Exploring Health Professional's Attitudes Towards Female Burns Victims, From a Patient Perspective.

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Abstract

Background: A significant amount of global burn injuries sustained by females occur in South East Asia and frequently have devastating physical and psychological consequences for victims, impacting on their domestic and familial roles. These patients require multi-faceted and specialist treatment beyond the usual basic medical care. This care needs to be delivered sensitively by professionals who approach the patients with empathy and without discrimination and needs to continue beyond hospitalisation through to the effective provision of support services. These need to be clearly signposted to ensure continuing preventive and curative self-care.

Aim: This study aimed to explore healthcare professionals' attitudes towards female burns victims and how these affect the patients, treatment and care experiences

Methods: Qualitative methods were used by way of semi-structured individual interviews with ten patients who had received treatment in state medical facilities and the Triple B Clinic.

Findings: A majority of participants identified negative attitudes from professionals in state facilities with more positive attitudes described in Triple B, which influenced their perceptions of the care provided and their experiences of their overall treatment. In addition, participants described a lack of information signposting them to support facilities.

Conclusions and recommendations: The patients' accounts identified gaps in medical care associated with poor attitudes of health care professionals, which undermined their treatment. Additionally, there was an obvious need for improvement in information provision through support services, in order to enhance their treatment experiences.

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Group Report Statement

The following Research Project was conducted as a group project with my colleague Emily Marshall. We designed the project together, coming up with the interview guide, information sheet and consent forms. We also submitted a joint application for ethical approval, however, we submitted separate risk assessment forms. When I left the Philippines Emily, alongside Jack, a medic from Sheffield University, conducted the interviews and sent me audio recordings of them. From this I transcribed and analysed only my own section of the interviews, starting from when Emily's section ended.

Table of Contents

1. Introduction

Of all injuries burns are seriously debilitating yet avoidable (WHO, 2018). It is estimated that 180,000 deaths annually result from burn injuries, with most occurring in low or middle-income countries. Burn risk typically rises amongst those of low socioeconomic status and consequently such injuries disproportionally affect the underprivileged (WHO, 2011).

Research has shown that an overwhelming 50% of these incidences occur in South East Asia alone (WHO, 2018). The Philippines is an example of a lower-middle income country where burns are frequently sustained (Alexandra Monica L. Tan et al., 2017). Burns are more commonly sustained by women due to their domestic roles which often involve exposure to open flames through cooking, heating and lighting (WHO, 2018).

Burns are defined as ‘an injury to the skin or other organic tissue primarily caused by heat or due to radiation, radioactivity, electricity, friction or contact with chemicals’ (WHO, 2018). The physical appearance of a woman and her physical capability can be severely impacted by a burn. This can result in a woman’s role within the family being impeded (Singh, 2016) .

Burn injuries involve not just physical but also psychological trauma (Heath, 2017), resulting in the need for lengthy hospital treatment and rehabilitation, costly to both the individual,

families and the economy (Nele Brusselaers et al., 2010). Treatment requires specialised medical care which is not easily accessible in developing countries.

Due to the complex nature of these injuries and the impact on the patient it is crucial that the care received is more than adequate (WHO, 2011). Overall treatment of burns victims requires well-structured and specialised care incorporating sensitive consideration of the traumatic experience suffered (Heath, 2017). For many victims, health professionals are the first point of contact following injury. Therefore, it is crucial that health professionals provide appropriate care, irrespective of their own perspective, act respectfully, ensuring that patients feel comfortable and supported. The manner in which burns victims are treated, including interactions with health professionals, can greatly influence short and long-term decisions as to whether to fully engage with the relevant health services. Patients' decisions at this early stage in their recovery can have profound consequences on patient outcomes. If health-seeking behaviour is actively and positively encouraged through a good working relationship within the hospital environment a patient will be more inclined to follow that course post-discharge (Heath, 2017).

Typically, there is limited information and research on outcomes for burns victims and on the subject generally in the Philippines. This was highlighted after a systemic literature search on databases, namely, the Cochrane Library, PubMed, Medline and Ovid, searching for key terms, such as 'burns', 'patient-centred care' and 'Philippines', which resulted in identifying limited resources on the topic, underlining the need for comprehensive research and data collation. This is probably not assisted by the limited number of tertiary hospitals in the Philippines, currently 6, which contain a burns unit (Alexandra Monica L. Tan et al., 2017). There are urban health clinics with burn treatment provision, but these are frequently under resourced and understaffed (Darang, 2012). In a country which consists of 7107 islands there is a decided paucity of burns treatment and care provision (Department of Health, 2012).

