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Service Delivery by Bureaucrats in Accident and Emergency Units of Selected Hopitals in Ekiti State

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ABSTRACT: *Service to the public should be satisfactorily done to fulfil public needs. It should be delivered in an effective predictable and customer-friendly manner. Bureaucratic procedures are particularly in separation and division of labour, adhering to formal rules and regulations. It has been observed that compliance with formal rules often put off innovative ideas and introduces avenue for the failure of healthcare employees. The capability of hospitals in providing adequate healthcare depends on how effective it can handle emergency health issues. Bureaucratic tendencies in the healthcare system have been a cog in the wheel of speedy care of patients. The cost and volume of bureaucratic directives has reduced the confidence of patients in public hospitals. The study, therefore, investigates patient's delight and satisfaction with the service provided in the Accident and Emergency unit in some selected hospitals in Ekiti State. The paper employs both primary and secondary sources. The study got its Primary data through structured in-depth interview with the medical staff, administrative staff and patients of the selected hospitals on bureaucratic procedures adopted in the management of patients in their Accident and Emergency (A & E) unit of the hospitals. The secondary data was from government publications, journals and articles. Data from the interview will be qualitatively analyzed using content and discursive analysis to understand the trend of bureaucratic procedures and quality of healthcare services in Ekiti State. The paper therefore recommends that Emotional intelligence training should be given to all healthcare employees. This will entail awareness and understanding of emotions and applying them to behaviour and decision making in the hospitals, Government partnership and collaboration with foreign organizations should be encouraged in order to improve on the quality of service given in the A&E unit of Nigeria Hospitals.*

KEYWORDS*:* service delivery, bureaucracy, hospitals, accident, emergency unit

INTRODUCTION

The health system in every society is expected to perform three fundamental functions of improving the health of the population, respond to people's expectations, and provide financial

protection against the cost of ill-health (WHO, 2002; Fabanwo & Okonufua, 2010).The effectiveness and efficiency of the healthcare delivery system in a state hinge, among other things, on how well its hospitals and other healthcare facilities can deliver qualitative and affordable healthcare services to its inhabitants. Consequently, the role of healthcare facilities, especially hospitals, in the healthcare service delivery system of a State cannot be overemphasized (Ojo & Popoola, 2015). However, the measure of the capability of a hospital in providing adequate healthcare may depend on how effective and efficient it can handle emergency health issues.

An Emergency Unit referred to as „Accident and Emergency Department" (AED), represents a portal of entry into a hospital for the care of diseases or injuries of patients without prior appointment either by their own means or an ambulance (Michael, Aliyu, Andesati, Grema, Musa, *et al.*, 2019). The hallmark of AED presentation is time-critical health problems requiring prompt diagnosis and medical interventions to prevent avoidable deaths and disability (Michael, *et al.*, 2019). Consequently, Emergency Unit specializes in the management of sudden and unexpected illness, major injuries and life-threatening conditions. The department provides initial treatment for a broad spectrum of illnesses and injuries, some of which may be life-threatening and require immediate attention without prior appointment (Opunabo, Paul & Kaine, 2015).

The Accident and Emergency Unity is expected not only to provide emergency care to patients but also to fulfil the needs of the providers, and the communities at large (Rasouli, Aliakbar, Nobakht, Eskandari, Mahmoodi, *et al*., 2019). Indeed, over the years, there has been an increase in global emergency healthcare service utilization largely because of increased population and increasing numbers of patients with serious illnesses or injuries requiring hospital and/or intensive care unit admission (Makama, *et al*., 2015) For instance, the English National Health Service (ENHS) recorded about 5.3 million emergency admissions in hospitals between 2012 and 2013, representing a 47% increase in ED admission over the preceding 15 years. Also, this represented about 67% of hospital bed-days and cost of approximately £12.5 billion in England (Morse, 2013). Unfortunately, data for Nigeria is not available because only a small proportion (<10%) of Nigerians are enrolled in the National Health Insurance Scheme (NHIS) (Gustafson-Wright & Schellken, 2016). However, it can be argued that the economic burden of emergency healthcare on the citizens is expected to be huge in Nigeria.

Excessive bureaucracy could negatively affect the running of an AED. For example, in Nigerian public hospitals, including General Hospitals, irrespective of the nature of health issues being brought in, the first point of call is the record unit, where patients" records are taken and kept – in most cases patients are not attended to until they have paid for and obtained „record cards". From this point through examination by medical doctors, laboratory tests down to the pharmacy where drugs are administered to patients, are usually characterized by an ineptitude service offering and delay processes. The ineptitude nature and delay have its root in bureaucratic management

dimensions of the hospitals. Besides, these hospitals, especially the Accident and Emergency Departments, are usually hierarchically managed, at times, requiring young/junior professionals taken instructions from their superiors before attending to a patient. Consequently, on the account of the bureaucratic tendency, majority of the healthcare workers have developed a poor attitude to work and this has an overbearing adverse effect on service quality to patients and their health systems. Consequently, understanding the working relationship between bureaucracy and service delivery in the context of AEDs in general hospitals will help in gaining adequate insight into how a balance in bureaucratic protocols and efficient emergency healthcare services could be achieved. It is for the foregoing reason that this study seeks to examine as well as interrogate the impacts of bureaucracy on the service delivery in Nigeria‟s General Hospitals with main focus on some selected hospitals Accident and Emergency Unit Service in Ekiti State Nigeria.

The challenges bureaucratic processes pose to timely treatment of patients that require urgent attention have recently been attracting scholarly attention. For example, Segel (2017) argues that bureaucracy is deterring healthcare in hospitals from getting better. Indeed, inefficiency in healthcare services is pervasive in public tertiary hospitals in Nigeria. According to Iloh, Ofoedu, Njoku, Okafor, *et al*. (2013), factors such as patient-related, health worker-associated and employer-associated interrelated and adversely negate the quality of healthcare services being obtained in Nigeria. The main challenge in government hospitals, especially in the AEDs of General Hospitals across the country, has been poor response and attention to patients requiring urgent attention. Indeed, many patients have lost their lives due to delay in giving prompt attention usually as a result of strict adherence to bureaucracy. In some cases, the bureaucratic process is extended more than necessary and often resulted in negligence and/or abuse of professional ethics by most health workers, especially in the emergency departments of general hospitals (Kuye & Akinwale, 2020).

