an increased level of identification with their respective departments, and seemed to forego their individual identities or even their shared identity of being hospital staff. This was observed as they constantly used specialty department levels as identity labels (e.g. Gastro for gastroenterology department) while speaking about themselves or others. This form of communication also appeared in their written medical records. In contrast, they rarely used individual names or their collective professional identities. These salient social identity groups often led to admission, informed consent, and other such management issues amongst the specialty groups. This was described by one of the participants as a "turf war", where issues such as patient ownership were the cause of rivalries. It is evident that these disagreements involving placing blame on "others" and contesting responsibilities for patient care, eventually mean that service delivered to the patients suffers.

Hewett and colleagues (2015) published additional findings about the communication between Australian hospital staff, which is studied in more detail in the next section of the paper. However, this study shed light on the effect of strong social identities amongst hospital staff on delivery of efficient healthcare. The researchers found that doctors from different specialty

departments recorded information in chart entries to keep other doctors updated, but their lack of confidence in outgroup specialists caused them to ignore the entries and they preferred conducting their own examinations to collect information they needed for their purposes. These doctors only had a strong identification with their ingroup specialists, resulting in a cooperative trustworthy relationship within their group, but distrust towards outgroups. What resulted from these conflicts amongst hospital staff of course was inefficient patient care, as not only were time and resources wasted, but patients who answered the same questions to several different doctors and underwent repeated tests for the same problem felt an increasing level of frustration and a decreased sense of trust in the service and treatment they were receiving.

Social Identity Theory in Collectivistic Cultures

Whilst much research has been discussed regarding the role of social identity in guiding interactions between professionals in healthcare, it is important to note that the vast majority of this research has been conducted in Western individualistic cultures. Since SIT is a framework of social interactions, the consideration of cultural differences is pivotal as the very roots of interpersonal behavior differ in individualistic cultures (Triandis, 1988). Thus, it is important to study the phenomenon of social identity in healthcare in collectivistic cultures before drawing any premature conclusions about how these effects influence intergroup relations in non-western contexts.

There has been limited social identity research in collectivistic cultures, yet it has been established that individualistic and collectivistic cultures differ. Collectivistic cultures are characterized by members who highly value the importance of relationships, interdependence and harmony. Members of collectivistic cultures tend to have interdependent self-construal, where their concept of self is interconnected to others in their social circle (Triandis, 1988).

Triandis (1988) contends that in groups are more important in collectivistic than in individualistic cultures; those in collectivistic cultures usually obey ingroup authorities without questions in order to maintain ingroup harmony. At the same time they are more distrustful and unwilling to cooperate towards those in outgroups (Triandis, 1972).

Yuki (2003) conducted a study comparing the influence of SIT on Japanese and North American participants. According to Yuki (2003), however, behavior in collectivistic cultures differs from what SIT proposes. Yuki (2003) found that amongst the Japanese participants, loyalty and identification with their group increased as their understanding of intragroup relations and their recognition of individual differences increased. This differed to those of the individualistic culture (USA), whose ingroup loyalty and identity increased as ingroup homogeneity and ingroup status increased. Furthermore, the Japanese did not show behavior aligned with SIT such as in thinking they share similar attributes with ingroup members or believing their group is superior to outgroups.

While results in the Yuki (2003) study point to differences between Japanese and North American participants in their conception of self and group, there are still many variations in self and group construal among different collectivistic cultures. It is possible that Yuki's (2003) findings on social identity in collectivistic cultures are due to specific cultural differences of each culture. The findings highlight once again the importance of noting that SIT research findings may not generalize to collectivistic cultures. While, social identity has been studied in East Asian cultures, such as amongst Japanese samples, the culture and thus the social interactions may still considerably vary in comparison to South East Asian cultures.

The aforementioned studies demonstrate that social identity may contribute to intergroup conflicts within the context of healthcare, which may in turn hinder the delivery of effective patient care (Street, Makoul, Arora, & Epstein, 2009). It has been established that a threat to one's group identity may change behavior, but research suggests that this may even be evident in the language they use. Research by Belmonte, McCabe, and Chornet-Roses (2010) and others suggests that attitudes towards ingroup and outgroup members can be assessed by using language tools as markers. An example of this in the context of healthcare was found in research conducted by Hewett and colleagues (2009a), where a discrepancy was found in doctors' attitudes towards in-group and outgroup doctors, as they used labels when referring to outgroup doctors and names for in-group doctors. The next section of this literature review goes further in depth on the role of communication style and language in asserting social identity.

Communication Accommodation Theory (CAT)

Communication accommodation theory (CAT) is linked to SIT such that it is a theory derived from Western cultures, used to explain different communicative strategies individuals employ to enhance comprehension or establish and maintain their social identity. Individuals can use language to show psychological closeness, *accommodation*, and also to create psychological distance, *non-accommodation* (Gallois & Giles, 2015).

Early research into the CAT identifies convergence, divergence and maintenance as different ways speakers can use language to manage their social identity (Giles & Baker, 2008). Convergence refers to the shift in a speaker's communication style to be more similar to their interlocutor as a way to be approved, liked or perceived as similar to them: it is often used amongst in-group members. Maintenance occurs when speakers do not change or adapt their communication styles to the interlocutor. Divergence is used when speakers try to socially

distance themselves from their interlocutor by accentuating the differences in communication style between them: a tactic often used towards outgroups members. Tajfel (1974) explained divergence as a tactic that individuals use to show that they belong to a superior group that is positively distinct from their communicative partner. These tactics can include verbal patterns such as, language, vocabulary style, and utterance length, as well as non-verbal patterns such as eye-gaze and smiles (Giles, Coupland, & Coupland, 1991).

Recent research extended CAT by including over-accommodation and under-accommodation to describe recipients' evaluation and interpretation of an un-accommodating communicative strategy used towards them (Gasiorek, 2013). Over-accommodation occurs when the recipients view the speakers as condescending towards their ability to comprehend by trying to over-facilitate the communication, whereas under-accommodation occurs when the recipients perceive the speaker as communicating insufficiently in a way that neglects their need to understand. Studies have found that over-accommodation is preferred over under-accommodation; even though, both types create social distance and belittle the outgroup members, over-accommodation still enhances the recipient's comprehension while under-accommodation does not (Gasiorek, 2013).

Furthermore, Gasiorek (2013) also looked at the different ways recipients respond to over-accommodation and under-accommodation. The type of response is usually determined by the valence of the recipient perception, or whether the recipient perceives the speaker's intention as positive, neutral, or negative. For instance, if a recipient views the speaker as over-accommodating towards them but sees that they have good intentions of wanting to facilitate the recipient's understanding, then the recipient might act favorably towards the speaker.

Gasiorek (2013) found that the more negatively the participants view their partner's under-accommodation, the more likely they will be to react by showing negative emotions and withdrawing from the interaction, or simply put, they will under-accommodate in reciprocity. However, Gasiorek (2015) found one factor that might improve recipient perception of the speaker's intention: perspective-taking, or the ability to imagine another's point of view, helps recipients perceive the speaker's non-accommodating communicative stance as more positive and accommodating. This only specifically applies to when speakers adopt over-accommodating and not under-accommodating strategy, which emphasizes that the two are driven by separate mechanisms. These findings validated the fact that communication is a dynamic process, one that involves both speaker and recipient acting in accordance to one another's mannerisms.

CAT Applied to Healthcare Contexts

Within the healthcare setting, communication failure is one of the main factors that can cause patient harm (Leonard et al., 2004). CAT has been increasingly used as a framework to study communication within a highly intergroup context such as healthcare. Good communication between different levels and departments in hospitals is crucial in delivering effective patient care; however, sometimes use of language can be a barrier in achieving effective communication. For instance, doctors and nurses may be taught different ways to communicate: nurses are told to be broad and descriptive whereas doctors are taught to be concise and use 'to the point' communication (Leonard et al., 2004). Research shows that medical staff can use language as a way to emphasize their social identity by facilitating understanding of in-group members and creating a gap in understanding for outgroup members (Hewett et al., 2009a). Further, individuals usually take a non-accommodative stance during an intergroup conflict in order to maximize the distinction between themselves and outgroup

members (e.g., Hewett et al., 2015). In a hospital setting, this non-accommodation may lead to miscommunication, which then could negatively affect the quality of patient care.

Bourhis, Roth and Macqueen's (1989) study found that doctors tend to take a non-accommodative stance towards patients as a way to maintain higher power status. This is done by using medical language (ML) to communicate rather than everyday language (EL) that patients can understand. These researchers also found that nurses use both ML and EL in communication, thus they often play the role of a messenger in the communication between doctor and patient. This suggests they take an accommodative stance to facilitate care.

Language use can portray strong in-group identity and heighten intergroup boundaries. For example, doctors have been shown to maintain higher status in hospital's hierarchical level by establishing themselves as a specialist group with their use of language between and among health professional groups (e.g., Setchell and colleagues, 2015). In an exploration of doctors and nurses views about change in practice boundaries, Setchell and colleagues (2015) found that doctors strongly disagree with allowing nurses to perform gastrointestinal endoscopy, a role traditionally performed only by specialist doctors. This disagreement was conveyed through their use of language via free-text responses, where doctors often used language to frame nurses as a distinct group with a task set that is inferior to their own. Some doctors even wrote in capital letters to emphasize their strong disagreement with allowing nurses to perform the endoscopies even though nurse endoscopy has been used in other countries with measurable patient benefit.

In the complex intergroup context of hospitals, collaboration between many specialist doctors is required for providing good patient care. Yet, barriers to collaboration have been identified by Hewett and colleagues (2015). Their study found that in-group bias among doctors of the same specialty can negatively influence patient care. For instance, doctors can interpret

communication in medical charts of in-group doctors more accurately than that of outgroup doctors. This may be because when writing medical charts, doctors use medical terms and vocabulary that is specific to their specialty even though they are aware that doctors from other specialties will read it. This type of bias hinders effective communication and collaboration between hospital departments, which then may interfere with patient care.

East Asian Culture and Communication

CAT is a highly respectable framework used to study communication in Western cultures. However, as noted by many scholars, it is inappropriate to generalize studies conducted in the West to the rest of the world due to differences in culture as suggested by the opposing paradigms of individualistic culture in the West and collectivistic culture in the East (Yum, 1988). Thus, it is important to explore the nature of communication from an Eastern perspective.

Much research has explored differences in behaviors of those in collectivists compared to individualist cultures (Brews & Cairns, 2004). Such studies have tended to make the distinction that East Asian people are more collectivistic than Western people (Brews & Cairns, 2004). Prioritizing groups, communities, and even one's nation's interest before the individual self is valued in collectivistic cultures (Vadi, Allik & Realo, 2002). Related studies have found that the idea of the self differs between collectivist and individualist cultures. For instance, Markus & Kitayama (1991) claim that in collectivistic cultures, individuals tend to have interdependent selves, meaning they see themselves as interrelated to their social circle whereas in individualistic cultures, individuals see themselves as autonomous and independent.

It can be argued that this collectivistic tendency in East Asia is greatly influenced by the religious and philosophical teachings of Confucianism and Buddhism (Yum, 1988). These philosophies emphasize on the importance of harmony and interpersonal human relationships,

especially among one's own kin. This emphasis on harmony and social relationships may form a unique pattern of communication that is specific to collectivistic cultures. Nonetheless, there is still variation among the different collectivistic cultures as determined by differences in religion, tradition and, norms (Williams et al, 1997; McCann, 2003). Komin (1995) found that the concepts of Buddhist teachings, such as saving face and filial piety (respecting elders), are prevalent and are used to maintain interpersonal harmony in Thai culture, whereas Vongvipanon (1994) and Knutson (2004) found hospitality to be a virtue in Thai culture. The following section explores the concepts of Buddhism, face saving, and filial piety, as these cultural values are found to be unique to Thai culture and may be reflected through Thai communication style.

Buddhism

Buddhism is the national religion in Thailand. Many Thais are exposed to Buddhist values at a young age through the Thai education system. One of the main doctrines behind Buddhism is the law of Karma or theory of action, which posits that the *boon* or merits that individuals make in one lifetime accumulate to benefit them in future lives, after reincarnation. In their work life, Thai individuals view those in higher organizational position as having accumulated more *boon* and treat them as superiors. This spiritual and cultural orientation to behavior is likely to affect intergroup relations and communication in healthcare contexts (Reynolds, 2002).

Indeed, Burnard and Naiyapatana, (2004) studied nursing culture in Thailand and found that Buddhist teachings and phrases permeate the communication regarding patient care. For instance, *khwan* in Thai means life spirit. Thai nurses believe that during illness, a patient's *khwan* can temporarily leave the body and whether it will return to the body is determined by whether the sick individual has done enough good merits. The nurses in the study said that they kept praying for the khwan to return to the patient's body during time of illness; suggesting that

Thai nurses may be heavily influenced by their superstitious beliefs when it comes to treating patients instead of exerting maximum professional effort.

Face Negotiation

The concept of "saving face" is central to many East Asian cultures, including Thai culture, where the emphasis is put on maintaining relational harmony (Gudykunst, Ting-Toomey & Chua, 1988). Ting-Toomey (1988) defines *face* as an individual positive self-image. In social situations, individuals may engage in *facework*, which is the act of maintaining and upholding another's positive self-image. This concept of *facework* strongly influences communication styles in Eastern collectivistic cultures: it fosters the prevalence of an indirect communication style and avoidant conflict management strategies (Sanchez-Burks, Lee, Choi, Nisbett, Zhao, & Koo, 2003).

In communication studies, direct communication usually refers to the congruency between speakers' verbal utterance and intentions. In contrast, indirect communication is when the speakers do not explicitly say what they intend to but use other methods to convey their messages, such as word play, facial expression, body language, saying the message is from someone else when it is one's own thought, or by asking someone else to deliver the message (Yum, 1988).

In Thai culture, indirect communication is the prevalent norm perhaps because it is viewed as good manners and polite. For instance, the Thai education system, involves teaching students to not overtly question or disagree with their teachers in front of the class because it is considered bad manners to question the knowledge of the teacher: the teacher would lose face, or feel embarrassed for being wrong and the student would lose face for causing the teacher the embarrassment of being wrong (Burnard & Naiyapatana, 2004). Thus, when students don't

understand what is taught, they may not feel comfortable directly saying so to the teacher because they want to save their teacher's face.

Furthermore, certain words and concepts in Thai language are directly linked to the concept of face. For instance the word *kreng jai* means to be considerate of another's feeling yet this interpretation does not fully define this word. Kreng jai cannot be directly translated into English and even when translated it is still a hard concept for Westerners to grasp (Komin, 1995). Ting-Toomey (1988) also found that Thais prefer obliging and avoiding conflict management style such that they are indirect rather than confrontational when dealing with conflict (Boonsathorn, 2007). According to McCann & Giles, 2004, to avoid conflict, Thai people often display an emotionally neutral state of "cheoi," which means to remain calm by not expressing one's true feelings even in uncomfortable situations. For instance a Thai person may be upset by what another person said to them but may still choose to remain *cheoi* in order to preserve the other person's *face* and maintain interpersonal harmony in the situation (McCann & Giles, 2004).

In the healthcare context krengjai or cheoi may inhibit effective collaboration between health professionals, as nurses may not feel empowered to communicate disagreement with doctor's medical decisions. This might be because nurses don't want to embarrass the doctor or in other words they want to save the doctor's face. The extent to which communication norms such as these affect healthcare delivery is yet to be fully explored.

Filial Piety

The concept of filial piety, seniority, or respect to elders is highly regarded in Thai society. Elders are placed at a higher rank on the social hierarchy. They are well respected, cared for, and are seen as the sources of wisdom from which younger individuals are expected to learn

from (Burnard & Naiyapatana, 2004). However, this concept may act as a barrier to intergenerational communication between younger and older adults and this may be problematic in healthcare settings. McCann, Ota, Giles and Caraker (2003) used CAT framework to study Thai intergenerational communication and found that older individuals are usually non-accommodative towards individuals from younger generations. Consequently the younger individuals also reciprocate this non-accommodation such that they report the highest levels of respect/obligation and avoidant communication towards the older adults.

In addition, the Thai communication code is also tied to the idea of filial piety. For instance, generally in English, "I" is commonly used as the first person pronoun and "you" is used as the most common second person pronoun; however, in Thai, there are up to 17 different first person pronouns and 19 different second person pronouns, which are specifically used in different contexts and varied in term of politeness and intimacy (Chantornvong, 1992). The complexity of these communication norms is likely to influence healthcare communication and thus needs to be investigated. Thai individuals are also expected to show respect to elders through the greeting of *wai*, which is bringing both palms of the hands together chest high, and slightly bending the body forward. Individuals who do not raise their hands or wai to their elders are viewed as disrespectful (Sriussadaporn-Charoenngam & Jablin, 1999). This tradition emphasizes the senior hierarchical nature of Thailand.

Healthcare Communication in Thailand

Srismith (2010) studied the types of communication present in Thai hospitals, relying on Gibb's (1961) communication system where he grouped the communication climates based on the speakers' stance: supportive or defensive. The results from this study showed that

communication in Thai healthcare was based on the supportive communication climate. This means the hospitals were well structured in terms of roles and position of staffs, job descriptions, and the distribution of staffs in each division. The system was found to facilitate communication among Thai health providers because the staffs were aware of who the appropriate receptors of their messages were and what the optimal medium was.

Also, Srismith (2010) found that the communication in Thai hospitals was facilitated through the use of technology among staffs and with the patients. They were open to communicate through online channels such as Internet, Intranet, online message boards, as well as through offline channels such as mobile short media service (SMS).

Furthermore, defensive communication is mainly used by superior hospital staffs. The defensive communication climate refers to a top-down communication process related to staffs' communication attitudes and behavior. For instance, if a manager makes a decision, subordinates are expected to execute it without further questioning or reasoning (Srismith, 2010).

Thai values also influence healthcare communication in Thai hospitals. Smith (2015) research on the procedure of care during child labor and delivery found that Thais showed respect for elders through body language and gestures, most explicitly through the use of the "wai" gesture, especially as those who were younger were expected to 'wai' to greet those who are older. Moreover, using soft voices and maintaining eye contact were also mannerisms used to show respect. The study also revealed that these Thai cultural values, beliefs, attitudes, and traditions influenced the way medical staffs planned patient care strategies.