1.1 Aims and Objectives

Aim: This study will consider health professionals' attitudes towards female burns victims from a patient's perspective. It aims to explore the patients' experiences, including their treatment by health professionals in the Philippines.

Objectives:

1. To identify the attitudes of health professionals towards burns victims from a patient's perspective.
2. To explore the influence, if any, of health professionals' attitudes, on the patients' experiences in different health facilities.
3. To explore the extent of information provision by health professionals to patients regarding support services and the accessibility of services from a patient's perspective.
4. To identify any gaps in health provision and support services for burns victims, how they can be filled and where improvements are required.

2. Method

This study was undertaken by a research team. I designed the framework with Emily Marshall; the interviews were conducted by Jack Cunningham and Emily Marshall; and I compiled the overall analysis.

2.1 Study Design

Qualitative methods, inspired by the phenomenological approach, were used to understand the individual's perception of health professionals' attitudes so as to inform practice and aid the development of innovative patient-focused health policy and practice. This method allowed the team to formulate a comprehensive description of the patient's experience, bringing to the fore the personal feelings of treatment received (Lester, 1999). This was required in order to fulfil the study's aims and objectives.

2.2 Study Location

This research was conducted in the Zambales province of the Philippines, on the Northern island of Luzon. A clinic, run by Nurse Val Smith-Orr, 'Triple B Care Projects', located on the island, specialises in burns. Many of the patients were previously treated in state-run health facilities, which introduced a comparative framework for their experiences.

2.3 Sampling Strategy

Potential participants were identified through Nurse Val using purposive sampling. The clinic records were screened, and potential participants were selected and informed of the research via the information sheet, shown in Appendix 1. If participants were able to read, a translated version in Tagalog was provided. If they were unable to read, the information sheet was read to them by an interpreter.

2.4 Data Collection

Semi-structured interviews were conducted with each of the 10 participants. This approach was selected as it was considered the most comprehensive and reliable way to explore patients' feelings and personal experiences (John W. Creswell, 2013). An Interview Guide can be seen in Appendix 2. Sections 1 and 3 are relevant to this study, section 2 relevant to my colleagues. While the interview guide is presented as a list of questions, these are in fact prompts for discussion. In allowing the interviews to be conversational, this enabled the participants to speak freely. The interviews were conducted in Tagalog, assisted by an interpreter.

2.5 Data Analysis

Once conducted the interviews were transcribed, and fully considered. Codes were generated, and themes emerged. Using Nvivo Software the codes were categorised by themes and a thematic map was then compiled for further review and assessment.

Thematic analysis was used to analyse the data to ensure patients' experiences were properly explained. Such thematic analysis is a method employed to classify, evaluate and report patterns within data, thereby enabling common themes that emerge from the different interviews to be more easily and readily categorised (Braun and Clarke, 2006).

2.6 Ethics

Ethical Approval was obtained by the University of Leeds prior to undertaking any research.

2.7 Limitations

There is always the risk when a translator is used that the version translated to the researcher may be tainted by the translator's own interpretation of the patient's narrative. This is known as miscommunication bias. The participants, at times, spoke at notable length to the interpreter who in turn provided considerably shorter answers to the researchers. However, this was not always the case and extended answers were also provided. This may simply be a result of the participant struggling to articulate experiences and/or being repetitious but there again, it may be of significance.

An additional limitation was that the project host acted as gatekeeper and purposive sampling was used, resulting in potential selection bias. Further, the interpreter was a nurse employed full time by Triple B and consequently knew all the participants and moreover the interviews took place in Triple B's facilities. It is highly likely that these conditions impacted on the participants' ability to speak openly about their experiences including inhibiting any critical appraisal of the provision of services.

The sample of participants was small due to time constraints and therefore was not representative of the population and thus, any conclusions extracted need to be treated with caution. Additionally, the level of intellectual functioning of participants varied; some were more confident, articulate, expressive and forthcoming with information than others. This in itself obstructed a reliable comparative analysis.

Reflexivity is an unavoidable limitation of any qualitative research as a researcher's understanding is naturally informed by their own limitations and experiences (Reid et al., 2018). Such subjectivity invariably skews to some extent the structuring of questions and interpretation of coding; thus, the conclusions drawn may have been inadvertently distorted due to the researchers' established preconceptions thereby reducing the reliability of the data.

