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Patient Satisfaction in Indigenous Medical System of Sri Lanka: A Literature Review

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Abstract

Ayurvedic medicine in Sri Lanka has four systems of medicine and they are collectively referred to as indigenous medicine. However, indigenous medicine is used by Sri Lankans and people all over the world. Because of this, World Health Organization (WHO) mentions that 80% of the world's population relies on indigenous medicine. This paper discusses patient satisfaction in Sri Lanka's indigenous medical system. Patient satisfaction is becoming increasingly important in the health care industry; measuring patient satisfaction with healthcare service quality is an important component of a healthcare system's overall evaluation. That is difficult to achieve in the indigenous sector. Review articles are obtained from Lens.org, Google scholar and high-index journals. Articles are selected through PRISMA. Patient satisfaction is determined by different categories of dimensions:

clinical or non-clinical, intrinsic - extrinsic and internal treatment – external treatment. The majority of articles discuss nonclinical aspects of patient satisfaction. Because of the nature of drugs, clinically related patient satisfaction is extremely difficult in indigenous medicine. Non-clinical related patient satisfaction is controlling in nature. If taken about non-clinical and clinical factors in this section as same as other dimensions. Patient satisfaction is influenced by both intrinsic and extrinsic factors. Intrinsic refers to the patient's internal causes, whereas extrinsic refers to the patient's external factors. Internal and external medicines are the foundations of indigenous medicine. Internal medicine has a bitter taste and slow onset of drug action that causes dissatisfaction, External medications are not the same as internal medications, which relieve pain and specific complaints and provide patient satisfaction.

Keywords: *External Medicine, Indigenous Medicine, Internal Medicine, Patient Satisfaction*

Introduction

The world health organization (WHO) defines traditional medicine as the sum of the knowledge, skills and practices based on theories, beliefs and experiences, indigenous to different cultures, whether explicable or not, used in maintenance of health, as well as in the prevention, diagnosis, improvement or treatment of physical and mental illnesses (WHO, 2019).

According to the World Health Organization (WHO), 75 to 90 percent of people in developing countries rely on herbal medicine for their primary care. The reasons for its growing acceptance around the world include its safety, effectiveness, biocompatibility, better cultural acceptability, ease of availability, and lack of severe side effects (Satrupa & Mitra, 2011). Numerous studies have been conducted on the topic of satisfaction in the fields of sociology, psychology, marketing, and healthcare administration. Consumer expectations and opinions of the questioned service or product must be balanced in order to achieve consumer satisfaction, which is

understood to be a complex process. According to the 1990s competitive environment, "The satisfied customer is an indispensable means of creating a sustainable advantage (Newsome & Wright, 1999). Even though the terms "satisfaction" and "quality assessment" are frequently used interchangeably, satisfaction is generally regarded as being the broader concept. It can be viewed at both the level of the specific service encounter (transaction) and at a more global level, which includes all experiences with an organization (Newsome & Wright, 1999).

The 1960s consumer movement sparked an interest on studying patient satisfaction with healthcare. After 1960, next 63 years measured the patient satisfaction. The different factors were taken into account when determining patient satisfaction such as ease of access to care, perception of waiting time, patient-provider relationship, payment, and hospital facilities/environment (Iliyasu et al, 2010). Patient satisfaction is a crucial and frequently used metric for assessing the quality of the healthcare industry. According to Donabedian (1980) theory, the interpersonal component of care is crucial in determining how satisfied patients are with their medical treatment. A patient needs to think favorably about all aspects of the quality of care received, especially when it comes to the interpersonal aspects of health care, to be satisfied with the way that it was provided. According to Fox and Storms (1981), the satisfaction can only be resulted from alignment between patients' and providers' perspectives on what constitutes satisfaction in medical care. According to Linder and Pelz (1982), the patient satisfaction is influenced by their prior expectations, beliefs, and values regarding receiving medical care. Fitz Patrick and Hopkins (1983) contend that a patient's particular social environment affects how satisfied they are with the medical care they had been received. Assess the perceived comfort or discomfort that patients feel in relation to the services when determining the level of patient satisfaction that they experience. According to Ware et al. (1983), the degree to which patients are satisfied with their care depends on their individual preferences and expectations. Clinical outcomes, medical malpractice, claims and patient retention are all had been impacted by patient satisfaction. It has an impact on the effective, timely, and patient-centered provision of high-quality medical care

