



Project Number: 2016-1-RO01-KA203-024630

# PAEDIATRIC HEALTH SURVEY IN SPAIN



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## PAEDIATRIC HEALTH SURVEY IN SPAIN

**BENJAMÍN HERREROS RUIZ VALDEPEÑAS, EMANUELE VALENTI**

**HOSPITAL UNIVERSITARIO FUNDACIÓN ALCORCÓN**

**MADRID, SPAIN**

**BHERREROS@FHALCORCON.ES**

### 1. INTRODUCTION

Health Care System in Spain is a public body encompassing health services, founded in 1908 as *Instituto Nacional de Previsión*, step by step extended its coverage to all the population. This universalization process has been driven by the application of a Bismarckian model implemented with a national law enacted in 1942, the *Ley de Seguro Obligatorio*, imposing health insurances for the private companies and offering health care to alternatives beneficiaries of insured. In 1963, in reason of the economical rising privates insurances became domain of public management and this process was completed in 1986 through the *Ley 14/1986 General de Sanidad* (General Health Law). This law accomplishes the mandate of the Spanish Constitution to protect health citizens and recognizes the right to have health services for all citizens and for foreigners resident in Spain. The sanitary management responsibility has been transferred to the local authorities since the 90s' years following the mandate of Title VIII of the Constitution conferring to the autonomous communities the territorial control of public services in order to afford the needs of specific areas, and health care system is included in all the competences delegated to the local governments. Currently health care services are on charge to the *Comunidades Autonomas*, regional institutions with a territorial responsibility in matter of public services. Health care system provides services in several areas: preventive, diagnostic, therapeutic, rehabilitative and promotion and implementation of population health. Health care is one of the main instruments of redistributive income policies among Spaniards: each person contributes taxes according to their economic capacity and receives health services according to their health need. Health care for common illness or non-work accident in Spain is a benefit independent from fiscal contributions and is financed by regionals administrations. In 2003 the General Health Law has been complemented by the *Ley 16/2003 de Cohesion y Calidad del Sistema Nacional de Salud* (Law of Cohesion and Quality) to face the cultural, technological and socioeconomic changes affecting contemporary Spanish society, and its patterns disease. This Law establishes a set of functions common to all autonomous communities in matter of health care services, such as benefits provided, pharmacy, health professionals, research, health information systems, and the overall quality of the health system. Several national institutions have been developed in order to promote the quality of services at national level, and assess regional health care services. In 2012 with *Real Decreto 16/2012* (Royal Decree Law) consistent modifications have been introduced to the national public health policies in relation to the economical sustainability of the public health services. This Law introduced a significant modification to the universal character traditionally assigned to the Spanish public health system: healthcare services are not free for all citizens but they could be on charge



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to the families' in reason to their incomes, and unregistered foreigners have not access to the public health, even than not all autonomous communities applied the this Law nowadays. The Ministry of Health and Social Policy establishes the national policies in matter of health in order to respect the constitutional right of citizens to health care services and regulates the functioning of *Sistema Nacional de Salud* - SNS (National Health System). As a consequence of the decentralization process promoted by the Constitution and enacted by General Health Law each autonomous community created a proper Health Care Service, with an independent administrative structure. The Law of Cohesion from 2003 establishes the institution of the *Consejo Interterritorial del Servicio Nacional de Salud* – CISNS (Council of the Spanish national Health Service) as the organ of general coordination in matter of health between the Central State and the autonomous communities and the institution giving the guarantee for the coordination of the SNS. Autonomous communities manage local health care services through the *Consejería de Sanidad* (Health Council) who has the task to coordinate and execute the autonomous Government health policies in matter of social security and coverage of health needs of population, health care system management, mental health, pharmaceutical services, health care professional training, research and development, public health, food security and addictions disorders. Autonomous health care system is divided in *Áreas de Salud* (Health Areas), administrative districts with the functions to organize primary care. *Atención primaria* (primary care) assures a comprehensive and continuous level of care through out the patient's life, from this perspective each patient can count on a personalized coordination and regulation of care plane through the role of a *medico de familia* (general practitioner). General practitioner plays a coordination role in order to assure health education, prevention, care maintenance, physical rehabilitation and social health care. Primary care covers home services, emergency services, and scheduled or on demand services. *Atención especializada* (specialized care) offers medical specialists services provided at the request of primary care general practitioner. This service is commonly sited in the hospital, where covers inpatient and outpatient care, or in specialist centres and day hospitals. Specialized care is integrated to primary care and covers patients' needs that are not affordable from primary care. Specialized care is commonly provided through outpatient consultation and day hospital, when patient's clinical circumstances are favourable for this kind of care. *Atención socio-sanitaria* (social health care) offer a service for chronic patients who require at the same time of health care services and social services to manage the limitation of chronic illnesses and promote social integration.

## 1.2 Paediatric Course of Study

Medical education in Spain is regulated by the Directive 2021 12 2004 enacted by European Parliament in 2004. Medical Schools according to the Bologna Agreement adopted the European Credit Transfer System to accomplish with the harmonizing strategy of education in the EU. Undergraduate medical students in Spain are introduced to paediatrics subject at the 5<sup>th</sup> year of the medicine, even than the number of credits (ECTS) could vary in reason of the University from 12 to 14 up total of 360 ECTS for the entire degree. In a public University where paediatrics curse correspond to 12 ECTS students follow 75 hours of theoretical study program and 84 of practical training, divided in 36 hours of guided activity and 48 hours of non-guided activity, integrated with 137 hours of individual study. Practical training generally corresponds to 1 month in a hospital paediatrics Unit, with a rotatory system where medical students stay 1 week in neonatology, 1 week in clinical consultation, 1 week in paediatric emergency, and 1 week in a the paediatrics Unit.

In Spain postgraduate medical students after a previous national exam can start their specialization training. In reason of the mark allowed they accede to a selected speciality and start a 4 years postgraduate program becoming *Medico Interno Residente* (MIR). Residency has duration of 5 years, but in case of paediatrics is 4 years, and the debate about this issue is common in Spanish paediatrics literature. MIRs are doctors with an agreement based on the national regulation, this activity is paid and physicians contribute to the taxation system as other professionals. Residency in paediatrics includes three kind of training: one proper of primary care, in the outpatients clinical consultation, that can be performed in the hospital or in the primary care centres. During the residency paediatricians accede to the sub-specialities of paediatrics through a cycle of rotations in neonatology, paediatric emergency, paediatric orthopaedic, paediatric surgery, paediatric intensive care. Hospital teaching board establishes a core of training courses common to all specialities that are mandatory for all the residents. During the residency 1<sup>st</sup> year paediatric residents must follow a mandatory training program related to the following specialities: introduction to paediatrics, paediatric radiology, paediatric cardiology (focused on electrocardiogram reading), workshop on communication skills and clinical interview, paediatric emergency. In the 2<sup>nd</sup> year residency training program includes Cardio-



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pulmonary resuscitation, bioethics and lactation as mandatory program, and optional programs related to the research skills, such as biostatistics, bibliographic research and other specific scientific workshop. Training programs can be different in order to the autonomous regulation, services area organization or hospitals in reason to the health care services needs, even than there is a common core of competences required to conclude residency. Rotations up to two or three months are mandatory for all the residents in all the paediatrics specialities and subspecialties, during the first 3 years of residency, in the last year residents can follow for 6 month a specific area in reason of their preferences. A tutor and the Head of the Unit supervise the rotation cycle of each resident. All residents doing rotation on emergency services, perinatal area, paediatric intensive care and neonatology intensive care, paediatric oncology and haematology, primary attention. Among the subspecialties available rotation are in the units of cardiology, endocrinology, nephrology, neurology, pneumology, digestive and allergy. In reason of the Ministry of Health directive residents can rotate in emergency among 4 and 6 time per months in reason of the services needs.

Soft skills in the Spanish medical education are developed in the subject *habilidades de comunicación* (communication skills) and *humanidades médicas* (medical humanities). The educational model applied in the Spanish Medical Schools is structured in the outcome-based curriculum. Medical students outcomes suggested by the *Agencia Nacional de Evaluación de la Calidad y Acreditación* (ANECA) are classified in two groups: general outcomes allowed through transversal competencies and specific outcomes, among them there are included soft skills. Specific competences of medical students are: 1) clinical skills, 2) scientific foundations of medicine, 3) population health 4), Professional values, attitudes, 5) Communication skills, 6) Population and health systems, 7) Management information. This subject can be taught by a psychologist, as a part of medical psychology course, or by an ethicist, as a part of medical humanities course, or both. In the first case soft skills are focused on the way of communication, it means how physician can communicate with the patient, in the second case about what communicate, it refers to the physician attitudes in doctor-patient relationship. Differences between the first and second aspect are essential, a psychologist can recommend a specific physical posture during the communication process, a group of preformed question to establish empathy. In the second case ethicist work on professional attitude, be proactive during the information process in order to involve the patient in decision-making processes. Both are essential aspect to improve soft skills, for that reason is essential an integration in the same course of psychological and ethical approach. In some Spanish private universities, softs skills are part of a course called *Humanidades Médicas y Habilidades de Comunicación*, though at the first year of medical school. In this course soft skills are part of 1 module constituted by 5 lectures each one during 2 hours per week: 1) introduction, 2) communication process, 3) active listening 4) assertively, 5) braking bad. Each lecture has a corresponding practice during 1 hour and an objective structured clinical examination (OCSE) in the simulation hospital. This format in Spain can show some variation but is adopted in all the University, and represents a structured approach to the soft skills for undergraduate medical students.

Continuing medical education in Spain is regulated by the *Ley 44/2003 de Ordenación de las Profesiones Sanitarias* (Law regulating health care professions), a comprehensive law integrating all previous legislation about the subject. Continuing medical education is defined as a training process focused on the active and continuing learning of graduate health care professional, in order to improve knowledge, skills and attitudes to face the challenges of technological progress in medicine and respond to the citizens health care needs. Continuing medical education has been regulated through a specific certification system by the Ministry of Health and is a requirement for each health care professional. Continuing medical education in the Spanish hospitals is on charge to the single Units and supervised by the *Unidad de calidad* (Quality Unit) of each hospital. Professionals' associations have in charge the organization of external or online activities for their health care professionals. Frequently professional association is coordinated with the quality unit in order to the organization of training programs. Continuing medical education in the hospitals includes constant teaching activities such as clinical session, training courses, oral presentations at national and international congress, research activities and papers publication. In order to have an official credit assignments training programs receive a previous assessment by the *Comisión de formación continuada de las profesiones sanitarias* (Continuing education board for health care professionals), on behalf of public administration in matter of certification for health care professionals. The *Asociación Española de Pediatría - AEP* (Spanish Paediatric Association) recovers an important role in continuing medical education program for paediatricians. Debate about the implementation of professional training to develop soft skills in paediatrics in Spain is focused generally on two subjects: paediatrician-patient-family relationship and bioethics. Literature about the subject has been frequent in the last decades especially in relation to the paediatrician competences. The need to improve the training of paediatrics residents in matter of communication skills, abilities to recognize and manage cultural differences, identify and promote values centred to involve families



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and promote shared decision-making are common in Spanish literature. A common belief among the paediatricians involved in the public debate about this issue in specialized reviews such as *Educación Médica*, or *Anales de Pediatría*, shows that current training program available for residents are not adequate to respond to the needs of the health care scenario and to the requirements of the outcome-based curriculum applied in medical education. An interesting initiative promoted through the AEP in Spain is the project *Continuum*, an on line platform to improve continuing medical education in paediatrics. This project started in 2003 and is based on the Global Curriculum for Paediatric Education a version for paediatrics of the outcome-based educational model proposed by the Institute for International Medical Education and recommended in Spain by the ANECA. Continuum promotes a competency-based training for undergraduate, graduate and practicing physicians and offer training courses and learning activities.

