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"Please don't call me Mister": patient preferences of how they are addressed and their knowledge of their treating medical team in an Australian hospital.

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Title:
"Please don't call me Mister": patient preferences of how they are addressed and their knowledge of their treating medical team in an Australian hospital.

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Keywords:
Patient-centered Care, Communication, Names, Patient Satisfaction, Physician-Patient Relations

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Article Summary:

Abstract

Objectives: Determine how patients prefer to be addressed by healthcare providers and their knowledge of their attending medical team's identity in an Australian hospital.

Setting: Single centre, large tertiary hospital in Australia.

Participants: Three hundred inpatients were included in the survey. Patients were selected in a sequential, systematic and whole-ward manner. Participants were excluded with significant cognitive impairment, non-English speaking, under the age of 18 years or were too acutely unwell to participate. The sample demographic was predominately an older population of Anglo Saxon background.

Primary and secondary outcome measures: Patients preferred mode of address from healthcare providers including first name, title and second name, abbreviated first name or another name. Whether patients disliked formal address of title and second name. Secondarily, patient knowledge of their attending medical team members name and role and if correct, what position within the medical hierarchy they held.

Results: Over ninety nine percent of patients prefer informal address with greater than one third having a preference to being called a name other than their legal first name. Fifty seven percent of patients were unable to correctly name a single member of their attending medical team.

Conclusions: These findings support patient preference of informal address however; healthcare providers cannot assume that a documented legal first name is preferred by the patient. Patient knowledge of their attending medical team is poor and suggests current introduction practices are insufficient.

Strengths and limitations of this study

- Main findings appropriately addressed intended aims
- Significant results which can readily be addressed by instituting a change of practice in administration, daily patient communication and training of junior medical staff
- Patient centred research intended to improve patient's experience whilst in hospital
- Single centre and predominantly Anglo-Saxon demographic
- No control for age or clinical condition of the patient

Background

Successful doctor-patient communication remains central to the establishment of a therapeutic doctor-patient relationship. A doctor's ability to communicate is not only a function to gather information and define therapeutic outcomes, but also importantly to build caring, shared relationships with patients.[1] Through the effective delivery of these core skills, the physician has the best opportunity to achieve patient satisfaction, which is known to help facilitate improved health outcomes.[2] The manner in which a doctor greets their patient is an influential aspect in establishing an effective and supportive rapport and provides the foundation of a satisfying patient experience.[4-6]

Ethnic and cultural factors can influence preferred modes of address. This has been demonstrated in Israel[3], Iran[7] and in African Americans in the United States of America[8], where formal address by title and surname name is preferred. In contrast, in an Irish geriatric unit[9] and also in a general practice setting in the United Kingdom[10], the majority of patients preferred first name greetings.

In the Australian setting, there has been limited research completed in this area. One study in general practice demonstrated that 90% of patients prefer to be addressed by their first name only and 3.4% prefer to be addressed by another name.[11] Established relationships between the doctor and patient was identified as a common factor which influenced the level of formality the patient was comfortable with,[11] this may not be applicable in the acute hospital

environment where such established relationships may not exist. The only other Australian study in 1994 found that 83% of patients preferred informal address across inpatient and private outpatient settings.[12]

In our hospital setting, the number of patients who prefer to be addressed by a name other than their legal name is not known. This may include an abbreviation of their first name or a different name entirely. Patients in hospital may be addressed by their legal name by default, as it appears on their medical record, yet may not be a name that they are known by. This was highlighted in a piece in JAMA, where use of a legal name was interpreted as a lack of personal interest in patients, creating an atmosphere of disconnect.[13]

Patients in hospital both need and should know, the name and position of the person or people providing their medical care. Ensuring a patient's knowledge of the caregivers name is significant in initiating and maintaining a positive therapeutic partnership with the patient.[14] Knowledge of the physicians' role on the attending team has been commonly associated with patient satisfaction,[15 16] however in one study in the United Kingdom only the minority of patients knew the name of their attending consultant.[17] This may be more prominent in teaching hospitals where changes in personnel occur more frequently.[18] In Australia, the knowledge patients have of their attending medical team has not been studied before.

The setting for this research was a 450 bed tertiary teaching hospital in Australia. The aims of this study were to identify what mode of address patients

in an Australian hospital prefer, what proportion of patients wish to be called a name other than their legal names and the number of patients who could correctly name any member of their attending medical team.