(Bhanu, 2010). Patient satisfaction and consumer satisfaction is not the same thing, but and many common medical situations do not fit the marketing-oriented conceptual model well or are inappropriate in other ways. The reasons why patient satisfaction with healthcare may vary especially in indigenous medicine are discussed below (Newsome & Wright, 1999). Communities in Sri Lanka possess a significant stockpile of underutilized, underappreciated, and unidentified indigenous knowledge and skills, most of which had become obsolete or go extinct for a variety of reasons. Particularly in medicine, the indigenous knowledge system largely still has a tacit nature. Consequently, it is extremely difficult to manage indigenous knowledge of indigenous medicine (Padmasri, 2018). Ayurveda, Siddha, Unani, and *Deshiya chikitsa* are among the four medical systems that make up Sri Lanka's indigenous medicine as mentioned Ayurveda in Ayurveda act 1961 no 31(Kamal, 2020). This review is discussed about patient satisfaction about indigenous medicine in different dimensions. Such as (1) clinical and non-clinical, (2) intrinsic and extrinsic, (3) internal medicine and external medicine.

Research Objectives

There are three objectives of this review.

1. To identify the clinical and non- clinical factors associated with patient satisfaction of indigenous medical system in Sri Lanka
2. To identify the intrinsic and extrinsic factors associated with patient satisfaction of indigenous medical system in Sri Lanka
3. To identify the internal and external treatment related factors associated with patient satisfaction of indigenous medical system in Sri Lanka

Research Methodology

This study's systematic literature review (SLR) methodology was used to review the literature. Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) is a common format for reporting the SLR (Liberati et al., 2009). To establish the criteria for articles and analysis techniques to be included, a protocol

was created. Inclusion standards are listed in Table 1. Following a standard procedure advised for a PRISMA systematic literature review (Liberati et al., 2009) articles were included. PRISMA is strongly advised in medicine. Authors who want to conduct the SLR, however, frequently use narrative and arbitrary guidelines because there isn't a framework like this in the social sciences (Pahlevan-Sharif et al., 2019). Identification, screening, and inclusion are the first three steps of the PRISMA.

The identification stage includes the use of keywords or search terms, search criteria, databases, and data extraction. The typical search terms used were "Patient satisfaction," "Indigenous medicine," “complementary alternative medicine” "external application," antecedents, and outcomes. The "OR" operative for terms that are similar to "patient satisfaction" and the "AND" operative between antecedents and outcomes were used to develop the search criteria. The search criteria were entered into LENS.ORG. Google Scholar and “My collection”. Article screening are divided into two categories: screening and eligibility checking. Both automatic and manual screening is used in the process. Following the inclusion criteria from one to five listed in Table 01, the articles were added using the databases' standard automatic screening functionality. The number of articles that have been excluded thus far and the causes are described in Table 02. Additionally, each article was manually evaluated by the author's two independent co-workers in accordance with the inclusion criteria listed in Table 01. The evaluation of methodological reporting is crucial for the eligibility check of the articles (Meline, 2006; Priyashantha et al., 2021; Priyashantha & Dilhani, 2022). Eighty articles met the inclusion criterion for the study, while the others were excluded, and the empirical research that used quantitative methodologies in those eighty were included. 38 articles from the lens.org database, 40 articles from the Google scholar database and 57 articles from “my collection” were retrieved. The retrieved list, which included the title, abstract, keywords, names and affiliations of the authors, the name of the journal, the number of citations, the year, etc., was then exported CSV files to a Microsoft Excel sheet. After that, the duplicates were looked up and eliminated.

Table 01: Inclusion Criteria

No	Inclusion criteria
01	Publication duration 2018-2023
02	Publication in academic journals
03	Publication as academic articles
04	The articles in the English language
05	Empirical research that employed quantitative methodologies

Source: Authors Conception, 2023

The task was completed independently by the author's two co-workers, and any disagreements over inclusion were settled through conversation. Table 02 explains the number of articles that were excluded at this time with justifications. The remaining articles were then exported to an MS Excel sheet, along with their title, abstract, keywords, authors' names and affiliations, journal name, citation counts, and year of publication, to be fed into the VOS viewer for the required analysis. The article selection process and the reasons for excluding the articles are shown in Figure 02 Assessment of the bias of the article (researchers' bias) in article selection and analysis lowers the quality of reviews (Kitchenham and Charters, 2007). By adhering to a review protocol and selecting articles in a methodological, objective manner, the selection bias could be reduced.