### 1.3 Paediatric Services

Paediatrics care in Spain is organized in 5 kinds of services: hospital, emergency, day hospital, home care and external consultation, performed in the *Centro de Salud* (Health Care Centre) or in the hospital, for those hospitals where the service is provided. Services are assigned in reason of the patients' health care needs and age. This model reflects the more general organization of health care system, divided in primary care, and specialized care and social health care. In this way paediatric patients receive an integrate care focused on physical, psychological and social patient's needs. Paediatrics Unit, Paediatric Surgery and Neonatology are commonly coordinated and cover all the pathologies of paediatrics patients during all the different ages. A model of excellence of paediatric attention in Spain can includes the following services: 1) perinatology unit, includes perinatal care in collaboration with obstetrician department; 2) neonatology unit, with a specific area for intensive care (*Unidad de cuidados intensivos neonatológicos*); 3) lactation unit; 4) paediatric intensive care unit (*Unidad de cuidados intensivos pediátricos*); 5) oncology and haematology unit; 6) paediatric unit, for the patients not included in the previous units with an age between 2 and 17 years; 7) paediatric surgery; 8) paediatric home care; 9) paediatrics emergency; 10) day hospital; 11) external consultation in the health care centres. All other pathologies not included in these services are on charge to the adult units, but include health care professional with specific competences for paediatric patients; i.e. ophthalmology, orthopaedic, psychiatry, otorhinolaryngology.

The current model of health care system in Spain coming from the *Ley General de Sanidad* de 1986, a national health system offering a universal care on the basis of citizens health right guarantee by the Spanish Constitution. This model offered a prevalent public provision of health care in Spain, even than since the 90s a slow process of modification opened to a mixed health care system started in some autonomous communities and became progressively a national standard. In reason of this local modification of the health care system a first national intervention has been proposed through the *Informe Abril* (April Report) on 1991, where have been proposed all the measures later adopted, such as co-payment, private criteria to manage health care services, implement the private market for the health care services, support the role of insurance and private provision of health services, change the agreement conditions of health care professionals. All these measures provoked a social refuse among health professionals, patients, policy makers, as a consequence most of them has been provisionally suspended or hidden applied progressively. Since the 1992 several public hospital have been created with the management criteria of a private company, under a different legal status, i.e. foundation using the new criteria applied for the *Ley de Fundaciones* on 1994, and constituted by autonomous communities legislation under the control of regional parliament. In 1994 start a new approach assigning competences to the private company to create a private hospital and provide health services to public demand of a specific area, management and provision of services are totally private, but the private company receive public funds. In 1999 with a specific legislation Government offer to the autonomous communities to switch from the traditional model of public hospital to the Public Foundations Model. This new legal framework provoked a great debate in all the stakeholders and currently is no completed applied in all the regions, even than the legal option is available at national level. The option to fund an health services only with private indicative and offer an exclusive private service started in Spain on 2007 in Madrid and is progressively extended to other autonomous communities. With the financial crisis a new Law, the *Real Decreto Ley 16/2012* introduces emergency measures in matter of sustainability of public health system. Among the interventions new criteria for the private funding and the promotion of private insurances are introduced in the majority of autonomous communities with the aim to introduce a private health care system in the future. One of the most important aspect of this Law is the discussion for the first time about the principle of universality of health care, only foreign residents have



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accesses to public health, for other foreigners public services are private and require an insurance to be provided. To conclude, in the private system paediatrics follow the same criteria and structure than in the public system, there are not significant criteria with all the other medical specialities, and the same legislation is applied in all the circumstances.

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- 3) Ley 16/2003 de Cohesión y Calidad del Sistema Nacional de Salud
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## 2. MATERIAL AND METHOD

*Please describe the surveyed groups, number of participants, the research method and variables in your country*

A questionnaire has been designed for health care professionals working in paediatrics, patients and families by the project coordinator. Research team after a common analysis and critical appraisals elaborated a final version, dully translated and administered to the target groups. Research team develop four questionnaires in reason of the sample explored in the survey: a) questionnaire for patients; b) questionnaire for relatives/parents; c) questionnaires for health carers; d) questionnaire for paediatrics.

50 health care professionals have been involved in three different hospitals, 25 Physicians working in paediatrics and 25 health care staff: 20 questionnaires at Hospital Universitario Fundación Alcorcón (HUFA), 10 at the Hospital Infantil Universitario Niño Jesus (HINJ), and 20 at the Hospital Universitario XII de Octubre (HUXII), all located in Madrid. 25 patients and 25 relative have been involved in the research at the Unit of the HUFA. The research team in each hospital through a one-to-one interview has administered the questionnaires.

### Health care staff profile

100% of health carers are females (Tab.1). The health carers who have been involved in this survey are: paediatrics nurses, midwives, healthcare workers. 10 work at HUFA, 10 at HUXII and 5 at HINJ.



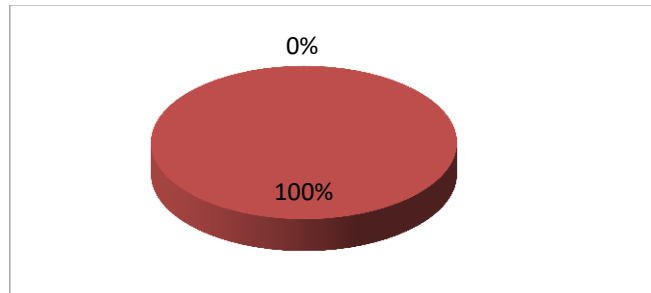
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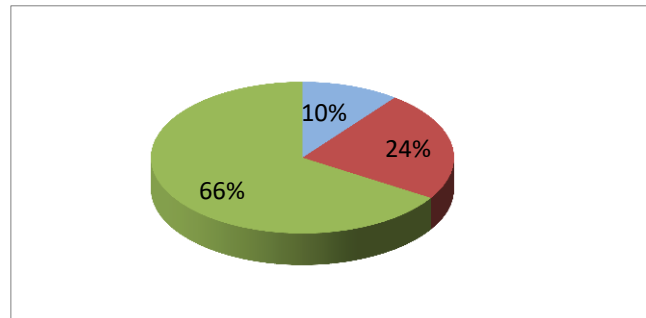
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Table1



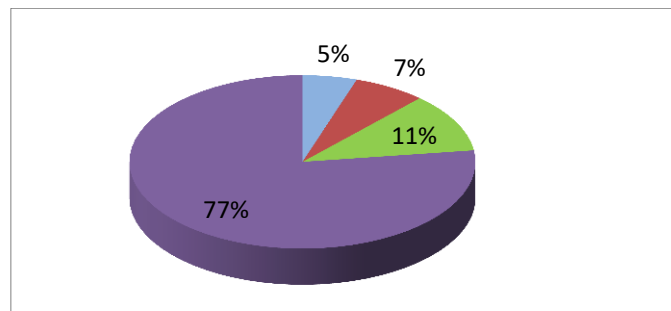
The majority of health carers are over 45 (66%), 24% between 36 and 45, and a 10% between 26 and 35 years (Tab.2).

Table 2



Their working experience is among 0 and 5 years for the 5% for the health carers, among 5 and 10 years for the 7%, among 10 and 15 for 11% and over 15 years for the 77% of the sample (Tab 3).

Table 3



### Paediatricians and experts in paediatrics

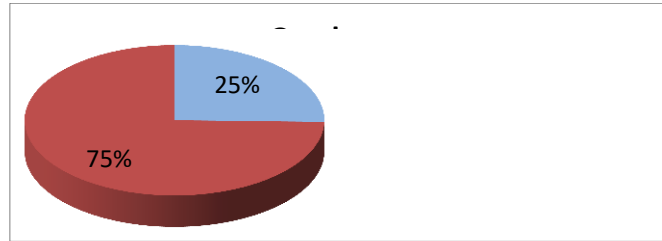
The 75% of paediatricians and physicians working in paediatrics surveyed are female and 25% are male (Tab 1).





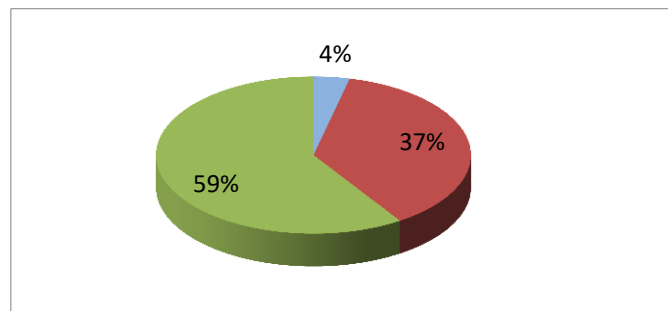
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Table 1



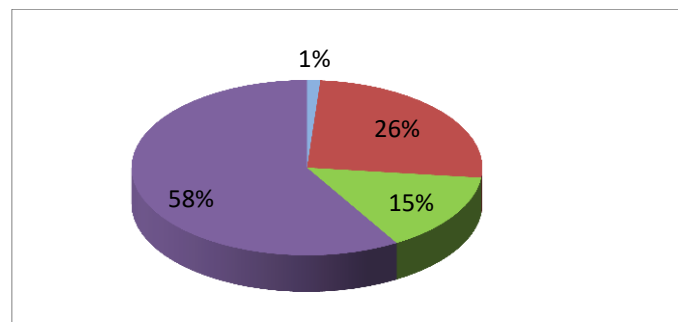
The age range corresponds to 4% for physicians among 26 and 35, 37% among 36 and 45, 59% over 45% (Tab 2).

Table 2



The working experience corresponds to the following rates: 1% between 0 and 5 years, 26% between 5 and 10 years, 15% between 10 and 15 years and 58% over 15 years (Tab 3).

Table 3



The 63% of surveyed physicians have been working on the same clinical areas, the 37% worked in several clinical fields (Tab 4).

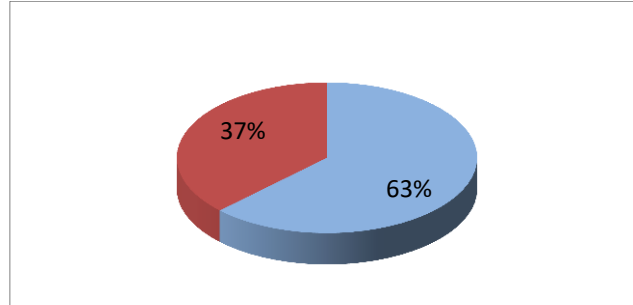






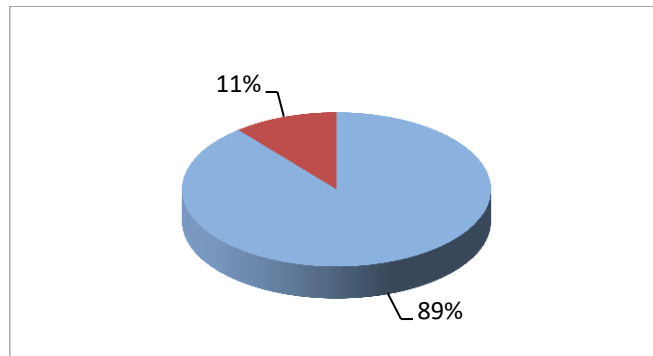
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Table 4



Among the physicians interviewed 89% received a training course in the last years and 11% didn't do it (Tab 5).