3. Findings

Analysis of the interviews established that the attitudes of health professionals towards the patients differs in the state-run facilities compared to Triple B. The health professionals in

the state-run facilities were typically associated with negative attitudes, whilst the attitudes of those at Triple B were described with greater positivity. An analysis of the overall responses in the patients' interviews identified a number of factors, which seem to have informed and influenced their opinion as to the attitudes of the clinicians and the quality of care they received. Recurring themes emerged, namely; individual qualities of treating professionals, financial motivation of doctors and the impact these had on the perceived level and standard of care.

There is some obvious overlap between these themes, but each is addressed individually below.

3.1 Individual qualities of treating professionals

A recurring theme was the lack of attentiveness, and personal focus from the majority of doctors in state facilities. One participant was satisfied with the standard of care she received from one out of two treating doctors but perceived the other as threatening.

Doctors were described as treating the patients as inferior and unequal. Some felt they were disinterested, failing to ask basic courteous questions as to their well-being.

A significant number of participants described the doctors as patronising, disrespectful and distant in their attitudes with some expressing frustration at not being listened to. One participant said:

P: 'For me it's not very what's that called? Comfortable. If you are in injury you expect someone can care a little bit for your pain, your feeling, but no because they are like a robot. No feeling at all.' P8

However, one did say that she did not extend her responses to include subjects beyond the parameters of the question. Therefore, whilst some regarded the doctors as not being attentive, equally the patients themselves may not have been sufficiently forthcoming with information and been more reserved about furthering discussions.

The participants were less critical of those nursing staff they identified as patient and attentive. The nurses were described as accommodating, but some as inexperienced. In assessing these responses, it may be relevant that as they spent more time with nurses they possibly felt more relaxed in their company.

In contrast, the descriptions of the attitudes of staff at Triple B were considerably more positive with the emphasis on nurturing care. One participant described Ma'am Val as being

P: 'Like a mother, very strict but very gentle.' P9

When asked to elucidate she clarified that she believed this firm approach contributed to a more effective recovery. In this case, it encouraged the patient to walk again by engaging in treatment.

This was echoed in further observations indicating more personal and patient centred attitude from the practitioners at Triple B.
Overall, in respect of state provision the participants identified failings in the attitudes of the doctors treating them and, in the facilities, accommodating them but were more complimentary of the attitudes and services at Triple B.

The participants identified the importance of receiving holistic, patient-centred care in a welcoming and nurturing environment with their welfare prioritised. This they recognised as an important factor in their recovery. It was apparent that a humanitarian and supportive facility creates a more positive approach from both patients and practitioners.

Gender was an additional theme identified as influencing attitudes of care providers. Male doctors scored considerably lower than female doctors did, on patient-focused care provision. This reflects a growing body of research that female doctors are better at empathy and spend more time with patients (Howick et al., 2017). This approach has been found to improve patient outcomes and was an important theme that came out of the interviews.

3.2 Financial Incentive

The majority of interviewees considered that the treating doctors in state facilities had no financial incentive to provide a good standard of care. This view was conveyed by accounts of rushed care, limited and distracted attention, and dismissive and unsympathetic responses. To a lesser extent, there were accounts of being advised to take treatment considered unnecessary, but which would be financially profitable for the doctor.

Triple B treatment patients reported a greater focus on individual personal care with no regard for cost, as treatment is free. One interviewee contributed:

P: 'As I told you the doctors are doing their job because they're getting their salary. People have different traits. Dr Val is for the cure and not the money.' P2

3.3 Level and Standard of Care

All of the factors set out above contributed to the participants' perceptions and experiences of the level and standard of care they received in the environment in which they were treated.

Generally, the views expressed indicated a lack of personal touch in the care received in state facilities save for one participant who was satisfied with the level and standard of care. However, it transpired during the interview that a member of her family was employed in the facility where she was treated which may have had some influence on her responses or it may simply be she was given preferential treatment due to her familial connections. The lack of patient-focused care caused the patients to convey feelings of dejection, which clearly coloured their experiences within state facilities, with overall negative views being expressed.