Table 02: Exclusion Criteria

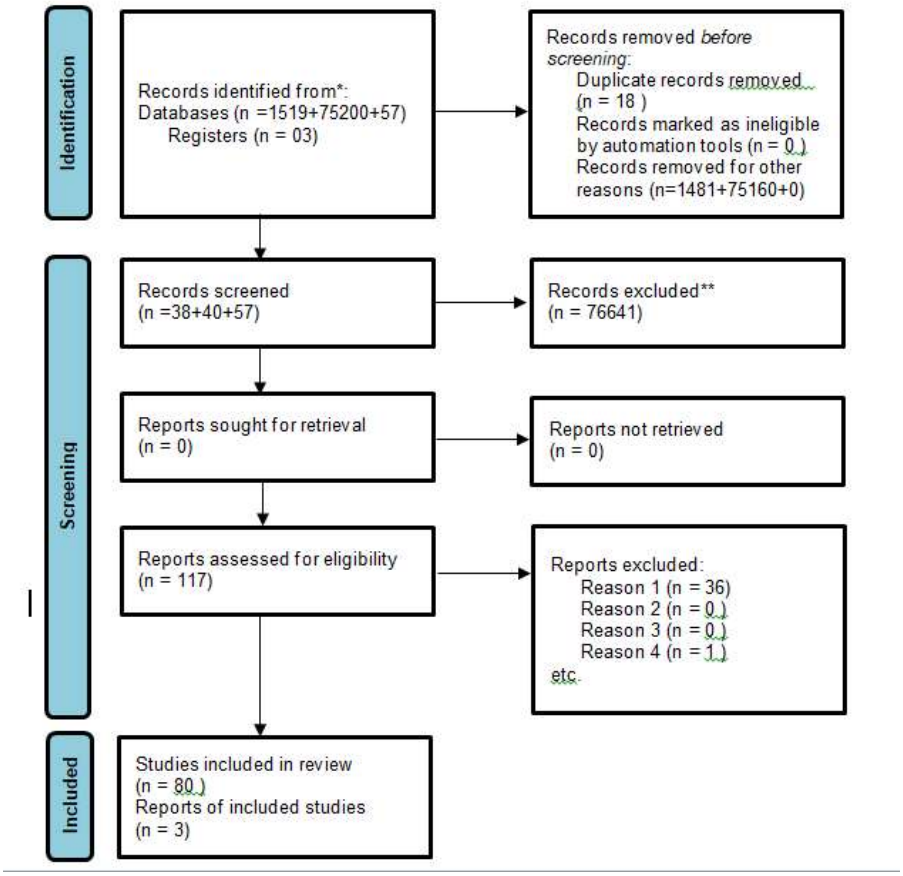
No	Exclusion criteria
01	Publications from non-recent years (others of 2018-2023)
02	Non patent application
03	Biological - non Homosapience
04	Publication from other language

Source: Authors Conception, 2023

As well as having two reviewers evaluate publications in parallel independently (Brereton et al., 2007). Additionally, it is possible to lessen analysis bias by using a preliminary protocol design that predetermines the analysis procedures (Xiao and Watson, 2019). Therefore, those steps were taken to remove bias from article selection and analysis.

A bibliometric analysis was the analysis technique employed. It was carried out using VOS viewer. Research activity is analyzed quantitatively using this technique (Aparicio et al., 2019; Paule-Vianez et al., 2020). The term co-occurrence analysis is one of the many bibliometric analyses that is essential to identifying the term used in article abstracts. The term co-occurrence network visualization was created using the term co-occurrence data that the VOS viewer had extracted. Using this method, the term is divided into a number of clusters so that the themes represented by each cluster could be found (Priyashantha et al., 2022). The modified Microsoft Excel sheet (CSV) was then used to feed the data into the VOS viewer Software, which ran the network visualization maps of the co-occurrence of terms and keywords (Figure 02 & Figure 03). That was done in an effort to determine the major themes in the studies that were chosen. As the keywords of a research article denote its primary content on a specific field of investigation, it is noteworthy that the keyword co-occurrence is to identify the main areas touched from the keywords of the studies. Furthermore, the term co-occurrence analysis searches key terms reflected in the titles and abstracts of each article in order to identify more about studies than the keywords co-occurrence. Lastly PRISMA flow diagram manually formed as follows in Figure 01.