Methods

Survey Tool

A survey was designed in SurveyMonkey®[19] and piloted to assess inpatient preferences of address and knowledge of their attending medical team. Questions included: what name do you prefer to be addressed by while in hospital?, do you object to being addressed as Mr/Mrs/Ms (Surname)?, are you able to tell me the name of any of your treating doctors?, if yes – do you know their role/position on the medical team?

Additional patient characteristics were recorded including; age, gender and whether they were a medical or surgical admission.

Responses to questions about preferred names were compared against hospital admission details of names and classified as: a legal first name, title and surname, abbreviation of first name or other name. Responses to naming their treating medical team were compared against the patients' allocated medical unit or through examining the patient's record.

Patient recruitment

Inpatients at this institution were approached during the month of October 2014 and invited to participate in a survey administered by the primary researcher. Patients were selected in a sequential, systematic and whole-ward manner. Patients were excluded from participation if they had significant cognitive impairment, were non-English speaking, were under the age of 18 years or were too acutely unwell to participate. Verbal informed consent was obtained from all participants. The study was unfunded and approved by the Barwon Health Research and Ethics Committee.

Data collection and management

Data collected during the survey was entered directly into SurveyMonkey®. Results were tabulated and analysed with descriptive statistics using the SurveyMonkey® web-based analytical tools.

Results

Three hundred patients were included in the survey conducted over a 1-month period. The majority of respondents were over 60 years of age with a slight male predominance (Table 1). The demographics of surveyed patients were comparable to the Australian Institute of Health and Welfare published statistics on Australian hospital population demographics.[20]

Approximately one third of patients preferred to be addressed by a name other than their legal name; 22.6% preferred an abbreviation of their first name and 11.6% wished to be called by another name entirely. Preference for a name other than their legal name was much more common in the older male demographic, with 88.5% being over 61 years and 71.4% male. Less than 1% of inpatients opted for formal address by title and surname (Figure 1).

Formal address (as Mr or Mrs for example) was disliked by 58.7% of surveyed patients. This was more common among men (63.6%) and there was no age bias with this opinion being shared by all age groups in the overall sample.

The majority of patients (57.3%) were unable to name a member of their attending medical team. Of those who were able to name any treating of their doctors, 24.7% could name one, 10% could name two and only 8% could name three or more (Table 2). Surgical patients performed better than medical with 47% of surgical patients able to name one or more attending doctors compared with 38.9% of medical patients. When the patient could nominate their medical caregiver(s) names, they were most commonly correct (86.7%).

In response to identifying the respective roles of correctly named doctors on the team, 20.3% were unaware of their position. Correct identification of the doctors' name and role was overwhelming for the attending consultant (95.9%), followed by the registrar/fellow (22.5%). Junior doctors were poorly identified with 5.1% naming the resident and no respondents correctly recalled the intern's name and role.

Discussion

The acute hospital setting is a unique environment with regard to dialogue between patients and healthcare workers. Patients are acutely unwell, vulnerable, seen by healthcare workers multiple times in a day and often given critical information about the state of their health by a group of strangers. Different from outpatient medical consulting settings where one doctor will see one patient at a time, the busy hospital environment does not usually foster the development of rapport. Central to the development of doctor-patient rapport is the respectful way in which patients are addressed by a name which they prefer. The reciprocal of this, and equally as important, is the knowledge that patients have of their treating medical team.

This short survey of hospital inpatients revealed that over one-third of patients prefer to be addressed by a name other than their legal first name. Although this was more common in males over 61 years, it was seen throughout all demographics. This area has limited prior research with one article in an Australian general practice setting finding the incidence of patient preference for a name other than their legal names was much lower at 3.8%.[11] One possible approach to ensuring that patients are addressed according to their preference is to question the patient about their preferred name during their initial presentation to a health service. This information should be both stored in the patient medical record and displayed so that it is easily identified by other healthcare workers, for example above the patient's bed.

Inpatients in this Australian hospital overwhelmingly preferred informal modes of address. This result supports data from Australia[11 12] and findings from overseas.[8 9 21] Over half of the surveyed patients expressed a dislike for formal address with common responses including: 'feels too impersonal' and 'that is my father's name'. It highlights the informal attitude seen in Australia culture, which has been linked to the egalitarian ethos held in our society.[22] We suspect this may not be generalisable to other countries and cultures.