In line with Smith's report (2015), Srismith (2005) revealed that the attitudes of Thai operational staffs were influenced by Thai cultural beliefs, namely seniority and harmony. Seniority refers to a belief that juniors must pay respect to and obey superiors, while harmony

places an emphasis on maintaining amicability and avoiding conflict amongst a group. Due to practicing these beliefs, confrontations between subordinates and superiors in Thai healthcare were rare.

Even though there are some communication studies in Thai healthcare, there is currently still a gap in the literature that exists regarding the study of social identity and communication within the Thai healthcare system. Thus, the current study used SIT and CAT as theoretical frames through which to explore the effects of identity and communication in interactions among health professionals within the Thai healthcare system in a hospital in Bangkok and perceptions of how these factors affect healthcare delivery.

Current Research

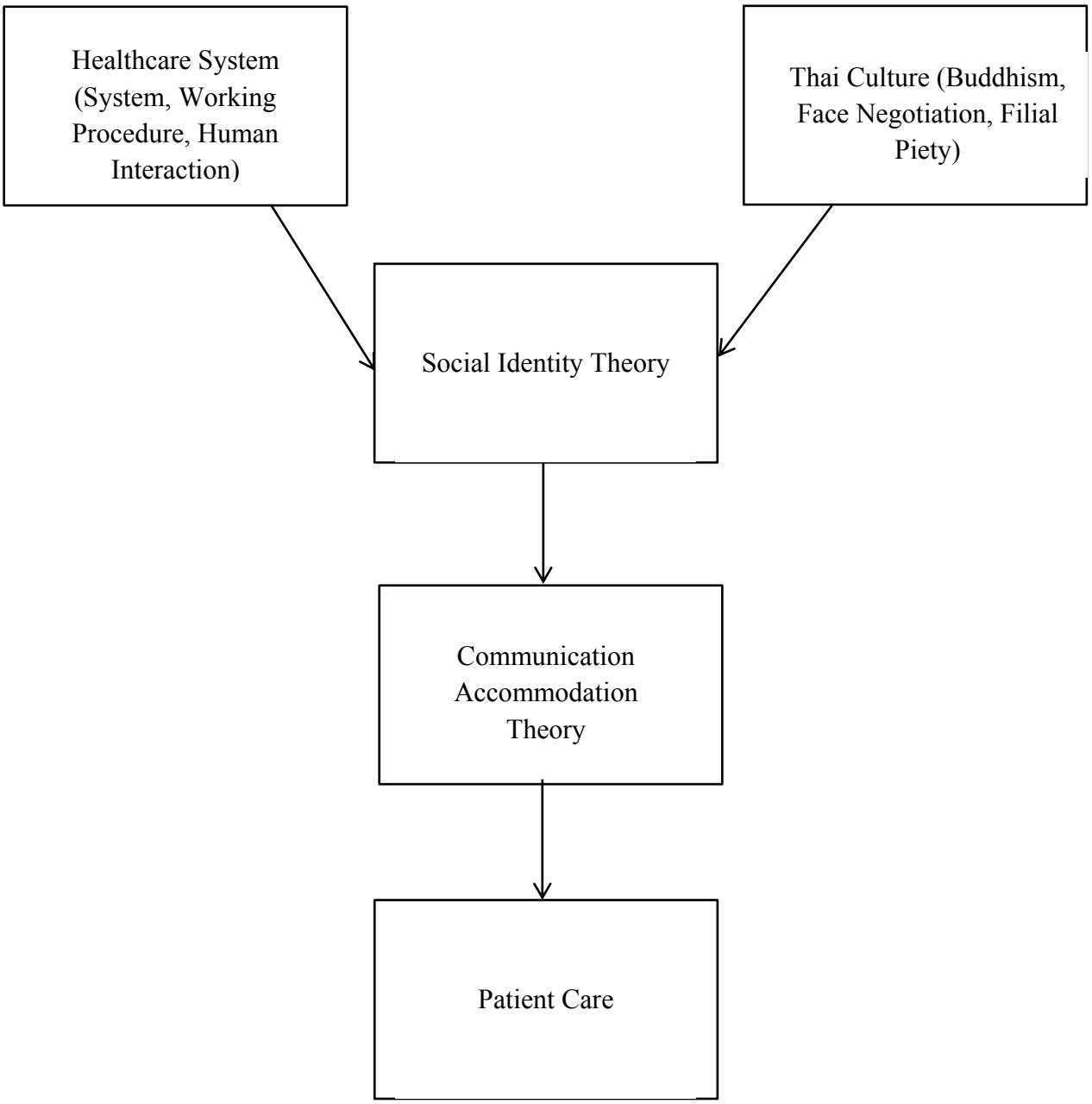

Figure 1. Current research framework

Research objective

This research explored Thai healthcare communication using the SIT and CAT framework. In addition, as mentioned above, Thai culture has many unique cultural customs, traditions and, values that may affect their communication style. Thus, this research also took into consideration those factors when exploring the communication within Thai hospitals

Research questions

1. How does social identity affect interactions among health professionals in Thai healthcare?
2. How does communication affect delivery of healthcare in Thai hospitals?

Expected benefits

1. To understand how social identity affects the communication processes in a Thai hospital
2. To further study how the elements of Thai culture (Buddhism, face negotiation and filial piety) influence the process of social identity formation and thus, affect the communication process among Thai hospital's staff.
3. To highlight the need for additional research and inform the further development of communication theories for application to future communication research in Eastern healthcare contexts.

Chapter 2: Methodology

Overview

The aim of our study was to conduct an exploratory qualitative study to examine the effects of intergroup relations and communication on healthcare delivery, utilizing the theoretical frameworks provided by SIT and CAT. We explored these dynamics through the perspective of the healthcare staff from two hospitals and one private medical practice located in Bangkok, Thailand. Their views were analyzed to provide an understanding of what helps or hinders the provision of high quality patient care.

The effects of intergroup dynamics on healthcare delivery have been identified in a growing body of research. Early work in this domain was done by Watson and colleagues (2012), who identified intergroup dynamics through the lens of SIT and CAT, and explored how these dynamics influenced the communication between medical professionals and ultimately the quality of patient care. A research project by Leach, Watson, Hewett, Schwarz, Gallois, Seoane, and Giles (in press) extended this research by qualitatively examining the opinions of representative health professionals across the hospital hierarchy, including managers, and used SIT and CAT as their theoretical framework. These researchers conducted a transnational study to examine the effects of intergroup relations and communication on healthcare delivery and patient safety in Brisbane, Australia and New Orleans, United States of America. The researchers used one-on-one interviews to seek health professional opinions. Although studying two distinct cultures, their research sample was nevertheless limited to two individualist Western societies.

Our proposed exploratory study further extended this health services research and was conducted in Bangkok, Thailand to explore these factors in an Eastern collectivist society. It is a replication of research conducted by Leach and colleagues (in press), and thus the methodology,

sampling design, data collection method, materials, and analysis methods were all informed by their research. This is because we found that using qualitative interviews was most appropriate for the current research, as it would allow us to receive in-depth insight on the social interactions and communication among hospital staff. Using convergent interviewing (CI), Leach and colleagues (in press) have identified themes and recurring issues progressively in each interview in order to develop probing questions to be used in later interviews. Since the themes of SIT and CAT have already been highlighted through their research, we decided to utilize them and conduct semi-structured interviews to explore the effect of social identity and communication in healthcare within the Thai context.

Sampling methods

Together, the sampling scheme, sample design, and sampling size of our research all contributed to help us explore our research objectives and questions.

Sampling scheme. We used a convenience sampling scheme, which involves selecting participants based on their availability to participate and the ease of their access (Teddlie & Yu, 2007), due to time constraints. This was done by utilizing personal connections to seek medical staff from different hospital. We systematically selected a balanced number of participants from different levels and departments from any hospital in Thailand, so to ensure no one occupational group's opinion was over or under represented and the different groups could be compared (Teddlie & Yu, 2007).

Sample design. We used a multi-level sample design, which involves sampling and comparing two or more subgroups belonging to different levels of the study sample (Onwuegbuzie & Leech, 2007). In this case we sampled two staff members from each hierarchical level of the hospital. Specifically, we included two directors or executive level members, two administrative officials,

two doctors, and two nurses. We chose to use a multi-level purposive sample design in order to gain perspectives from members of different positions in the hospital hierarchy, to explore the intergroup relations between them, and to have the opportunity to compare the influence of their differing social identities on their views of healthcare delivery and patient safety.

Inclusion criteria.

1. The participants were full time hospital staff that has been working at the hospital for a minimum of 2 months.
2. The participants were from one of the hierarchical levels that we are interested in.
3. The participants were willing to participate in sharing their experiences.

Exclusion criteria.

1. Any participants that showed discomfort or disinterest in sharing their experiences would have been excluded from the research.
2. Any participants that expressed a desire to withdraw from the study for any reason were reassured by the researcher that they are free to do so without any prejudice.

Sample size. We had sample size of eight participants. While the sample size is small due to time constraints and due to the research being a small exploratory study, it is an appropriate size for qualitative research using interviews. We hope that our study leads to a larger research study in the near future and expands on the sample size. The small sample size, however, allowed in depth analysis of each interview.

Access. We received access to our six interviewees, directors, nurses and administrative staff, through the director of the hospital, who played the role of a gatekeeper. This gatekeeper was found through a personal acquaintance and was contacted by one of our researchers through

email. The other two interviewees, who are doctors from other medical organizations, were contacted through personal connections of the researchers.

Setting

Two hospitals and one private medical practice located in the Bangkok Metropolitan area of Thailand were used to conduct the study. Both hospitals were equipped with 150 beds.

Instruments

Our research consisted of the following instruments that were used during the interview.

1. ***Interviewers.*** The two researchers themselves were one of the instruments, as they conducted the face to face one-on-one interviews, and conducted the data analysis manually. The two researchers were fluent in Thai and English, and were trained by an experienced qualitative researcher to do so. The details of their training session are outlined later on in the paper. One researcher abstained from the role of the interviewer due to language barriers, as she is not fluent in Thai language. The interviews were conducted in Thai language for the comfort of the interviewees as it is their native language and the language used at the workplace. All three researchers were instruments for the data analysis.
2. ***Information sheet.*** The information sheet (See Appendix A and B), includes brief descriptions of the researchers and our study.
3. ***Informed consent form.*** The informed consent form (See Appendix C and D) outlines the interview procedure and requirements that the interviewee agreed to before proceeding with the study. We proceeded with the interviews only once the interviewees consented by signing the form.

4. ***Interview Guide.*** Our four-item interview guide (See Appendix E and F), was used to guide a semi-structured interview. The interview guide consists of four open-ended questions that are designed to encourage a fluid conversation that naturally elicits topics that are under our area of interest, without excessive probing, such as using leading questions or demonstrating an expectancy bias. However, probing and follow-up questions were used when relevant, as the interview guide is a flexible instrument. It has been designed and sequenced in order to guide interviewees' focus towards healthcare communication and social identity issues. Each question of the interview guide was designed by the interviewers and its content and order were approved by our advisors. For example, one of the questions on the interview guide asks, "**จากประสบการ์ณทำงานในโรงพยาบาล คุณคิดว่าอะไรเป็นปัจจัยสำคัญสำหรับการรักษาคนไข้ที่ดี? ยังไงค่ะ**?" This translates to "From your experience working in this hospital, what factors do you think contribute most to good patient care and how?" Both Thai and English versions of the interview can be found in the appendix (See Appendix E and F, respectively).
5. ***Note taking Materials.*** Each interviewer used a notepad and a pen to collect data not recordable otherwise, such as noting interviewees' facial expressions and body language. Permission from the interviewee was taken for note taking in the consent form.
6. ***Audio recorder.*** An audio recording device was used to collect data during the interview. Permission from the interviewee was taken for audio recording in the consent form.
7. ***Transcript.*** The audio recordings were transcribed into transcripts for analysis after the interview. During the transcription process, all participant, department, unit, or hospital identifying information were deleted. The de-identified transcripts were used for coding and data analyses.

Data Collection Methods

Semi-structured Interview. Leach and colleagues (in press) used convergent interviewing (CI) as their data collection method. This involves the researchers asking open-ended questions and building on knowledge progressively using probing questions developed from earlier interviews. During the CI procedure, themes, ideas, and common issues are identified from the interviews. Our research also used semi-structured interview as our method, based on the preliminary findings of Leach and colleagues' (in press) study. According to Smith (2015), semi-structured interview is a method that is more flexible, compared to structured interviews. This is because the interviewers can follow the questions in the interview guide but the order of the questions can be sequenced based upon the response from the interviewees. Moreover, follow-up questions or probes may be used to elaborate on any interesting points that come up during the interview about which the researchers may have initially been unaware of. In short, the interviewees' responses will lead the direction of the interview rather than letting the interviewer be the lead. Therefore, the amount and quality of the information from the interviewees may be denser and richer than structured interviews. Hence, the semi-structured interview approach was selected as a means of collecting our data.

Interview Procedure

The following interview procedure is guided by Jacob and Furgerson's (2012) instructions on conducting an interview for qualitative research.

Interview Overview. In this study, the two student researchers took on the role of the interviewers. Six of the interview sessions were held in quiet rooms at the hospital to ensure confidentiality, exclude potential distractions, and allow convenience for the interviewees. However, two interviews were conducted in an opened office space due to unavailable space.

The interviews were conducted with a one-on-one semi-structured format, where there was only one interviewer with each interviewee at a given time. However, in line with the CI method, two interviews were conducted simultaneously in separate rooms.

Interviewer training. The two researchers were trained by their advisor Dr. Nattasuda Taephant, who is an experienced qualitative researcher from Chulalongkorn University. Consistent with training for the CI method, their training involved practicing appropriate body language use, tone of voice, and probing questions. The appropriate body language use involves leaning slightly forwards as to seem interested, maintaining eye contact, nodding appropriately, and maintaining an open posture without crossed arms. This also includes sitting at a comfortable distance, avoiding physical contact, and maintaining an accepting and attentive attitude and facial expression towards the interviewee. The interviewers were also taught to respond to interviewees' responses and summarizing their responses back to them at times, paraphrasing, to demonstrate understanding and attentiveness. The interviewers were advised to conduct the interviews at a steady pace without making the interviewee feel pressured or rushed (Gill, Stewart, Treasure, & Chadwick, 2008)

Trial interview. Before conducting the actual interview, the researchers conducted a trial interview with a medical practitioner who was contacted through personal connections. This assisted the researchers in practicing their interviewing skills as well as provided them with feedback about the functionality of the interview questions and how to adjust them accordingly.

Interview orientation. Researchers started the interview by introducing themselves and the project they are working on to make the interviewee feel comfortable in answering questions. The consent form and informational sheet were handed out to the participant for ethical reasons and to make sure that the participant understood the objective of the project. Importantly, it is

imperative to note that no interview was conducted if the interviewee did not agree and did not sign the consent form. Additionally, the interviewer asked the interviewee for permission to use the audio recorder, its extracted transcripts, and the handwritten jottings as data. The interviewer allowed the participant to ask any questions related to the procedure or the general information of the research. The interview session only commenced once there were no further questions and the permissions were granted from the interviewee.

Interview session. Importantly, the interviewer created a natural environment where the interviewee could feel comfortable to answer the questions. This was achieved by ensuring there were no distractions in the interview room and making the interviewee feels comfortable at all times according to the training detailed earlier. The researcher also had to observe the body language of the informant by jotting down the information in the notepad in order to use this information in the analyzing process.

In the interview session, the interviewers followed the interview guide from the beginning to end. The questions were asked one at a time and were followed by probes or follow-up questions based on the interviewee's responses. However, in the case that the interviewee misunderstood the interview questions, the interviewer rephrased the question to create a clear understanding for the interviewee. Yet, the formulated questions and the probes excluded any leading questions that can elicit any bias or expected answers from the interviewer.

Before the interview session was scheduled to end, the interviewer allowed the participant to share any information he or she wants to add to the interview that may not have been visited during the interview. At the end of the interview, the interviewer also explained how the data will be used and presented.

Post-interview procedure. At the end of the simultaneous interviews, both researchers met privately with the third researcher to briefly discuss the responses they received from their interviewees. This discussion facilitated their understanding of the broad content of the interviews and how they went, and helped guide what changes they can make in future interviews, such as which probing and follow-up techniques have been effective, or need to be added (Leach et al., in press).

Time. Interviews were conducted over a one to two month period. Two trial-interviews were conducted prior to the focal eight interviews. Each interview lasted about 15-30 minutes. Post-interview transcription and subsequent data analysis was completed within one month of data collection.

Data Analysis

As part of the CI procedure, each interviewer immediately met up after each interview session to summarize, reflect and note down key points. These collaborative discussions between interviewers guided subsequent interview sessions. For example, it may be appropriate to add a probe or explore a common point raised further.

After collecting our data through the interview sessions, we conducted our data analysis. We used guided thematic analysis, which is a qualitative data analysis method informed by the theoretical frame chosen by the researchers and aimed to identify patterns across the data (Clarke, Braun, & Hayfield, 2015). The details of the thematic analysis are as follows.

1. The first step was to familiarize ourselves with the data. This was done by the interviewers who listened to the recorded interviews and then conducted a verbatim transcription. In addition to transcribing the interviews, the interviewers also took into consideration the handwritten notes taken during each interview about the interviewee's non-verbal facial expression and body

language, as well as the notes that were taken in-between the interview sessions after discussion amongst the researchers. The interviewers then re-read the transcription twice to check the accuracy and removed any identifying information about the interviewee or the study hospital.

2. Next was the translation process. Out of the eight interview transcriptions, each interviewer translated four of the transcriptions from Thai to English. Then each interviewer checked the other's work to ensure consistent translation and accuracy.

3. After translating the data, all three student researcher team members then went through the data by re-reading it twice in order to familiarize ourselves with the content of the data and understand it better.

4. The next step was initial coding, which was manually done by each of us researchers. We re-read the data again and coded it according to similar content and any emerging recurring issues.

5. Once we collated a list of codes, we categorized them into themes, categories, and subcategories. This process was predominantly "theory driven," which means that we were coding the content of our data based on the framework of SIT and CAT. However, there could be overlaps, and certain data fell under multiple themes and categories, while some data did not fall under any code. For such data, new themes were formulated. Then we compiled a thematic map and explored the relationships between the different themes and subthemes in our data.