Figure 01: PRISMA Flow Diagram



Source: Authors Conception, 2023

Results and Discussion

Results and discussion are describing the factors associated with the patient satisfaction of Indigenous medical system in Sri Lanka under three dimensions. The first dimension includes of clinical factors and non- clinical factors while the second dimension considered for instinct and extinct factors. Internal and external treatments related factors were considered under the third dimension. Those are predictors of patient satisfaction (Ahmed et al, 2011).

The First Dimension: Clinical vs Non Clinical Factors

The clinical and non- clinical factors associated with the patient satisfaction using indigenous medicine in Sri Lanka were reviewed under this section. Doctor - patient relationship, Patient and therapist/attendants/dispenser relationship, time spends with the doctors, post treatment relationships, privacy plans, preparative process, Personal hygiene of doctors/therapist, Technical skills of doctors/therapist, Doctors attention during/after treatment process, doctor's instruction, doctor equity thinking, Doctor's empathy to patients, harassment related matters, external treatment types are some of the important clinical factors discussed under this section while the non- clinical factors including, telephone conversation, front office conversation, contact details issuing, telephone reminding, availability and accessibility and infrastructure development are considered on the other way around.

Clinical Factors

a) Doctor- patient relationship

Over the time, the doctor-patient relationship has changed from a paternalistic model in which doctors made decisions on the patients' behalf to one that is more collaborative and patient-centered. In ethics, patient autonomy, and the understanding that the patient is an active participant in their care have been all contributed to the shift toward shared decision-making. Those are under history of doctor patient relationship and patient satisfaction (Brody, 1982).

The doctor-patient relationship is essential to providing quality healthcare and has a big impact on patient outcomes, satisfaction, and overall healthcare quality. The key conclusions from the literature on various facets of the patient-doctor relationship are synthesized in this review. The need for effective communication and trust-building in patient and doctor relationships (Matusitz & Spear, 2014). Shared decision-making improves the doctor-patient relationship (Legare & Witteman, 2013; Elwyn et al., 2012); patient-centered care makes good patient-doctor relationships

(Epstein et al., 2005); and patient-doctor relationships consist of ethical consideration. Cultural competency and diversity also affect the doctor-patient relationship (Eiser & Ellis, 2007; Ihara, 2004). The changing dynamics of the doctor-patient relationship emphasize the importance of trust, empathy, and communication (Brody, 1982), the essential elements of trust in the doctor-patient relationship, and provide insight into how fostering this trust improves patient outcomes. The concept of physicians empathy, its components, and its impact on patient satisfaction (PS) and adherents to treatment plans (Hojat et al., 2002) Shared decision-making between doctors and patients, making benefits, challenges, and strategies for implementation in clinical settings (Legare & Witteman, 2013), the four habits model, a framework for physician and patient communications, and its utility in improving patient outcomes (Epstein & Street, 2001), the importance of patient-centered communication in oncology care and its impact on patient emotional wellbeing and treatment decisions (Epstein & Street, 2007); the relationship is between physician empathy and patient satisfaction and adherence to medical recommendations (Kim et al., 2004).

The development of trust and a fruitful patient-doctor relationship depends on the effective communication. (Epstein & Street, 2001) Open, sympathetic, and transparent communication improves patient satisfaction and adherence to treatment plans, according to studies. Transparent communication, consideration for patient preferences, and the dissemination of accurate information all contribute to the development of trust. The above-mentioned point is under the collaborative doctor-patient relationship and patient satisfaction categories. In order to choose the best course of treatment, patients and doctors must collaborate in shared decision-making. This method takes into account the values, preferences, and scientific data of the patient. Shared decision-making, according to research, enhances patient satisfaction, treatment adherence, and healthcare outcome (Epstein,2005).