This survey revealed that patient's knowledge of their attending medical team was poor with the majority of patients being unable to name a single member of their treating medical team. This outcome correlates with prior international evidence.[14 17] This implies that doctors in our setting have not properly introduced themselves or have relied solely on verbal introductions, which patients tend to not be able to recall. The result is that patients are receiving information and acute medical care from persons with whom they have little or no rapport. When the physicians name and role were correctly recalled, only 5% were junior doctors. This is surprising given that junior medical staff commonly have more contact with the patient[23] and suggests this group of doctors should significantly improve the way they introduce themselves to patients.

Providing the patient with an information sheet or card on admission that defines the attending medical team members name and role, and wearing a name badge in a visible location could improve patients ability to recall names and create a greater sense of familiarity with their treating team.

There are several limitations of this study. Firstly, it was undertaken at a single site, and there may be local and regional differences in the way that patients and medical teams interact. Secondly, our hospital has a Caucasian and Anglo-Saxon predominant demographic, which would affect patients' preferences with regard to mode of address. Finally, patients were not asked about their knowledge of their treating nursing or allied health staff, and it is possible that patients may have better knowledge of these members of the healthcare team.

Conclusions

Our findings support patient preference for informal greetings from their healthcare providers however, it highlights that it is not safe to assume that a legal first name would be preferred. Patient knowledge of their attending medical team was poor suggesting current practices of introduction are insufficient. A practical approach for improvement would be for doctors to introduce themselves at first meeting with their full name and role on the team, name of the attending consultant and then ask the patient's preferred name of address. We propose that these findings may be applicable at other health services.

Contributorship statement

- Study concept and design: SP, AH, NDF
- Data collection: SP
- Data management: SP
- Data analysis: SP
- Manuscript drafting: SP, AH, NDF
- Manuscript editing: SP, AH, NDF

Competing interests

- Nil

Funding

- This project was entirely unfunded

Data sharing statement

- Extra data is available by emailing corresponding author

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Table 1. Characteristics of survey respondents (N=300)	
Characteristic of respondents	**Frequency (%)**
Age (years)	
18 - 30	16 (5.3)
31 - 45	20 (6.7)
46 - 60	47 (15.7)
61 – 75	108 (36)
76+	109 (36.3)
Gender	
Male	171 (57)
Female	129 (43)
Admission	
Medical	149 (49.7)
Surgical	151 (50.3)

Figure 1: Patient preferences for mode of address

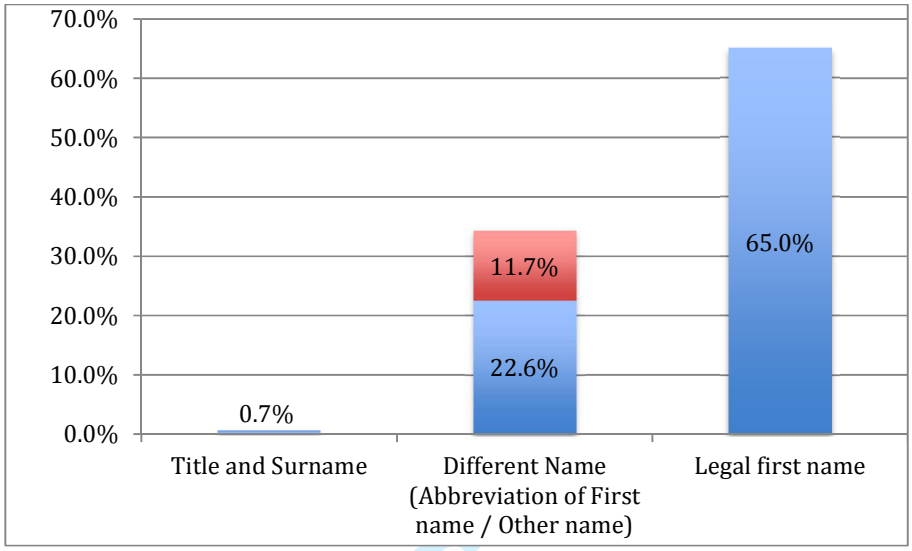

Table 2. Patient knowledge of treating medical teams identity and role	
Question	**Frequency (%)**
Number of treating doctors names recalled (N=300)	
0	172 (57.3)
1	74 (24.7)
2	30 (10)
3	24 (24)
Accuracy of recalled name (N=128)	
All correct	111 (86.7)
Partially correct*	6 (4.7)
Incorrect	11 (8.6)
* Multiple responses where one was correct and one or more were incorrect	