6. We then revisited the definition of each theme in order to make sure that there is a clear distinction between them. This is done by going back to the codes and rereading the extract from our data to understand how it forms a coherent logical pattern and appropriately falls under a specific theme.

7. According to the themes and categories, the findings will be reported in the paper. In this process, the relationships between the data and the themes will be conveyed in a concise and understandable manner.

8. Finally, we considered the trustworthiness of our research by analyzing the validity and reliability of the results of the data analysis.

8.1 Analyzing the validity involved examining the accuracy of the data analysis results through two main strategies.

i. Peer debriefing: This involved verifying the results with experts of the field, which will be done by approaching our two advisors, Dr. Nattasuda Taephant and Dr. Lori Leach.

ii. Clarifying researcher bias: Unlike quantitative research, qualitative research does not aim to extract bias from research by manipulating variables in controlled experiments. Qualitative research accepts that bias can never be completely removed, and instead, acknowledges the existence of such bias (Pannucci & Wilkins, 2011). This was done by providing a researcher stance for each researcher, as to ensure that any biases held by the researcher that may influence data interpretation are foregrounded.

8.2 Analyzing the reliability and the replicability involves examining whether similar results would be achieved if the research were repeated. This is achieved through two main strategies.

i. Audit Trial: The interview guide, all recordings, transcripts, data analysis and handwritten notes are kept in a secure, accessible location for future reference and any future replication studies.

ii. Inquiry Audit: We checked the accuracy of the data analysis process and results by verifying the data analysis results with our advisors at each stage of analysis.

Ethics

Before conducting a qualitative study, ethical issues must be addressed. We received consent to proceed with this research from the Joint International Program in Psychology (JIPP) program committee and the board of the hospital where we intended to conduct our research. Firstly, consent was gained by requesting permission from the university research board at Chulalongkorn University. Secondly, informed consent was gained from the director of a public hospital located in Bangkok, Thailand. Once these permissions were granted, each individual interviewee was asked for their informed consent, meaning their permission was taken after explaining the entirety of the study's procedures, through an informed consent form (See Appendix C and D) on the day of the research. This included the permission to audio record the interview, to transcribe the interview, and to translate the interview transcript from Thai into English. Participants were also asked for permission for the de-identified aggregated data to be published in the scientific community. Participants were also informed that their participation is voluntary and they may choose to not participate, pause the interview, or withdraw consent at any point. In addition to this, all responses and identities were kept anonymous and a randomized interview number will be used when referring to each interviewee. The data responses we received, including the observational notes and the audio recordings of the interview are secured on a password-protected drive to ensure all information is kept confidential. We intend to ensure no physical, mental, or emotional risk or harm is implicated onto the participants. However, under any circumstance the participant seemed to report or display any discomfort, an opportunity to temporarily pause the study or withdraw completely would be offered. However

none of this occurred. Before conducting the interviews, each of the interviewers underwent two mandatory interview training sessions conducted under the supervision of our co-advisor, Dr. Nattasuda Taephant, who is an experienced qualitative researcher from Chulalongkorn University. The training sessions involved using appropriate techniques such as eye contact, body language, and language to ensure our interviews are effective and ethical (Lincoln & Guba, 1985).

Researchers' Stance

This qualitative study is conducted by three researchers as a part of their senior thesis required for their graduation with a Bachelor of Science degree from the faculty of Psychology, Chulalongkorn University in Bangkok, Thailand. One of the researchers has previous experience volunteering with Dr. Lori Leach in her research on communication and social identities and their effect on delivery of efficient healthcare in Brisbane, Australia, and thus may be biased to expect similar findings in this research as well. The other two researchers are new to this field, and thus may not have such bias.

Post-Data Analysis

As described in the methods, the researchers conducted a guided thematic analysis of the interview transcripts after translating them from Thai. Recurrent keywords, topics, and themes were identified and based on this the themes and subthemes were generated. These themes and subthemes were organized, polished, collapsed, and re-grouped based on their significance and prevalence. The developed themes and subthemes were as follows:

- Communication
    - Importance of Communication
    - Negative Consequences of Miscommunication

    - Medium of Communication
- Traditional Role Identity
    - Traditional role
    - Hierarchy
    - Leadership
- Resources
    - Time/Staffing
- Thai Cultural Values
    - Seniority/Filial Piety
    - Harmony
    - Hospitality
    - Duty Towards Nation

The findings of this paper will first provide brief information about the informants. It will then provide descriptions of these themes and subthemes, as well as the interviewee quotes that guided their development.

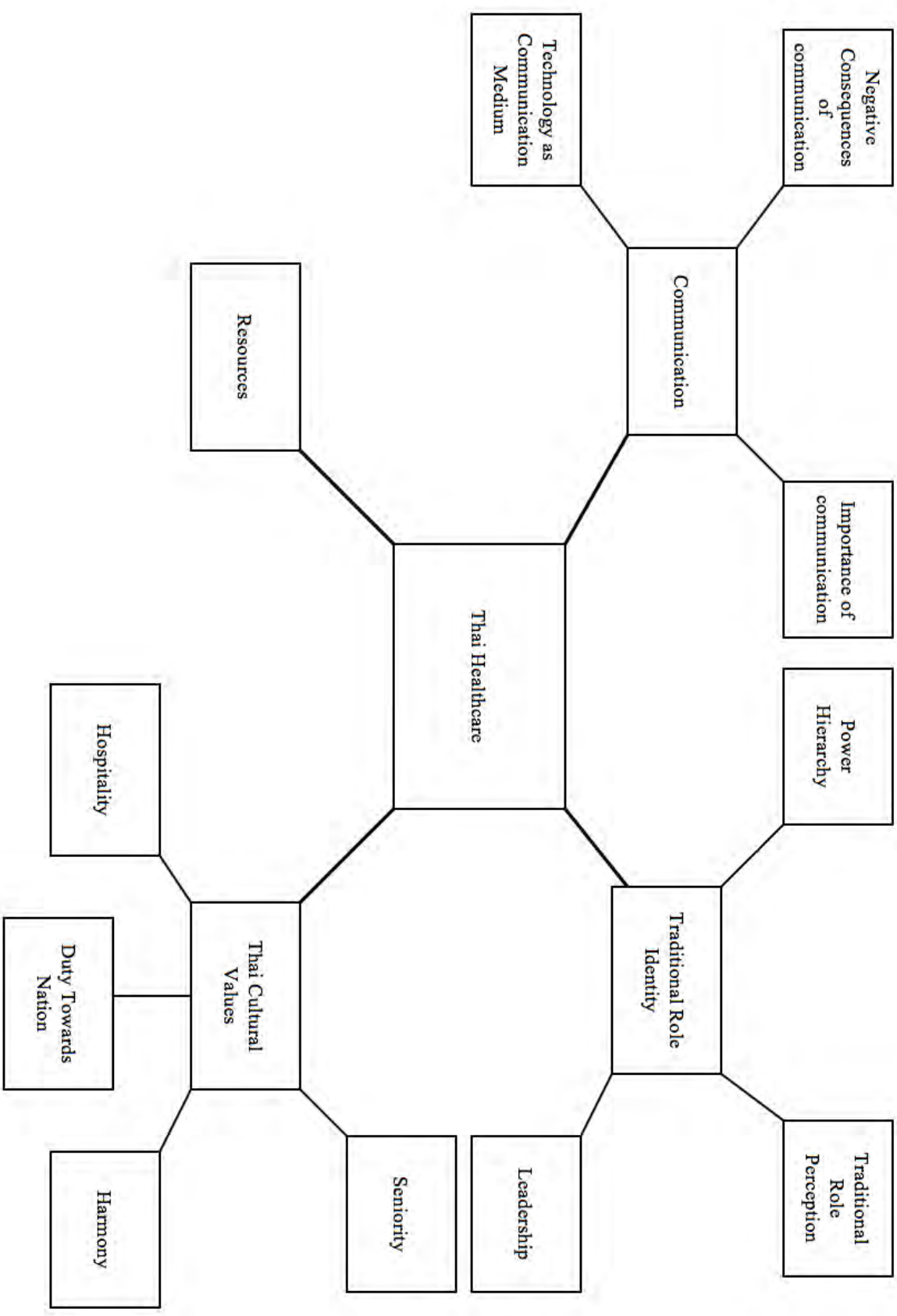

Figure 2. Concept map illustrating themes and subthemes

Chapter 3: Findings

This chapter of the paper will report the findings of this study. Firstly, information about the informants is provided briefly. The developed themes and subthemes are explained, and are supported by the interviewees' quotes that guided their development. Each of the quotes are taken from the interview transcripts. The quotes are followed by an abbreviation representing which participant the quote is taken from (e.g. P1 from participant 1, P2 from participant 2, etc.). The quotes are followed by brief analyses.

Informant Information

Participant 1. Participant 1 is a deputy director aged around 40 years old. He wore glasses and was dressed very formally in a white long-sleeved shirt with golden adornments. His hair was styled with hair gel, neatly and sharply set. The interview was conducted in his private office, which was brightly lit and located in the top floor of the hospital next to the director's office. Participant 1 talked very fast before and during the interview. He was agitated giving the impression of being in a rush. He answered each interview question very descriptively; most of the time ending each response by repeating and making sure that the interviewer understood what he was saying. He always maintained eye-contact with the interviewer and was very confident and firm with his answers.

Participant 2. Participant 2 is a hospital director whose age is approximately 40 years old. She was dressed up in a formal outfit with her eyeglasses. She was polite and calm throughout the interview. Her office is isolated from the other hospital areas where patient were treated. It is located on the top floor with two entrance gates before reaching her office. At the beginning of the interview she requested in a friendly manner to shorten the interview to 15 minutes due to her upcoming schedules. However, the interview session went on for almost 20 minutes with her enthusiasm to share her life experiences and attitudes towards the interviewee's topics. The

information she gave was mostly involved the healthcare system in general and her roles as a director of the hospital.

Participant 3. Participant 3 is an obstetrician at his own clinic and was around 60 years old. He is a husky man, quite tall with broad shoulders and a bulging tummy. His hair is thinned and light gold. He was dressed in a long sleeved shirt. The interview was conducted in his private office, which is a small room lighted with neon light. Before the interview, he took around 10 minutes to thoroughly read the information sheet. During the interview he talked in a deep and hoarse voice while sitting in a laid back manner, occasionally twisting his office chair from time to time. He was very confident during the interview, assertively and elaborately answering each question by giving concrete examples from his past experiences.

Participant 4. Participant 4 is a middle-aged dentist who works both at the hospital and at his own private clinic. His gestures and the way he spoke was friendly and calm. He paused a lot to think, and laughed often during the interview. The interview lasted for around 30 minutes due to the distraction from people who walked past.

Participant 5. Participant 5 is a nurse. She is in her 40's. She is a petite and chubby lady with a plump but warm face. She was dressed in her nurse's outfit. Due to a lack of space, the interview was conducted in a shared office space at an empty table in the corner of the room. Participant 5 talked in a very steady pace. During the interview, sometimes her eyebrows would furrow, and she would look down when certain interview topics were touched on. At the end of the interview she showed nervousness about her previous interview answers, and seeked confirmation from the interviewer that what she shared about a doctor would not be used against her.

Participant 6. Participant 6 works as a breastfeeding nurse and referred to herself as "Miss Breastfeeding" throughout the interview. She is in her late 40s. She was dressed in her nurse

uniform. The room where the interview as held is an instruction room that is full of tools and equipment for teaching female patients how to breastfeed their babies. It appeared that she has a deep passion in sharing experiences regarding her role. She gave some breastfeeding demonstrations to the interviewer and referred to her as 'child'. Moreover, she told the interviewer about the achievements her unit received throughout the years. Interestingly, the interviewee avoided eye contact with the interviewer most of the time.

Participant 7. Participant 7 is an administrative officer. She is a lady in her 30's. She wears glasses and is stoutly built. Her hair is dark brown and is cut at shoulder length. She wore a light pink short sleeved shirt. The interview was conducted at her office table in her department office, a medium sized room which she shared with 10 other people. There was loud Thai music playing in the background throughout the interview. Participant 7 seemed very cautious about her answers, repeatedly asking the interviewer whether she is correctly answering the question. At the end of the interview she was very eager to learn more about the present research and expressed enthusiasm in reading the finished interview transcript.

Participant 8. Participant 8 is an administrative officer, in the department of Financial Budgeting and Accounting at the hospital. She has been working at the hospital for 2 years, and it is her first job since she graduated. The department is located near the director's office and other management sectors. The interview lasted for about 26 minutes in a non-private room. During the session, she tried to use real life examples to support her points, although she had to pause to think most of the time. The language she used differed from the director's in the sense that it was non-formal and easy to understand. Possibly due to being of a similar age to the interviewer, the interviewee was more open to talk. Overall, she was willing to share her

experiences, thoughts, and feelings in response to the questions. She frequently mentioned the importance of good patient care and collegiality amongst staff.

Themes

1. **Communication.** This theme is about communication processes between hospital staffs and departments. According to SIT, each individual may have different social identities within the hospital depending on their roles and departments. Thus, each individual may psychologically identify with their roles and value their position in the hospital. This different social identity may affect the different communication styles and strategies each participant uses to communicate with the different positions or departments in the hospital, as predicted by CAT. Overall, the participants mostly mentioned about the importance of communication, negative consequences that can arise from miscommunication, and the use of technology to enhance communication between staffs and departments within the hospital.

    1.1 Importance of communication. This is when the participants explicitly state the importance of communication and describe the communication pattern in the collaboration of different hospital staffs and departments. Participants mostly talk about how communication should go in the same direction and needs to be clear in order to enhance staff's understanding of one another.

> "For one, when you are going to speak, think before you speak, right? Whether our words will hurt others because of some issue, it can be interpreted in many different ways. When it can be interpreted in different ways, communication is so important, we have good intentions but other people may think we have bad intentions…..Because if we keep doing it, every year, do it every year in order to create a culture of good communication for them to know, or good relationships, it will make a happy organization, do you understand?" [P1]
> "If we have clear communication it will help the working process go smoothly...Between nurses and doctors? There needs to be a discussion. We rely

on activities within the hospital, activities that exchange knowledge or activities when there are different events in the hospital like World Diabetes Day, World Kidney Day." [P2]

"In reality, to fix the problem there needs to be more communication and open opportunities for patient to ask, does the patient want to ask the nurses anything before going home? Is there any reason they are not ready to go back home or they want to go back home and there's something they want to know?" [P2]

When the interviewer asked if communication is important in the participant's

working process, the participants responded with the following:

"Oh it affects. It affects because sometimes staff needs to communicate with one another because it's how… so information will go in the same direction because if like right now, we mainly use the method of medical recording. If there is consultation from different departments from different fields, there will need to be a medical record of inpatient. Once there is record, nurses will have to check and when giving that patient information, the information must go in the same direction." [P2]

"We also have to rely on talking in communication. Recording only is not possible. [Because] Mostly nurses only read [medical records]" [P2]

"Therefore in any kind of hospital, I believe there needs to be a regular conference. Ideally, there needs to be morning round every morning where each staff from each department comes together, including the manager. Here, there will be a discussion about what has happened the previous days and how should today be carried out, if there is any problem awaiting or any misunderstanding or damage that happened, so we can know, find solution and make plans." [P3]

" I believe that intercommunication between departments has a lot of involving factor. If we are able to link the understanding of each staff's then I think it's good. Knowledge and understanding of each staff, in theory, must go in the same direction." [P3]

"There needs to be communication. Without it we don't know if there is accurate information….If there is a problem, we need to know if our problem affects other people and if other people's problem affects us, how can we solve it." [P4]

"Yes like for myself I have to receive the shift in the morning and talk to the doctor every day, therefore the problem will not slip away." [P6]

"Sometimes there can be a mistake or confusion. We need to ask and contact them, there needs to be cooperation from every department every unit. And with the pharmacy and doctor, we all have to communicate." [P8]

"Very much. Within unit as well because when changing shift, sometimes we have to leave it with them. If there is a case on hold, if there is an in-patient whose relatives will come a pay for the medical fee and there is a problem, this one we have to communicate to the next shift. And with people in the same unit but different department is very important. It's like we have to give the patients our best, we have to collaborate to give an answer to patients." [P8]

"Yes, within unit we will communicate and understand one another. If we have any problem we can call and talk to that person even if they are away. They've worked there for a long time so we can talk and communicate with them always, "like I have this problem, how do I solve it?" it's like working together." [P8]

1.2. Negative consequence of communication. This is when the participants talk about how bad communication or miscommunication can lead to negative consequences such as risk to patient care and safety.

"Because if we communicate incorrectly like saying this case needs this kind of medicine but someone, for instance, say something a tiny bit incorrect, it can cause mistake in treatment. Communication is the most important thing and it is the hardest thing to fix." [P1]

"Or else if they miscommunicate there will be conflict whether psychologically or physically or from whatever. Conflict is part of miscommunication." [P1]

Participant 2 talks about how bad communication can have negative consequences such as patients misunderstanding their own medical condition

"Sometimes the issue that patient are unhappy with the hospital, partly is the information. Not receiving enough information or false information. And sometimes hearing doctor talk to nurses but didn't hear it clearly and personally interpreting that it's like this. And if that issue is not something that staff take interest in and patient didn't ask, maybe it will be overlooked and patient will misunderstand." [P2]

"Here there may be too little talk. Sometimes this makes the patient worried once they know what diagnosis they have, doctors may say something that is sometimes understandable sometimes not, and patients never got a chance to ask." [P2]

Participant 3 gave an account of how bad communication can affect patient care in emergency situation, such as when the patient who is in labor has a prolapsed cord. He emphasized that in this situation, everyone must understand that it is an emergency event and shouldn't follow normal anesthetizing routine, which will waste a lot of time.

"Sometimes I said emergency, and the staff is still bleaching the patient's skin. Once the patient is anesthetized, I must be able to do bring it down immediately without bleaching. Bleaching is for later. Bringing the baby out first and whatever needs to be done can be done later. Once the critical time is passed then what's need to be done can be done. Bleaching and applying medicine can be done later but this emergency crisis needs to pass first." [P3]

CAT can be observed here when Participant 4 explains how different doctors can use language that may affect how they collaborate with one another in delivering good patient care.