The patient-doctor relationship is influenced by socioeconomic and cultural factors. Patients from various backgrounds might have different communication styles and viewpoints on health. To ensure effective communication and the development of trust, doctors need to be culturally competent and sensitive to these differences (Epstein & Street, 2001).

The patient-doctor relationship faces difficulties despite its importance. The effectiveness of interactions is affected by time restraints, electronic health records, and administrative burdens. The training and communication abilities of doctors also influence how patients are treated. The patient-doctor relationship now has additional dimensions due to the technological advancements. Although telemedicine, electronic communication, and patient portals are practical, they also make it difficult to preserve the human and personal elements of healthcare interactions. The doctor-patient relationship is still changing as a result of the shifting healthcare environment. Understanding the effects of new communication technologies, interventions to enhance doctor-patient communication, and methods to address healthcare disparities across various populations should be the main areas of future research (Elwyn et al, 2012).

The standard of the doctor-patient relationship is impacted by race, ethnicity, and language. According to the literature, a more diverse physician workforce is necessary because minority patients are more likely to select minority doctors, to be happier in relationships based on language compatibility, and to feel more connected and involved in decision-making with racially compatible doctors (Ferquson & Candib, 2002). Similar to what is happening in Sri Lanka, fluency in another language is required for employment in the government sector in order to pass the efficiency bar exam. That resolves the aforementioned issue. In order for doctors to practice medicine effectively, patient equity is crucial. According to an indigenous belief system, a doctor, a patient, a staff member, and a drug working together in harmony will result in effective treatment. That is called *Chatus Pada or Nat patham* (Four limb) As a result, patients are more satisfied (Parimelalakar, 1956).

Patient and Therapist/Attendants/Dispenser Relationship

Patient satisfaction and knowledge of prescribed medications are both improved by pharmacist interaction and consultation with patients. The strongest correlation between patient knowledge, satisfaction, and communication tasks was observed (Garjani et al., 2009). Additionally, native druggists or dispensers must mention *Patiya* and *Apatiya* (wholesome and unwholesome diets) as well as *anuphana* (medicinal vehicles). As a result, patients are more satisfied.

In conclusion, the doctor-patient relationship is a dynamic and intricate part of providing healthcare. Patient outcomes and the standard of care are greatly influenced by effective communication, developing trust, and shared decision-making. Fostering a healthcare system that is patient-centered will be easier if historical evolution is acknowledged and problems are addressed.

b) Time spend with doctors

A crucial component of healthcare delivery that can have an impact on the standard of care, patient satisfaction, and health outcomes is the amount of time patients spend with doctors during clinical encounters. Physicians spend time with patients during the visit, and they also spend time with administrative work and electronic health records in developed countries (Gottschalk & Flocke, 2005). Primary care physicians allocate their time and their self-efficacy to discussing physical activity with older patients. Nowadays, with the elderly population increasing, primary care workers spend their time with elders in Sri Lanka, just as they do in other countries. Reduce the appointment duration impact on patient satisfaction. That means reduce patient satisfaction. Rheumatologists spend their time with their multidisciplinary team discussing training and patient care; here also, *kadum Bidum* traditional physicians spend their time with their patients and their students. The consulting room also makes a difference in patient satisfaction. The effect of time restraints on the standard of care provided during patient-doctor interactions has been highlighted by research. Shorter visit times may result in hurried decision-making,

poor communication, and incomplete medical histories. The efficacy of treatment regimens and the accuracy of diagnoses may be compromised as a result. Patient satisfaction has been linked to the amount of time spent with doctors. Longer consultations frequently lead to improved patient-doctor communication as well as better patient understanding of medical conditions and available treatments. Patients are generally more satisfied with their care when they feel like they have more time to talk about their worries and ask questions. For shared decision-making, the length of patient-doctor interactions is essential. A thorough discussion of treatment options, potential risks, and benefits can take place with enough time, allowing patients to actively participate in making decisions about their healthcare. Longer visits encourage group decision-making and aid in tailoring treatment plans to individual patient preferences (Gottschalk & Flocke, 2005).

The amount of time patients spend with doctors depends on a number of factors. These factors include patient preferences, the healthcare environment, the complexity of the medical condition, and the doctor's workload. Due to different patient needs and the nature of the care given, primary care visits may last less time than specialty consultations (Ogden et al, 2004).