Consequently, studies have revealed that bureaucratic processes often take too much time and lead to unproductivity, prevent innovative ideas and improvement, frosty and unconcerned, hindered hierarchical control, permeated with red-tapism, and subject to considerable goal displacement which is termed “bureaucratic dysfunction” (Ibietan & Oni, 2013; Maduabum, 2014; Irfan, 2016). Indeed, this routinized operating structure, most times, adversely influence quality healthcare service delivery in government-owned general hospitals, which is the main focus of the current study, especially public perception of the bureaucratic processes in the management of patients in the AEU at the selected hospitals in Ekiti State.

Another pervasive issue that informed this study has to do with the challenge of quality of services in the Nigerian healthcare industry. Indeed, and as observed before in this study, due to the delay in response and the lackadaisical attitude to work by healthcare workers, several patients‟ health systems have been thwarted. For example, what could have been done by one personnel to avert

possible frustration or death of patients in the AEU in hospitals may be extended to more than three personnel before patients could be attended to. Indeed, the deplorable conditions of service delivery due to bureaucratic processes in tertiary and public hospitals were put in perspective by Nwankwo, Ananti and Madubueze (2015) when they argued that bureaucratic line of authority, division of labour, administrative procedural rules, impersonality and waiting time are the major adverse influence to achieving quality service delivery in Nigerian public hospitals. The situation is worrisome in the Nigerian public general hospitals, especially in AEU and calls for an urgent intervention.

The major concern in this study is how bureaucratic procedures, which are put in place to enhance effectiveness and efficiency in service delivery in hospitals, have become a major clog in the wheel of emergency healthcare service delivery in the Nigerian general hospitals, especially in AEU Ekiti State Hospitals Indeed, this study is an attempt to contribute to the existing literature on how Max Webber‟s dimensions of bureaucracy as line of authority, division of labour, administrative procedural rules, impersonality and waiting time have enhanced or constrained healthcare services in Nigerian government hospitals. However, while many studies have been conducted on the interactions between bureaucratic procedures and healthcare service delivery in public hospitals in Nigeria, most of them have only harped on the perception of the management and employees of these hospitals. Consequently, to fill this identified gap in the literature, the current study would, apart from focusing on the management and employees, directly survey the attendees and patients, AEU, which are the major people concerned when it comes to investigating quality healthcare service delivery in public hospitals.

Theoretical Framework

This paper anchored on Max Weber (1946) “theory on bureaucracy”. Weber defines bureaucracy as the bedrock of public organizations “as a system aimed at achieving precision, speed, unity, unambiguous knowledge of the files, continuity, discretion, strict subordination, and reduction of friction between management and employees….” He explains that these “qualities” are capable of eliminating from official business hatred, laziness and emotion in order to enhance productivity. He went further to enumerate eight guidelines of bureaucracy which are:

1) The official activities or duties to be distributed in a fixed way
2) The staff to be competent in the chosen field and jobs to follow a systematic division of labour;
3) The staff to be subjected to strict and systematic discipline and control in the conduct of official duties;
4) All official activities to be governed by consistent system of abstract rules;

5) The organization of offices to follow the principles of hierarchy whereby each staff is under the control and supervision of a higher one;
6) Officials are to be subjected to authority only with respect to their impersonal obligations;
7) Staff are to be recruited on the basis of their technical qualifications tested by examinations or guaranteed by certificate, or both; and
8) Staff to be careerists, with a system of promotions according to seniority, achievement, or both.

The principles have been increasingly criticized over the years, especially from the 1980s as perceived to be the cause of low productivity, inefficiency and ineffectiveness in the public sector. It is also said to have led to redtapesim. Merton (1957), for example, describes bureaucracy as the source of "over-organization", that is, an excessive development of routines which impedes efficiency. Dimock (1944) examines the aspect of specialization, and concludes that "specialization tends to restrict and narrow individuals, just as hierarchy makes institutions rigid."

In spite of the criticisms, there are some other writers, including Adebayo (2001: 27) that have defended bureaucracy in the public sector. He says: …it is important that while bureaucracy has inherent elements that make its processes often cumbersome or distasteful to its publics, yet it is indispensable and indeed an instrument for the achievement of efficiency in large organizations. It is concerned with the most efficient means of planning and control, and the fact that these processes are often misused and abused by inefficient, corrupt, and stubborn officials is not a case for the total condemnation of bureaucracy (as responsible for low-productivity).

Conceptual Discourse

The term „bureaucracy" is derived from the French word *bureau*, meaning desk or office, and Greek *Kratos*, meaning rule or political power (Wikipedia, 2020). However, just like most concepts in the social sciences, bureaucracy has not been amenable to a generally acceptable definition. While the concept has emerged as a dominant feature of our contemporary world, it has equally become a perplexing term which has been a subject of different interpretations. The definitional controversies, nonetheless, the term „bureaucracy", in its modern form, has been traced to the works of the German sociologist Max Weber (1864-1920), who argued that "bureaucracy constitutes the most efficient and rational way in which human activity can be organized and that systematic processes and organized hierarchies are necessary to maintain order, maximize efficiency, and eliminate favouritism" (Wikipedia, 2020).

Consequently, bureaucracy is a specific form of organization defined by complexity, division of labour, permanence, professional management, hierarchical coordination and control, strict chain of command, and legal authority (Rockman, 2020). As a formal organization, bureaucracy is

distinguished from informal and collegial organizations. In its ideal form, bureaucracy is impersonal and rational and based on rules rather than ties of kinship, friendship, or patrimonial or charismatic authority. Indeed, from his analysis on bureaucracy, Max Weber came out with three types of authority identifiable with the forms of human existence. Thus, the Weberian conception of bureaucracy is situated within his explication of „authority" as a form of control.

According to Weber, "authority can be distinguished from power in that while power refers to any relationship in which one member can enforce his will despite resistance of the other, authority on the other hand operates when obedience to commend is based on the belief that orders are justified and it is right to obey" (Agagu, 2000: 30). Weber, therefore identified three types of authority corresponding with the three identifiable forms of human organization – traditional authority, charismatic authority, and legal-rational authority. The traditional authority is based on respect for customs and tradition. Charismatic authority is based on the sacred or outstanding characteristic or quality of the individuals. And, legal-rational authority is based on the legitimacy of the pattern of the normative rule of and the right of those who hold authority under such rules to command (Agagu, 2000: 30-31).