"Maybe how they write it's not clear. Cannot be explained in a way for us to understand, using language that we don't understand, but it doesn't mean that it's wrong." [P4]

"If we happen to not communicate, the person at the other end will not be notified. Things will not proceed. Or if the message is received at the end but there is not understanding behind, must rewind and ask why or else there will be this and that. There are a lot of stories to it." [P5]

"Like for instance if there is bad relationship there will be some kind of avoided communication. Avoid to not communicate. Not telling stuff. Something like that. It will have bad consequences." [P5]

"Like if we don't feel good towards them we will talk to them badly. We will then get something bad in return. There will be bad feeling. When asking for favors, it gets harder." [P7]

"We send it through paper. We don't talk. We send it through computer and talk once we send the wrong person or we mix up the queue. We will talk then." [P7]

When the interviewer asked if the participant has ever found it difficult to continue working due to communication problem.

"Yes. It's my first job, there will be issues like this. Like I don't know and call to ask to make sure for the sake of the patient. I will give in here because I understand that I am new. They, some units, they are happy to answer the question but some people, sometimes, they don't understand us." [P8]

When the interviewer asked the participant if there had ever been a time when they had to ask their colleague to recheck certain information.

"There has been a lot of time. Like for instance, this medication might be wrong, because there has been double the cost or instances of prescription. The cost of cleaning wound has doubled, or sometimes doing physiotherapy but there is no cost. So we need to call and notify them." [P8]

"Like patients can use their rights from the gold card. But that department I don't know how they miscommunicate. Patients ended up having to pay for themselves, but they can use the card rights but with other places. So the person who grants the right must communicate to the beginning person." [P8]

When the interviewer asked the participants for examples of when there was a communication struggle.

"Sometimes there is. Patients lash out over there, that department then throw them here and we then throw them elsewhere. In the end, where exactly do they have to go? We have to contact to find out where exactly the patient needs to go." [P8]

1.3 ***Technology as communication medium.*** This is when participants talk about how technology is used as a tool to enhance communication between hospital's staffs and departments. Most participants mention the use of phone application called "Line" as an effective way of communicating within hospital. Some nurses and administrators also mentioned using line as a way of overcoming communication barrier with higher level position such as director and doctor.

"We have Line[1], something like that. I think there are better ways. Can send photos. Like with X-ray result, before doctor needs to use film sheet to show but now they can take photo and send through line. Result of heart scan or something like that. This is communication of information. It is better" [P5]

> "Yes, sometimes we report verbally and they have to visualize an image. If we send a picture like of a wound, it will be clear how the wound is, is there any pus or something else. Can show the doctor what it is like before and after." [P5]
>
> "Yes. Nowadays there is Line. I think it is better." [P7]
>
> Participant 7, who works as an administrator, specifically mentioned how line is a good way for her to communicate with doctors. This is because sending messages through line would prevent her from seeing any negative reaction from the doctor.
>
> "If we have to Line again, the doctor would send "Thank you krub, if I have the time I will do it." There's no silence. I think it reduces the striking force because we don't know at that moment if we are there physically how they will reply. The feeling that we have for them will not be negative. If they maybe think like "here we go again," we are not there to hear it." [P7]

2. **Traditional Role Identity.** This theme is when participants' social identities in hospital are salient when they talk about their own or other staff's role in the hospital. This social identity may include the participants' roles and departments in the hospital, which they psychologically values and thus affects their behavior and work interaction with one another. They may talk about how different positions, levels and departments have their own norms, including expectations, thoughts, beliefs and behaviors. This is also when the theme of power hierarchy between different positions and levels of hospital become salient, participants who are directors and doctors show authority when identifying with their superior role whereas participants who are nurses and administrators are more reserved and humbled when talking about their working role in the hospital. Some participants also mentioned the importance of having a good leader in managing the internal working of the hospital.

    2.1 Traditional role perception. This is when each participant reflects on their own and other hospital's staff role and duty.

Director. This is the directors' opinions about their own and/or other occupational role.

Participant 2 who is a director clearly state the role of nurses as the communication bridge between doctors themselves or between doctors and patients.

"Right now in our hospital, what we do is that we have nurses who will help in terms of giving information, information about preparing to see doctor" [P2]

"Nurses have to have a systematic checklist for themselves about what kind of knowledge they want to give to patients." [P2]

"When doctors from different departments come in to check, nurses have to be there too because it's not just doctors communicating, doctors talk to patient and nurses have to be there, not just doctor alone. Nurses have to go too so there can be communication." [P2]

"If there is no communication between department maybe because doctor from one department and another department, like these doctors from two departments wouldn't walk in together, [they] need to rely on nurses as a communication medium. Therefore nurses have to always follow doctors. Doctor from this department comes in, you have to be there. Doctor from another department comes in, you have to be there because you are the bridge." [P2]

Doctors. This is the doctors' opinions about their own and/or other occupational role.

Participant 3, who is an obstetrician, stated that the doctor role is to have knowledge about different illnesses whereas the nurse's role is to follow doctors and to put doctor's knowledge and plan into practice.

"For doctors, it's knowing the disease, knowing how to predict the illness. Nurses need to know how to take care of patients and how to follow, follow doctors." [P3]

Participant 4 who is a dentist stated that during surgery, their role is to directly communicate with the patient whereas their assistant's role is to not talk. When

further probed after he mentioned that assistants remain quiet during operation,

Participant 4 responded,

"It's their role. We are the talker, we ask and communicate with patient. We talk to the assistant youngster too, if there is too many people talking, the patient might get confused." [P4]

Nurses. This is the nurses' opinions about their own and/or other occupational

role.

Participant 5 and Participant 6 who are nurses both acknowledges the doctor as a

knowledgeable role and themselves as following the doctor's plan.

"The care starts with the doctor, doctor will give diagnosis, plan the care, and diagnose what illness the patient has and how it should be treated. The nurse will be the one who use the plan to practice the care." [P5]

"The head there will advise [regarding the treatment]. Our duty is to see if the patient is on time with their labor or if still early" [P6]

Administrators. This is the administrators' opinions about their own and/or other

occupational role

Participant 7 who is an administrator mentions the doctor's job as being very busy

and their own role is to remind doctors to complete document deadlines.

"Yes yes, there will be times when doctors have a lot of work, they don't have time. But we, we have to remind them. It takes many of us need to do that, not just one person." [P7]

2.2 Power hierarchy. This is when the participants talked about the power

dynamic within the hospital as a result of the hierarchy of different staff's

position.

Superior's viewpoint. Throughout the interviews the director and doctor

participants identified with the role of a superior. This is shown through their

authoritative expression or defining the role of nurses and administrative staffs as that of an inferior.

> "Yes because there are different kinds of relationship. It doesn't have to be the relationships; well it's the relationship between doctor and nurse. We don't use personal relationship right? We use the relationship in terms of us being the doctor and them being nurses. We want to communicate in a way for them to communicate back to us like this. But with personal relationship, maybe being colleagues, being a junior colleague, maybe after work, social interaction is another story..." [P1]

Participant 1 was very authoritative about his role as the director of the hospital. The way he described communication between staff as "those under his command" or the communication direction as "top down," suggests that to him, communication is a top down authoritative command instead of a mutual interaction between different individuals.

> "We have to create correct understanding between those who are involved or those under command, right?" [P1]

> "We have to teach people and build team to communicate downwards and to make communication right. Or else from bottoms up they will communicate different, do you understand?" [P1]

Participant 2 mentioned that the owning doctor, or the doctor who is in charge of patient care, is the final decision maker even when in collaboration with doctors from other fields. This shows that even amongst the superiors, directors and doctors, there seem to be a clear hierarchy. He also mentioned that the person who leads is the doctor while other staffs play more of a supporting role.

> "There will be a consultation system. A consulting doctor will give advice but the person who will give the final decision is the owning doctor. Because in the case that this patient come in about bone issue, the owning doctor is the orthopedic doctor who will take the opinions of doctor from other fields into consideration when making a final decision on how to treat the patient." [P2]

"The doctors are the leader, lead maybe lead in thinking and coming up with ideas but the process needs to have the help from the working team to actually execute it." [P2]

Participant 3 is a doctor who authoritatively expressed his expectation that other staffs and departments must immediately follow his order in emergency situation. He also believes that the manager is the most important role in managing the interaction of hospital's staff.

"The surgery team must know immediately when I call them to say prolapsed cord; they must be ready to open a room for me within a matter of minutes. The anesthetists must be ready to put the patient to sleep or to immediately not feel pain in order for me to bring down the knife and remove the baby. [P3]

"Yes, I mean they have to know when I call and say prolapse cord. You need to know and prepare a room immediately. Notify immediately, notify the doctors immediately to be ready for me to bring down the knife within 5 minutes or less. I can bring down the knife within 5 minutes as well…altogether it will be 10 minutes, and I can deliver the baby." [P3]

"I am the sole owner with a few subordinates, therefore it is easy. But in hospitals with so many departments, the top managers, not just the director but also every position, the deputy director, the director of doctors or heads of different departments, they have to try to manage their own department to be able to engage in inter-departmental activities." [P3]

Participant 4 mentioned how he doesn't have to attend the 10 minutes morning meeting with other healthcare staff because he is a doctor. He also talks about how the assistant junior shouldn't give opinions and must only talk when they are talked to.

"When there is any discussion it will be the younger staffs that received information from the doctor. The doctor doesn't have to go into the 10 minutes brief." [P4]

When the interviewer asked about the morning brief, the doctor was unsure, and also referred to the assistants as youngsters.

"Not sure too, it's only amongst the youngster." [P4]

"During treatment there is none [communication]... [junior assistant] must be spoken to before they speak, do you understand?" [P4]

Subordinate's viewpoint. Contrastingly, nurses and administration participants seemed to identify with the role of a subordinate. This was evident as they both referred to the superiors or director and doctor, as the decision-making, conflict-solving, and more knowledgeable members of the hospital. They identified with and behaved according to the role of a submissive follower.

"Sometimes it must be fixed individually. Like for instance people from our department can only warn those within the department. But another thing is with doctor. If with the doctor it depends how they will react." [P5]

"Like theoretically doctors they have a lot of work or sometimes they react, the nurses don't do their job, sometimes we try to avoid reacting (speak softly) but if they come to the unit, they we can, we can talk." [P5]

One participant showed some nervousness about making comments about doctor, saying they "did not mean to criticize them".

"But the information about doctor, I didn't mean to criticize them" [P5]

Participant 7 described how doctors are the most important person in the hospital, praising the doctor's knowledge. She also discussed how when approaching or communicating with doctors there needs to be a specific techniques such that it appears that they themselves are inferior and asking for doctor's help instead of directly communicating what needs to be done. In their response, it also seems that doctor does not have the time to pay the attention to administrative businesses.

"Personally, I think the main factor is the doctor, which is an important factor in contributing to good patient care. It is the doctor's knowledge and also the equipment together with the doctor that is also important." [P7]

When talking with doctors we need to have techniques. We don't use command but we ask for help. Doctors already have natural tendency to be kind that want to help people. If we go ask them for help, they would quickly do it but if we go order or command them, they will be … something like that" [P7]

"We need to walk over and talk, the success rate is higher. Go like one on one. If we use calling, it doesn't work. If we use calling as the initial communication, it's like an interruption of their work. If they are in the process of treating patient and we call, they will feel like they're doing this and our issue is not important, the issue there is more important. They wouldn't have the concentration to listen to us, they wouldn't understand." [P7]

"If we are following up, "doctor, I have a chart that you haven't summarize," if we call they might just say "krub krub krub krub" and then forget. At that time they might not have the concentration to listen to us." [P7]

2.3 Leadership. This sub-theme is about how interviewees talk about the importance of having an effective leader for conflict-solving, decision-making, and supervising different staffs and departments within the hospital.

"Yes, In terms of group, there will be a deputy head do the taking care duty. If it is the medical doctor group, there will be the deputy director of doctors to take care, In part of the managerial department, there will be managerial deputy director to take care." [P2]

"Oh, of course. Sometimes there is misunderstanding between departments. Sometimes the concept within each department differs. In this case I believe that it is the manager's responsibility to handle. [P3]

"If the working plan of each department is not the same then we cannot make it work together. Krub. To make this successful, the director needs to manage it. " [P3]

"How can we get rid of personal conflict, it's really hard. But in principle, we have to try. Sometimes a doctor and another doctor do not get along. Sometimes doctors from the same department... one uses one kind of treatment while the other uses another kind of treatment. Sometimes there is the issue of personal interest that is contradicting. It's difficult [heavy tone] but we have to try to make everything come together as much as possible.

> Like I said, I think [pause] it's not anyone's job but the job of the manager, who has to manage every department to be able to work together." [P3]
>
> "The director help form good head of departments, who will give knowledge. Like for us, we are heads of the building and work according to hospital's policy, the director and bring the policy to the practitioner." [P6]
>
> When the interviewer asked where a strong team comes from, Participant 6
>
> answered,
>
> "The implementation of system from our director. The director set a good system from the start that our hospital will be a top hospital in mother and children. Our uniqueness has always been in this area." [P6]

3. **Resources.** This is where resources, such as time and staffing is mentioned by the participants as factors that hinder or help communication between groups.

> "In public hospital, one of the main problems of public hospital is that there are a lot of patients therefore doctor may not have a lot of time with each patient. Each doctor may give the correct diagnosis but the way they give information to patient may be limited due to little time and not a lot of discussion. The diagnosis may include asking patient's history, diagnose, prescribe medicine, here there may be too little talk." [P2]
>
> "The counter staffs are limited. There are about 10 doctors. It's not that they are not efficient but if there is only one person at the counter who has to handle everything." [P2]
>
> "We often come across this kind of situation. In most medical school, there is a high chance of a success rate, but in hospitals that are not well equipped, most of the time the baby will not make it. Time will be wasted communicating and preparing." [P3]
>
> "It's just problem with delay, staff is not ready, room is not ready, not understanding the basic principle." [P3]
>
> "In university's hospital it really is chaotic because one, there are a lot of patients, the hospital cannot quickly provide service to everyone [stress the word], therefore sometimes there are instances of cutting queue" [P3]
>
> "We have limited staff" [P6]

4. Thai Cultural Values. This theme is when participant's Thai cultural and social identity is shown through their mentioning of thoughts or behaviors that reflect Thai cultural values such as seniority, harmony, and hospitality.

4.1 Seniority/ Filial Piety. This is when participants demonstrated importance of respect, reverence, and obedience towards elders, those with more professional experience, or of higher status, as is common in Thai culture. Throughout each interview, the theme of seniority and respecting elders is common. Most of the time directors and doctors refer to themselves as teachers and refer to junior healthcare staffs as youngster, kid and children. The nurses and admin mostly shows respect and humility in their interaction with the superior director and doctor.

Participant 1 referred to himself as a teacher who has the duty to teach and pass on knowledge to other staffs or those of younger generation. His superior teacher role was also conveyed in how he talked about disciplining any new hospital staffs who he referred to as "new kid."

> "Thai culture as seen through social media, people like to see things in a negative way... Therefore, there needs to be attempt to instill new values for people in organization and if they can do it, habits can be created and they can use it elsewhere" [P1]
> "I am happy, happy because I consider myself a teacher, a teacher to teach kids of the next generation.." [P1]
> "Early if there is a new kid that just came, they will have it the hard way, we, we will be harsh. If you ask whether we are fierce? We are, but we, we'll be harsh with them until they will be like how we want" [P1]

Participant 4 referred to the other nursing or junior staff as a "youngster," who needs to be taught. He also mentioned how senior staffs need to look after the junior staff, by using the word "babysitting."

"The youngsters have to have the knowledge to help us" [P4]

"The youngster here they need to be trained to have good understanding, there will always be teaching." [P2]

"The senior assistant will also be a babysitter for the student assistant." [P4]

Participant 6 portrayed the concept of respect and seniority through her interviews when she used the pronoun, "P" before referring to the name of an older individual and expressed the importance of always greeting one another. Both of these are a common language rule to show respect within Thai culture.

"Yes, we look at each case when receiving the shift. When they pass over the shift in the morning, when I receive the shift every day I will know which case that Miss breastfeeding need to go help. The ward will tell me, Oh **P'V** (her name), this bed cannot be use. They will count this first second and third cannot. They will inform us of the daily policy." [P6]

"Respect the elders. Seniority, senior and junior. When we see each other we must always say hello and introduce ourselves." [P6]

Participant 7 talked about how one must always show respect to the doctor when asking for their help using specific techniques.

"The admin said that before approaching the doctor there needs to be a certain technique. They need to ask, "Doctor, are you free to talk?" If they say yes then, we cannot just immediately shoot them information. We have to ask first." [P7]

"we have to think what we are going to say in order to convey that we are nice, and not like commanding. We have to have a way of speaking; "doctor, can I please interrupt you, please help us, the medical department we are overdue on this chart, a couple of chart" [P7]

"When I first came here, when I had to contact people, I got scared of annoying them, but when I joined the activities, I felt like I understood [them] better. When I talked to them, it wasn't that hard, they will understand and they will ask if they don't" [P8]

4.2 Harmony. This is when participants placed an emphasis on maintaining cooperative, warm, and close-knit relationships with colleagues, similar to relationships shared with family members, as a means to avoid conflicts and enhance collegiality amongst staff and departments.

"Another thing is organizational culture, which we have to develop. The organizational culture of love and harmony is the most important basis. With love and harmony within an organization there wouldn't be conflict and misunderstanding. There would be none. Well zero conflict is impossible but at least try to minimize it as much as possible in order for good collaboration." [P3]
"It's about relationships that will make communication and collaboration smoother. Sometimes we try to reach out and collaborate..." [P5]

Participants mentioned a lot about collective harmony within their group and having sibling-like relationships, such as those of a brother and sister, in assisting them in their work collaboration process.