A prominent feature of participants' descriptions of care at Triple B was that their emotional and psychological needs were prioritised. A patient at Triple B described being bathed, fed and having her hair restyled to promote her self-esteem. The nurturing attitudes of the treating professionals clearly contributed to the patient's assessment of a calm, empathetic environment. One participant credited her experience at Triple B with a resounding eleven out of ten.

All these factors contributed to the participants' perceptions and experiences of the level and standard of care they received in the environment in which they were treated.

A dominant factor was the patients' tendency to conflate poor attitudes of health professionals in state facilities with the standard of care received and thus to conclude that if the patient/doctor relationship was lacking the level of medical treatment would be substandard. If the participant perceived the doctor's approach as professional and positive it seemed to follow that this inspired greater confidence and trust in his/her competence. This clearly enhanced patients' feelings of positivity towards Val and her unit.

The participants identified competent doctors as those who responded to their needs and expectations through good communication skills and trust building. Very few indicated that this had been achieved in the state facilities.

3.4 Information Provision

The overall impression from participants was that information sharing about their treatment was inadequate; leaving them feeling they would have to fend for themselves once discharged. This restricted their ability to make informed health and treatment decisions, disadvantaging them in their recovery.

There was scant information provided to the participants about availability and accessibility of support services. This applied to both facilities, however, participants were more inclined to criticise the state facilities on this issue. This may be because of an overall reluctance to criticise Triple B or it may be a genuinely held belief. One woman spoke of how Ma'am Val had helpfully assisted her in identifying an expert who could stimulate her stunted hair growth. This supports the participants' views that Triple B's focus extends to rehabilitation. In addition, Triple B was able to arrange referrals to specialists in other jurisdictions. One patient stated when asked if Ma'am Val informed her of other places where she could receive help she stated:

P: 'Yes, yes she gave another referral... She give Australian doctors.' P6

The majority of participants pointed to the guidance from Triple B promoting wound healing. They were appreciative that such treatment advice remained available post discharge and identified this as an ongoing support service through clinic follow-ups. Such services were notably absent from the state facilities. However, one participant considered that she had not been provided with sufficient information on prevention at both Triple B and within the state facilities, which would have assisted her in educating her family. This answer illustrates that poor dissemination of information does deprive patients of the opportunity to make informed decisions about their care and treatment, in partnership with their healthcare professionals.

Many cited the withholding of information by the state facilities of the existence of the Triple B Clinic, in some cases felt to be deliberate, as an example of being unsupported and ill-informed by the professionals at the state facilities. If this is so this will have undoubtedly introduced suspicion and trust issues into the relationship.

The participants expressed their need to be informed to protect their own health, which they considered was not adequately addressed. They identified the need to be consulted and to participate in the decision-making. This level of patient involvement was in their view hindered by a lack of an effective partnership between patient and doctor.

3.5 Gaps in health provision for burns victims

Many participants identified gaps in health care provision, which impeded their recovery. They were particularly critical of the poor provision in state run facilities but were more tempered, expressing concern as opposed to criticism, in respect of Triple B.

Many reported having to pay for their own medicines in state facilities, which some could ill afford and resulted in them going without. One described how she refused to remain in hospital contrary to medical advice due to cost. Restricted access to medical treatment caused by financial hardship leads to inconsistent and interrupted health care resulting in delayed or poor recovery outcomes

Many were worried about the lack of or limited supply of medicines at Triple B. Whilst the patients do not have to pay for medicine, they were typically concerned by the prospect that the supplies could run out and their treatment stopped.

Additionally, Triple B patients informed that as bed space was limited this curtailed the length of hospital stays with concerns that decisions could become resource as opposed to patient led.

Participants placed a lot of value on their personal relationships with Triple B staff, in particular Ma'am Val, with many being concerned that she was aging, and would soon be unable to work, causing them to worry about the future of the clinic. This emphasises how they considered Ma'am Val to be pivotal in their treatment.

When responding on this issue some may have been unconsciously influenced by the nationality and perceived wealth of the researcher, in that they were quick to identify the need for greater financial aid. One participant observed:

P: *'I think if you give them some more donates like medicines because sometimes Ma'am Val gives us medicines, but we cannot buy them here in the Philippines. It's hard for us.'* P3.

4. Discussion

This small study indicates that the participants' views of health care provision in the Philippines, in some respects, mirror those of many patients throughout the world highlighting that standard of health care provision is a global issue.