Table 5



### Patients

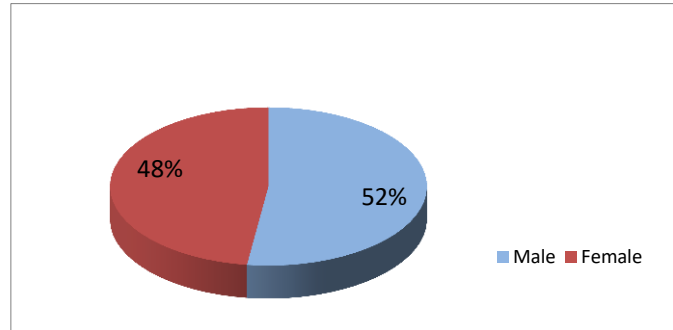
The 52% of surveyed patients in charge at the paediatric unit of the HUFA are male and the 48% female (tab.1)





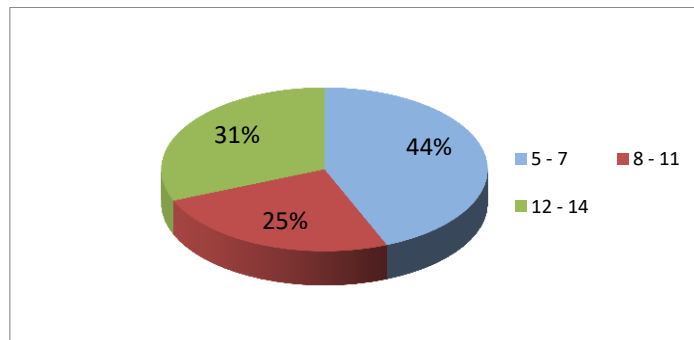
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Table 1



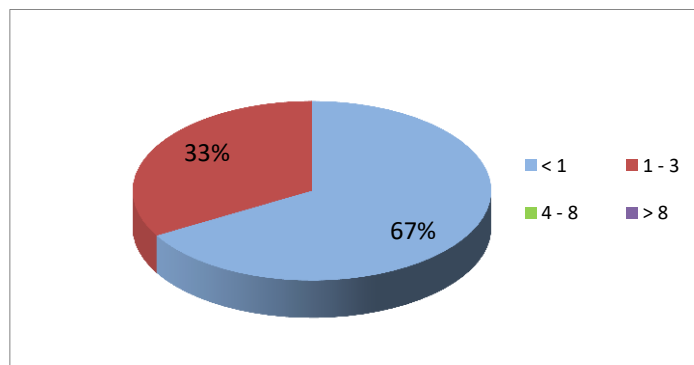
The patients' age range corresponds to 44% among 5 and 7, 25% among 8 and 11, 31% among 12 and 14 (Tab.2)

Table 2



The duration of illness corresponding to the patients varies from the 67% of patients in charge for a time inferior to 1 week to a 33% of patients in charge for a time among 1 and 3 weeks (Tab. 3).

Table 3



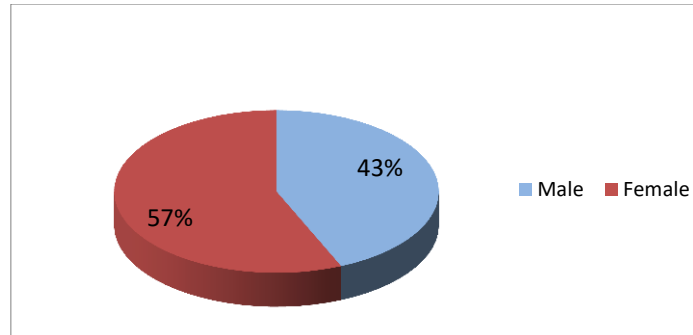


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## Relatives

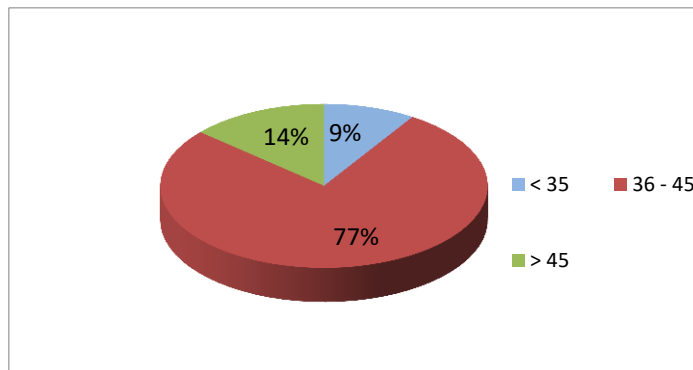
The 57% of surveyed relatives of patients in charge at the paediatric unit of the HUFA are female and the 43% male (tab.1)

Table 1



The relatives' age range corresponds to 9% inferior to 35 years, 77% among 36 and 45, and 14% over 45 (Tab.2).

Table 2



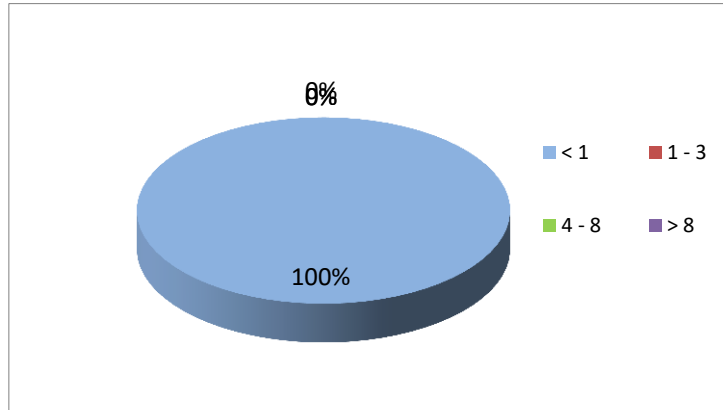
The duration of illness corresponding to the patients' relatives interviewed is less than 1 week for the 100% of interviewees (Tab. 3).





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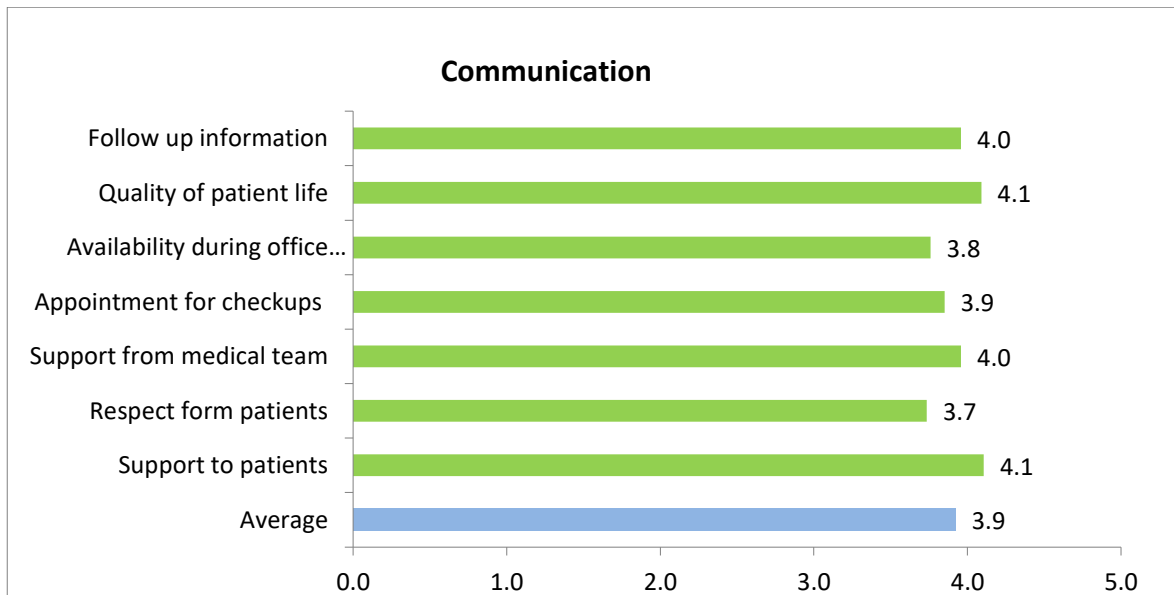
Table 3



### 3. RESULTS AND DISCUSSION

#### 3.1 COMMUNICATION

Health care staff results:  
Table 1



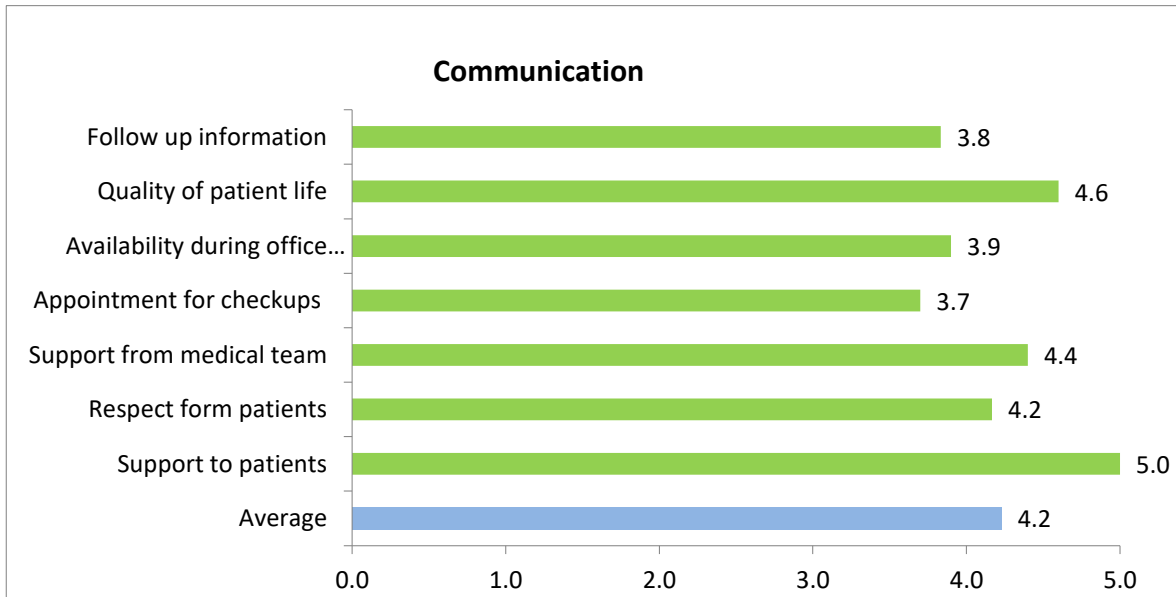
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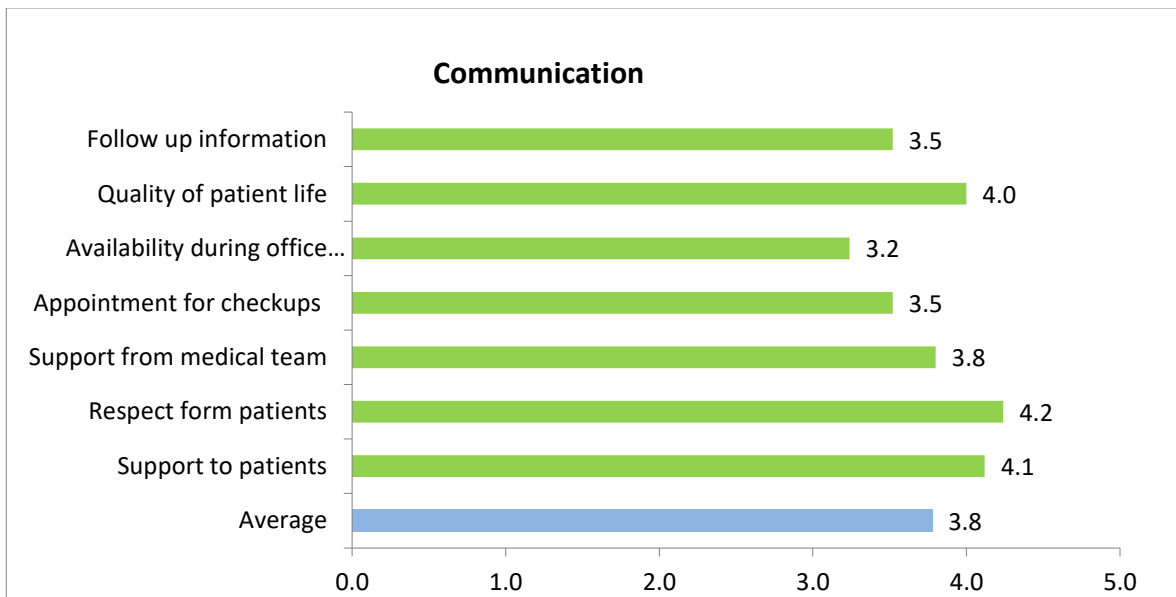