"If we communicate with good word, good talk, have reason, respect each other like siblings, the collaboration will be smooth. So far with the ward that I am in, there has never been issue with communication. We are very close, including different ward like the surgery rooms have to take our case. We will have good communication. Introduce ourselves who pick up the phone and have process. Even newbies must have this kind of supervision." [P6]

"...our team is really strong. I just come in and add on to the last jigsaw piece as Miss Breastfeeding and lecturer to teach breastfeeding for the rest of the hospital." [P6]

"For mum and children and obstetric team and children team, the doctor, the nurses are lovely team, understand and communicate well. It has always been like this whether it is serious or not serious issue we talk with good word" [P6]
"We work like brother and sister" [P6]

"I think in my society, I think if we are like siblings it is easier. When we want to do something it is easier." [P7]

"Most of the time having tight knit relationship plays a part. Because if we feel like they feel good towards us, like we are okay, we don't have much problem during work, once we go ask them for help or if we make a mistake, they will feel like they want to help."[P7]

Some participants also mentioned how Thais sometimes try to maintain relationship harmony through in-group bias.

"Thai society is something like this. But it's really weird, if one group feels negative with another person, everyone in the group will communicate with that person negatively" [P7]

When asked if there ever been a time Participant 8 ever feels tired of relationship or communication problems, she mentioned the importance of avoiding conflict and maintaining harmony

When the interviewer asked the participant if they ever feel like the communication ever becomes too much for them to handle, the participant responded,

"Yes, keep it inside but can't do much because we are in service job, we have to do our best." [P8]

"Never complained yet. I want to keep working, if I complain there will be an issue. We try to communicate in the best way. I am young and try to be polite, ask them if there is any problem with a soft tone." [P8]

"Everything whether it is the same age, we still have to ask using words that show genuinity not like we want to cause problem. We want to keep working together so we have to use good word." [P8]

"Must start with yourself. Then next we have to always be humble and know manner when approaching someone whether higher or lower position than us. We must show them that we are determined to work together as a team, not competing but work together to create good outcome for patient" [P8]

"There might be problem and conflict but if have to work together must separate personal and work issues. With work we have to do our best. We have to clear it through and not let it affect." [P8]

"In managing the hospital, must create a good feeling in different department. Create an environment where people in the hospital doesn't have problem with one another." [P8]

"Yes, the hospital organized events constantly like sport game to build relationships between people in the hospital, to create good feeling and helping relationship." [P8]

When asked about attendance at staffs' outdoor retreat,

"But mostly everyone give equal importance to this, like attend courses or sport game, everyone come to enjoy it together. Like for me from the finance department, I will get to know this nurse who sometimes I've never seen the face but only talk on telephone. When I get to meet, from a person who I only talk on the phone, I get to know their personality and build good relationship." [P8]

4.3 ***Duty towards nation.*** This theme identifies instances where the participants reported feeling a sense of responsibility towards their country or reported serving the nation to be one of the important roles they fulfill as healthcare professionals.

"This is so teenage parents don't have to, one, waste money on buying milk, second, the children will not get sick and have to return to us, and third, this is to help out the country because this is our main responsibility." [P6]

"And those kids [that I taught] will build the future of our nation, I ask nothing of life, if I can instill this for them then I am happy to help." [P1]

4.4 Hospitality. This is when the specifically Thai expectation of being welcoming, nurturing, and hospitable towards guests, customers, and clients appeared to be salient in participant's responses.

"Everyone has to have the intention to provide the best treatment service for patients. With this, our hospital will have a good reputation, everyone saying this is a good hospital in terms of both service and treatment. If the staffs are rough, even with good treatment, patient wouldn't want to return to the same hospital. This should not happen." [P3]

"Important factor in good patient care is like being considerate or caring for patients. Using your heart in giving treatment. When patient feels good they will trust the hospital to do the treatment." [P8]

"Try to smile to patients. Like if the patients have any problem, we will try to help as much as we can. If they have anything they don't understand, we will try to

find an answer for them. Also showing them where to go after they paid for their fees." [P8]

When the interviewer asked how the participant reacts to an angry patient

"Have to be calm, smile or else if we create an emotional striking force with the patient, there will be verbal conflict. It will not end. We need to find a reason for them, "Patient please be calm, let me ask around first" something like that." [P8]

"Yes it must be better. It's really important. The patient is the heart of the hospital; we have to do all that we can to provide them with convenience." [P8]

Chapter 4: Discussion

Our research aimed to explore the Social Identity Theory (SIT) and Communication Accommodation Theory (CAT) within the Thai healthcare context. Our research questions were whether social identity and communication among Thai health professionals interact and influence the quality of healthcare delivery in Thai hospitals. Our aims were to firstly, understand how social identity affects the communication processes in a hospital within a collectivistic culture such as Thailand. Secondly, we aimed to further study how elements of Thai culture, including but not limited to Buddhism, face negotiation, and filial piety influence the process of social identity formation and thus, affect the communication process among Thai hospital staffs. Thirdly, we aimed to highlight the need for additional research and inform the further development of communication theories for application to future communication research in Eastern healthcare contexts.

Our findings and themes succeeded to cover these aims, as a strong sense of social identity was observed throughout our data, but most specifically in the themes of Traditional Role Identity and Thai Cultural Values under the sub-theme of Seniority. Instances of CAT were also observed as well as specific elements of Thai culture, which are categorized under the Thai Cultural Values theme. From this study, Thai healthcare can be categorized in the following themes: Communication, Traditional Role identity, Thai Cultural Values, and Resources.

Communication

One of the main themes in our interviews was Communication, in which the sub-themes are Importance of Communication, Negative Consequences of Communication, and Technology as Medium for Communication. Watson and Gallois (1999) stated in their research that communication is crucial in the healthcare context, highlighting the importance of effective

communication in determining successful delivery of patient care. Similarly, in our findings we found that many participants acknowledged the importance of communication within and between departments, for instance Participant 4 mentioned,

> "There needs to be communication. Without it we don't know if there is accurate information….If there is a problem, we need to know if our problem affects other people and if other people's problem affects us, how can we solve it."

This statement shows that communication is a crucial process in avoiding any problematic occurrences, through communication, factors leading to conflict can be identified to minimize the negative impact it can cause to different involving parties.

Participant 8's response conveyed the importance of communication but at the same time highlighted importance of this process in connecting different intergroups, including different health occupations, departments and units.

> "Sometimes there can be a mistake or confusion. We need to ask and contact them, there needs to be cooperation from every department every unit. And with the pharmacy and doctor, we all have to communicate."

The responses suggested that issues rooted in miscommunication were not alien to the healthcare staff, and Participant 3 emphasized on the importance of developing an organized system for efficient communication.

> "Therefore in any kinds of hospital, I believe there needs to be a regular conference. Ideally, there needs to be morning round every morning where each staff from each department comes together, including the manager. Here, there will be a discussion about what has happened the previous days and how should today be carried out, if there is any problem awaiting or any misunderstanding or damage that happened, so we can know, find solutions and make plans."

Additionally, Participant 3's response also depicts a strong embodiment of social identity, as he clearly mentioned the management department as a separate group from the rest of the healthcare staff, suggesting the presence of an implicit in-group out-group categorization.

Furthermore, participants also commonly brought up negative instances that could result from miscommunication. According to a research by Watson and Gallois (1999), the communication between health professionals and patient is crucial to the success of patient care. Consistent with this, Participant 2 explicitly mentioned how poor communication between different health professionals, in this case doctor and nurses, can lead to patient's misunderstanding regarding their own care.

> "Sometimes the issue that patient are unhappy with the hospital, partly is the information. Not receiving enough information or false information. And sometimes hearing doctor talk to nurses but didn't hear it clearly and personally interpreting that it's like this. And if that issue is not something that staff take interest in and patient didn't ask, maybe it will be overlooked and patient will misunderstand."

The final subtheme of using technology as a communication tool aligns with previous research that have found technology as useful in enhancing communication between staff (Schaffer and Munyer, 2015; Daker-White et al., 2015). In our findings, the participants commonly mentioned the use of the phone application "Line" as a communication medium between different hospital staffs. For instance, Participant 5 referred to the use of Line in assisting health professionals communicate about patient's condition,

> "We have Line, something like that. I think there are better ways. Can send photos. Like with X-ray result, before doctor needs to use film sheet to show but now they can take photo and send through line. Result of heart scan or something like that. This is communication of information. It is better"

Social identity is salient in Participant 7's response, when she mentioned how this Line technology can aid and help overcome communication barriers between doctors and other healthcare professionals. This is because doctors were usually referred to as being too busy and having other priorities than to give the time to communicate with other healthcare staff.

> "If we have to Line again, the doctor would send "Thank you krub, if I have the time I will do it." There's no silence. I think it reduces the striking force because

> we don't know at that moment if we are there physically how they will reply. The feeling that we have for them will not be negative. If they maybe think like "here we go again," we are not there to hear it."

This is Participant 7's response, which also sheds light on the presence of tension between the administrative staff and the doctors, as it suggests that the administrative staff have previously sensed annoyance from doctors when trying to communicate with them in person. Thus, they have resorted to using Line to communicate with their superiors, as a means to avoid confrontation or conflict. Moreover, this process of communicating through Line is an informal channel of communication in healthcare. Thus, there needs to be a further follow up study to explore the effectiveness of this use of Line in healthcare communication process since previous studies have found that poor use of technology can actually hinder instead of help improvement of patient care (Yang, Kelley, and Darzi, 2011).

Lastly, when one participant was discussing a negative consequence of miscommunication, non-accommodation, as outlined by CAT, was detected in Participant 4's response. He described difficulties he encountered in understanding records written for him by other dentists.

> "Maybe how they write it's not clear. It is not explained in a way for us to understand, using language that we don't understand, but it doesn't mean that it's wrong."

Participant 4 described an instance where he had to collaborate with another dentist, with a different area of expertise, for a certain patient's case. His colleague communicated by updating the patient's record history, but used jargon that was difficult for Participant 4 to understand, thus using a non-accommodative communication technique towards him. This finding was consistent with that of Hewett et al. (2009) as well as Hewett et al. (2009a), who reported that doctors use non-accommodative communication techniques towards doctors of

their outgroup, causing ingroup doctors to interpret medical charts more accurately than outgroup doctors.

Traditional Role Identity

Our second main theme is Traditional Role Identity; this includes instances during the interview where participants' social identities in hospital settings are salient when they talk about their own or other staff's role in the hospital. The first sub-theme is Traditional Role Perception where participants explicitly mention their own and other staff's official and unofficial role within the hospital. The second sub-theme is Power Hierarchy, which is where instances where the director and doctor participants took on the role of the superior and nurse and administrative participants took on the role of a subordinate as evident through their interview responses. The third sub-theme is Leadership, which is where participants mentioned the importance of having a strong managerial role in the hospital.

In this theme, participants' social identities were salient through their interview responses, which matched the prediction of CAT that explains that the communicative strategies employed by different healthcare professionals are influenced by their social identity.

In the participants' perceptions of their own and other staffs traditional roles, a strong sense of social identity could be observed through their responses. Generally, directors and doctors showed a tendency to perceive their own role as that of a decision-making knowledgeable professional, while nurses were viewed as communicators, followers, and those with less power in comparison to them. This is also consistent with the nurses' perceptions of the doctors' and their own role, as they had seemed to internalize these identities as the norm. Participant 2 who is a director explicitly mentioned how the nurses' duties is as a follower and a

communication "bridge" between doctors. This is similar to what Burnard and Naiyapatana (2004) research found that nurses are often the communication mediator in the hospital.

"If there is no communication between department maybe because doctor from one department and another department, like these doctors from two departments wouldn't walk in together, [they] need to rely on nurses as a communication medium. Therefore nurses have to always follow doctors. Doctor from this department comes in, you have to be there. Doctor from another department comes in, you have to be there because you are the bridge."

Participant 3 who is a doctor also highlighted the nurses' roles as followers.

> "For doctors, it's knowing the disease, knowing how to predict the illness. Nurses need to know how to take care of patients and how to follow, follow doctors."

This is consistent with the finding from Setchell and colleagues (2015) on doctor's attitude towards nurses. Doctors strongly highlight their superior role possibly because they want to maintain their distinct social identity as higher and a more competent profession within the hospital.

Our findings also showed that nurse participants also acknowledge their own role as being a follower. This acceptance of an inferior role could be explained through accommodation, the nurses accommodating towards the doctor to maintain the inter-group boundary and hierarchy, by giving respect to the doctor, in order to preserve the harmony within the hospital, this is evident through Participant 5's response,

> "The care starts with the doctor, doctor will give diagnosis, plan the care, diagnose what illness the patient has and how it should be treated. The nurse will be the one who use the plan to practice the care."

Furthermore the distinction between the different hierarchical positions in the hospital is made clear through the participant's response regarding the power dynamic. Participants either identify with a superior or subordinate role depending on their positions in the hospital. Similarly

to Setchell and colleagues (2015) research, who found that doctors framed doctors and nurses as different from one another according to the differences in power dynamic in SI, in our study, the director and doctor participants' also responded in a way that exalted themselves as in position of authority and different from the rest of the healthcare staffs, rather than as being in an integrated group of healthcare professionals. This is done by highlighting the different set of tasks of that those in higher and lower positions have to perform. Participant 1 viewed communication as a top-down command from high position to low position rather than a two way direction.

> "We have to create correct understanding between those who are involved or those under command, right?"

By referring to "those under command," this participant clearly made a statement of being in a higher position of authority. Similarly Participant 2 also state the role of doctors being superior leader whereas the nurses are inferior follower, who follows the doctor's order.

> "The doctors are the leader, lead... maybe lead in thinking and coming up with ideas but the process needs to have the help from the working team to actually execute it."

However, what is striking is that the nurse and administrator participant also accepted and identified with an inferior role. This may be their way of accommodating or trying to maintain an inter-group harmony. Participant 5 who is a nurse discuss about how it is not easy to communicate with doctor since they may negatively react to the nurse's approach.

> "Sometimes it must be fixed individually. Like for instance people from our department can only warn those within the department. But another thing is with doctor. If with the doctor it depends how they will react."

Towards the end of the interview, this participant also showed sign of nervousness, through furrow brow and soft tone, about her previous interview answer, by asking,

> "But the information about doctor, I didn't mean to criticize them"

This nervousness is suggestive that she is afraid about giving her true opinions about how it is hard to communicate with the doctor. According to Smith (2015), this sign of communicative gesture such as using soft tone was a way of communicating respect in Thai culture. In this case, the nurse may feel that her previous comment of the doctor convey disrespect and thus, she wants to clarify that she did not mean to criticize them. Our administrative participants also show this kind of uncertain approach when communicating with the doctors. Participant 7 mentioned that when approaching doctor, they have to take on an inferior role and approach the doctor as if they are asking for help rather than as another help professional approaching another.

> When talking with doctors we need to have techniques. We don't use command but we ask for help. Doctors already have natural tendency to be kind that want to help people. If we go ask them for help, they would quickly do it but if we go order or command them, they will be … something like that"

At the same time this participant also the exalted the doctor as a figure who generally possesses the attribute of kindness. It is observed through each participant's response that this power dynamic in a Thai hospital is preserved through healthcare staff holding on to a superior or a subordinate role depending on their position in the hospital. This status maintenance may be a collectivistic tendency to create harmony between staffs in the hospital; this will be further mentioned below in the Thai cultural value theme.

This segregation of a superior and subordinate role may also explain the emphasis that the participant gives on having an effective leadership role in the hospital. The superior may be exalted because they are expected to be in charge of handling all the collaboration between staffs. Participant 3 clearly stated how vital the manager is in the hospital,

> "Oh, of course. Sometimes there is misunderstanding between departments. Sometimes the concept within each department differs. In this case I believe that it is the manager's responsibility to handle."

Participant 6 also agreed that having a good managerial role is important in setting a reliable system and establishing a good name for the hospital,

> "The implementation of system from our director. The director set a good system from the start that our hospital will be a top hospital in mother and children. Our uniqueness has always been in this area."

The above are instances where there is Interplay of SIT and healthcare staff collaboration. This was explored in several of the interviews. The directors and doctors are viewed as more superior while the nurses and administrators are viewed as more inferior. Consistent with the finding from Burnard and Naiyapatana (2004), the traditional role of nurses included the responsibility of being a communication bridge, as they were responsible for ensuring information was relayed from doctor to doctor and doctor to patient. Nurses in our study also showed understanding and acceptance of this role. Overall the power dynamic in a Thai hospital is generally accepted among the healthcare staffs who expressed and communicated accordingly to their role.

Resources

In Burnard and Naiyapatana's (2004) study, time is reported to be an insufficient resource that hinders the communication between doctor and patients. Similarly in our study, participants consistently reported insufficient staffing and time as factors that were hindering effective patient care. Participant 2 suggested that often a lack of time disallowed doctors from communicating with their patients, which was a source of misunderstandings and inefficient delivery of healthcare.

> "In public hospital, one of the main problems of public hospital is that there are a lot of patients therefore doctor may not have a lot of time with each patient. Each doctor may give the correct diagnosis but the way they give information to patient may be limited due to little time and not a lot of discussion. The diagnosis may include asking patient's history, diagnose, prescribe medicine; here there may be too little talk."

Therefore the communication problem could most possibly be improved with staff having more time to communicate with one another and with the patient.

Thai Cultural Values

The theme of Thai Cultural Values is one of the main themes in this study. This theme is categorized by instances when participants' Thai cultural and social identity is shown through them mentioning thoughts or behaviors that reflect Thai cultural values. Since our research aimed to explore how Thai values interplay with western SIT and CAT on the effectiveness of healthcare delivery in Thailand, this theme is of our main interest. Initially, from our literature review, we expected to find an emerging theme of Buddhism, face negotiation, and seniority in our participants' interview responses. We found responses that illustrate presence of the latter, but not the two former concepts. Interestingly, although we did not find explicit instances of facework, certain examples that will be discussed within this section indirectly explore this Thai value.

Under this theme, the first sub-theme is Seniority, which is similar to the Power Hierarchy sub-theme in Traditional Role Identity, but the main distinction is that it is culturally guided, and the superiority is determined by age and experience in contrast to traditional hierarchy, where superiority is determined by occupational status. The second sub-theme is Harmony, where the participants' collectivistic tendencies to maintain a tight knit relationship with co-workers became salient through their interview response. According to Srismith's (2015)

publication, the working procedure of medical staff was influenced by their cultural value of seniority and harmony. The third sub-theme is Duty Towards Nation, where participants strongly feel the responsibility to give back to their country. Finally, the fourth sub-theme is Hospitality, which is to provide good service to patients.