Consolidated criteria for reporting qualitative studies (COREQ): 32-tem checklist

No	Item	Guide questions / description
	Domain 1: Research team and reflexivity	
	Personal Characteristics	
1.	Interviewer / facilitator	SP
2.	Credentials	MBBS, B.Pharm
3.	Occupation	Medical Student
4.	Gender	Male
5.	Experience and training	Final year medical student, pharmacist, previously completed one other research project as primary author
	Relationship with participants	
6.	Relationship established	No
7.	Participant knowledge of the interviewer	Conducting a study to improve the patient experience in hospital, improve hospital stay for future patients
8.	Interviewer characteristics	The interviewer was introduced as a final year medical student based who was interested in patient-centred care and hoped to improve patient's experience while in hospital
	Domain 2: study design	
	Theoretical framework	
9.	Methological orientation and Theory	Grounded theory
10.	Sampling	Consecutive ward inpatients in the hospital wards who fitted the inclusion criteria
11.	Method of approach	Face to face
12.	Sample size	300
13.	Non participation	Not recorded
	Setting	

14. Setting of data collection	Inpatient hospital wards
15. Presence of non-participants	Primary researcher only
16. Description of sample	The sample demographic was representative of populations as inpatients in Australian hospitals with a predominately older population of Anglo Saxon background. The data was collected in October 2014
Data collection	
17. Interview guide	The questions were pilot tested. The primary researcher was guided through the interview with a provided guide
18. Repeat interviews	Nil
19. Audio/visual recording	Nil
20. Field notes	Patient responses were recorded during the interview and also brief notes of common responses or themes
21. Duration	2 – 5 minutes
22. Data saturation	Yes, the researchers feel the sample was adequate to explore the clinical questions adequately
23. Transcripts returned	No
Domain 3: analysis and findings	
24. Number of data coders	One
25. Description of the coding tree	Yes, it is detailed in the methods
26. Derivation of themes	In advance
27. Software	SurveyMonkey® web-based analytical tools
28. Participant checking	No
Reporting	
29. Quotations presented	Quotations were presented to illustrate findings however each quotation was not identified as they were repeated themes
30. Data and findings consistent	All data presented was consistent with the findings

31. Clarity of major themes	The major themes are clearly demonstrated in the findings
32. Clarity of minor themes	Minor themes which developed in the article are described and explored

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Word Count: 2016

Abstract

Objectives: To investigate how patients prefer to be addressed by healthcare providers and to assess their knowledge of their attending medical team's identity in an Australian Hospital.

Setting: Single centre, large tertiary hospital in Australia.

Participants: Three hundred inpatients were included in the survey. Patients were selected in a sequential, systematic and whole-ward manner. Participants were excluded with significant cognitive impairment, non-English speaking, under the age of 18 years or were too acutely unwell to participate. The sample demographic was predominately an older population of Anglo Saxon background.

Primary and secondary outcome measures: Patients preferred mode of address from healthcare providers including first name, title and second name, abbreviated first name or another name. Whether patients disliked formal address of title and second name. Secondarily, patient knowledge of their attending medical team members name and role and if correct, what position within the medical hierarchy they held.

Results: Over ninety nine percent of patients prefer informal address with greater than one third having a preference to being called a name other than their legal first name. Fifty seven percent of patients were unable to correctly name a single member of their attending medical team.

Conclusions: These findings support patient preference of informal address however; healthcare providers cannot assume that a documented legal first name is preferred by the patient. Patient knowledge of their attending medical team is poor and suggests current introduction practices are insufficient.

Strengths and limitations of this study

- Main findings appropriately addressed intended aims
- Significant results which can readily be addressed by instituting a change of practice in administration, daily patient communication and training of junior medical staff
- Patient centred research intended to improve patient's experience whilst in hospital
- Single centre and predominantly Anglo-Saxon demographic
- No control for age or clinical condition of the patient

Background

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Ethnic and cultural factors can influence preferred modes of address. This has been demonstrated in Israel[6], Iran[7] and in African Americans in the United States of America[8], where formal address by title and surname name is preferred. In contrast, in an Irish geriatric unit[9] and also in a general practice setting in the United Kingdom[10], the majority of patients preferred first name greetings.