Weber"s conception of bureaucracy is based on legal authority. This is because he sees bureaucracy as the normal way in which legal rational authority manifests in institutional form since it is the main element regulating and controlling modern society (Agagu, 2000). Consequently, bureaucracy could be seen as a rationally and hierarchically designed to coordinate the activities or work of employees in the pursuit of largescale administrative tasks (Rockman, 2020). That is, bureaucracy is a type of formal administration with the characteristics of formal division of labour, hierarchy of authority, impersonality of social relationships and technical competence. The essence of bureaucracy is to enable large organizations to be managed to achieve efficiency and to be accountable to the people (Rockman, 2020). In other words, bureaucracy is the coordination of organizational activities for effective, efficient and economical provision of services by public and private organizations. The beauty of bureaucracy is embedded in its tendency to ensure impartiality in the treatment of clients (Agagu, 2000; Rockman, 2020).

However, recently there has been the introduction of the concept of "professional bureaucracy" to describe the power resources of professional workers in organizations. In the professional bureaucracy, the power resources of professional workers are salient, meaning that these workers have great autonomy and freedom to implement their work based on their knowledge and professional skills (Mintzberg, 1983). The professional bureaucratic organizational form differs from what Mintzberg refers to as the machine bureaucracy, the traditional form consistent with Max Weber"s classical definition. The machine bureaucracy is a hierarchical form of organization in which both managers and employees have well-defined work positions and specified duties, and

work processes are coordinated by predesigned standards that determine what is to be done (Andreasson, *et al*., 2017). In the professional bureaucracy, the professional workers consist of specialists with comprehensive control over their own work, which means that the managers often have a hidden role in implementing the organization‟s goals. In Mintzberg‟s (1983) model, the function of managers is primarily to support the professional workers. The work standards and institutional scripts or norms the professional workers follow originate outside the organization‟s own structure, for example, from regulatory institutions or are defined by other authorities. This also influences the power of managers to conduct their work and, in particular, their ability to steer professional workers. The authority of professional organizations relies more on the professions and the power of expertise than on top-down steering. The professionals also work autonomously from their colleagues but close to their clients, for example, patients (Glouberman & Mintzberg, 2001; Mintzberg, 1983).

In the case of healthcare, professionals have well-defined skills and have learned how to undertake their tasks in a professional and specific manner (Berlin & Kastberg, 2011; Glouberman & Mintzberg, 2001). Implementing new ideas in the professional bureaucracy can be difficult, depending on the professional workers‟ potential reluctance to adapt to change (Mintzberg, 1983). The professional bureaucracy has a clear bottom-up decision-making structure in which both independent professionals and strategic managers must agree to proposed changes. This makes the professional bureaucracy a rigid structure that functions well in producing standardized outputs but is slow to adapt to change and alter production methods (Mintzberg, 1983). The power to change organizations is according to Mintzberg (1983) conditional on the manager‟s ability to involve employees in development work. Manager knowledge of change management is also crucial for the possibility of working with organizational development (Andreasson et al., 2015; Glouberman & Mintzberg, 2001; Kotter, 1996; Mintzberg, 1983).

Thus, whether Weber‟s bureaucracy or Mintzberg‟s professional bureaucracy, it is possible to isolate certain bureaucratic elements that impact healthcare management in hospitals, especially in Nigeria. The bureaucratic attributes examine are: bureaucratic impersonality, division of labour, administrative procedures, rules, and policies, and patients‟ waiting time/turnaround period. These are thematically examined below.

Bureaucratic Impersonality

The dysfunctional feature of bureaucracy is evident in the Nigerian situation and it has eaten deep into her national fabrics. This dysfunctional nature has branded public service with hatred, loathing and jealousy, rather than fostering a spirit of oneness, cooperation and teamwork to achieve a goal of delighting members of the public when it comes to offering public services. This attitude of hatred and loathing occur among peers, superiors and subordinates in Nigeria public offices as

well as hospitals (Maduabum, 2014), and this precludes the workers from giving quality services to the members of the public. In addition to this, the Nigeria bureaucracies are marred with corruption, inefficiency and overstaffed offices (Lawal, Kirfi & Balarabe, 2013). This confirms the report of Udoji of 1974 in Nigeria which reproaches Nigerian bureaucracies of prejudice and favouritism, ethnic fidelity and affinity, dishonesty, incompetency of boss to entrust and assign tasks and duties to subordinate, incompetence among young staff in carrying out delegated assignments, lack of necessary skills, knowledge in coordinating public services, inability to stick to deadlines and ineptitudes in productivity (Kuye & Akinwale, 2020).

Consequently, this study assumes that the adoption of bureaucratic procedures in the management of general hospitals in Nigeria, especially the A&E departments, may likely negatively impact desirable quality service delivery. Thus, in view of the explanation under this conceptual review, we can postulate that "bureaucratic impersonality does not favourably impact on quality service delivery in Ekiti Hospital's A&Es."

Separation and Division of Labour

The concept of separation and division of labour is an integral element of bureaucracy. It shows a stable corporate organisation, managing individuals or teams that are working on different but integrated tasks. The origin of division of labour has its root in classical political economy, the precedent to contemporary economics (Gupta, Gauri & Khemani, 2015). The division of healthcare personnel has a hierarchical component inherently fused in the organisation. One purpose of separation of health workers or dividing job functions according to skill sets and the experience is to apportion work to people who have the competence and can better handle such a job function effectively. Studies have shown the merits of careful consideration of the efficient separation of medical workers and workflow (Hughes, 2015). Regarding division of labour in healthcare management, it would appear that the delivery of healthcare service is susceptible to striking a balance between public demand for quality service and the supply of the right workforce Schoenfelder, Klewer & Kugker, 2011). Division of labour is appropriate but a situation whereby an aspect of the workforce is posing a challenge in giving timely attention to a patient will cause dissatisfaction and patients with urgent medical needs may develop complication or their condition might worsen due to delay in giving prompt attention from a division of the workforce. The delay in progress as a result of division of labour is connected with the service delivery in healthcare has made bureaucracy unacceptable to members of the public. It is this delay that has made the division of health workers‟ tasks in the hospital becoming too cumbersome and challenging for patients to be satisfied with the management of hospitals and this has rendered quality service inaccessible. Furthermore, the division of labour among health-workers gives room for over-dependence on a particular division especially when the team is not available at a given time or partial non visibility occur when a patient wants to access them. A favourable example in support of this is the record

division of the hospital. At times, when the staff on duty is absent for a known reason and a patient is willing to consult a medical doctor, without the record unit to fetch-out the patient file, accessing medical treatment becomes difficult. Also, if a medical doctor is not on the desk when a patient‟s file is passed forward, to see a doctor may also be quite difficult for such a patient. Therefore, this study predicts that the concept of division of labour hinders progressive service delivery in public hospitals in Nigeria.