In the sub-theme of Seniority, there is a clear hierarchy, with those staffs who are older and with more experience holding a higher status, while those staffs who are younger and have less experience holding a lower status. The former tend to take on the role of a teacher or mentor, with the duty to teach the younger staff. This can be seen through managerial staffs acting as mentors to the subordinates as found in research by Srismith (2005). This is observed in the current study as well when the Participant 1 took on the role of a teacher in training the new staff, who he also referred to as "kid."

> "Early if there is a new kid that just came, they will have it the hard way, we, we will be harsh. If you ask whether we are fierce? We are, but we, we'll be harsh with them until they will be like how we want"

Here there is a clear hierarchy between new staff and older staffs who will teach the new staffs the right ways to do things or "norms" of the hospital. This participant's SI as a teacher was also evident when the interview was coming to an end, as he offered to read the interviewer's research paper and give feedback because he sees himself as educating the kids of the next generation.

> "I am happy, happy because I consider myself a teacher, a teacher to teach kids of the next generation."

This senior status was also suggested when Participant 2 mentioned teaching the other healthcare staff but also referring to them as "youngster."

> "The youngster here they need to be trained to have good understanding, there will always be teaching."

Also the other healthcare staffs are expected to show respect to in their communication strategy towards the more senior position of the hospital. This is done through assuming an inferior role and asking for help rather than directly and explicitly communicating their intentions. Participant 7 demonstrated this with this quote.

> "We have to think what we are going to say in order to convey that we are nice, and not like commanding. We have to have a way of speaking; "doctor, can I please interrupt you, please help us, the medical department we are overdue on this chart, a couple of chart"

Through this response, we can observe how practicing seniority can sometimes involve the Thai concept of "saving face", also referred to as facework. This indirect approach to communication is consistent with Ting-Toomey's concept of facework, where the administrator may be using indirect communication style in order to preserve the doctor's face, or positive self-image of being in a more superior role. This indirect communication style may also be a conflict avoidant strategy (Sanchez et al., 2003) or a way to maintain the doctor's higher status, as a way to maintain the power dynamic within the hospital. Interestingly, it was also observed that another participant placed importance on Thai values such as seniority and harmony, but prioritized transparency of workplace errors in order to improve patient care over "saving face".

It is well established in current literature that East Asian cultures tend to be more collectivistic than Western cultures (Brews & Cairns, 2004). This means Asian cultures tend to place more emphasis on group's interest rather than their own. Also the research by Sanchez and colleagues (2003) found that Asians tend to value maintaining relational harmony between colleagues in the workplace more than Westerners. This is evident in our study where our

participants commonly refer to the importance of maintaining a harmonious working relationship with other healthcare staff. Participant 3 clearly demonstrated that a harmonious organizational culture based on love and culture is important for good collaboration between healthcare staff.

> "Another thing is organizational culture, which we have to develop. The organizational culture of love and harmony is the most important basis. With love and harmony within an organization there wouldn't be conflict and misunderstanding. There would be none. Well zero conflict is impossible but at least try to minimize it as much as possible in order for good collaboration."

This harmony in staff's working relationship may also be maintained through having a close-knit relationship analogous to being family members, such as siblings. According to Odell (2011) effective relationships between team members can minimize error in the staffs working collaboration. This can also be observed in our study where Participant 6 stressed on having good sibling-like relationships and respect in assisting effective working relationship between staff.

> "If we communicate with good word, good talk, have reason, respect each other like siblings, the collaboration will be smooth. So far with the ward that I am in, there has never been issue with communication. We are very close, including different ward like the surgery room have to take our case. We will have good communication. Introduce ourselves who pick up the phone and have process. Even newbies must have this kind of supervision."

> "We work like brother and sister"

Furthermore harmony is maintained by means of avoiding conflict in the work collaboration. Participant 8 mentioned trying to avoid conflict by being polite and being cautious in her communication style with other staffs in the hospital.

> "Never complained yet. I want to keep working, if I complain there will be an issue. We try to communicate in the best way. I am young and try to be polite, ask them if there is any problem with a soft tone."

This shows that often to maintain harmony, healthcare staff may ignore negative feelings rather than confront colleagues regarding their concerns.

Participant 8 strongly convey collectivistic ideals of valuing teamwork over competitive individual gain in the hospital workplace.

> "Must start with yourself. Then next we have to always be humble and know manner when approaching someone whether higher or lower position than us. We must show them that we are determined to work together as a team, not competing but work together to create good outcome for patient"

Participant 8 explained that a harmonious working environment in Thai hospitals is created through events organized by the hospital, such as sports game, where healthcare professionals from different fields can participate in joint activities that will help build their relationships. This suggests that harmony amongst hospital staff is also valued by those in managerial positions, as they supported the organization of such events.

> "Yes, the hospital organized events constantly like sport game to build relationships between people in the hospital, to create good feeling and helping relationship."

Whilst harmony may be helpful in enhancing relationships and communication in healthcare settings, it can also have negative effects, such as exacerbating conflicts through ingroup bias, as can be seen in Participant 7's response.

> "Thai society is something like this. But it's really weird, if one group feels negative with another person, everyone in the group will communicate with that person negatively"

This aligns with Triandis' (1988) finding that those from collectivistic cultures placed more emphasis on ingroup and out-group norms, in comparison to those from individualistic

cultures. Similarly, our finding suggests that collectivistic cultures involve a strong tendency to conform to ingroups, even when the behavior is socially undesirable.

Another sub-theme under Thai Cultual Values that emerges from our findings is Duty Towards Nation, or patriotism, where participants expressed their love for their country by wanting to make a contribution. Since patriotism is a national form of collectivism (Vadi, Allik & Realo, 2002), it then seems logical that our participants who are from a Thai collectivistic culture would convey this need to help out their country. Participant 1 mentioned wanting to teach the junior staff, as a way of supporting the upcoming generation of the country.

> "And those kids [that I taught] will build the future of our nation, I ask nothing of life, if I can instill this for them then I am happy to help."

Participant 6 stressed on the importance of her teaching role as Ms. Breastfeeding in helping out others, because she believed she was contributing to the betterment of her country and its people

> "This is so teenage parents don't have to, one, waste money on buying milk, second, the children will not get sick and have to return to us, and third, this is to help out the country because this is our main responsibility."

Hospitality is a known mannerism in Thai culture, to the extent that it has even become characteristic of the country (Vongvipanon, 1994; Knutson, 2004). In this theme, participants commonly mentioned the importance of providing a good service to patients. This is done through practicing respectful gestures such as greeting, smiling, and using a soft tone of voice. This is possibly also a way of maintaining harmony and avoiding conflict in Thai culture. For instance, Participant 8 mention non-verbal gestures such as smiling and showing willingness to help as important in providing service for patients.

> "Try to smile to patients. Like if the patients have any problem, we will try to help as much as we can. If they have anything they don't understand, we will try to find an answer for them. Also showing them where to go after they paid for their fees."

Smiling is also emphasized as important in service giving in hospital, even if the participants are experiencing negative emotions. Those negative emotions are put aside because providing good service to patients come first. In an interview with Participant 8, when the interviewer asked how the participant reacts to an angry patient, she replied,

> "Have to be calm, smile or else if we create an emotional striking force with the patient, there will be verbal conflict. It will not end. We need to find a reason for them, "Patient please be calm, let me ask around first" something like that."

This good hospitality towards patients is better understood when Participant 8 described that the patient is the core or the heart of hospital.

> "Yes it must be better. It's really important. The patient is the heart of the hospital; we have to do all that we can to provide them with convenience."

Additional Observations

Apart from the data gathered from the participants' responses, additional data were collected in the interviewer's fields notes, where CAT, SIT, and Thai culture-specific behavior was observed.

The researchers observed that SIT may be embedded in Thai language when they were translating the interview transcript from Thai into English: unique aspects of Thai language were observed that may enhance the tendency of Thai people to identify more strongly with their ingroup as well as their power status in relation to their communicative partner. In Thai, it is common to refer to yourself with your first name instead of using the pronoun "I", and so it is

normal to do so with titles such as “doctor” as well. When a doctor does this, it does not necessarily suggest an emphasis on social identity from them personally. However, the language itself works as a tool to communicate, highlight, and reinforce the importance of this hierarchical differences and social identity.

Additionally SIT can be seen through the power dynamic in the hospital, which can be observed in the manner in which different participants from different level of the hospital respond to the interview questions. For instance, the researcher wrote that one nurse was reluctant to share their real experience and provide information. This can be seen when she made sure that the information she shared will not be revealed to the doctors, “please forget what i said about the doctors earlier.” Contrastingly, the director and doctor participants were more relaxed and opened in answering the interviewer’s question. This difference in response style reveals the existing power dynamic within the hospital, as nurses who are lower in status may be more reserved about sharing their opinions about those in the higher status, such as about director and doctor.

This power dynamic can also be observed through the participants’ communicative strategy when speaking to the interviewer, as predicted by CAT. The director and doctor participants were over-accommodating towards the interviewer. The researchers observed that during the interview, two directors and one doctor constantly checked the interviewer’s understanding regarding their responses through repeatedly asking questions such as “Do you understand?” This wasn’t observed in the interview with the nurse and administrator participants. This demonstrates how the director and doctor participants may be maintaining their status as superior to the interviewer, albeit unintentionally. Additionally, this is also an example of the embedded seniority within the Thai culture, as the interviewees identified with a more

superior role of a teacher or someone with more knowledge while they underestimated the interviewers' understanding.

Conclusion

This paper has offered insight into the social identity, culture, communication processes, and role perceptions within the Thai healthcare system. We found that effective communication plays an important role in executing efficient healthcare, and the participants reported that miscommunication often lead to negative consequences. Even though, instances of accommodation and non-accommodation, as predicted by CAT, were reported by interviewees and even observed between the interview participants and the interviewer, our research also highlights that western communication theories cannot be generalized across languages, as Thai language is unique and complex. In their research, Leach and colleagues (in press) found that the SI of each healthcare staffs in different positions and level of the hospital can affect their communication process. Replicating Leach and colleagues' (in press) research in the Thai context, we also noted a similarity to their research such that our finding shows a strict hierarchical structure in Thai hospital setting, which is based on the power status of the different healthcare staffs. However, our study also found that this hierarchy is exacerbated in Thailand, where a strong culture value is placed on seniority; the power status of healthcare staff also depends on their age and year of experience. This research also revealed characteristics unique to Thailand, as we also found that Thai cultural values such as harmony, duty towards nation and hospitality interact with SI, in a way that it alleviates intergroup conflict and lead to a more collectivistic collaboration between staffs, units, and departments working towards providing the best patient care. Unlike their Australian counterparts, Thai healthcare staff were influenced by their collectivistic values in delivering treatment.

Limitations

Several limitations need to be addressed in this current student research. Firstly due to time constraints, our study was based on a small convenience sample of eight interviews. This may limit the amount of data we were able to collect and provide fewer opportunities for anecdotal evidence from different healthcare staffs' experiences. Moreover, the use of convenience sampling caused our 8 interviewees to come from 3 different healthcare organizations, thus hindering the opportunity to firstly, observe interactions amongst colleagues of different hierarchical positions within one hospital and to secondly, use any consistent opinions from different interviewees regarding role perception and norms to draw stronger conclusions about the culture in the hospital. For instance our participants' experiences may be unique to the hospital system that they work in; a nurse may report strong hierarchical norms in the workplace, while a doctor from another hospital may have more equal distribution of power in another hospital's context. In addition to this, the two doctors and nurses we interviewed work in different medical departments, such as obstetrics, dental care, and the special ward; thus future research might consider interviewing doctors from other departments to gain insight into their experiences. To address this issue, we suggest that this study be replicated with a larger sample size, focusing on the accounts of a specific hospital or practice's staff members. Secondly, the researchers' lack of interviewing skill may pose as a limitation; our researchers had no previous interviewing experience prior to this research, thus there is still room for improvements. The researcher may have asked leading questions or may have missed the chance to ask the participants to elaborate on their answers. Thus, we suggest these researchers improve on their skills with practice, as they have over the course of conducting this study, or interviewers with more expertise could conduct the interviews. Thirdly, our interviews were conducted in Thai

before being transcribed and translated into English. In the process of translation, it is possible that some of the participant's initial meaning could be lost due to the inconsistency and complexity in each language. If this study were replicated on a larger scale in the future, we suggest professional translators be approached for the translation process. Despite this, it must be understood that languages, especially Thai, are complex and certain nuances may never be directly translatable.

Implications for Future Research and Application

The findings from our study have several implications since it concerns itself with the healthcare system and much is at stake in this field. Thus, it is essential that firstly more research be conducted in this area, as little previous research has been conducted and an in-depth analysis on healthcare culture is necessary. Secondly, we recommend that workshops or orientations regarding communication issues are mandatory for healthcare staff to attend at all hierarchical levels, as previous research as well as this study has consistently reported that role perception, communication style, and cultural context have heavy influence on healthcare delivery. Since the patterns of communication are reported by the staff themselves, it is likely that they will understand this issue well and cooperate together to work on improving communication amongst staff.

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Appendix A

ข้อมูลสำหรับกลุ่มประชากรหรือผู้มีส่วนร่วมในการวิจัย

ชื่อโครงการวิจัย **การศึกษาทฤษฎีอัตลักษณ์ทางสังคมและการสื่อสารระหว่างบุคคลากรและแผนกในโรงพยาบาล**

ชื่อผู้วิจัย นางสาวพรธิดา ธัญจิตปิยานนท์ นิสิต คณะจิตวิทยา จุฬาลงกรณ์มหาวิทยาลัย
นางสาวเหมยฟ้า ลิ่มสกุล นิสิต คณะจิตวิทยา จุฬาลงกรณ์มหาวิทยาลัย
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โทรศัพท์มือถือ 098-2750721 E-mail : ptanjitpiyanond@gmail.com

1. ขอเรียนเชิญท่านเข้าร่วมในการวิจัย ก่อนที่ท่านจะตัดสินใจเข้าร่วมในการวิจัย มีความจำเป็นที่ท่านควรทำความเข้าใจว่างานวิจัยนี้ทำเพราะเหตุใด และเกี่ยวข้องกับอะไร กรุณาใช้เวลาในการอ่านข้อมูลต่อไปนี้อย่างละเอียดรอบคอบ และสอบถามข้อมูลเพิ่มเติมหรือข้อมูลที่ไม่ชัดเจนได้ตลอดเวลา

2. โครงการนี้เกี่ยวข้องกับการวิจัยเรื่อง "**การศึกษาทฤษฎีอัตลักษณ์ทางสังคมและการสื่อสารระหว่างบุคคลากรและแผนกในโรงพยาบาล**" ทฤษฎีอัตลักษณ์ทางสังคม (social identity theory) กล่าวไว้ว่า บุคคลหนึ่งสามารถนิยามตัวเองโดยใช้กลุ่มที่ตัวเองเป็นสมาชิกอยู่ กลุ่มในที่นี้อาจแบ่งเป็น เชื่อชาติ เพศ หรือ อาชีพ เป็นต้น ในการวิจัยนี้ กลุ่มอาจหมายถึงแต่ล่ะอาชีพในโรงพยาบาล อย่างเช่น หมอ พยาบาล เป็นต้น หรือกลุ่มอาจแบ่งได้ตาม แผนกต่างๆใน โรงพยาบาลอย่างเช่น แผนกสูติ แผนกฉุกเฉิน เป็นต้น ในการวิจัยนี้ การสื่อสาร หมายถึง กระบวนการแลกเปลี่ยนข้อมูลจากผู้ให้สาร ถึงผู้รับสาร ในรูปแบบของภาษาพูด หรือ ภาษาเขียน

3. วัตถุประสงค์ของการวิจัย งานวิจัยชิ้นนี้จัดทำขึ้นเพื่อศึกษาว่า อัตลักษณ์ทางสังคมที่เกินขึ้นในโรงพยาบาลสามารถเป็นปัจจัยส่งผลต่อการทำงานหรือไม่

4. รายละเอียดของกลุ่มประชากรหรือผู้มีส่วนร่วมในการวิจัย

4.1 ผู้มีส่วนร่วมในการวิจัยครั้งนี้คือ บุคคลากร โรงพยาบาลในประเทศไทย ที่แสดงความสนใจเข้าร่วมในการสัมภาษณ์ โดยมีเกณฑ์การคัดเข้าและเกณฑ์การคัดออกดังต่อไปนี้

<u>เกณฑ์การคัดเข้า</u>

1. ผู้มีส่วนร่วมต้องแป็นบุคคลากรโรงพยาบาลในประเทศไทย
ที่มีประสบการ์ณการทำงานขั้นต่ำในโรงพยาบาล สองเ ดือน
2. ผู้มีส่วนร่วมต้องมาจากหน้าที่ตำแหน่งการงาน ภายในโรงพยาบาล
ที่ผู้ทำวิจัยได้กำหนดไว้ (ตำแน่งผู้บริหาร, หมอ, พยาบาล หรือ ฝ่ายจัดการทั่วไป)
3. ผู้มีส่วนร่วมต้องยินยอมที่จะแบ่งเล่าประสบการ์ณผ่านการสัมภาษณ์กับผู้ทำวิจัย

<u>เกณฑ์การคัดออก</u>

1. เมื่อผู้มีส่วนร่วมมีการแสดงความไม่สบายใจในการตอบคำถามในแบบสัมภาษณ์
2. เมื่อผู้มีส่วนร่วมขอถอนตัวจากการสัมภาษณ์
3. ผู้วิจัยจะทำการเก็บข้อมูลจากผู้ให้ข้อมูลทั้งสิ้น 8 คน

5 กระบวนการการวิจัยที่ท่านจะมีส่วนร่วมในการวิจัย

5.1 ผู้วิจัยทำการติดต่อโรงพยาบาลในกรุงเทพมหานคร โดยผู้วิจัยจะติดต่อโรงพยาบาลผ่านทางอีเมล โดยแนบเอกสารข้อมูลงานวิจัย แล้ว ตัวอย่างคำถามสัมภาษณ์เพื่อขอเข้าไปใช้สถานที่และสัมภาษณ์บุคคลากรภายในโรง พยาบาลเพื่อทำการวิจัย