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**Paediatricians results:  
Table 2**



**Patient results:  
Table 3**



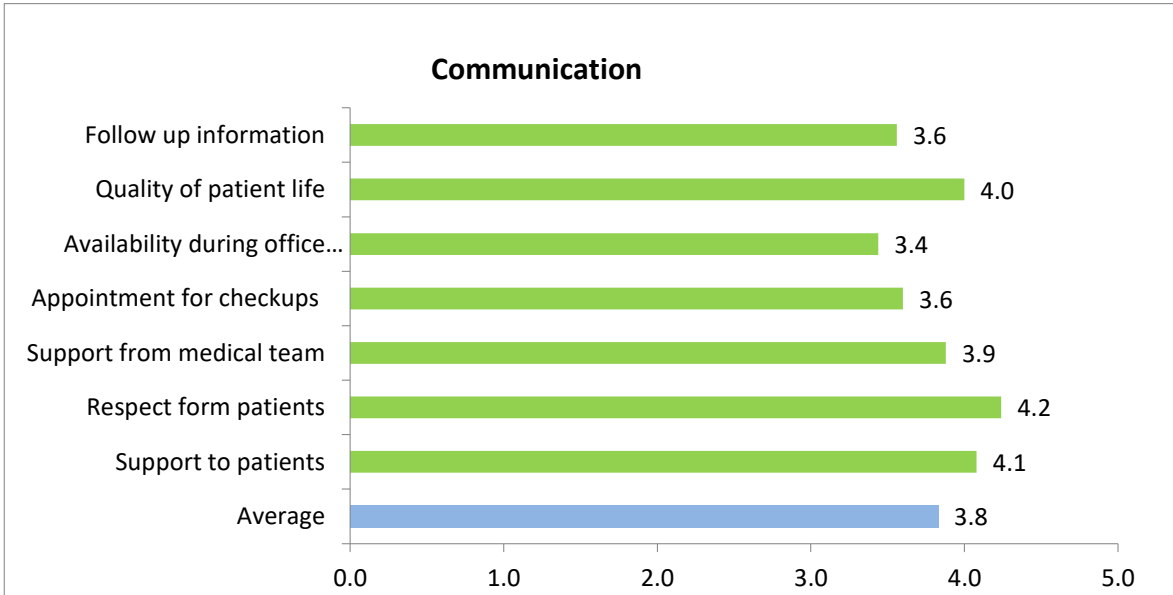
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**Relative results:  
Table 4**



**3.1.1 Doctor's support to the patient**

Health care staff 4.0  
 Paediatricians 4.4  
 Patients 3,8  
 Relatives 3,9

The health care perception of doctor's support to the patients is slightly inferior to paediatricians' perception. Physicians have a better perception about their work than other health care staff. Among users patients have a small difference with relatives, both perceive the support as inferior to the health care professionals perception.

**3.1.2 Respect in the hospital**

Health care staff 3.7  
 Paediatricians 4.2  
 Patients 4.2  
 Relatives 4.2

The results average of health care staff is 3.7/5.0 and this of paediatricians is 4.0/5.0. The difference between health care staff and physician is consistent, and could be attributed to the different relationship, in the case of doctor-patient relationship the role of confidence can improve the sense of respect toward the doctor. Interesting correspondence is showed between physicians, patients and relatives' results, a data supporting the link between this item and the quality of clinical relationship.

**3.1.3 Support offered by the medical team**

Health care staff 4.0  
 Paediatricians 5.0  
 Patients 3.8



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### Relatives 3.9

The results average of health care staff is 4.0/5.0 and this of paediatricians is 5.0/5.0. The difference between the sample groups is well marked, physicians they perceive them self more supported than health care staff. Perception of patients and relative are consistently different, and they correspond as rate.

#### **3.1.4 Quality of the patient's life**

Health care staff 4.1

Paediatricians 4.6

Patients 4,0

Relatives 4,0

The results average of health care staff is 4.1/5.0 and this of paediatricians is 4.6/5.0. Doctor considers the patient's quality of life better than health care staff; perhaps the different aims of their role make tem aware about the efficacy of the treatment offered to the patients. Health care stuff is closer to the daily life of the patients and they can perceive the lack of attention respect the quality of life in their stay at the hospital independently of the therapeutic results. Patients and relatives have the same perception slightly different than health care professionals.

#### **3.1.5 Doctor's availability**

Health care staff 3.8

Paediatricians 3.9

Patients 3,2

Relatives 3,4

The results average of health care staff is 3.8/5.0 and this of paediatricians is 3.9/5.0. The difference between the groups is not significant, in order to this aspect both agree about the need to increase the availability of clinicians in the unit. Patients and relatives have a different perception than healthcare professionals, interesting highlight all ratio are under 4.0/5.0.

#### **3.1.6 Making appointment for check-ups**

Health care staff 3.9

Paediatricians 3.7

Patients 3.5

Relatives 3.6

The results average of health care staff is 3.9/5.0 and this of paediatricians is 3.7/5.0. Again in in order to the evaluate the efficacy of health care services perceptions among the groups are not different, both consider waiting list and overload of patients as an obstacle to assure the best quality of the services in matter of response time. Patients and relatives consider this aspect with a different perception and results are all under the 4.0/5.0.

#### **3.1.7 Follow-up information**

Health care staff 4.0

Paediatricians 3.8

Patients 3.5

Relatives 3.6



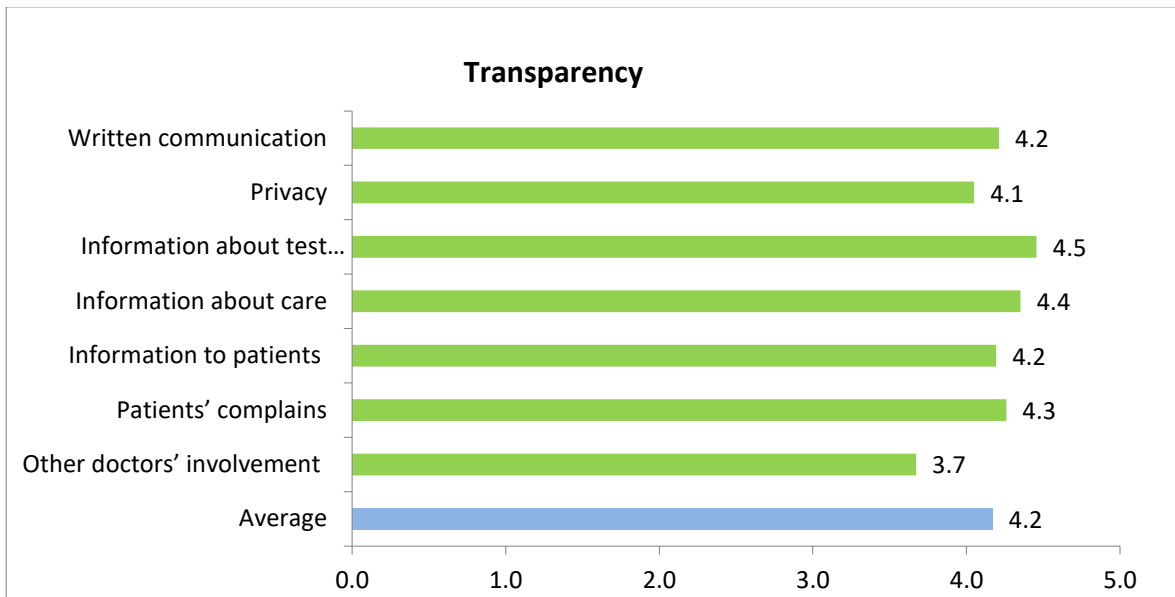


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The results average of health care staff is 4.0/5.0 and this of paediatricians is 3.8/5.0. The difference between the sample groups is not significant; they have a common perception in order to the information level received by patients after the hospitalization. Patients and relative are slightly under paediatricians.