Administrative Procedures, Rules and Policies

Another major characteristic of bureaucracy usually being adopted in healthcare sector is the administrative procedure. Indeed, administrative procedures, rules and policies in the management of healthcare centres, especially tertiary hospitals, could have significant impact on the quality of service provided to patients. However, these administrative procedures, rules and policies are usually found in all bureaucratic organisations. They are crucial such that virtually every healthcare worker manifests the administrative designation in their job descriptions (Kuye & Akinwale, 2020). Carefully constructed policies are fashioned-out, maintained, and passed on to all healthcare workforce and strict adherence is authorised. Regular orientation to these administrative procedures of bureaucratic processes is mandated and job task is frequently defined by these policies and rules (Egeberg, 2012).

Administrative procedures, rules and policies aspect of bureaucracy is argued by several contemporary thinkers as being diametrically opposed to innovation and creativity (Knill & Grobs, 2015). However, administrative rules and policies are not sufficed to elicit quality service delivery in healthcare management (Kuye & Akinwale, 2020). Such a situation needs flexibility in attending to patients as different strokes for different folks. Within bureaucratic firms, rules are the major features of formal organisations, where formal rules and regulations are employed to stipulate what individuals in corporate firms have to do (Knill & Grobs, 2015). Unfortunately, the idea of adhering to formal rules streamlines the chances open to healthcare staff to not only be involved in the formulation of objectives and goals but also even to use their own initiative on the possible means of conducting their job task.

Consequently, this has an overbearing effect on the quality of service delivery to patients being attended to. As the rules have its attendant difficulty on health employees so also it may hamper the satisfaction of patients and attendees visiting the hospitals. For this reason, health-care workforce in bureaucratic firms could be inhibited by the bureaucratic practice of control, which impede the multiplicative tendencies of the workforce and suppress their capabilities in producing innovative ideas and this has a resultant effect in the delivery of quality service to patients visiting the hospitals (Trondal & Veggeland, 2013). Thus, it could be argued that administrative procedure, rules and policies in the management of tertiary hospitals AEDs in Nigeria may likely deter quality service delivery.

Waiting Time/Turnaround Period

Another component of bureaucratic processes in the management of tertiary and government hospitals is the waiting time or turnaround moment in attending to patients/attendees visiting the healthcare centres. Patients visiting hospitals for medical attention exhaust an extensive period of time in the clinics waiting for services to be delivered by physicians and other health-related professionals. The rate at which health consumers are not satisfied with the care obtained is strongly associated with the waiting time experience. Healthcare organizations that seek to deliver par excellence services must be keen to manage their clinics‟ waiting time (Ballini, Negro, Maltoni, Vignatelli, *et al.*, 2015). Inability to integrate consumer/patient-focused components into the structure of the waiting experience could result in patient dissatisfaction.

Waiting time is expressed as the amount of time a patient spends in the clinic before being attended to by any of the clinic health worker (Oche & Adam, 2013). Patients clinic waiting time is a critical pointer of quality services delivered by hospitals (Chen, Li, Yamawuchi, Kato, Naganwa & Miao, 2010). The amount of time it takes a patient to wait before being attended to is determinant element that influences the utilization of healthcare services (Kuye & Akinwale, 2020). Consequently, patients may see protracted waiting time as a challenge to offering quality services in hospitals. Keeping patients waiting pointlessly may lead to tension and anxiety for patients and their relatives. Waiting time is one of the parameters in which health workforce quality service delivery is determined, even more than their competence, knowledge, and skill (Kuye & Akinwale, 2020).

Thus, going by impersonality dimension, division of labour, administrative procedures, rules and policies of bureaucratic processes, waiting time on outcome of patient in hospitals may not witness the improved process and outcome. Studies have discovered that several times in public hospitals, patients may have to wait for a very long period of time before getting the attention of doctors and pharmacists. This may not be unconnected with the paucity of the employees available to the hospitals at a given time (Kamil & Lyan, 2013; Sun, Lin, Zhao, Zhang, Xu, *et al*., 2017; Yahya, Shahimi, & Abdullahi, 2015). Further argument by several authorities established that patients‟ dissatisfaction alongside the astronomically high waiting time, poor service quality, drugs that are not relevant for the treatment of ailment complained upon, and poor treatment are increasingly attracting serious concern from experts and several other world health organisations. This is the fall-out from public service that is not backed up by strong laws but hampered by bureaucratic processes (Carson, Carson, Knouse, & Roe, 2014). Therefore, this study envisages that turnaround time and patient’s waiting time does not reflect on quality service delivery in A&Es of Ekiti State sampled Hospitals.

Accident and Emergency Healthcare

Hospitals have always had to make arrangements for those who arrive at their doors seeking help. Over the years, as the world population grows, the numbers and complexity of problems presenting in this way have increased at an exponential rate. This increase in demand has been managed in divergent ways in different countries. It has, however, given birth to a new medical specialty, that of accident and emergency (A&E) medicine or emergency medicine (Sakr & Wardrope, 2000). The A&E department is the "shop window" of acute hospitals. It is the part of the hospital most closely in contact with the public as it offers the most informal access (Lowden, 1956, cited in Sakr & Wardrope, 2000: 314). Indeed, it is the first point of contact with the health system for many people, providing timely recognition of time-sensitive conditions, resuscitation and referral for severely ill patients, and the delivery of definitive care for many others (WHO, 2019). Especially when there are barriers to accessing health care, people may seek care only when they are acutely ill or injured.

Consequently, the A&E is an integrated platform to deliver time-sensitive healthcare services for acute illness and injury across the life course. It is the eye of the hospital receiving and stabilizing patient before either discharge or send to wards for further treatment. It provides a system that delivers services which extend from care at the scene through transport and emergency unit care, and it ensures access to early operative and critical care when needed (WHO, 2019). The A&E Departments (AEDs) are intended to deal with critical or life-threatening incidents rather than minor injuries or illnesses. They must meet an uncertain demand from patients. Consequently, emergency health care is an essential element of universal health coverage, responding to a range of acute conditions in children and adults, including injuries, infections, acute exacerbations of non-communicable diseases, and complications of pregnancy (WHO, 2019). Effective emergency care systems are designed to respond rapidly to people‟s acute needs even before a diagnosis is known, and they ensure continuity of care and safe transition from the primary through the secondary to the tertiary level of the health system.