5.2 หากได้รับการอนุมัติจากฝ่ายบุคคลของทางโรงพยาบาล ผู้วิจัยจะเตรียมคัดผู้เข้าสัมภาษณ์โดยตระหนักถึงความประสงค์ใจของโรงพยาบาลและ บุคคลากรและเกณฑ์ที่ผู้วิจัยได้ระบุไว้ จากนั้นผู้วิจัยจะอธิบายรายละเอียดของงานวิจัย พร้อมทั้งมอบเอกสารรายละเอียดการวิจัยและเอกสารยินยอมเข้าร่วมการวิจัยให้ผู้ร่วมสัมภาษณ์ได้พิจารณา รวมถึงตอบคำถามหรือข้อข้องใจเกี่ยวกับงานวิจัยดังกล่าว โดยหากผู้ร่วมสัมภาษณ์

ยินยอมมีความประสงค์จะเข้าร่วมการวิจัย ผู้วิจัยจะขอให้ผู้เข้าสัมภาษณ์ลงนามหรือประทับลายนิ้วมือเพื่อแสดงความยินยอมเข้าร่วมการวิจัย เพื่อทำการสัมภาษณ์

5.3 ในการสัมภาษณ์ ผู้วิจัยจะใช้ระยะเวลาประมาณ 15-30 นาที โดยผู้วิจัยจะขออนุญาตบันทึกเสียงสัมภาษณ์ของท่านก่อนการสัมภาษณ์ทุกครั้ง สถานที่ในการสัมภาษณ์คือ โรงพยาบาลที่เข้าร่วม โดยจะทำการสัมภาษณ์ในสถานที่ ที่เป็นส่วนตัว และจะต้องคำนึงถึงความปลอดภัยและการรักษาความลับของข้อมูลเป็น หลักทำการสัมภาษณ์ในช่วงวันและเวลาที่ผู้สัมภาษณ์สะดวก

5.4 ในการถอดความบทสัมภาษณ์ตลอดจนขั้นตอนการวิเคราะห์ข้อมูล ผู้วิจัยจะนำเสนอผลการวิจัยในภาพรวมโดยไม่มีการระบุชื่อของท่าน บุคคล หรือสถานที่ที่เกี่ยวข้องซึ่งอาจระบุถึงตัวท่านได้โดยผู้วิจัยจะใช้ชื่อสมมติแทนชื่อเฉพาะ ดังกล่าวทั้งหมด ข้อมูลที่ได้จากการสัมภาษณ์จะเก็บรักษาไว้เป็นความลับ ในที่ที่ไม่มีใครสามารถเข้าถึงได้นอกจากตัวผู้วิจัยและข้อมูลทั้งหมดจะถูกทำลายทิ้งทันทีหลังจากการวิจัยเสร็จสิ้น

5.5 กรอบแนวคำถามในการสัมภาษณ์ จะเป็นการสัมภาษณ์แบบไม่เป็นทางการ โดยเน้นสัมภาษณ์เจาะลึกถึงประสบการณ์ทางด้านอารมณ์ ความรู้สึก ความคิดของผู้ร่วมสัมภาษณ์

6. กระบวนการให้ข้อมูลแก่ผู้มีส่วนร่วมในการวิจัย ผู้วิจัยจะเป็นผู้ติดต่อด้วยตนเอง พร้อมทั้งมอบเอกสารและอธิบายรายละเอียดของการวิจัย โดยหากผู้ให้สัมภาษณ์มีข้อสงสัยใดๆ สามารถติดต่อสอบถามผู้วิจัยได้ตามเบอร์โทรศัพท์หรือที่อยู่ที่ระบุไว้ข้างต้น

7. ประสบการณ์ที่ผู้ให้สัมภาษณ์ถ่ายทอดออกมาจะเป็นประโยชน์ในการช่วยให้เกิดความรู้ ความเข้าใจเกี่ยวกับความสัมพันธ์ระหว่างทฤษฎีอัตลักษณ์และการสื่อสารระหว่างบุคคลากร และแผนกต่างๆในโรงพยาบาล อีกทั้งสามารถนำผลการศึกษาจากปรากฏการณ์ต่างๆในหลาย แง่มุมทั้งในระดับเรื่องราว ระดับความรู้สึกของบุคคลากรเพื่อนำมา พัฒนาความสัมพันธ์ระหว่างบุคคลากร และแผนกต่างๆในโรงพยาบาลให้ดียิ่งขึ้น ซึ่งผู้ทำวิจัยเชื่อว่าจะมีประโยชน์อย่างมากต่อการผสานงาน และการดูแลคนไข้ที่ดี

8. การเข้าร่วมในการวิจัยเป็นโดย**สมัครใจ**และสามารถ**ปฏิเสธ**ที่จะเข้าร่วมหรือ**ถอนตัว**จาก การวิจัยได้ทุกขณะ โดยไม่ต้องให้เหตุผลและไม่สูญเสียประโยชน์ที่พึงได้รับ รวมถึงไม่มีผลกระทบต่อ ปคดีของผู้ให้สัมภาษณ์แต่อย่างใด

9. ในการเข้าร่วมการวิจัย อาจมีความไม่สะดวก โดยผู้ให้สัมภาษณ์อาจจะต้องสละเวลาในการ ให้สัมภาษณ์ประมาณ 15-30 นาที

10. หากผู้ให้สัมภาษณ์มีข้อสงสัยให้สอบถามเพิ่มเติมได้โดยสามารถติดต่อผู้วิจัยได้ตลอดเวลา และหากผู้วิจัยมีข้อมูลเพิ่มเติมที่เป็นประโยชน์หรือโทษ เกี่ยวกับการวิจัย ผู้วิจัยจะแจ้งให้ท่านทราบ อย่างรวดเร็วเพื่อให้ผู้มีส่วนร่วมในการวิจัยได้ทบทวนว่ายังสมัครใจจะอยู่ในงานวิจัยต่อไปหรือไม่

11. ข้อมูลที่เกี่ยวข้องกับผู้ให้สัมภาษณ์ ผู้วิจัยจะเก็บเป็น**ความลับ** หากมีการเสนอผลการวิจัยจะ เสนอเป็นภาพรวม ข้อมูลใดที่สามารถระบุถึงตัวผู้ให้สัมภาษณ์ได้จะไม่ปรากฏในรายงาน

12. การสัมภาษณ์จะเป็นแบบสมัครใจเข้าร่วม โดยมีการให้ของที่ระลึกเป็นค่าตอบแทนให้แก่ ผู้เข้าสัมภาษณ์ในการเข้าร่วมการวิจัย

13. มีข้อความระบุว่า หากท่านไม่ได้รับการปฏิบัติตามข้อมูลดังกล่าวสามารถร้องเรียนได้ที่ คณะจิตวิทยา จุฬาลงกรณ์มหาวิทยาลัย เบอร์ติดต่อ (662) 218-1189, (662) 218-1197 Email: jipp.cu@gmail.com

Appendix B

Information sheet

Research project: The influence of social identity theory and communication on healthcare delivery in Thailand

Researchers:

Porntida Tanjitpiyanond Faculty of Psychology Chulalongkorn University

Maeyfah Limskul Faculty of Psychology Chulalongkorn University

Monisha Agarwal Faculty of Psychology Chulalongkorn University

Contact address: 54/420 Pattanakarn 69 Prawet 10250 Bangkok

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1. Before participating in this research, we want to make sure that you've completely understood the purpose and rationale of our study. Please feel free to ask us to clarify any points or ask us any questions that you may have as we progress with the study.

2. This research aims to explore "social identity theory and communication between hospital's department and staff." Social identity posits that individuals can identify themselves in terms of group membership through racial, sexual or occupational identity etc. In this research, groups that individuals identify with may refer to the different position or department within the hospitals. Communication means the process of exchanging information from one individual to another through verbal or written language.

3. This research aims to study whether social identity in hospital settings could be a factor affecting the quality of patient care.

4. Participant's information

4.1. Participants will have to voluntarily participate in this study and must also be a staff currently working in a Thai hospital with the following inclusion and exclusion criteria:

Inclusion criteria

1. The participants must currently be full time hospital staff that has been working at the hospital for a minimum of 2 months.
2. The participants must be from one of the hierarchical levels that we are interested in.
3. The participants must be willing to participate in sharing their experiences.

Exclusion criteria

1. Any participants that show discomfort or disinterest in sharing their experiences will be excluded from the research.
2. Any participants that express a desire to withdraw from the study for any reason will be reassured by the researcher that they are free to do so without any prejudice.

4.2 The researchers will conduct a total of 8 interviews

5. The research process

5.1 Firstly the researcher will contact one of the hospitals within Bangkok through the Human Resource (HR) department by email. The email will also include information sheet regarding the research project and sample questions.

5.2 Once HR approved the research, the researchers will recruit interview participants based mutual agreement with the hospital as well as on the inclusion and exclusion criteria listed above. The researcher will then explain their research to the participants as well as give them the information sheet and informed consent for them to consider and

answer any questions the participants might have before commencing the interview. The participants who agree to be part of the research must sign the consent form.

5.3 The interview should take approximately 15-30 minutes. It will be conducted at the hospital in a quiet room at a time that is convenient for each participant. At the start of each interview, the researcher will always ask each participant for permission to audio record the interview session.

5.4 The questions used for the interview will be open-ended, which aim to gain insight into the participant's personal experience, feeling and perspective about what constitute to good patient care.

5.5 From the transcription through to the analysis process, the interviewer will remove any identifying information of the participant and hospital. All data collected will be kept confidential and can only be accessed by the researcher. Once the research process is finished, all data will be terminated in order to maintain the confidentiality of the participants

6. The researcher will personally inform the participants about the research and answer any further inquiries that the participants might have. If the participant wishes to contact the researcher, they can do so through the contact information provided above.

7. Through this research, the participant's experience, feelings and perspective would help give insight to the mechanism of social identity and communication between healthcare department and staff within the Thai context. The researcher hope that the finding from this study would be used to help understand and improve the healthcare communication in Thailand, which would potentially elevate the quality of patient care.

8. Participation in this study is based on a voluntary basis and a token of appreciation will be given to participants. Participants are given the right to participate or withdraw at anytime without having to clarify their reason for doing so.

9. The researcher acknowledge that this study might bring inconvenience to the participants since they might have to spare their personal time of 15-30 minutes.

10. The researcher would contact the participants immediately if their has been any update about the research that could benefit or harm the participants, as well as whether the participants would want to continue being part of the study.

11. All data relating to the participant and the hospital would be confidential. The finding of this research would be reported as a general overview of Thai hospital without any including any identifying information of the participants.

12. If the participants feel that the researchers are not fulfilling the aforementioned guidelines stated above, the participant can contact the Faculty of Psychology Chulalongkorn University Phone: (662) 218-1189, (662) 218-1197 Email: jipp.cu@gmail.com

Appendix C

หนังสือแสดงความยินยอมเข้าร่วมการวิจัย

ทำที่.....

วันที่.....เดือน.....พ.ศ. .....

เลขที่ ประชากรตัวอย่างหรือผู้มีส่วนร่วมในการวิจัย….....……

ข้าพเจ้า ซึ่งได้ลงนามท้ายหนังสือนี้ขอแสดงความยินยอมเข้าร่วมโครงการวิจัย

ชื่อโครงการวิจัย **การศึกษาทฤษฎีเอกลักษณ์ทางสังคมและการสื่อสารระหว่างบุคคลากรและแผนกในโรงพยาบาล**

ชื่อผู้วิจัย นางสาวพรธิดา ธัญจิตปิยานนท์ นิสิต คณะจิตวิทยา จุฬาลงกรณ์มหาวิทยาลัย

นางสาวเหมยฟ้า ลิ่มสกุล นิสิต คณะจิตวิทยา จุฬาลงกรณ์มหาวิทยาลัย

นางสาวมนนิชา อักราวัล นิสิต คณะจิตวิทยา จุฬาลงกรณ์มหาวิทยาลัย

ที่อยู่ที่ติดต่อผู้วิจัย 54/420 ซอย. พัฒนาการ 69 เขต ประเวศ แขวง ประเวศ 10250 กรุงเทพฯ

โทรศัพท์มือถือ 098-2750721 E-mail: ptanjitpiyanond@gmail.com

ข้าพเจ้า **ได้รับทราบ**รายละเอียดเกี่ยวกับที่มาและวัตถุประสงค์ในการทำวิจัย รายละเอียดขั้นตอนต่างๆ ที่ข้าพเจ้าจะต้องปฏิบัติหรือได้รับการปฏิบัติ ความเสี่ยง/อันตราย และประโยชน์ซึ่งจะเกิดขึ้นจากการวิจัยเรื่องนี้ โดยได้อ่านรายละเอียดในเอกสารชี้แจงผู้เข้าร่วมการวิจัย โดยตลอด และ**ได้รับคำอธิบาย**จากผู้วิจัย **จนเข้าใจเป็นอย่างดี**แล้ว ข้าพเจ้าจึง**ยินยอม**เข้าร่วมใน โครงการวิจัยนี้ ตามที่ระบุไว้ในเอกสารชี้แจงผู้เข้าร่วมการวิจัย โดยข้าพเจ้ายินยอมให้ข้อมูลส่วนตัว โดยการสัมภาษณ์ รวมถึงการบันทึกเทปการสนทนาเป็นเวลาประมาณ 15-30 นาที และเมื่อเสร็จสิ้นการวิจัยแล้ว เทปบันทึกเสียง รวมถึงข้อมูลที่เกี่ยวข้องกับผู้มีส่วนร่วม ในการวิจัยจะถูกทำลายทิ้งทั้งหมด

ข้าพเจ้ามีสิทธิ**ถอนตัว**ออกจากการวิจัยเมื่อใดก็ได้ตามความประสงค์**โดยไม่ต้องแจ้งเหตุผล** ซึ่งการถอนตัวออกจากการวิจัยนั้น จะไม่มีผลกระทบในทางการศึกษาหรือในทางใดๆ ต่อตัวข้าพเจ้าทั้งสิ้น

ข้าพเจ้าได้รับคำรับรองว่า ผู้วิจัยจะปฏิบัติต่อข้าพเจ้าตามข้อมูลที่ระบุไว้ในเอกสารชี้แจงผู้เข้าร่วมการวิจัย และข้อมูลใดๆ ที่เกี่ยวข้องกับข้าพเจ้า ผู้วิจัยจะ**เก็บรักษาเป็นความลับ** โดยจะนำเสนอข้อมูลการวิจัย เป็นภาพรวมเท่านั้น ไม่มีข้อมูลใดในการรายงานที่จะนำไปสู่การระบุตัวข้าพเจ้า

หากข้าพเจ้าไม่ได้รับการปฏิบัติตรงตามที่ได้ระบุไว้ในเอกสารชี้แจงผู้เข้าร่วมการวิจัย ข้าพเจ้าสามารถร้องเรียนได้ที่ คณะจิตวิทยา จุฬาลงกรณ์มหาวิทยาลัย เบอร์ติดต่อ (662) 218-1189, (662) 218-1197 Email: JIPP.CU@gmail.com

ข้าพเจ้าได้ลงลายมือชื่อไว้เป็นสำคัญต่อหน้าพยาน ทั้งนี้ข้าพเจ้าได้รับสำเนาเอกสารชี้แจงผู้เข้าร่วมการวิจัย และสำเนาหนังสือแสดงความยินยอมไว้แล้ว

ลงชื่อ.....
(นางสาวพรธิดา ธัญจิตปิยานนท์)
ผู้วิจัยหลัก

ลงชื่อ.....
(.....)
ผู้ให้ข้อมูล

ลงชื่อ.....
(.....)
พยาน

Appendix D

Consent Form

Date/Month/Year…….

At……..

Participants' Thai national identification number ……

I hereby sign this form to indicate my consent to participate in this research project.

Project's detail: The study on social identity theory and communication between hospital's department and staff.

Researchers details: students from faculty of Psychology at Chulalongkorn University (Thailand)

Pontida Tanjitpiyanond

54/420 Patanakan street 69, Pawet district, Bangkok, Thailand 10250

Tel: 098-275-0721 email: ptanjitpiyanond@gmail.com

Maeyfa Limskul

30/37 The Concord, Sukumvit 15, Sukumvit road, Wattana district, Bangkok, Thailand, 10110

Tel: 085-112-4392 email: limskul.m@gmail.com

Monisha Agarwal

9D 87 Siam Mansion Sukhumvit Soi 12 Klongtoey 10110 Bangkok, Thailand

Tel: 095-2522-193 email: monisha_a@hotmail.com

I hereby acknowledge the importance and objectives of this research. After reading the information sheet, I understand the procedure I need to engage together with the risks/harms and benefits I can gain from this project.

I am willing to participate in this project and agree to share my personal information during the interview session for duration of 15 to 30 minutes. I allow the interviewee to use a voice recorder in recording the interview and use the information for transcription later. I also understand that all of my identifying information that will be destroyed after the project is published without any exceptions.

I understand my right to freely withdraw from the interview and this research without providing any reasons beforehand.

The researchers need to treat me according to the terms presents in the information sheet I read. My personal information will be kept confidential and deidentified throughout the study.

If in any circumstances the researchers cannot respectively treat me in according to these terms I can file a complaint to Faculty of Psychology Chulalongkorn University Phone: (662) 218-1189, (662) 218-1197 Email: jipp.cu@gmail.com

I here by confirming my willingness in participate in this project and all documents regards to this project have been given to me in advance.

……. ……

(……..) (……..)

(main researcher) (participant)

……

(……..)

(eye-witness)

Appendix E

แนวคำถามสำหรับการสัมภาษณ์

ตัวอย่างคำพูดเกริ่นนำ

“ขอบคุณ คุณ ผู้อำนวยการ/หมอ/พยาบาล/ ที่ยินดีให้หนูสัมภาษณ์วันนี้ค่ะ รายละเอียดของงานวิจัยและการสัมภาษณ์วันนี้ได้สรุปอยู่บนเอกสารข้อมูลนี้ ก่อนเริ่มการสัมภาษณ์หนูขออนุญาตอธิบายเกี่ยวกับงานวิจัยคร่าวๆและขอให้คุณ ... ช่วยอ่านดูรายละเอียดบนเอกสารก่อนที่ตัดสินใจร่วมการสัมภาษณ์ค่ะ หากคุณ... มีคำถาม หรือ ข้อสงสัยอะไร สามารถถามหนูได้เลยนะคะ ...