In light of objective 1, the care provided, and the manner of delivery was shown to be very important. This reflects the findings in multiple studies on health professional's attitudes towards patients. Communication is vital in the patient/doctor relationship; good communication enhances feelings of trust (Corbett and Ennis, 2014). In a study by Larivaara et al the main factor identified as influencing patient satisfaction and patient's rating of their doctors performance was communication (Pekka Larivaara, 2001). This is reflected in this study as those professionals who were described negatively in state facilities were those who were inattentive, poor communicators and unsupportive.

A number of studies have found that the manner in which professionals communicate with patients and the language used does affect the patient's perception of the treating doctor's attitudes (Sofaer and Firminger, 2005). Health professionals in this study were often described as impersonal, judgemental and detached with one describing the language used as threatening. This is in contrast to participants' descriptions of their interactions with Val as warm and friendly, and maternal in her approach.

Those who sustain disfiguring burn injuries are often stigmatised and require positivity in their treatment to promote self-worth (Larkin, 2011). However, many participants described not feeling reassured by doctors in state facilities with one remembering how a doctor laughed at her when seeing her injuries, causing her to feel shunned and isolated.

Research on this subject shows that an open and reassuring environment where problems are freely discussed is the preference of most patients (Sofaer and Firminger, 2005). This was demonstrated by patients' praise of Ma'am Val and her promotion of self-care through non-judgemental guidance. One participant emphasised this difference in approach when she explained that she could say anything she wanted to Ma'am Val whereas she found other doctors in state facilities to be distant and unapproachable. The latter approach reflects the perceived sense of superiority of many doctors in the hospital environment and is indicative of the power imbalance which runs counter to the ethos of holistic patient-centred care (Larkin, 2011). Participants expressed greater satisfaction with those doctors who built a relationship by encouraging them to talk through their feelings. This method also benefits the doctor enabling him to gain more information about the patient's condition, which can be crucial to their treatment plan. An example of this is evident in this participant's comment

P: 'The doctor doesn't like me he doesn't care for me when I'm in the hospital. He checked every now and then but didn't ask anything if I have pain or if I feel comfortable.' P4

In regard to objective 2, the attitude of the treating doctors are fundamental to the patient's experience. This view is confirmed by existing studies as well as in the findings of this study. Typically, patients perceive their experience as beneficial if they feel the attitudes of those treating them is positive. One study found that when patients feel considered and

cared for mental and physical health outcomes improve (Roy et al., 2015). Such focused care can reduce the length of a patient's stay in hospital and care costs, which benefits the doctor, the patient and the hospital (Roy et al., 2015).

A further study conducted by Larivaara et al. found that a doctor response to the patient is determinative of the quality of the overall doctor-patient relationship (Pekka Larivaara, 2001). It has been observed that even a competently undertaken medical procedure may be regarded as substandard by a patient if the doctor has failed to offer support and reassurance (Pekka Larivaara, 2001).

The fact that the higher echelons of the medical profession are male dominated has led to "male structured" treatment plans with little regard for patient gender differences thereby adversely effecting women's views of hospitals in general (Larkin, 2011). As all the participants of this study sample were female and all the treating doctors in state facilities were men, whereas all the doctors at Triple B were female, it is likely that these gender differences contributed to and influenced the participants' overall assessment of their experiences.

In addressing objective 3, it was clear that access to and information regarding support services are vital components of the treatment plan for victims of burns injuries. Victims endure mental, physical and psychological trauma and have to learn to address, cope with and adapt to any disfigurement or resulting disability (Larkin, 2011). They need support to adopt cognitive and behavioural strategies to assist their rehabilitation, and the use of certain coping strategies is beneficial to health. There are strong emotional dimensions to such treatment particularly where a victim feels redundant and unable to fulfil her previous role in the family (Larkin, 2011). Therefore, the provision of support through the dissemination of information needs to be an ongoing service.

This study is limited as it presents only one view and, in that sense, provides a restrictive and unbalanced perspective. A further study to incorporate the views and experiences of health care professionals may fuller inform as to the standard of care provision for burns victims. Patients and health professionals have different priorities and diverging perspectives, all of which carry weight. Whilst patients are often regarded as the best

placed to assess their care experiences they are more inclined to value comfort and reassurance than the standard of the doctor's clinical skills (Roy et al., 2015).

Further, attitudes can be learned and in a male dominated hospital the majority of doctors may fall in with a prevailing attitude of superiority, distance and professional arrogance which conflicts with a vulnerable patient's needs.