The Nigerian Policy on Emergency Medical Services (EMS) states that the goal of emergency care in Nigeria is to get people safely from the world into the hospital, from the site of acute injury or illness to definitive care (Federal Ministry of Health, 2016). According to the EMS policy A&E provides emergency medical care for all types of emergencies such as medical, surgical, Obstetrics & gynecological, pediatric emergencies, accident and intentional injuries, disasters and epidemics (FMH, 2016). The objective of the EMS is to reach those in need of urgent medical care in order to satisfactorily treat the presenting conditions, from the scene of the incidents to the point of definitive care, most likely an emergency department of a hospital. EMS thus involves a continuum of pre-hospital, hospital and rehabilitative care and the linkages between the components, including but not limited to emergency personnel, emergency communication system, Emergency

Infrastructure, integrated emergency ambulance service system, emergency equipment and a functional trauma system in the receiving facility (FMH, 2016).

Section 5.7 of the Nigerian EMS Policy provides among other things that "the A&E units of all hospitals (Federal & States) must be ready to receive patients 24/7; must have qualified emergency personnel on ground 24hrs a day; ...shall have emergency lines open 24/7; …and shall ensure Compulsory prompt treatment of emergency patient without requirement for Police report or payment of deposit" (FMH, 2016: 21). Despite providing for „compulsory prompt treatment emergency patient", the EMS policy does not specify waiting time of patients from arrival until seen by a doctor or trained nurse. This is very important to measure performance and quality of healthcare service delivery in the A&Es. For example, the United Kingdom Department of Health introduced measures for A&Es in 1997 and these have taken two forms:

1. Waiting time of patients from arrival until seen by a doctor or a trained nurse. The target was set at 15 minutes when introduced in 1997 (Department of Health, 1997). As might be expected, the introduction of this target led to gaming and some A&Es employed a "welcome nurse", given the task of seeing each patient within 15 minutes of their arrival, but doing little or nothing to treat them.

2. Total time of patients in A&E, measured from arrival to discharge or admission. This was introduced in 2002 and replaced the 1997 measure. A&E Departments are required to measure the % of patients whose total time in A&E exceeds 4 hours. Currently, these breaches must not exceed 2 %. Though this target presents fewer opportunities for gaming, there is the risk that patients will be discharged too soon or admitted prematurely as inpatients. The former could lead to poor quality of care and the latter could transfer the pressure elsewhere in the hospital (Gunal & Pidd, 2006: 466-467).

3.

However, some scholars have found issues with the performance target in A&E departments. For example, Locker and Mason (2005) note, in the case of A&Es in the UK, that 1 in 8 patients who are admitted to hospital are moved out of A&E just before their stay would breach the 4-hour target. Consequently, it seems clear that the 4-hour target and the small number of breaches allowed are affecting the performance of A&E departments in England. Furthermore, there may be risk of compromised clinical standards just to squeezed out problems out of A&E into the rest of the hospital just to meet performance targets. Indeed, given the complexity of some case being presented to A&Es, setting discharge time may be out of place. For example, it may not be uncommon to see a change in case mix with many people attending A&E with minor injury, especially in elderly people, many of which are attributable to other medical problems (Gunal & Pidd, 2006). Indeed, patients may present other problems that will influence management. Thus,

while it would be foolish to set discharge time, it is wise and important to set waiting time to ensure that patients are promptly cared for.

To ensure effective and efficient patient management and to avoid overcrowding of the A&Es, most facilities employed „triage system". In Nigeria, A&E departments are required to use a 4colour triage system to assessed patients for actions – Red, Yellow, Green, and Black (FMH, 2016). In this, Red is the most severe case and require immediate advanced medical care that must not exceed an hour at most. The Red signifies critical condition and the patient would die without immediate assistance. Yellow means the patient"s condition is stable but require medical assistance. Green means the patient only has minor injury and may not require advanced medical care for at least several hours. Patients in this category are able to walk without help, and may only require bandages and antiseptic. The fourth category, Black, means the case has no remedy as the patient is confirmed „dead". (FMH, 2016). Patients in A&E departments in Nigeria are usually triaged into 3 categories as Minor, Major and Life Threatening except for cases of „brought in dead" (BID). The triage system is thus crucial for the effective patient management in the A&E departments.

METHODOLOGY AND STUDY AREA

The paper employed a comprehensive plan for data collection in an empirical research project. A case study research design was employed for collection and analysis of data from health workers, administrative staff, and patients in the A&E departments in the selected Hospitals in Ekiti State, data was collected using a combination of interviews, personal observations, and administrative document. This study considered the A&E department of the sampled Hospital in Ekiti State. The staff and patients that were currently working or receiving treatment at this department at the time of this research respectively constituted the study population. Thus, the criterion of inclusion in the research was to be a staff in the A&E department or patients currently receiving treatment in the facility.

This study considered staff and patients of A&E department of Ekiti State as the study population from which samples were selected. This study adopted a purposive sampling method. Purposive sampling, otherwise known as judgmental sampling, this study adopted the stakeholder purposive sampling to select healthcare givers – doctors and nurses, paramedics – health assistants and attendants, health information record officials, management members – Head of Department, Matron, and Secretary, and patients in the A&E Department in Ekiti State. in-depth interview on bureaucratic procedures adopted in the management of patients in the A&E and how this impact on quality healthcare. The staff in the A&E were interviewed to gain insight into the bureaucratic process put in place in the management of the department, while patients were interviewed to know how such measures have impact the quality of healthcare they received.

In all, 40 interviews were conducted by the researcher for this study. This includes 18 health workers and administrative staff, and 22 patients. However, it must be stated that most of the interview respondents, especially staff of the hospital, granted interviews under the condition of anonymity. That is, most respondents only agreed to grant interview when the researcher assured them, she would not disclose their names or official status (positions currently hold) in the A&E. Also, the same procedure was adopted in the interviews with patients.

Data for the study was collected from both primary and secondary sources. Primary data was collected mainly through in-depth interviews with respondents. Interviews were usually formal and of a semi-structured nature. The interview protocol made use of interview schedule containing guiding questions, which were open to follow-up and in-depth probing into other issues raised during the interview process. The interview schedule was splited into two separate categories – 1) healthcare givers and administrative staff, and 2) patients. Also, primary data were collected through personal observation The researcher took note of such things as availability of beds, promptness at receiving and commencement of treatment of patients, attitude of health workers to patients or the relationship between care givers and patients, hygiene of the A&E wards, etc. to buttress or refute information provided during interviews. Furthermore, secondary data were collected for the study through administrative rulebook guiding the operation of the A&E department and other relevant documents were made available for the research.

Data collected were content analysed. The primary data were tape recorded, transcribed, coded and later analysed based on the objectives of the study. Data collected were systematically examined in order to understand contexts, patterns and trends, which the research questions were set out to establish. Consequently, data of the interviews and observation were closely cross-examined against those of the secondary data to understand trends, similarities and dissimilarities in peoples experiences of bureaucratic procedures and quality of healthcare services in the A&E of selected hospitals in Ekiti State. Thus, both the secondary and primary textual data were subjected to the same critical perspectives to understand the underlying meanings behind the research work.