In order to maximize patient-doctor interactions while maintaining time constraints, technological solutions have recently been investigated. Telemedicine, patient portals, and electronic health records can all promote more effective information exchange and communication, potentially enhancing the standard of care provided within constrained time frames (Rastogi et al, 2020).

In order to maximize the amount of time patients spend with their doctors, a balance must be struck between providing high-quality care and preserving productivity. To ensure patient satisfaction and healthcare provider productivity, it is important to focus on streamlining administrative tasks, improving communication, and putting effective time management techniques into practice (Ogden et al, 2004).

According to the literature, policy modifications may be required to address the problem of insufficient time for patient-doctor interactions. The effectiveness of patient-doctor interactions can be raised with adequate compensation for longer visits, better workload management, and the promotion of patient-centered care models (Gottschalk & Flocke, 2005).

The effects of various interventions aimed at maximizing the amount of time patients spend with doctors should be the subject of future study. This might entail researching the efficacy of communication training for healthcare professionals, assessing the impact of technology on interactions between patients and doctors, and investigating cutting-edge care delivery models that guarantee quality while accommodating time restraints (Rastogi et al, 2020).

Dissatisfaction among patients has been addressed in two different ways. Some researchers have first addressed how long a consultation actually lasts. This has either included a call for longer consultations or a suggestion to alter the way time is allocated through the use of new technologies and more adaptable practice management. These solutions have been informed by research showing that longer consultations are of higher quality, are linked to a number of better patient outcomes, and acknowledge that each patient's problem necessitates a different amount of time for appropriate management. Others, however, have concentrated on how the time is used. From this angle, it has been asserted that the time allotted for the consultation should be managed rather than prolonged (Ogden et al., 2004). In any case, consultations in the indigenous sector last longer than regular consultations.

In conclusion, the length of time patients spend with doctors affects the caliber of care, patient satisfaction, and healthcare outcomes in a significant way. It remains difficult to strike a balance between the need for comprehensive care and the realities of time constraints, necessitating ongoing research and creative strategies to improve patient-doctor interactions.

c) Post treatment relationship

The post-treatment care-related role of health care providers is important in health (Kamal et al., 2012), which leads to Ayurveda, one of the main aims of healthy long life. The doctor-patient relationship of communication after patients are discharged from the hospital achieves the system network of health care with the community. Post-treatment relationships need to be developed in acute to sub-acute transition treatment settings. The post-hospital experience of older adults and their family caregivers leads to interaction with health care providers during transition (Bowles et al., 2009). The doctor-patient relationship, after long-term follow-up, presents challenges and opportunities for improved communication. Not only doctor-patient relationships, but nurses-patient relationships also build bridges from hospital to home through nurses phone calls. Some of the treatment, like breast cancer survivors post-follow-up treatment, requires ongoing support and communication (Beaver et al, 2010).

The post-treatment phase emphasizes the significance of doing so. After receiving treatment, patients require continued observation and follow-up to make sure their condition is improving as anticipated and to address any potential complications that may develop. Scheduled follow-up visits give medical professionals the chance to evaluate a patient's progress, keep tabs on any alterations to their health, and alter the course of their treatment as necessary. These appointments give us the chance to address patient concerns and respond to inquiries (Duffy & Baldwin, 2013).

Post-treatment monitoring and surveillance are crucial for some medical conditions. Healthcare professionals can monitor the efficacy of treatment and spot any signs of recurrence or new problems with the help of routine medical exams, imaging studies, and other diagnostic procedures. Patient education is still crucial in the post-treatment stage. Patients should have thorough knowledge of the warning signs and symptoms, possible treatment side effects, and lifestyle changes that can aid in their recovery and long-term wellbeing. Following treatment, patients might face emotional and psychological difficulties. By addressing any anxiety, depression, or

emotional distress that patients may be experiencing as a result of their medical journey, healthcare providers play a role in providing psychosocial support (Castillo et al, 2010). Adequate medication management and adherence are essential when patients are taking long-term medications. Healthcare professionals should keep an eye on the efficacy, potential interactions, and side effects of medications. For some patients, rehabilitation and regaining physical function come after treatment. To support their recovery and improve their quality of life, healthcare professionals may collaborate with patients to develop exercise plans, physical therapy schedules, and other interventions (Tennakoon & Zoysa, 2014).