4.1 Conclusion and Recommendations

The findings of this study are consistent with research findings that patients' expectations of good healthcare provision are frequently not met due to a lack of patient focus and poor communication skills of doctors. The range of contributory factors identified by patients focused in the main on the overall attitudes of doctors and lack of information and direction towards support services as undermining of an effective service. Triple B, the only clinic singled out for its exemplary health care standards and exacting attitudes elicited deep concern from participants at the prospect of its potential demise should Ma'am Val retire. In light of these findings, the following recommendations are made:

- It would assist if the Filipino Department of Health implemented training in holistic and patient centered care and counselling in all state facilities with the aim of achieving non-discriminatory, supportive and compassionate practices across all heath facilities.

- The culture at Triple B needs to be preserved. It would be advisable for Triple B to construct a succession plan to secure staff consistency and retain and promote the strong, personal relationships observed between patients and Ma'am Val. This is achievable through a robustly structured training program to retain the current standard.

- Awareness of Triple B needs to be promoted to reach those patients in the wider community seeking burns treatment. Currently the network of awareness is limited to the immediate community or to those connected to previous patients and their families. There may be a reluctance on the part of the state facilities to inform patients about Triple B for fear of reducing patient numbers and thus resources and funding. If this is the case, then Triple B

5. Reflection

Prior to the research project I had always assumed undertaking qualitative research would be a simple process. I had heard of all of the concerns associated with this type of research but felt they wouldn't apply to me. Having planned and proposed my research focus to be domestic violence, as I have a particular interest in women's health, my host informed me that domestic violence victims could not be a part of my inclusion criteria as a significant number of women were uncomfortable and thus reticent about discussing their experiences and therefore participant selection would be particularly complex. However, I was assured that the study sample may nevertheless include some participants who satisfied these criteria. Unfortunately, I was soon to discover that there were no available burns victims whose injuries were a direct result of domestic violence. This required me to completely rethink the direction and focus of my research. Being an ambitious perfectionist, the situation was deeply frustrating as I felt my detailed plans were thwarted. However, I readjusted my plans and used my initiative to reconstruct a feasible project that I hope will still be of use to the organisation. On reflection, I can now see that I underestimated the difficulties that would arise from this change of direction and the extent of my disappointment that I was unable to proceed with a topic that really holds my interest and about which I feel very strongly. However, the change has been beneficial as I have spent

time researching and reading about patient care and quality improvement, a topic in respect of which my knowledge was no way near as extensive as it is now. This realisation has taught me that research is a learning experience with unexpected twists and difficulties, which whilst taxing and at times frustrating can also be immensely gratifying particularly when solutions to unforeseen problems are found. It has also taught me the importance of careful pre-planning and accurate record keeping. These experiences have given me the skills to think swiftly and effectively in the face of the unforeseen, which I hope, will enhance my approach to research and the vagaries thrown up by life in general.

Word Count: 4,874

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Appendix 1: Participant Information Sheet

Our names are Emily Marshall and Chrissie Bradley, and we are International Health students from the UK. We are carrying out some research into burns as part of our sheet will tell you more about the project, and what you will be asked to do if you take part. Please read this sheet in full and take some time to consider whether you would like to be involved. Thank you.

Background

Burn injury is very common in South East Asia, with women being disproportionately affected. Currently, there has been very little research into burn injuries in the Philippines. This project aims to understand the experiences of burns victims in the Philippines regarding burns treatment and care from healthcare professionals.

Why have you been chosen?

You have been identified by Nurse Valerie as one of her patients who has experienced burns care both in a state facility and at Triple B Care Projects.

Do you have to take part in the study?

No. There is absolutely no obligation for you to take part in this study, it is completely voluntary. You can withdraw from the study up to 24 hours after your interview has taken place. Participating in this study is unrelated to your right for future support or treatment from Triple B Care.

What will you be asked to do in the study?
You will be asked to read this information sheet carefully and decide whether you want to take part. If you are willing to take part, you will be asked to take part in an interview in Integritas House, the base of a charity (Integritas Healthcare) who work in your local area. Your travel to and from Integritas House will be reimbursed. You do not have to answer any questions you don't want to, and the interview can be stopped at any point.

Who will be present during the interview?
Yourself, the researcher and interpreter.