The study was carried out in some selected hospital across the three tiers of administration in Ekiti State. The Primary Healthcare which belongs to the local government; the General hospitals for the State and the Teaching Hospital. Specifically, data for the study was collected in the A&E departments of the hospital.

Hospital's mission is to provide safe, quality, affordable, adequate, equitable, and accessible health services to all Nigerians. In addressing ethical issues in the study, I assured the interview respondents that the study would not be injurious to them for participating in the study.

Respondents' opinion to withhold their identities were respected. Consequently, most respondents were identified in an occupational capacity rather than being identified by name.

RESULT OF FINDING

Bureaucratic Impersonality

Participants in the study, were asked questions bothering on the issue of bureaucratic impersonality and how it impacts patient management or quality healthcare service delivery in the A&E department at the selected hospitals. Staff participants (health workers and administrative staff) in the study stated that the management of the A&E Department is based on strict adherence to rules and regulations. They stated that the Department is hierarchically structured with a head of department (HOD), a Medical Consultant, who is both the medical and administrative head of the department. There is equally a Matron, who is the nursing head of the department as well as a secretary, who is the administrative head. Thus, the management model in the A&E Department is the governance model, which is commonly used in Nigeria, where the main responsibility for running clinical departments usually lies with a doctor, either alone or together with a general manager and a nurse.

Furthermore, participants told that staff conducts were guided by impartial rules and regulations that apportion rewards and sanctions accordingly. Above all, interviewees stated that patient management in the A&E are based on impersonality and patients are treated on the basis of first come first serve or on the basis of their health conditions. However, irrespective of patients" health conditions when they arrived or brought in, staff, particularly healthcare workers (doctors, nurses and paramedics) are expected to attend to the patients impartially. Furthermore, the relationship between staff and patients are expected to be formal but cordial so as to give patients quality healthcare without favouritism. For instance, a senior medical consultant interviewed noted that:

> We (healthcare workers) are professionals and are not expected to perform our duties based on emotions or primordial connections even when maintaining some level of cordiality with our patients. We are guided by both administrative and professional ethical procedures, which require that we treat our clients (patients) impartially and cordially while keeping their medical records secret. We are not expected to be unnecessarily emotionally attached to a patient to give her/him unwarranted an edge over other patients. That is, our relationship with patients must not go beyond what may be considered normal patient-caregiver relationship, even when these patients are known to us. For instance, I cannot say because my patient is my son or wife, he/she should enjoy undue advantages over other patients who may not know anyone. Furthermore, in the

> A&E department, we are dealing with emergency health conditions that require immediate and/or spontaneous attention. In this kind of situation, you cannot abandon a patient just because someone being rushed in is known to you except you are sure the person you are attending to is now in a very stable health condition and you are required to render other emergency medical help. For instance, you may be the only brain surgeon on duty and a newly brought in patient needs an emergency brain surgery. Ethically, you are required to stabilise the patient or have him/her attended to by another doctor on duty who could not perform the emergency surgery required by the new patient. But, you cannot just leave the patient because there is another emergency. In such a critical moment the principle of first come first serve may come in. However, this is just hypothetical because, in most cases, the A&E has adequate medical personnel.
>
> What am saying, in essence, is that caregivers (doctors or nurses) are expected to discharge their duties promptly and without favouritism, particularly in the A&E. Anything short of this is professionally unethical and may lead to stringent sanction. (Interview with a Senior Medical Consultant at Ekiti A&E Department, June, 11, 2022).

Consequently, patient management in the Ekiti A&E department is based on the bureaucratic principle of impersonality and both caregivers (doctors, nurses, and paramedics) and administrative staff are expected to attend to patients impartially. For instance, an interlocutor, a cashier, said "I have offended some people, particularly relations or neighbour, who may want to shunt queues because I know them. At times, there may be a very long queue and some people may be impatient. So, they feel because they know you, you just have to attend to them immediately irrespective of their position on the queue. Most people do not understand that we are und er obligations to attend to everyone without bias" (Interview with a Cashier at the A&E Department, June 11, 2022).

However, some patients interviewed did not agree that staff, particularly administrative staff, discharge their duties impartially. For example, a patient stated that "some of these people who work in the Bank (Payment Point) have a way of helping people who are either known to them or their colleagues to jump the queue. At times, you see some of their colleagues entering into their cubicle to make payment on behalf of their friends or relatives, while the leave people on the queue. Sometimes, this may affect prompt medical attention, especially purchase of some medications a patient needs urgently, since the payment receipt is needed to get drugs from the pharmacy" (Interview with a patient at the A&E Department of June 14, 2022). Similarly, some patients said

preferential treatments are accorded certain patients (elites) in terms of ward or bed spaces. They said these patients are usually not put in the general ward or are given special bed and beddings. However, as an insider (a staff at A&E), the researcher knows that the preferential treatment may have to do either health condition or willingness to make preferential payment. For instance, because of their health conditions, some patients would have to be isolated from other patients in the different zones created by the unit.

However, majority of the interviewees (both patients and staff) believed that the bureaucratic principle of impersonality did not negatively impact the quality of patient management and/or healthcare delivery in the A&E department. Indeed, majority of the interviewed patients stated that they are being attended to promptly and impartially, particularly by the caregivers. The opinion of the husband of a patient, who could not talk to the researcher because of her critical condition, clearly summarises the views of most of the interviewees. He noted that one did not need to know anyone in the A&E before s/he was given adequate medical treatment, particularly when a patient ju st arrived. In his own words:

> As you could have seen for yourself, about 5 persons have been brought in since we started talking and all of them were received and attended to promptly. They do not need any connection before they were attended to. This was the same way we were treated the first day we came. Though, after the initial sessions of treatment, which I think is to put patients in stable conditions, I can say some patients enjoy some preferential treatments. This may, however, be due to their health conditions and not who they know. For instance, my wife was seen by different doctors within the first 5 hours of our arrival. The following day was not too different from our experience the first day in terms of number of doctors who examined her. But, today, apart from normal ward round in the morning when a doctor examined her, she has since only been attended to by nurses, administering injections or drugs. However, at times, I notice that some patients enjoy preferential treatment based on man know man. Well, this is Nigeria, where one cannot totally rule such out. But, largely, I can say everyone is treated almost fairly impartially. This may be the reason why some people prefer the A&E to other departments even when their health conditions may not really be critical or life threatening (Interview with a patient's relative at the A&E Department, June 14, 2022).