Similar to the treatment phase, the post-treatment phase also emphasizes the value of shared decision-making. Discussions about the patient's current condition, available treatments, and any potential changes to the care plan should involve the patient actively (Elwyn et al 2012). A crucial component of the post-treatment relationship is empowering patients to take charge of their own health and recovery. To assist patients in making educated decisions about their lifestyle, self-care, and well-being, healthcare professionals can offer information, resources, and counseling (Garjani et al., 2009).

The post-treatment phase for patients who have finished treatment and are in long-term survivorship involves regular check-ins to guarantee ongoing health and well-being. Healthcare professionals can provide advice on maintaining a healthy lifestyle and addressing any potential long-term treatment effects. Participants finishing residential treatments were more likely to attribute aftercare to their treatment agency. People who finished community treatment, however, were more likely to admit to setting up their own aftercare or to say they did not want or need ongoing support (Duffy & Baldwin, 2013). The same situation exists in both conventional and Sri Lankan indigenous medicine. It is essential to follow up with patients after treatment. The patients will be happy if we take that action. Indigenous medicine talks about preventing illness and extending life.

In conclusion, it is crucial for patients and healthcare professionals to maintain a positive relationship after treatment in order to ensure the best possible recovery, ongoing care, and quality of life. To promote a successful and fruitful post-treatment phase, effective communication, shared decision-making, patient education, and psychosocial support are essential.

d) Privacy plans

Privacy is important for patient consultation and treatment; every institution has its own privacy plans. Especially, external application therapy, need privacy plans. During consultation, treatment procedures, and nursing practice, ethical and legal aspects of patient privacy and confidentiality are considered (Gallagher et al., 2017). Health care organizations have strategies to enhance compliance with patient privacy regulations and safeguard patient information. The challenges are maintaining patient privacy while sharing patient information across the various platforms. We need a balance between patient privacy concerns and the drive for innovation in the digital health landscape. Translational researchers should be aware of privacy and security considerations in the context of digital health (Filkins et al, 2016) challenges and strategies for ensuring patient privacy as health care organizations transition to electronic health care records.

According to some studies, patient satisfaction is significantly influenced by the provider's respect for their privacy, waiting times, and consultation times (Quitana et al., 2006). *Thokkanam* (massage) and external treatments like *Sarvanka dhara* require privacy in the indigenous sector. If you respect the patients' privacy, it will result in their satisfaction. Sri Lankan indigenous treatment centers have maintained their privacy plans by creating separate rooms, dividing them with dividing boards, or dividing them only slightly with a curtain. Some indigenous physicians do not give privacy any thought.

e) Preparative process

On the other hand, the study (Ahmad et al., 2011) revealed that most patients did not enjoy the way nurses behaved and had negative experiences because they saw the nurses failing to pay attention to their needs. Patients in other studies of a similar nature expressed displeasure with the staff's lack of courtesies (Quitana et al., 2006).

f) Personal hygiene of doctors/therapist

A doctor's and therapist's personal hygiene is crucial because certain disease conditions, such as skin diseases and infectious diseases, can spread to them or to other patients through them. If patients are protected from those diseases by personal hygiene, it increases patient satisfaction. According to research, it is essential to provide sufficient resources (liquid soap, paper towels, gloves, and masks) to encourage health care workers (HCWs) to practice proper hygiene standards (Akkadian et al., 2006). This is very essential for indigenous medical systems, especially external application therapies. While most practitioners take personal hygiene into consideration, some do not.

g) Technical skills of doctors/therapist

Anyone can question qualified doctors' and therapists abilities; they are learned from recognized universities and achieved through graduations (BAMS, BSMS, BUMS), diplomas (DA, DAMS, DSAMS, DIMS), traditional knowledge from their families, and post-graduation employment (Pg Dip, M.Sc., MD) in both the public and private sectors. However, if a new technical skill is introduced, they must learn it in order to improve patient satisfaction (Banerjee & Mitra, 2012).

h) Doctors attention during/after treatment process

The majority of traditional healers in Sri Lanka focus both during and after treatment. Someone's disregard for their responsibilities damages the industry's reputation. It consists of five A components: "asking about smoking", "advising to quit," "assessing willingness to quit", "assisting the patient in trying to quit," and