### 3.2 TRANSPARENCY

Health care staff results:  
Table 5



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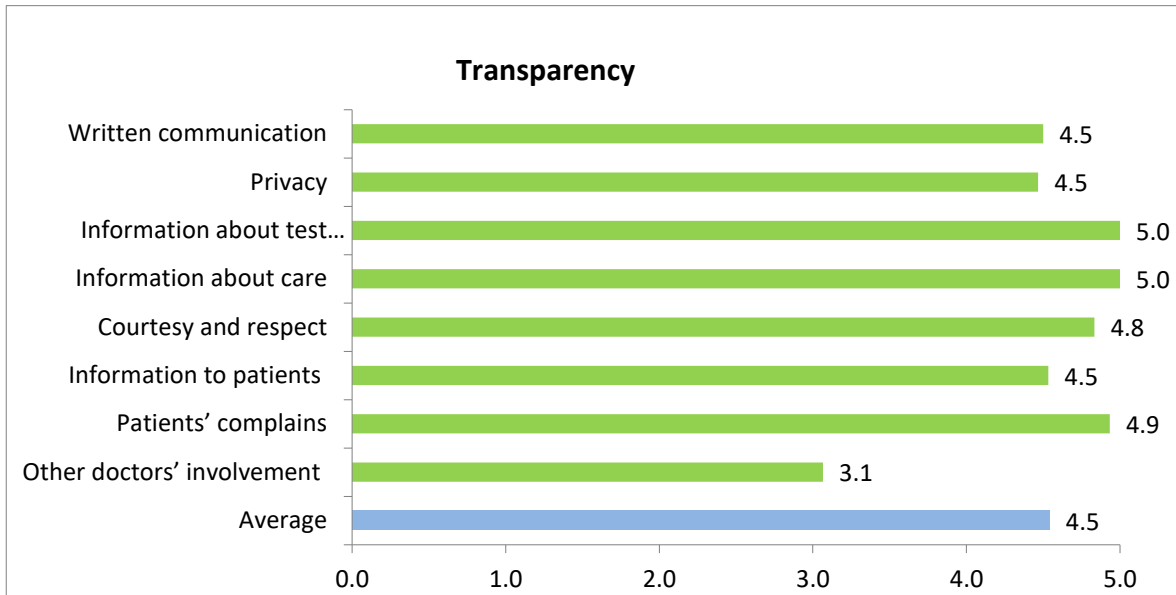
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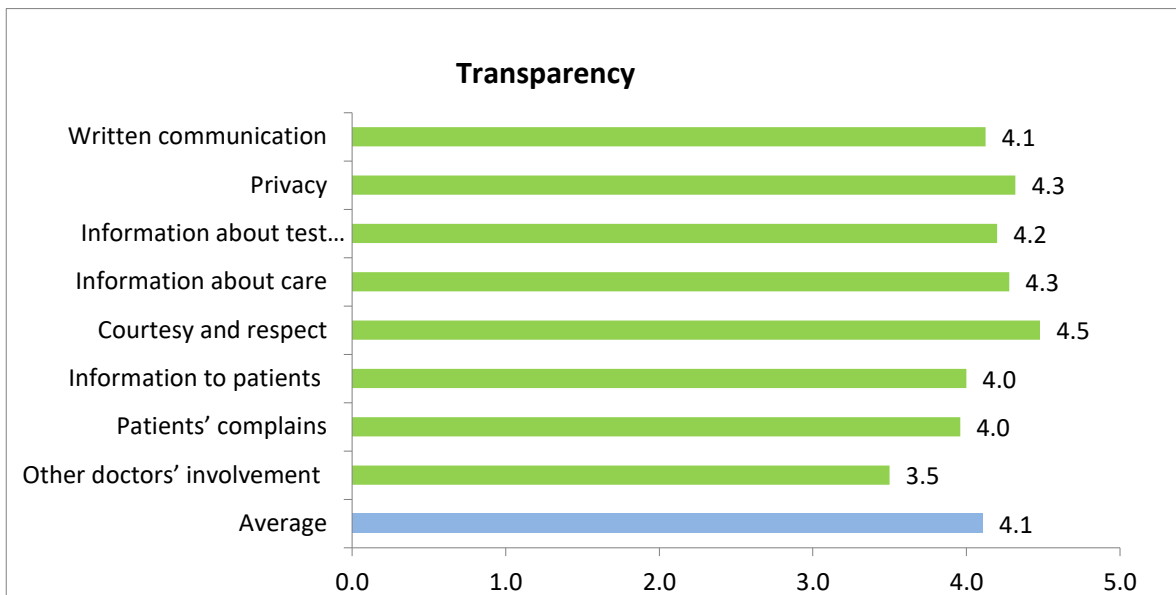


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**Paediatricians' results:  
Table 6**



**Patients  
Table 7**



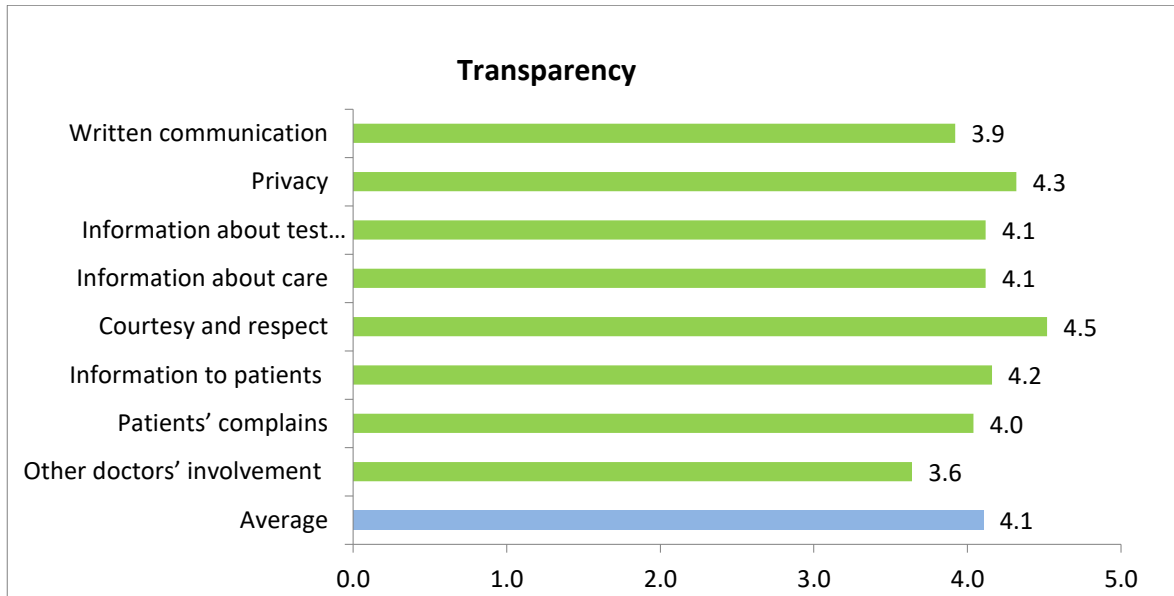
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**Relatives  
Table 8**



**3.2.1 Other doctors' involvement**

Health care staff 3.7  
 Paediatricians 3.1  
 Patients 3,5  
 Relatives 3,6

The results average of health care staff is 3.7/5.0 and this of paediatricians is 3.1/5.0. The difference between staff and doctors is clear, perhaps doctors perception are influenced by their role in decision making processes. Patient's responsibility, confidence, trust are all aspects that in some way personalize the clinical relationship, more than health care staff, were rotation are frequents. Patients and relatives have perceptions similar to those of health care staff and slightly different than physicians.

**3.2.2 Patients' complains**

Health care staff 4.3  
 Paediatricians 4.9  
 Patients 4,0  
 Relatives 4,0

The results average of health care staff is 4.3/5.0 and this of paediatricians is 4.9/5.0. The difference between the groups is not consistent, health care staff seems to give less attention to the patients claims, perhaps for the typology of claim a patient can show to a doctor, generally considered responsible of the patients condition in the unit. Patients and relatives do not consider complains aspects of the communication that ere not shared by health care professionals.

**3.2.3 Information to patients**

Health care staff 4.2  
 Paediatricians 4.5



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Patients 4.0  
Relatives 4.2

The results average of health care staff is 4.2/5.0 and this of paediatricians is 4.5/5.0. Information process presents some uniformity for both sample groups, even than in the case of patients and relatives is a little inferior.

### **3.2.4 Courtesy and respect**

Health care staff 4.3  
Paediatricians 4.8  
Patients 4,5  
Relatives 4,5

The results average of health care staff is 4.3/5.0 and this of paediatricians is 4.8/5.0. Health care staff perceives this aspects slightly different than physicians, even than difference is not consistent, patients and relatives confirm the good environment of health care services.

### **3.2.5 Information about care**

Health care staff 4.4  
Paediatricians 5.0  
Patients 4.3  
Relatives 4.1

The results average of health care staff is 4.4/5.0 and this of paediatricians is 5.0/5.0. Staff perception about information processes is not full, paediatricians are totally aware about the maximum effort done to inform patients and families, that have a perception unimportantly different.

### **3.2.6 Privacy**

Health care staff 4.1  
Paediatricians 4.5  
Patients 4.3  
Relatives 4.3

The results average of health care staff is 4.1/5.0 and this of paediatricians is 4.5/5.0. About this aspects health care staff perceive a lack of privacy in the unit, this difference could be related to the role of professionals in the unit, staff is more in contact with all the patients and for more time, perhaps this factor is a reason to perceive more situations were privacy is not respected. Patients and family have the same perception about privacy, and they shows a similar assessment of the item confirming a uniform tendency.

### **3.2.7 Written communication**

Health care staff 4.2  
Paediatricians 4.5  
Patients 4.1  
Relatives 3.9

The results average of health care staff is 4.2/5.0 and this of paediatricians is 4.5/5.0. Paediatricians consider written information somewhat better than staff even than difference is not significant. Perception of relative about this item is under 4.0/5.0 and very close to the health care staff.

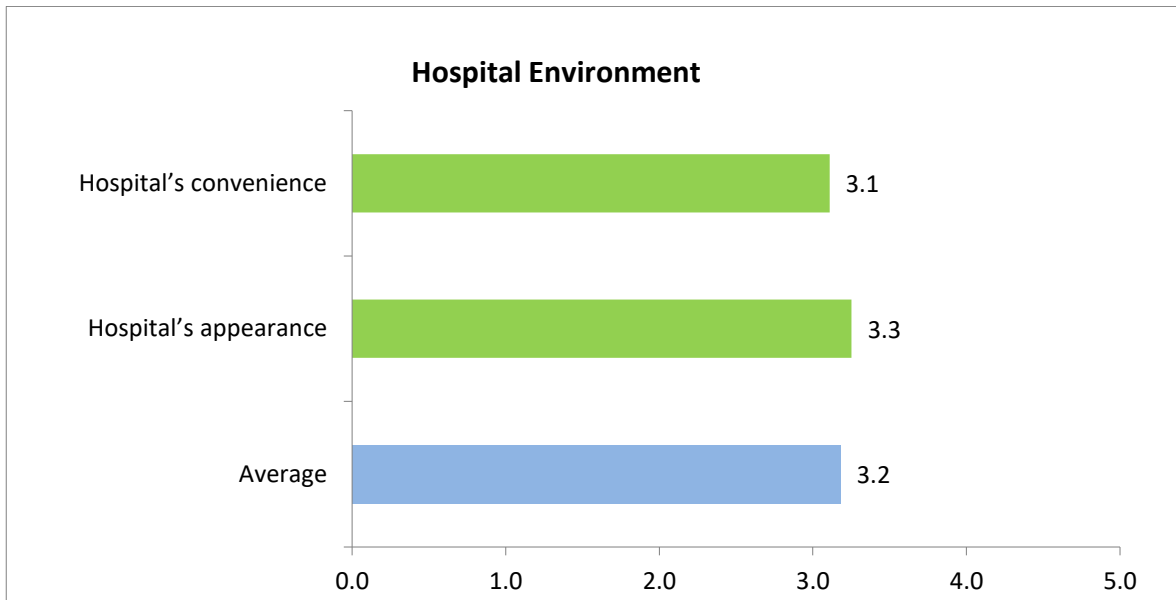




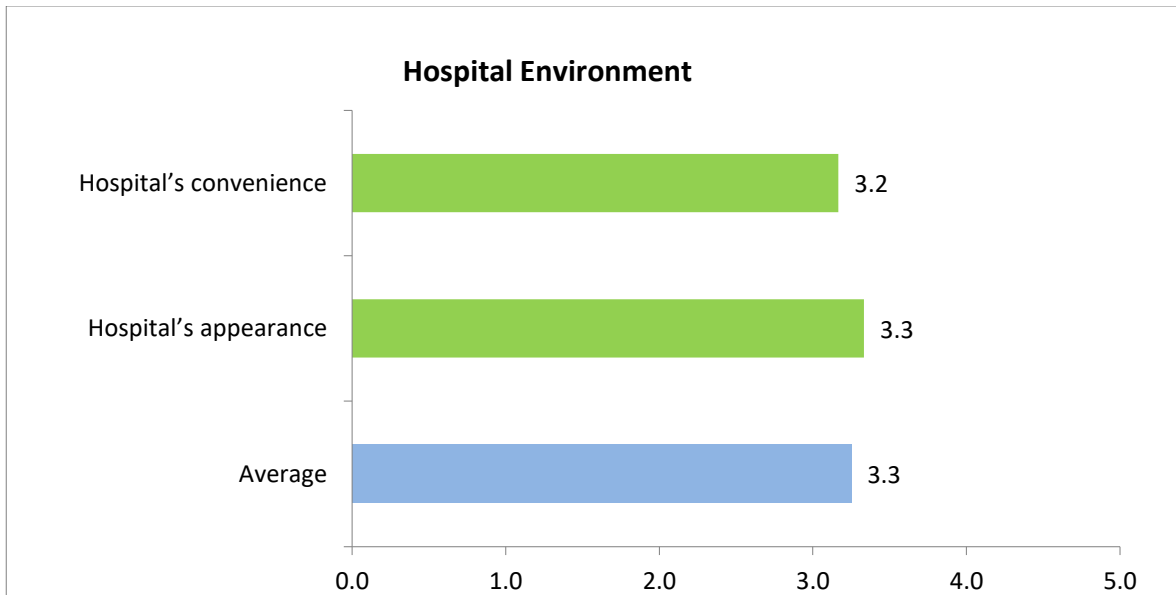
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### 3.3 HOSPITAL ENVIRONMENT