Separation/Division of Labour

The idea of separation and division of labour is a sociological concept with considerable relevance for healthcare professionals. The idea is one which calls for effectiveness and productivity and which allows healthcare professionals to maintain a coordinated task function divisible according to skills and competence. Thus, participants, particularly the staff, in the study stated that there was a hierarchical reporting structure and clear division of labour in the A&E Department at IGH. An interlocutor, a medical doctor, said:

> the A&E, just like the entire hospital, is hierarchically structured and there exists separation and division of work between healthcare workers – doctors, nurses, pharmacists, and paramedics – on the one hand, and between healthcare workers and administrative staff. Apart from this and despite that the A&E is expected to provide caring for undifferentiated, unscheduled and unprepared patients, which mostly represents the hospital-based generalist physician, as healthcare demands evolve, there has been growing consideration of the role of subspecialist that requires specialists concentrate on a narrow field of practice. In other words, the medical practice in the A&E is based on subspecialties of the caregivers, particularly medical doctors. For instance, the proven benefit of stroke specialist team care and primary reperfusion therapy for ST-elevation myocardial infarction, clearly demonstrate the need for sub-specialization or division of work among health caregivers, even in A&E which is a subspecialty in itself. Consequently, work schedules are based on specialization and level of training (Interview with a Medical Doctor at the Ekiti A&E Department, June 14 2022). Field source.

However, because of the metaphoric assumption that division of labour underline "professional struggle" and/or "professional dominance". Professional dominance is a theory about doctors and their control over healthcare work. The researcher, therefore, sought to know whether the division of labour, particularly the professional dominance of doctors, was a source of tensions among health caregivers (doctors, nurses, laboratory scientists, and pharmacists) and whether the tension negatively affect patient management or quality care being received by patients. Virtually all health caregivers who participated in the study stated that there existed cordiality and coordinated working relationships among all the health professionals and that no profession dominated others since everyone/profession is a specialty in itself. Also, they noted that the primary objective of all professions in the A&E was the quality healthcare given to patients irrespective of who heads the Department. For example, a very senior nurse stated that:

> I have never experienced or noticed any tension among healthcare workers in this Department. I can say that I have spent most of my working years in this general hospital here in the A&E unit. Being that as it may, it is not uncommon to experience occasional conflict where two or more people interact. But, most conflicts I have witnessed here are not professional and, even when they are professional, they are majorly on the best way to care for patients and have nothing to do with professional superiority. And these are mostly resolved in the best interest of our patients, which is always the ultimate goal – quality care for patients (Interview with a Senior Nurse at the A&E Department, June 14, 2022). Field source.

Consequently, findings of the study reveal that separation and division of labour among health caregivers have no significant effect on patient management and quality service delivery in the A&E Department. However, the opinion of virtually all patients or their relatives who participated in the study differ greatly from this position. Most attendees believed that separation and division of labour sometimes cause unnecessary delay in giving medical attention to patients. For instance, virtually all patients interviewed complained about the separation between cash points and the pharmacy. A patient stated that:

> …as you could see for yourself, to buy medications, however urgent it is, you would first go to the pharmacy, within the A&E, with doctor‟s prescriptions for costing. Then you go to the bank to pay before going back to the pharmacy with evidence of payment before drugs are dispensed. At times, it takes about 30 minutes or more to complete a circle, depending on the crowd. Anything could have happened as one transverses the pharmacy and the bank. Apart from this, imagine what could happen to a patient who does not have someone to run the errands
> (Interview with one of the relative of patient A&E
> Department, June, 2022).

Similarly, another participant stated that:

> Before a patient's blood or other samples are tested in the laboratory, you will first take the samples to the laboratory with doctor's test requests. You then go to the bank to make payment and go back to the laboratory with evidence of payment. That is when the samples would be taken for screening by the lab scientists. This cause unnecessary delay in diagnosing a patient's health challenge

> and commencement of adequate treatment. Apart from this, the samples are given to the relatives of patients to be taken to the laboratory. Anything could happen to the samples since these people are not medical practitioners (Interview with a patient's relation, at the A&E Department, June, 2022). Field source.

Consequently, unlike staff participants, attendees who participated in the study argued that separation and division of labour often caused unnecessary delay and negatively impact on the quality-of-service delivery. In fact, most of the participants equally spoke about the lackadaisical attitudes of staff in the record section. Patients are not being attended to promptly and, at times, the policy of "emergency card" is abused as returning patients are often issued a new card instead of promptly looking for his/her old card through which caregivers could have insights into the health history of the patient.

Procedures, Rules and Policies/Patient's Waiting Time

Here the researcher sought answers to procedures, rules and policies of admitting patients to the A&E facility as well as patients" waiting time or turnaround period in the facility. Specifically, the researcher wanted to know whether or not any triage system was adopted in screening outpatients before admission to the A&E facility. Participants stated that there was no any triage procedure in place in the A&E to determine severity of patients" illness/sickness when they are being admitted. Instead, health caregivers rely mostly on information from patients or their relatives and laboratory screening to determine the severity of illness and the nature of treatment required. For instance, a medical consultant in the A&E said:

> We do not triage for now. The facility and/or personnel requirements for triaging are not yet in place. The procedure being used presently to is still the interview model. Here, a doctor asks a patient or a close relative (may a spouse) series of questions to determine first and foremost first aid needs of the patient and to know the type of tests require for further diagnosis and treatment (Interview with a Consultant at the A&E Department, June 11, 2022).

Similarly, there is no policies or rules in place on patients" waiting time before being attended to in the A&E. Participants only mentioned that the policy is that patients must be attended to immediately, they get to the facility. Furthermore, turnaround period is affected by the severity of a patient's illness and availability of bed space. An interviewee stated that:

> In the A&E, by rule, treatment must commence immediately a patient comes into the facility. The main objective is to save life first in the A&E. So, irrespective of whether payment is made or not,

> treatment must commence at least to put the patient in a stable condition. Then, depending on the severity of a patient illness or injury, a patient may be discharged the same day he/she comes in or within twenty-four hours. However, even after stabilizing some patients, they may require further observation or treatment. In some of these cases and to avoid overcrowding the A&E, some of the patients may be transferred to other facilities or departments within the hospital for further medical attention. So, the turnaround period in the A&E varies, depending largely on severity of patients‟ illness or injury or availability of bed space (Interview with a Medical Doctor at the A&E Department, June 10, 2021). Field source.