งานวิจัยนี้เป็นงานที่สืบเนื่องจาก งานวิจัยจากต่างประเทศ ที่จัดทำขึ้นที่ที่เมืองบริสเบน ประเทศออสเตรเลีย และ เมืองนิวออร์ลีนส์ ประเทศสหรัฐอเมริกา พวกเราเลยมีความสนใจที่จะทำการศึกษาในเรื่อง ดังกล่าวในประเทศไทยด้วยคะ ในงานวิจัยก่อนหน้านี้ นักวิจัยได้อัดเสียงบทสัมภาษณ์และ คัดลอกบทสัมภาษณ์เพื่อเป็นการศึกษา เนื้อหาและข้อมูลของบทสัมภาษณ์

โดยจะตัดข้อมูลส่วนตัวของผู้สัมภาษณ์รวมถึงวันและเวลาของการสัมภาษณ์ออก เพื่อให้ข้อมูลส่วนตัว ของคุณถูกเก็บเป็นความลับค่ะ ถ้าวันนี้หนูขออนุญาตคุณ.... อัดเสียงการสัมภาษณ์เพื่อเป็นการเก็บข้อมูล และคัดลอกบทบทสัมภาษณ์ เพื่อให้ข้อมูลที่คุณแบ่งปันไม่ตกหล่นหรือบิดเบือนจากความจริง

คุณ...สะดวกไหมค่ะ? ถ้าหากคุณอยากจะอ่านบทสัมภาษณ์อีกครั้ง เพื่อใช้ประกอบการตัดสินใจใน การอนุญาตให้หนูใช้ข้อมูลของคุณ คุณบอกหนูได้เลยค่ะ

ระหว่างการสัมภาษณ์ อาจจะมีการจดบันทึกใจความสำคัญ ได้ไหมค่ะ? หนูยินดีให้คุณ...อ่านโน๊ตหลังการสัมภาษณ์ และถ้าคุณ... รู้สึกอึดอัดใจในการที่หนูจดบันทึกข้อมูล บอกหนูได้เลยค่ะ

ถ้าคุณ... ไม่มีข้อสังสัยแล้ว กรุณาช่วยเซ็นใบยินยอมในการร่วมการวิจัย ใบนี้ด้วยนะค่ะ ”

(เริ่มบทสัมภาษณ์)

*1. “ขอบคุณคุณ... ที่เข้าร่วมและอณุญาตให้อัดเสียงการสัมภาษณ์ค่ะ ในการสัมภาษณ์วันนี้หนูมีสี่คำถามที่จะถามคุณ... คำถามแรกเป็นคำถามทั่วไป สอบถามถึงตำแหน่ง แผนก และหน้าที่ภายในโถงพยาบาลของคุณ.. แต่ในที่นี้หนูอยากให้คุณวางใจได้ว่าข้อมูลทุกอย่างเป็นความลับและ จะไม่มีการใช้*ชื่อจริงของ บุคคล

หรือ โรงพยาบาลใน ในการวิจัยนี้ค่ะ อีกสามคำถามที่เหลือจะเป็นคำถามเกี่ยวกับงานวิจัยที่อยากถามถึงความรู้สึกและประสบการ์ณ ในการทำงานในโรงพยาบาลของคุณ.. ไม่ว่าจะที่คุณทำงานอยู่ ณ ปัจจุบันหรือโรงพยาบาล ที่เคยทำงานในอดีตนะค่ะ หนูขออนุญาตเริ่มการสัมภาษณ์เลยนะคะ"

2. คุณ...ทำงาน ในตำแหน่งและแผนก อะไรในโรงพยาบาลคะ แล้วคุณต้องทำหน้าที่อะไรบ้างคะ (ถามถึงระยะเวลา ปี ประสบการ์ณในการทำงานในโรงพยาบาล ทั้ง โรงพยาบาลปัจจุบันและในอดีต)

3. จากประสบการ์ณทำงานในโรงพยาบาล คุณ... คิดว่าอะไรเป็นปัจจัยสำคัญในการช่วยรักษาคนไข้ที่ดี? (ยกตัวอย่าง)

4. คุณคิดว่า การสื่อสาร ระหว่างบุคลากรและแผนกต่างๆในโรงพยาบาล มีผลต่อการทำงานที่ดีไหมค่ะ? (ยกตัวอย่าง) เคยมีไหมคะที่ คุณหมอพบว่าในการรักษาและดูแลคนไข้ ค่อนข้างยากขึ้น เนื่องจากปัญหาเรื่องการสื่อสาร? คุณภาพความสัมพันธ์ระหว่างบุคลากรในโรงพยาบาล ช่วยในการพัฒนาการสื่อสารไหมค่ะ?

5. โดยส่วนตัวแล้วคุณ...มีความคิดเห็นอย่างไรที่จะช่วยพัฒนา การสื่อสาร ระหว่างบุคลากรและแผนกต่างๆในโรงพยาบาล ให้ดียิ่งขึ้นไปอีก? ทำไมการพัฒนาแบบนี้ถึงสำคัญ และผลลัพท์ที่ต้องการคืออะไรคะ

เกริ่นจบบทสัมภาษณ์

*"*คุณ...ค่ะ คำถามมีทั้งหมดแค่ 4 ข้อที่เราคุยกัน คุณ...รู้สึกว่ามีประเด็นไหนที่ตกหล่นไปในการ สัมภาษณ์แล้วคุณ..อยากจะชี้แจ้งไหมคะ? คุณมีคำถามเกี่ยวกับงานวิจัยหรือการสัมภาษณ์ครั้งนี้ที่คุณ ยังสงสัย คุณสามารถถามได้เลยนะคะ*"* *"*หนูอยากจะชี้แจงอีกทีคะว่า การบันทึกเสียงจะถูกนำมาถอด เทปเพื่อให้ในงานวิจัยนี้เท่านั้น ข้อมูลส่วนตัวที่คุณให้จะถูกเก็บเป็นความลับแน่นอนคะ ถ้าคุณสบายใจที่จะให้หนูใช้ข้อมูลดังกล่าว ช่วยกรุณาตอบตกลงอีกทีได้ไหมคะ?*"* *"*ทั้งนี้ทางเราสามารถส่งข้อมูลเมื่อถูกคัดลอก ถ้าเสร็จหากคุณต้องการที่จะเก็บฉบับคัดลอกไว้*"* *"*ขอขอบคุณอีกครั้งนะคะ ที่คุณสละเวลาเพื่อมาแบ่งปันประสบการณ์ในการทำงาน ขอบคุณอีกครั้งคะ*"*

(จบบทสัมภาษณ์)

Appendix F

Interview guide

Introductory statement

"Thank you for agreeing to participate in this interview. For your convenience, the details of this research and the interview questions are summarized in this information sheet, which you can take with you for your record. Before we begin, I would like to tell you a little about the research. Then I would like you to read the information sheet, which explains our research, and your part in this study. And let me know if you have any questions at all about this research.
This is an experimental study under the supervision of a researcher who conducted a similar study in Brisbane and New Orleans. In those studies they recorded and transcribed the interviews for the accuracy. Personal information such as names and dates were excluded to protect confidentiality. Thus, we would like to proceed with the same procedure. Is it okay with you If I record the audio of this interview for later transcription and to make sure we do not miss any valuable information you give us?
Also, during the interview, I will be jotting some brief notes just to remind myself of any points, you are welcome to take a look at them after the interview if you like. Is that ok with you too?
If you don't have any further questions, please sign this form as consent to participate in this study"

Beginning of interview

1. "Thank you for participating and allowing me to record this interview. There are a total of 4 interview questions that I will use to structure the interview. However, please feel free to choose what you would like to speak about, as we are interested in Thai health practitioner's experience

and this may be unique to Thai culture. Please rest assured that we will remove all identifying information of you or the hospital and we will keep the interview content confidential.

The first question is a general inquiry about your position, department and years of experience, We ask this question so we can match our study sample with our sample in Brisbane and New Orleans.

The other three questions are research focused. We ask that you comment on your experience working in hospitals, whether it is the present or past hospitals. We ask you to comment on what helps or hinders quality of healthcare and patient safety. May I proceed with the interview?"

2. Could you tell me about your position and department in the hospital?

3. From your experience working in the current or past hospitals, what factors do you think contribute to good patient care? How?

4. Some of our Australian and North American interview participants talked about the role of communication. Do you think communication among hospital staff affects delivery of patient care? How? Can you give an example of what you mean?

5. Have there been any instances when you found that communication problems affect delivery of patient care? Can you give an example?

6. Personally, could you share any ideas you might have that could further help improve the communication between hospital staff in the hospital?

    a. Why is this improvement important? What do you think will be the end results?

Ending statement

"Those are all the questions I have, do you feel like there are any important points I haven't touched on that you would like to share with me?" "Do you have any final questions about the research that you would like to ask?"

"As I mentioned earlier that the audio record of this interview will be transcribed and all information will not be de-identified with you, I want to ask you again to assure that we can use this information, would you agree so? We can also send you a copy of the transcript if you would like. Anyway, this is the end of the interview, thank you so much again for your time, participation and for sharing your experience with us."

Appendix G

ตัวอย่างบทสัมภาษณ์ : P1

ผู้สัมภาษณ์: ก็ขอบคุณค่ะ ที่ให้หนูเข้าสัมภาษณ์ค่ะ ก็ขอบคุณที่ให้ยินยอมอักเสียงแล้วก็พอสัมภาษณ์นี้จะถูกทอดเทปเพื่อไปวิเคราะห์ข้อมูลนะค่ะ

P1: ได้จ๊ะ

ผู้สัมภาษณ์: คำถามแรกนะค่ะ พี่ทำงานในตำแหน่งอะไรในโรงพยาบาลค่ะ

P1: ตอนนี้เป็นโรงผู้อำนวยการโรงพยาบาลจ๊ะ ฝ่ายการแพทย์

ผู้สัมภาษณ์: ค่ะ แล้วหน้าที่ที่พี่ต้องทำงานในแต่ละวันมีอะไรบ้างค่ะ

P1: ก็คือเออ ถ้าโดยส่วยตัวเนี่ย ตัวเองเป็นสูติแพทย์ เพราะฉนั้นเนี่ยส่วนหนึ่งจะต้องมีการตรวจคนไข้ แล้วก็เออ ทำคลอด ผ่าตัด แต่ว่า เออ ประมาณสักตอนนี้ เดิมเนี่ยทำประมาณ 80 90 เปอร์เซ็นต์ แต่ตอนนี้เนี่ยเหลือสัก 20 เปอร์เซ็นได้มั้ง เออ ซะเพราะตอนนี้ส่วนใหญ่เนี่ยก็ต้องมานั่งดูงานบริหาร ของโรงพยาบาล เนอะ เพราะว่าต้องดูแลกลุ่มงานต่างๆ กลุ่มงานทางการแพทย์ ไม่ว่าะเป็นคุณหมอ คุณเภสัช เออ หรือว่าคุณพยาบาล เออ ไม่ใช่คุณพยาบาล เพราะส่วนใหญ่คุณพยาบาลเนี่ยจะขึ้นตรง ต่อผู้อำนวยการโดยตรง นะค่ะ

ผู้สัมภาษณ์: เออ ก็ไม่ได้เจอคนไข้มากเท่าก่อนแล้ว

P1: เออใช่ๆ ลดลงๆๆ แต่ถามว่าลดลงไหม เฉพาะที่โรงพยาบาล แต่ถ้าที่คลินิกเนี่ย มีคลินิกส่วนตัว ก็ยังเจอตามปกติทุกวัน อืมหืม

ผู้สัมภาษณ์: แล้วไปทำที่คลินิกส่วนตัวบ่อยไหมค่ะ หรือส่วนใหญ่..

P1: ทุกวันจ๊ะ

ผู้สัมภาษณ์: โอเคค่ะ และจากประสบการณ์ทำงานในโรงพยาบาลเนี่ย ไม่ว่าจะเป็นโรงพยาบาลปัจจุบันหรือในอดีตอ่ะค่ะ พี่คิดว่าอะไรเป็นปัจจัยสำคัญที่ช่วยรักษาคนไข้ที่ดีค่ะ

P1: ปัจจัยสำคัญในการรักษาใช่ปะ ถ้าปัจจัยสำคัญในการรักษษก็คงต้องเป็นมาตรฐาน มาตรฐานวิชาชีพของการดูแลไม่ว่าจะเป็นของทางแพทย์ พยาบาล ทันตแพทย์ เภสัช มาตรฐานของทุกคน ซึ่งเค้าจะมีวิชาชีพรองรับ สภาวิชาชีพ อย่างเช่นของแพทย์ก็จะมี แพทย์สภา ของทันตะก็มีของทันตะสภา ก็คือทุกอย่างจะมีวิชาชีพรองรับ เป็นมาตรฐานในการดูแลรักษาคนไข้ ในหนึ่งโรคเนี่ยมันจะ มีเกณฑ์ว่าจะต้องทำนี่ๆๆๆ ถ้าในโรงพยาบาลรัฐบาลเนี่ย ขอยืนยันว่า มาตรฐานค่อนข้าง 100 เปอร์เซ็นต์ แต่ว่าถ้าเป็นในส่วนที่ ถามว่า ปัจจัยสำคัญในการรักษาคนไข้ที่ดีเนี่ย มันต้องประกอบไปด้วยอย่างอื่นอีก ไม่ว่าจะเป็นมาตรฐานถูกปะ อันที่หนึ่งคือมาตรฐาน แต่อันที่สองเนี่ยก็คือ ความสำคัญ ก็คือความพึงพอใจของลูกค้า ก็คือความพึงพอใจผู้ป่วย ไม่ว่าจะเป็น ทุกส่วน ทุกภาคส่วนมีส่วนร่วม ในการดูแลผู้ป่วยหมด ไม่ว่าจะเป็นตั้งแต่ รปภและ เข้ามาโรงบาลอ่าหาที่จอดรถ ไม่ดีเค้าก็ไม่พึงพอใจล่ะ ถูกปะ หรือว่าจะเป็นเวรเปล รวมไปถึงผู้ช่วยพยาบาล พยาบาลเอง มาถึงหมอ มาถึงเภสัช จนกระทั่งจ่ายยา จนถึงห้อง lab เจาะเลือด X-ray หรือว่าจะเป็นเก็บเงิน สุดท้ายคือด่านเก็ยเงิน ถูกปะ เพราะฉะนั้นปัจจัย ทั้งหมดจะเป็นส่วนรว่วมกันหมดเลย ส่วนเล็กส่วนน้อย แต่ที่สำคัญๆ เนี่ยก็สองอย่างนี้แหละ ก็คือเรื่องมาตรฐานวิชาชีพและเรื่องความพึงพอใจที่จะเป็นปัจจัยสำคัญ ที่จะทำให้การรักษาคนไข้ดี หรือไม่ดีในภาพรวม

Appendix H

Excerpt of Translated Interview Transcript: P1

Interviewer: Well thank you for letting me conduct and audio record this interview. After this I will transcribe the interview to analyze the data.

P1: Sure ja

Interviewer: First question, what is your position in the hospital?

P1: Right now I'm the deputy director of Ratchapitpat hospital, the doctoral department.

Interviewer: Ka, so what is your normal daily routine?

P1: Well er, personally, I am an obstetrician, therefore one part I do check up with patients and er, deliver babies, surgery but er. Right now, before I do 80 – 90 percent of it but now it reduces to maybe 20 percent. Mostly, the 80 percent is spent managing the hospital work because I have to take care of different groups, different medical groups, whether its doctors, pharmacists, er nurses, er not nurses because most nurses would report directly to the director.

Interviewer: Er so not seeing patients as much as before

P1: Er yes yes, it reduces, but if you ask if it reduces, then it is mainly at the hospital but if at the clinic, I have a personal clinic, I still regularly see patients daily. Umhm.

Interviewer: So do you do work at your own personal clinic often or mostly..

P1: Everyday ja.

Interviewer: Okay ka. From your experience working in hospitals, whether it is the current or past hospital, what do you think is an important factor in contributing to good patient care?

P1: An important factor in patient care? If an important factor in patient care then it has to be a standard of delivering the service. Occupational standard in care, whether it is the doctor's, nurses's, dentist's, pharmacist's, dentist's, the standard of everyone's, which they have occupational standard, occupational council. Like for doctors, there will be doctor council, for dentists there will be a dentist doctor council. So everything have occupational standard, it is the standard in taking care of patient. In one disease there is a criteria to do this this and this. In public hospital, I confirm that the standard is somewhat 100 percent. But if you ask what is an important factor in good patient care, it must consist of other things too, whether standard, right? First is standard, second is importance, customer's satisfaction, patient's satisfaction. Whether it is, every part, every part plays a role in patient care, from the security guard. Once enter the hospital and cannot find good parking, they will be unhappy, right? Or the staffs pushing the hospital beds, including nurse assistant, the nurses themselves to the doctor, to the pharmacists until the prescribing medicine to the lab, taking blood test, X-ray, or the cashier. The end is the cashier right? Therefore all factors contribute altogether, it's the small parts, but importantly I think it's these two things. Occupational standard and satisfaction are important factors that will contribute to good or bad patient care in the overall picture.

Bibliography

Porntida Tanjtpiyanond

Porntida Tanjitpiyanond is an undergraduate psychology student at Chulalongkorn University in Bangkok, Thailand. She previously completed her Bachelor of Arts degree in Psychology from University of Queensland (UQ) in Brisbane, Australia. During her study in UQ she got a chance to volunteer on a healthcare communication with Dr. Lori Leach, the experience motivated her to replicate that study as part of her senior project focusing on healthcare communication in Thailand.

Monisha Agarwal

Monisha Agarwal is enrolled in the Joint International Program of Psychology (JIPP), as a part of which she received a Bachelor of Arts with an extended major in Psychology and a minor in Sociology from the University of Queensland, Australia. She is currently pursuing her second degree, a Bachelor of Science in Psychology from Chulalongkorn University, Thailand. Growing up as an outsider in Thailand, Monisha was intrigued to study about implicit Thai values and culture. Monisha hopes to work in the field of clinical psychology and hopes insight about the Thai healthcare system gained from this research will prove helpful in the future.

Maeyfa Limskul

As a former student from the University of Queensland, Maeyfa Limskul acknowledges the opportunity to conduct a qualitative study on Thai healthcare as a part of her dissertation at Chulalongkorn University, Thailand. She hopes to use her work to shed a light on the importance of having an effective communication in the organizations as a way to improve the quality of living for Thai people in the future.