In the Australian setting, there has been limited research completed in this area. One study in general practice demonstrated that 90% of patients prefer to be addressed by their first name only and 3.4% prefer to be addressed by another name.[11] Established relationships between the doctor and patient was identified as a common factor which influenced the level of formality the patient was comfortable with,[11] this may not be applicable in the acute hospital environment where such established relationships may not exist. The only other Australian study in 1994 found that 83% of patients preferred informal address across inpatient and private outpatient settings.[12]

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Currently, newly admitted patient's names are automatically populated onto hospital admission records from an Australian Government issued healthcare card such as a Medicare card. Patients are not routinely questioned how they wished to be addressed by hospital staff or if their legal first name is their preferred name. Hospital policy defines that name badges or identification (ID)

cards are provided to all staff, however they may not displayed in a standardised visible manner with many staff choosing to attach the ID to a poorly visible location, such as their waist belt. There is no policy regarding how hospital staff must introduce themselves to patients.

The setting for this research was a 450 bed tertiary teaching hospital in Australia. The different aims of this study, were to identify what mode of address patients in an Australian hospital prefer, what proportion of patients wish to be called a name other than their legal names and the number of patients who could correctly name any member of their attending medical team.

Methods

Survey Tool

A survey was designed and piloted to assess inpatient preferences of address and knowledge of their attending medical team. The survey was administered face-to-face with the primary researcher entering the participant's responses directly to SurveyMonkey®[19] through a tablet PC. Questions included: what name do you prefer to be addressed by while in hospital?, do you object to being addressed as Mr/Mrs/Ms (Surname)?, are you able to tell me the name of any of your treating doctors?, if yes – do you know their role/position on the medical team?

Additional patient characteristics were recorded including; age, gender and whether they were a medical or surgical admission.

Responses to questions about preferred names were compared against hospital admission details of names and classified as: a legal first name, title and surname, abbreviation of first name or other name. Responses to naming their treating medical team were compared against the patients' allocated medical unit or through examining the patient's record.

Patient recruitment

Inpatients at this institution were approached during the month of October 2014 and invited to participate in a survey administered by the primary researcher. Patients were selected in a sequential, systematic and whole-ward manner. Patients were excluded from participation if they had known cognitive impairment (including dementia and delirium), were non-English speaking, were under the age of 18 years or were too acutely unwell to participate. Prior to approaching a patient, their medical record was assessed for diagnoses of cognitive impairment that was then confirmed with the patient's primary nurse. Verbal informed consent was obtained from all participants. The study was unfunded and approved by the Barwon Health Research and Ethics Committee.

Data collection and management

Data collected during the survey was entered directly into SurveyMonkey® by the primary researcher via a tablet PC. Results were tabulated and analysed with descriptive statistics using the SurveyMonkey® web-based analytical tools.

Results

Three hundred and fifty five inpatients were approached to be included in the survey over a 1-month period. Fourteen patients refused to participate in the study and 41 met the exclusion criteria resulting in 300 participants included in the final sample. The majority of respondents were over 60 years of age with a slight male predominance (Table 1). Our sample was consistent with the age of general medical patients at our institution. When correlated to the Australian Institute of Health and Welfare published statistics on Australian hospital population demographics, our sample was comparable but with a greater proportion of patients over 60 years.[20]

Approximately one third of patients preferred to be addressed by a name other than their legal name; 22.6% preferred an abbreviation of their first name and 11.6% wished to be called by another name entirely. Preference for a name other than their legal name was much more common in the older male demographic, with 88.5% being over 61 years and 71.4% male. An abbreviated first name was preferred across the sample demographic and did not demonstrate age bias. Less than 1% of inpatients opted for formal address by title and surname (Figure 1).

Formal address (as Mr or Mrs for example) was disliked by 58.7% of surveyed patients. This was more common among men (63.6%) and there was no age bias with this opinion being shared by all age groups in the overall sample.

The majority of patients (57.3%) were unable to name a member of their attending medical team. Of those who were able to name any treating of their doctors, 24.7% could name one, 10% could name two and only 8% could name three or more (Table 2). Surgical patients performed better than medical with 47% of surgical patients able to name one or more attending doctors compared with 38.9% of medical patients. When the patient could nominate their medical caregiver(s) names, they were most commonly correct (86.7%).

In response to identifying the respective roles of correctly named doctors on the team, 20.3% were unaware of their position. Correct identification of the doctors' name and role was overwhelming for the attending consultant (95.9%), followed by the registrar/fellow (22.5%). Junior doctors were poorly identified with 5.1% naming the resident and no respondents correctly recalled the intern's name and role.