Furthermore, participants stated that while there are laydown rules and policies that must be followed in the management of patients, these rules or policies are not cast in stone and iron. They noted that healthcare workers are allowed to be innovative in using initiatives in the management of patients so long such do not contravene any known medical procedures. That is, bureaucratic procedures may not be strictly adhered to by healthcare workers in the management of patients in the A&E. However, caregivers are expected to state clearly whatever procedures being adopted in the management of any patient in their reports. Also, there is usually weekly and monthly health workers meeting where issues of procedures in patients‟ management are debated and/or fine-tuned to meet the international best practices, especially in emergency medicine.

DISCUSSION OF FINDINGS

The study has exhibited significant outcome regarding the results presented above in relation to bureaucracy and patient management in the A&E Department of the Hospital Ekiti State, Nigeria. The results of the study demonstrate that there is no significant relationship between bureaucratic impersonality and quality patient management and healthcare service delivery in the A&E Department. By implication, this shows that impersonality and personal differences speak great volume on efficiency through impersonal conduct of an individual and firm adherence to rules and regulations governing the policies of the Department. Indeed, most of the patients and their relatives, who participated in the study, confirmed that health caregivers are always eager to attend to most of them promptly when it comes to giving medical attention and positively affects the quality of care being received at the facility. Healthcare service is critical to human endeavour, the finding discovered that impersonality and impartiality are pervasive among healthcare workers in the A&E Department. Also, findings showed that patients are giving quick attention and quality care. The result depicts that bureaucratic impersonality positively impacts on patient management quality service delivery in the A&E Department. This finding is asymmetrical with the study of Kuye and Akiwale (2020), whose study discovered that bureaucracy has a negative influence on the quality of service delivery in government hospitals in Nigeria.

Furthermore, while the idea of separation and division of labour in hospitals is a good one which calls for effectiveness and productivity, the study has discovered that separation and division of labour among health workers have no significant effect on quality patient management and service delivery in the A&E Department at Ekiti hospitals. The study discovered that the division of labour usually brings about an unnecessary delay in giving medical attention to patients visiting the facility. The study confirmed that in the record section of the hospitals, patients are usually made to queue indefinitely before being attended to. Another aspect is the pharmacy and laboratory section where patients experience a great challenge for drugs to be dispensed to them or for tests to be conducted. This finding takes a similar position with the study of Lavander et al. (2017) which concludes that challenges and issues in developing the division of labour were associated with personal experience, technical know-how, and firm's elements vis-à-vis attitudes, predispositions regarding competence and the restrictions and uncertainty of health-care labour.

Moreover, findings of the study indicate that administrative procedure, rules, and policies does not serve as a deterrent to quality patient management and service delivery in the A&E Department. The study revealed that formal rules and standard operating procedures in the A&E Department did not usually deter patients from experiencing quality care in the facility. Formal rules and policies did not often lead to issues and challenges that outpatients encounter when visiting hospitals. The study established that formal rules and regulations did not prevent health workers from being creative and innovative in the discharge of their duties. This finding is contrary to the argument of Trondal and Veggeland (2013), who maintained that formal rules and regulations of bureaucracy inhibit and impede the multiplicative tendencies of the workforce and suppress their capabilities in producing innovative ideas.

Finally, the study shows that patients‟ waiting time/turnaround period of attending to patients does not impact negatively on quality service delivery in the A&E Department a. The study discovered that patients are attended to promptly by health caregivers and usually spend an average of 5 minutes before obtaining medical attention. This finding is not consistent with the result of Sun et al. (2017) whose position was that several times in public hospitals, patients may have to wait for a very long time before getting the attention of doctors and pharmacists, as this may not be unconnected with the paucity of the employees available to the hospitals at a given time. Also, this finding is not in consonance with the study of Carson et al. (2014) which held that patients' dissatisfaction alongside astronomically high waiting time, poor service quality, the absence of the prescribed drugs for the treatment of ailments complained of and poor treatment is not necessarily a result of inadequate laws but bureaucratic process*es.*

CONCLUSION

Bureaucratic tendencies in the healthcare systems may be a cog in the wheel of speedy care for patients. Bureaucratic processes in hospitals tend to engender inflexibility and rigour. Consequently, compliance with formal rules and regulations rather put-off innovative ideas and introduces avenues for accepting responsibility for the failures of healthcare employees. This is why, often times, when error occurs in hospitals, they never accept that the mistake was as a result of the negligence of the staff on duty. Also, impersonality in bureaucracy stresses a mechanical means of getting work done faster while organisational rules and regulations are given high precedence over an individual's emotions. The overall outcome of this study largely indicates that patients are not delighted and satisfied with the service provided in the A&E Department due basically to bureaucratic procedures, particularly separation and division of labour. Thus, this study concludes that formal rules and regulations of bureaucracy and other features of bureaucracy are to be properly applied in the management of hospitals or patients in Nigeria.

Recommendation

The paper recommends the followings for improving quality of healthcare service delivery in Nigeria:

1. The cost of bureaucracy and volume of bureaucratic directives should be drastically decreased in order for patients to have confidence in public hospitals. This is another reason some wealthy patients seek medical attention oversea due to prompt attention.

2. Qualified and zealous personnel should be matched with certain units such as record point, pharmacy, laboratory, and cash payment point.

3. The management of both federal and state-owned hospitals in Nigeria should allow and encourage patients‟ feedback after they have received medical treatment and attention. This will enable the management a clearer understanding of where improvement is required in service delivery.

4. Emotional intelligence training should be given to all healthcare employees. This entails awareness and understanding of emotions and applying them to behaviour and decision making. This will help in awareness and management of their own emotions and patients' emotions. In the end, they will leave the patients better-off by treating them well with the right attitude and right spirit.

5. The government should also motivate healthcare workers by making the work environment conducive for them to work and adequately remunerated. This will prevent most of the doctors from running private hospitals, otherwise called employee moonlighting. Surprisingly, privately

run hospitals in most cases are owned by qualified doctors working in government hospitals. It is, therefore, possible for these doctors to refer patients to their private hospitals, usually (although not by any reason always) to generate income. Therefore, when they are wholesomely remunerated, they would be more likely dedicated to quality service delivery.

6. Government should ensure adequate facilities needed at the A&E unit of the hospital is provided to avoid referring patients to private hospitals to carry out some tests, often time before the result of such arrives the patients would have died but if A&E is adequately equipped for prompt treatment, rate of mortality will reduced.

7. Government partnership and collaboration with foreign organizations should be encouraged in order to improve patients' experience.

8. Government should introduce e-governance into the public hospitals to facilitate quick and easy service among the bureaucrats.

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