Will the interview be recorded?
Yes, if you agree. Otherwise notes will be made by the researcher. This recording will only be listened to by the researcher and will anonymized as soon as possible. All information will be kept confidential. Any personal information recorded will be kept separately to the recording of your interview so that they cannot be linked.

What are the risks of being involved in the study?
Some people might find it distressing talking about their burn injury. Please remember this when deciding on whether you would like to take part. You can stop the interview at any point. If you find the interview distressing at any point, you will be referred to Nurse Valerie to speak about any problems. We would ask that you also contact either one of us, or Nurse Valerie if you want to withdraw from the study (which is possible up to 24 hours after your interview).
What are the benefits of taking part in the study?
It is hoped that this research will raise awareness of burn injury in the Philippines. Furthermore, it could help Nurse Valerie in guiding her future burn education programs.

What will happen to the research results?
All personal identifiable data will be removed. The results from the interviews will be analysed and written into a report. A final copy of this report will be sent to the clinic in August, so that you can read it if you wish. Also, the findings of this study might be disseminated through conferences and publication.

Will your information be kept confidential?
All information will be kept confidential. Anyone who is present during your interview will be asked to keep all information completely confidential. After the interview all identifiable information will be removed from the interview. We may use direct quotes from you in the final report but names, addresses and any other identifiable information will be removed from the interviews. It will not be possible to trace your answers back to you from the report.

What should you do next if you want to be involved in the study?
If you would like to be part of this study, please tell the researcher or Nurse Valerie. You will then be asked to sign a consent form to confirm that you wish to be involved. If you are unable to sign the form, you will give verbal consent our loud and this will be recorded.

Appendix 2: Participant Consent Form

Consent to take part in ‘exploring the experiences of burns victims in the Philippines regarding burns treatment and care from healthcare professionals.’

	Please initial box
I confirm that I have read and understand the information sheet dated _____ explaining the above research project and I have had the opportunity to ask questions about the project.	
I understand that my participation is voluntary and that I am free to withdraw at any time up until when the interview data is anonymized, without giving any reason and without there being any negative consequences. In addition, should I not wish to answer any particular question or questions, I am free to decline. (Contact number to be inserted). Should I wish to withdrawal from the study I understand that my data will not be included in this research.	
I understand that my responses will be kept strictly confidential. I give permission for members of the research team to have access to my anonymized responses. I understand that my name will not be linked with the research materials, and I will not be identified or identifiable in the report or reports that result from the research.	

I agree for the data collected from me to be used in future research	
I agree to take part in the above research project and will inform the lead researcher should my contact details change during the project and, if necessary, afterwards.	

Name of participant	
Participant's signature	
Date	
Name of lead researcher	
Signature	
Date*	

Appendix 3: Interview Guide

Section 1
Question 1: When did you receive your burn injuries?
Question 2: Is this the first time you have been burned?
Question 3: Where did you receive treatment before Triple B Care Projects?

Section 2
Question 1: Did anyone perform First Aid?
Prompts: Run under water? Cover the burn? Painkillers?
Question 2: How long did you wait to receive treatment?
Question 3: Describe your experience of burns treatment initially?
Prompts: Any dressings? Surgery? Splints? Medicine? Complications?
Question 4: How did you hear about Triple B Care and why did you choose to get treatment there?
Question 5: Describe your experience of burns treatment from Triple B Care Projects.
Prompts: Any dressings? Surgery? Splints? Medicine? Complications?

Section 3
Question 1: Were you treated by a male or female professional?
Question 2: How would you describe the doctors and nurses attitudes towards you and your situation?

Prompts: Would you describe their response as (i) sympathetic; (ii) unsympathetic (iii) helpful (iv) unhelpful (v) respectful (vi) disrespectful (vii) friendly (viii) rude (ix) welcoming (x) professional– please provide reasons for your response

Question 3: Did they ask you how your injuries were caused?

Question 4: Did you feel you were able to discuss freely with them what had happened to you? Why? Why not?

Prompts: Is there anything that worries you about discussing your injuries and their cause with doctors/nurses, for example, issues of trust or feeling judged?

Question 5: How long did the doctor spend with you?

Prompts: Did you think this was sufficient time or would you have preferred a longer consultation? If the time was insufficient, what effect did this have on the consultation?

Question 6: Were you informed of and provided with any information regarding further help or counselling?

Question 7: Is there anything that you consider would have improved the experience of your treatment from the way the doctors and nurses behaved towards you?