Discussion

The acute hospital setting is a unique environment with regard to dialogue between patients and healthcare workers. Patients are acutely unwell, vulnerable, seen by healthcare workers multiple times in a day and often given critical information about the state of their health by a group of strangers.

Different from outpatient medical consulting settings where one doctor will see one patient at a time, the busy hospital environment does not usually foster the development of rapport. Central to the development of doctor-patient rapport is the respectful way in which patients are addressed by a name which they prefer. The reciprocal of this, and equally as important, is the knowledge that patients have of their treating medical team.

This short survey of hospital inpatients revealed that over one-third of patients prefer to be addressed by a name other than their legal first name. This was predominantly demonstrated in males over 61 years, however it was seen throughout all demographics. This area has limited prior research with one article in an Australian general practice setting finding the incidence of patient preference for a name other than their legal names was much lower at 3.8%.[11] One possible approach to ensuring that patients are addressed according to their preference is to question the patient about their preferred name during their initial presentation to a health service. This information should be both stored in the patient medical record and displayed so that it is easily identified by other healthcare workers, for example above the patient's bed.

Inpatients in this Australian hospital overwhelmingly preferred informal modes of address. This result supports previous data from Australia[11 12] and findings from overseas.[8 9 21] Over half of the surveyed patients expressed a dislike for formal address with common responses including: 'feels too impersonal' and 'that is my father's name'. It highlights the informal attitude seen in Australia

culture, which has been linked to the egalitarian ethos held in our society.[22] We suspect this may not be generalisable to other countries and cultures.

This survey revealed that patient's knowledge of their attending medical team was poor with the majority of patients being unable to name a single member of their treating medical team. This outcome correlates with prior international evidence.[14 17] This implies that doctors in our setting have not properly introduced themselves or have relied solely on verbal introductions, which patients tend to not be able to recall. The result is that patients are receiving information and acute medical care from persons with whom they have little or no rapport. When the physicians name and role were correctly recalled, only 5% were junior doctors. This is surprising given that junior medical staff commonly have more contact with the patient[23] and suggests this group of doctors should significantly improve the way they introduce themselves to patients.

Providing the patient with an information sheet or card on admission that defines the attending medical team members name and role, and wearing a name badge in a visible location could improve patients ability to recall names and create a greater sense of familiarity with their treating team.

There are several limitations of this study. Firstly, it was undertaken at a single site, and there may be local and regional differences in the way that patients and medical teams interact that may affect generalisability. Secondly, our hospital has a Caucasian and Anglo-Saxon predominant demographic, which would affect patients' preferences with regard to mode of address. Finally, patients were not

asked about their knowledge of their treating nursing or allied health staff, and it is possible that patients may have better knowledge of these members of the healthcare team.

Conclusions

Our findings support patient preference for informal greetings from their healthcare providers however, it highlights that it is not safe to assume that a legal first name would be preferred. Patient knowledge of their attending medical team was poor suggesting current practices of introduction are insufficient. A practical approach for improvement would be for doctors to introduce themselves at first meeting with their full name and role on the team, name of the attending consultant and then ask the patient's preferred name of address. We propose that these findings may be applicable at other health services.

Contributorship statement

- Study concept and design: SP, AH, NDF
- Data collection: SP
- Data management: SP
- Data analysis: SP
- Manuscript drafting: SP, AH, NDF
- Manuscript editing: SP, AH, NDF

Competing interests

- No, there are no competing interests

Funding

- This project was entirely unfunded

Data sharing statement

- Additional data is available by emailing corresponding author shaun.r.parsons@gmail.com

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Table 1. Characteristics of survey respondents (N=300)	
Characteristic of respondents	**Frequency (%)**
Age (years)	
18 - 30	16 (5.3)
31 - 45	20 (6.7)
46 - 60	47 (15.7)
61 – 75	108 (36)
76+	109 (36.3)
Gender	
Male	171 (57)
Female	129 (43)
Admission	
Medical	149 (49.7)
Surgical	151 (50.3)

Figure 1: Patient preferences for mode of address

Table 2. Patient knowledge of treating medical teams identity and role	
Question	**Frequency (%)**
Number of treating doctors names recalled (N=300)	
0	172 (57.3)
1	74 (24.7)
2	30 (10)
3	24 (24)
Accuracy of recalled name (N=128)	
All correct	111 (86.7)
Partially correct*	6 (4.7)
Incorrect	11 (8.6)
* Multiple responses where one was correct and one or more were incorrect	