Health care staff results:  
Table 9



Paediatricians' results:  
Table 10



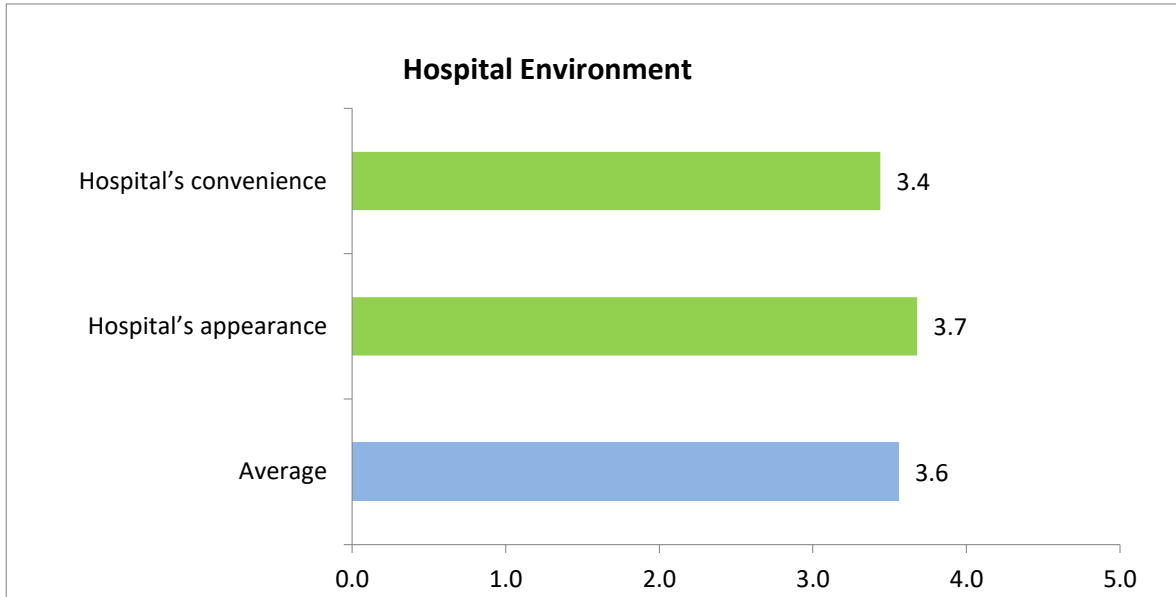
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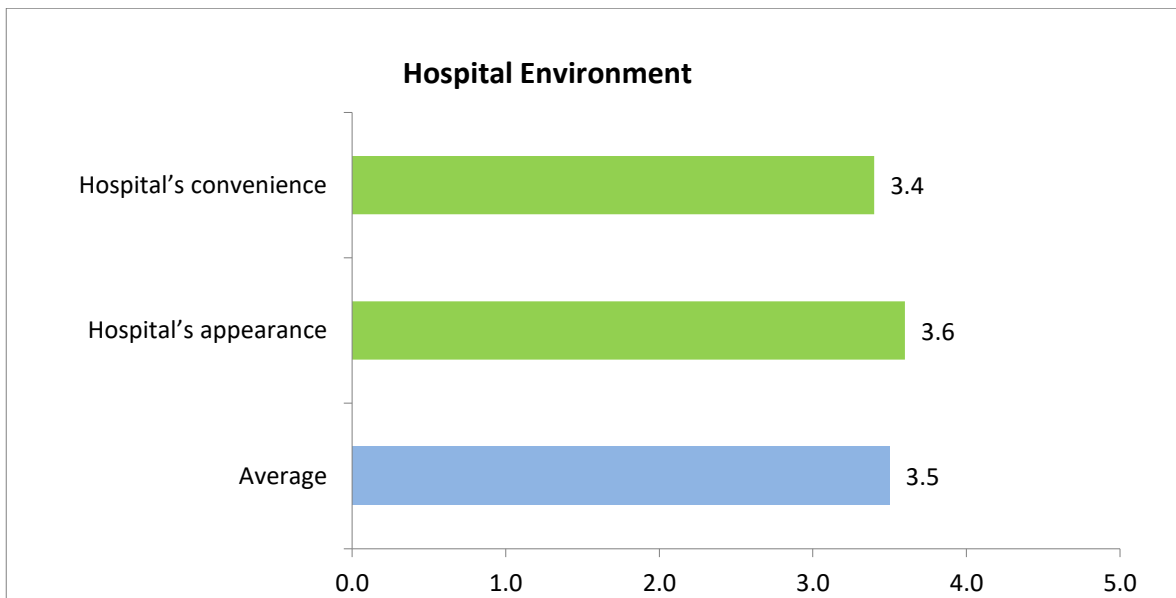


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**Patients**  
**Table 10**



**Relatives**  
**Table 11**



**3.3.1 Hospital's appearance**

Health care staff 3.3  
Paediatricians 3.3  
Patients 3.7



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### Relatives 3.6

The results average of health care staff is 3.3/5.0 and this of paediatricians is 3.3/5.0. Perception of both group are the same and rate average is extremely poor respect to other items explored by the survey. Perceptions of patients and relatives are much better than health care professionals.

### 3.3.2 Hospital's convenience

Health care staff 3.1

Paediatricians 3.2

Patients 3.4

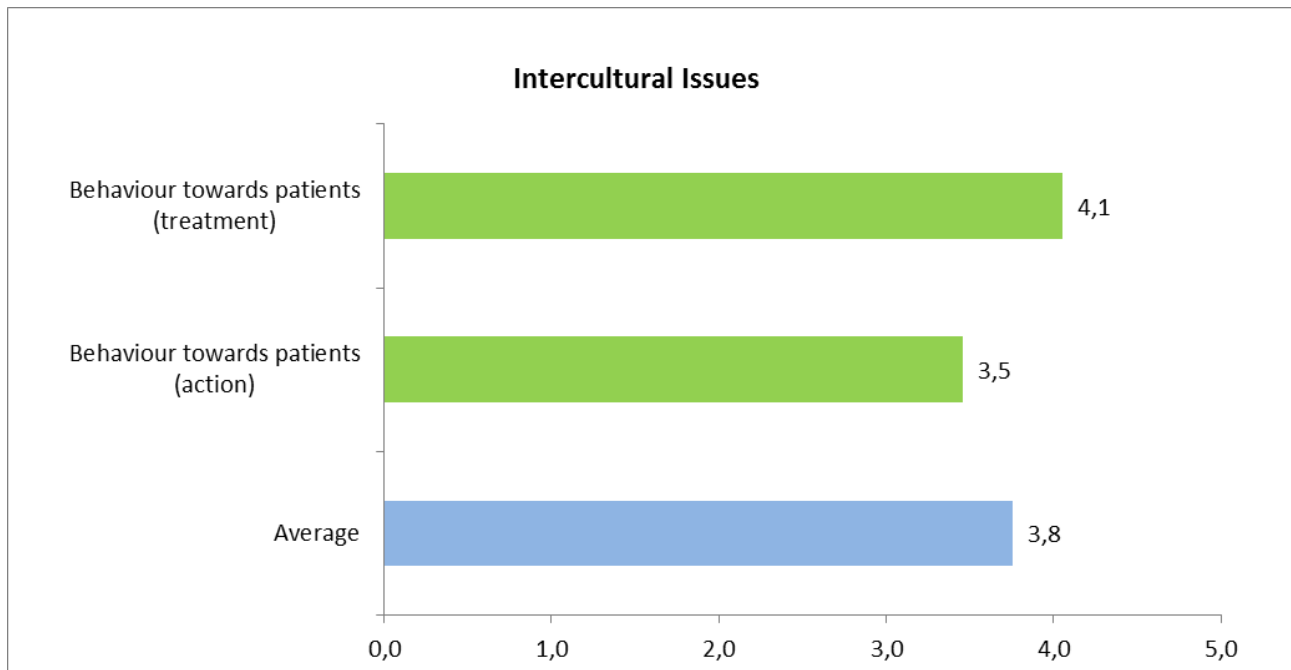
Relatives 3.4

The results average of health care staff is 3.1/5.0 and this of paediatricians is 3.2/5.0. The difference between the groups is not significant and the rate average is low respects to other items. Patients and relative show a little increasement of the rate corresponding to this item, even than is not significant respect to the general perception.

### 3.4 INTERCULTURAL ISSUES

Health care staff results:

Table 12



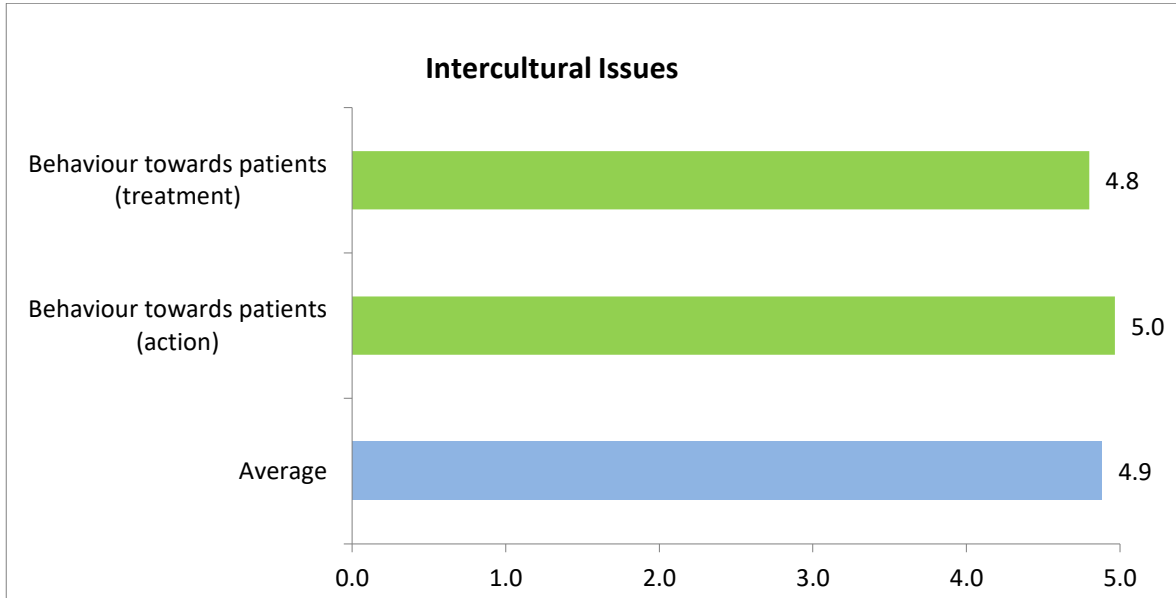
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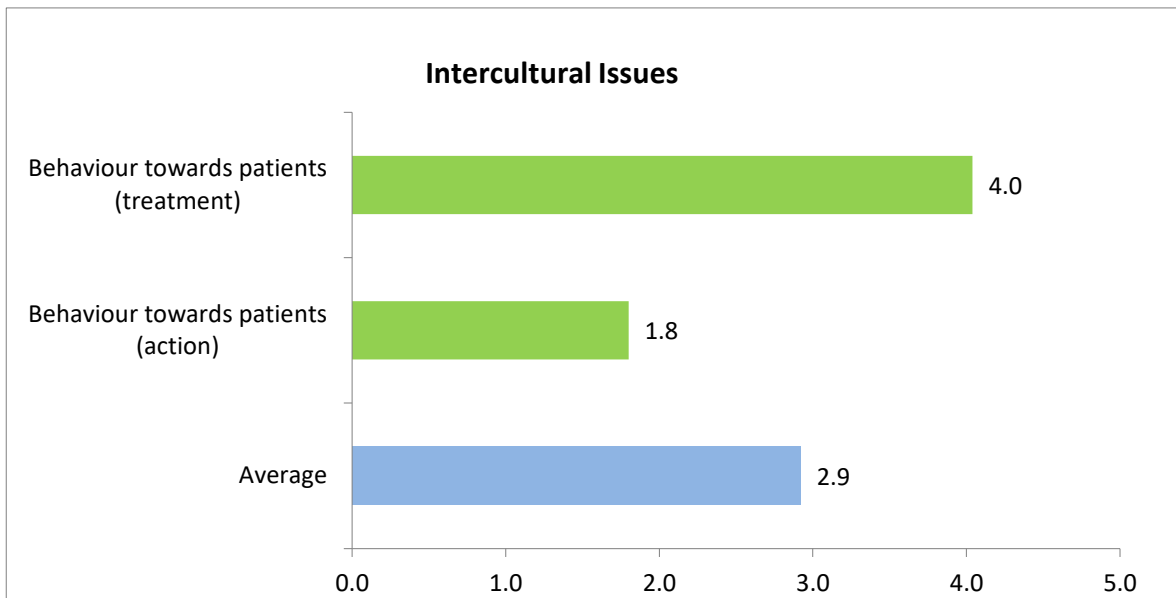


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**Paediatricians' results:  
Table 13**



**Patients  
Table 14**



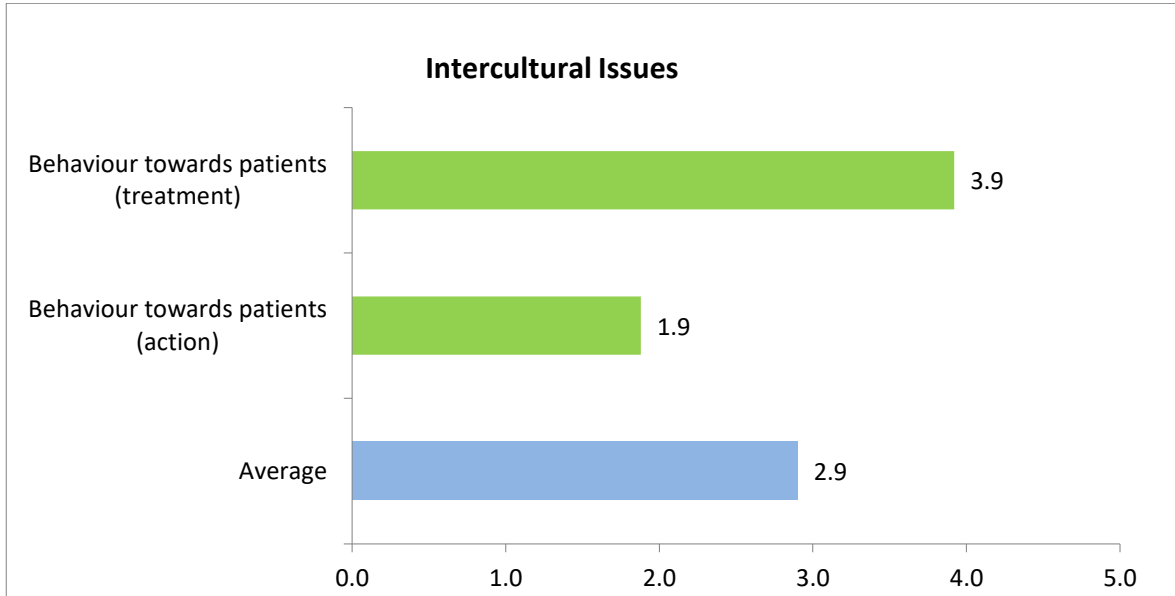
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**Relatives  
Table 15**



**3.4.1 Behaviour towards patients (treatment)**

Health care staff 3.5  
Paediatricians 5.0  
Patients 4.0  
Relatives 3.9

The results average of health care staff is 3.5/5.0 and this of paediatricians is 5.0/5.0. The difference between the groups is consistent; physicians have a better perception about their behaviour toward patients, showing a complete good attitude. Staff does not agree with this perceptions. In order to the treatment the perceptions of patients and relatives are different than health care professionals but this difference is not significantly, interesting the frequent accord between health care staff and relatives.

**3.4.2 Behaviour towards patients (action)**

Health care staff 4.1  
Paediatricians 4.8  
Patients 1,8  
Relatives 1,9

The results average of health care staff is 4.1/5.0 and this of paediatricians is 4.8/5.0. Perception of both group are similar and very positive, paediatrics have a more strong awareness about their good relationship with patients. Patients and relative perception is consistently different between users and providers, perhaps health care professionals are not aware about the role of culture and traditions in communication such as the same the direct interested. This aspect is really important in order to elaborate new tools to detect the lack of satisfaction related to the cultural issues.



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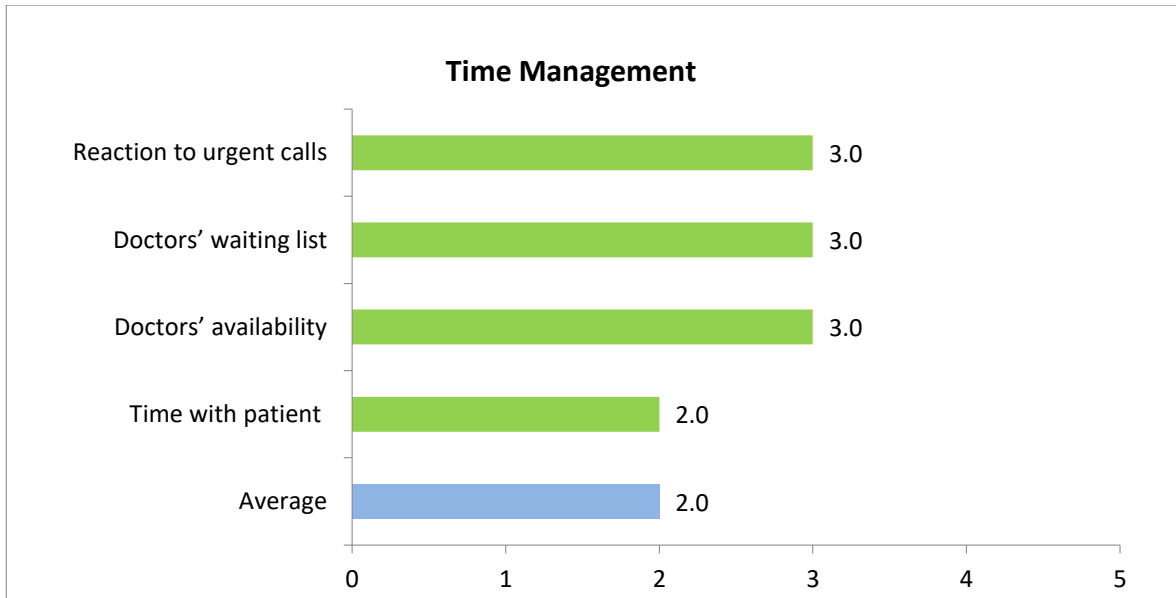




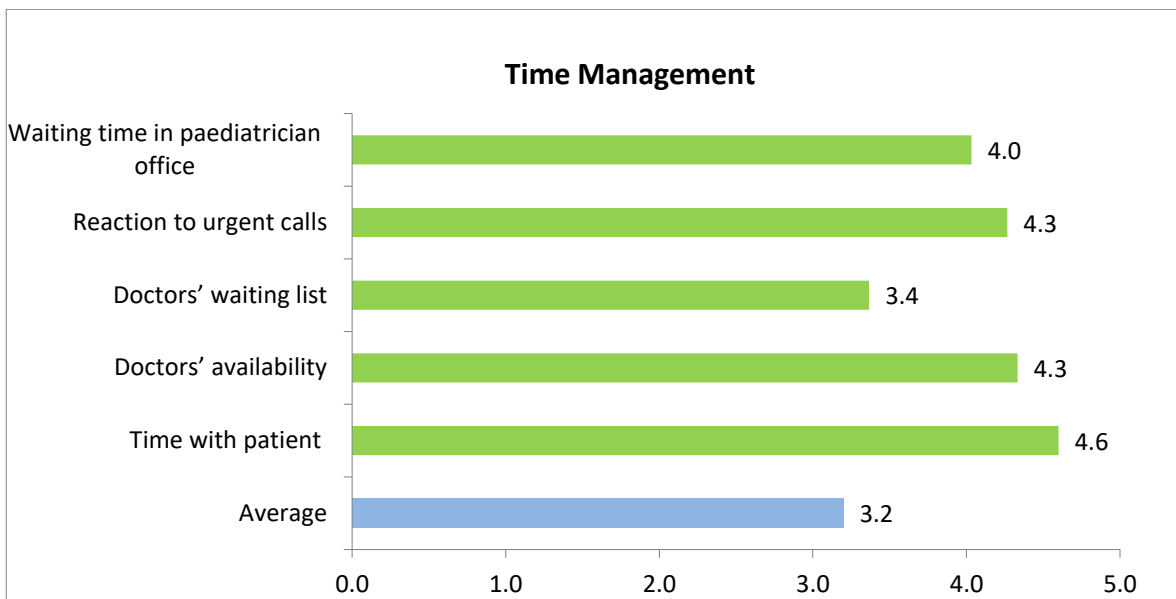
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### 3.5 TIME MANAGEMENT