Figure 1: Patient preferences for mode of address

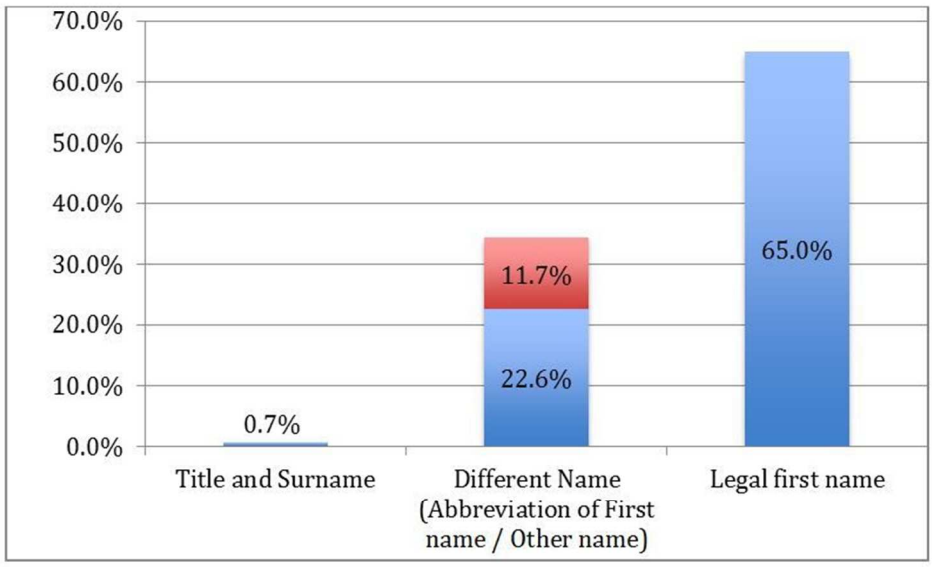

Figure 1: Patient preferences for mode of address
225x175mm (96 x 96 DPI)

Consolidated criteria for reporting qualitative studies (COREQ): 32-tem checklist

No	Item	Guide questions / description
	Domain 1: Research team and reflexivity	
	Personal Characteristics	
1.	Interviewer / facilitator	SP
2.	Credentials	MBBS, B. Pharm
3.	Occupation	Medical Student
4.	Gender	Male
5.	Experience and training	Final year medical student, pharmacist, previously completed one other research project as primary author
	Relationship with participants	
6.	Relationship established	No
7.	Participant knowledge of the interviewer	Conducting a study to improve the patient experience in hospital, improve hospital stay for future patients
8.	Interviewer characteristics	The interviewer was introduced as a final year medical student based who was interested in patient-centred care and hoped to improve patient's experience while in hospital
	Domain 2: study design	
	Theoretical framework	
9.	Methological orientation and Theory	**Descriptive**
10.	Sampling	Consecutive ward inpatients in the hospital wards who fitted the inclusion criteria
11.	Method of approach	Face to face
12.	Sample size	300
13.	Non participation	Not recorded
	Setting	

14. Setting of data collection	Inpatient hospital wards
15. Presence of non-participants	Primary researcher only
16. Description of sample	The sample demographic was representative of populations as inpatients in Australian hospitals with a predominately older population of Anglo Saxon background. The data was collected in October 2014
Data collection	
17. Interview guide	The questions were pilot tested. The primary researcher was guided through the interview with a provided guide
18. Repeat interviews	Nil
19. Audio/visual recording	Nil
20. Field notes	Patient responses were recorded during the interview and also brief notes of common responses or themes
21. Duration	2 – 5 minutes
22. Data saturation	Yes, the researchers feel the sample was adequate to explore the clinical questions adequately
23. Transcripts returned	No
Domain 3: analysis and findings	
24. Number of data coders	One
25. Description of the coding tree	Yes, it is detailed in the methods
26. Derivation of themes	In advance
27. Software	SurveyMonkey® web-based analytical tools
28. Participant checking	No
Reporting	
29. Quotations presented	Quotations were presented to illustrate findings however each quotation was not identified as they were repeated themes
30. Data and findings consistent	All data presented was consistent with the findings

31. Clarity of major themes	The major themes are clearly demonstrated in the findings
32. Clarity of minor themes	Minor themes which developed in the article are described and explored