Health care staff results:  
Table 16



Paediatricians' results:  
Table 17



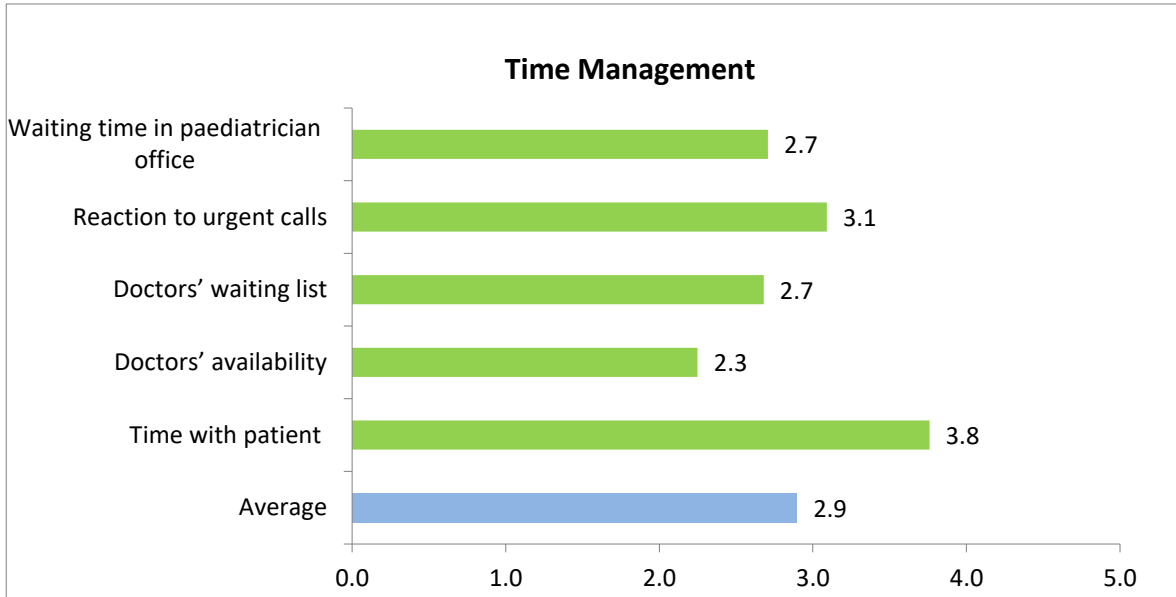
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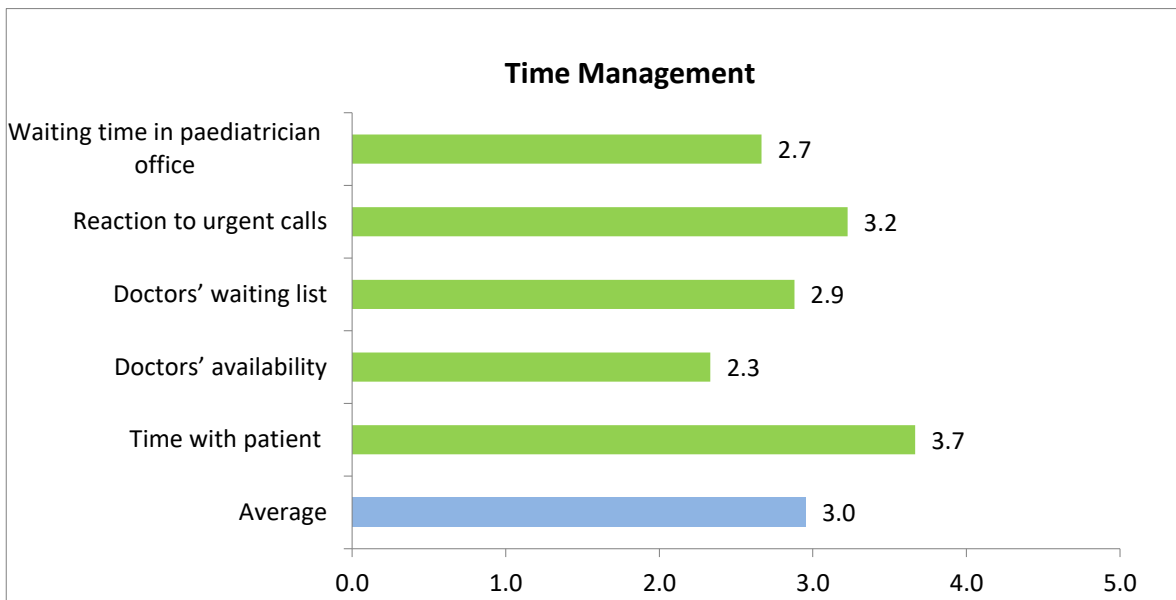


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**Patients  
Table 18**



**Relatives  
Table 19**



**3.5.1 Time with patient**

Health care staff 2.0  
 Paediatricians 4.6  
 Patients 3.8  
 Relatives 3.7



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The results average of health care staff is 2.0/5.0 and this of paediatricians is 4.6/5.0. In this aspects difference are relevant, the perceptions of health care staff are consistently different and totally opposite to the paediatricians. Perceptions of patients and relatives are better than health care staff and under those of paediatricians.

### 3.5.2 Doctors' availability

Health care staff 3.0  
Paediatricians 4.3  
Patients 2.3  
Relatives 2.3

The results average of health care staff is 3.0/5.0 and this of paediatricians is 4.3/5.0. In this aspects perceptions are consistent between the groups. The needs of patients and relatives are different respect to the perceptions of health care professionals, this items shows a real deeply distance between users need and provider awareness of health care service.

### 3.5.3 Doctors' waiting list

Health care staff 3.0  
Paediatricians 3.4  
Patients 2.7  
Relatives 2.9

The results average of health care staff is 3.0/5.0 and this of paediatricians is 3.4/5.0. Perceptions are similar even than health care staff has a more marked opinion. The difference between users and providers is not consistent, even than patients and relatives show less satisfaction.

### 3.5.4 Reaction to urgent calls

Health care staff 3.0  
Paediatricians 4.3  
Patients 3.1  
Relatives 3.2

The results average of health care staff is 3.0/5.0 and this of paediatricians is 4.3/5.0. Differences are clear in this respect, where paediatricians are convinced to support patients in the best way. Relatives and health care staff have very close perceptions respect to this item.

### 3.5.5 Waiting time in paediatrician office

Paediatrician 4.0  
Patients 2.7  
Relatives 2.7

The results average of paediatricians is 4.0/5.0. Waiting list is not a big problem even than paediatricians recognize the need to improve the service and reduce waiting time. Perceptions between physicians and patients are different, even than not consistently.

## 4 CONCLUSION

Differences among the health care professionals and paediatricians are not so sensitive if we consider the global survey, in most aspects the health care professionals have the same perceptions or differences are not relevant. In order to the communication process there is an agreement in relation to the use of





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communication skills. Patients support, respect and patients' quality of life during the hospitalization are perceived with high scores, and the difference in the results average is always around 0.5 or less. The difference is relevant in the case of support offered by the medical team, in this case results average shows a variation of 1.0. This data seems highlight a shortage in the strategy of health care professionals to support patients. The score averages are really inferior in both groups for those items related to the efficacy of health care services. Data shows clearly communication process is altered in reasons to the availability of human resources. Health care professionals skills are enough to offer an awareness about the value of communication with patients and families, but the time spent with them is limited, and patients' waiting or information are selected in order the level of relevance for the therapeutic process. Health care professionals select the information in order to their relevance for the therapeutic process, as a consequence doctor-patient relationship is not altered by the context, but information related to the follow up the patients or to their situation it looks affected when is not strictly linked to the symptoms control or therapeutic process. The quality of the information process is perceived by health care professional as enough to improve patients' participation in therapeutic process. This aspect is supported by a consistent legislation about the need to inform patients and the physicians' professional responsibility in case information are not enough to improve patients skills to participate in decision making processes. Global average difference between the groups respect to this dimension of the survey is 0,3, so data shows a common perception about the information quality process. Differences, always inferior to the 0.5 are present in health care staff, where the score is always lower than for physicians. This data could be related to the different role in the patient care, and to the different approach to the communication process. The law regulates duties and expectation in doctor-patient relationship, deontological and ethical codes, in case of health care staff control dispositive are not so precise, and role is in patients' approach change consistently. Paediatricians have precise responsibility toward the patients in relation to this aspect. Staffs spend less time individually with the patient, and the quality of time could be affected for the environment conditions. This aspects is clearly highlighted by other items of the questionnaire, the hospital environment, the results average is surprisingly low respects to other dimensions explored. Convenience and appearance of services are essential in order to affects communication process, and this perception is common in both groups surveyed. Global results average difference between the groups is 0,1. Services are not built for a patient-centred service, and this is in relations with the facilities and the organization of the service. Perhaps communication improvement can play an important role in order to identify patients needs and respond them offering alternative to the current situation.

Health care professionals perceive intercultural issues in a very different way, the results average shows a global score difference between the groups up to 1.1, and this data highlight a clear difficult for health care staff. If doctors have communication skills to manage different cultural backgrounds, staff perceives the context as an obstacle to the quality of care. This aspects is very clear if we consider the difference between the two items related to this questionnaire dimension: in order to the treatment perceptions are similar and positive, in order to the action, differences are evident, perhaps in reason of the role of staff in the patient care, where all the responsibility is in the hand of doctor. This data offer a lack of health care staff participation in the strategies to approach the cultural issues in the hospital units.

Time dimension play a big role in the communication process, both groups perceive this aspect as relevant, even than this aspects is specially relevant for health care staff, because the result average related to this item shows the worse score of the entire survey. The average in the case of physicians improves, even than is clearly low if we consider other aspects of the survey. The different role of physician to explain this aspect is clear, time with patient spent by paediatricians results average is 4.6, those of health care staff is 2.0. Considering the different requirements attributed to the professionals role, data shows a really big difference which impact on the global quality of patient care could be relevant.

In order to compare patients and relatives results is really important observe a character of the sample can be useful in order to understanding data: just the 31% of patients surveyed are between 12 and 14 years old, this can be a very important aspect in order to consider the scarce difference between patients results and relatives results. 69% of patients received relatives' helps to answer to the questionnaire, and perceptions are overlapped in order to several aspects explored by our investigation.

Communication results show the role of doctor-patient relationship and clinicians' attitudes to improve patients' confidence. The aspects linked to the dyadic communication between doctor and patients shows better results than other linked to the care community. The difference between the perceptions related to items such as support, respect or quality are not so consistent than those related to other items, like team and availability, more dependent on the circumstances of care. Data related to the item transparency show more homogeneity a global perception related to the information and decision-making processes.



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Environment perception is relatively better in patients and relatives than in the health care professionals, this aspects is a clear sign of the quality of health care services, even than providers are not fully satisfied, user are not aware about the dysfunctions of the services.

The needs identified in the national survey to improve the communication process and the professional soft skills are relevant: 1) Format, communication process needs a new format, were the mediation of health care professionals is not the only option to interacts in the health care. Patients need to empower their role in the information management, and solutions would have focused on this new role of the patients. New technologies can help to develop a new format to communicate with the patients and face the chronic lack of time and resources of health care professionals and health care system. 2) Individual communication, health care staff has not access to the individual communication with the patients, specific moments are required in order to identify patients needs and give to the health care professionals more chances o be aware abut solution and strategies. From this point of view, is relevant improve the communication between health care staff and physicians and share information. Promote a better access to the information available for the physicians could be a good strategy to help staff to improve their communication with the patients. 3) Patient-centred communication, in order to personalize information process is important assign a new role to the patients, and to offer them new access to the information, consent them to select information and demand for further details. Information offer should increase and be available without the strict mediation of the physician where possible. 4) Intercultural skills, health care staff needs to improve its role in the management of intercultural issues and be aware about the role of this issues in the therapeutic results. Soft skills are essential to accomplish with this requirement. 5) Timing, time will be the problem of the future for health care professional, and resources are the big reason for this circumstance. If financial resources have not a direct solution form the professionals' perspective, new communication strategies can be implemented in order to face this challenge. Health car staff needs alternative approaches to the direct communication with the patients, and technology again could be relevant to find alternative solution. In order to the cultural issues results present some difference, data related to the quality of treatments are positive and present a not significant difference of rate between health care professionals, patients and relatives.



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