"arranging" follow-up to prevent relapse (Persai et al. 2014). This seems to indicate that doctors are paying attention and can discuss smoking habits with specific patients. Nonsmokers of patients are the cause of the patient's dissatisfaction (Persai et al. 2014).

i) Doctors instructions

Doctors giving patients advice on drug use, diet (*Patya and Apatya*), and lifestyle changes in the indigenous medical sector (*Aushadha, Ahara, and Viharana*) give their patients advice that results in satisfaction. In some European countries, many people are unwilling to rely on doctors when they are ill, as evidenced by the demand for over-the-counter (OTC) medications and complementary therapies (Coulter & Magee, 2003), but our context is entirely different.

j) Doctors equity thinking

If you look at some countries that have implemented equity policies, like Russia, China, and Cuba, doctors rarely do so due to national circumstances. Patient satisfaction is affected by Sri Lanka's and India's unfavorable conditions. In the private sector, the majority of users are financially stable (Kamimura et al, 2020).

k) Doctors empathy to patients

Different doctors have different levels of empathy for their patients, which can impact how satisfied they are. Patients anticipate compassion from doctors (Kim et al., 2004) did not cause harassment.

Patients dislike being harassed during their care. That creates negative opinions and dissatisfaction, which are extremely uncommon in Sri Lanka, particularly in the indigenous sector (Kim et al , 2004).

l) Different type of external treatment

The treatment process, or clinical base, is what determines the health sector's main objective. The patient's main objective is to receive care that leaves them satisfied. It offers both internal and external treatments. In contrast to conventional treatment, various external treatment modalities are employed in the indigenous sector. Various forms of external application therapy produce varying degrees of satisfaction. For instance, while most patients prefer massage therapy, some patients reject cupping therapy (Shifa, 2022).

It appears that the Ayurvedic healthcare system places a high value on patient satisfaction. The term "*Chatushpada*" refers to four quadruples, each with four qualities: the doctor (*Vaidyapada*), the medication *(Aushadhapada*), the nursing staff (*Upasthatapada*), and the patient (*Rogipada*). Only when these four quadruples are present and successfully deliver the required care can a treatment be considered successful (Deepa et al., 2017).

Only in *Vaidyapada* was excellence in medical knowledge, clinical expertise, skill, and cleanliness attained, proving the essential interdependence of all four qualities. Although there are two factors related to *Paricharakapada*, the first one concerns the skill, nursing quality, affection, and cleanliness of the nursing staff, and the second one refers to the knowledge and expertise of the staff (the therapist) involved in medicine preparation. These two can be regarded as one. The therapist, or masseur, is an essential component of therapeutics (Deepa et al., 2017).

Rogipada only produced one factor, which is representative of the class of patients seeking Ayurveda who are aware of the types of diseases that can be treated by Ayurveda, the cost of treatment, the doctor's insistence on adhering to the recommended course of action, which includes dietary changes and lifestyle modifications for the best results, and patient participation in the therapeutic process (Deepa et al., 2017).

By implementing client-centered health education strategies, particularly those related to physical activity and weight control, physiotherapists with advanced knowledge of physical activity and exercise can play a significant role in lowering the risk of chronic lifestyle-related condition (Pang, 2012).

Satisfied patients were more likely to adhere to treatment, keep follow-up appointments, and use health services, according to health service researchers. Dissatisfied patients exhibited different behaviors. Such satisfaction-related behavior effects may have an impact on treatment outcomes. A behavior that seeks health compared to those in advanced countries, health care recipients in developing countries are more sensitive to perceptions of the quality of health care delivery (Iliyasu et al., 2010).

1) Non - clinical Factors

a) Telephone conversation

Telephone conversations are important in health care, especially in emergency medical settings, for patient satisfaction and their perception of care. Relationships exist between physician-patient telephone communication, job satisfaction, and the quality of care provided. Role of telephone communication in emergency departments and its influence on patient satisfaction and perceived quality of care (Brown et al., 2013). Telephone conversation, between pediatrician and patient, is highlighting its potential impact on patient satisfaction and health care outcomes. Patient satisfaction is enhancing with telephone-based primary care interactions (Beaver et al., 2010).

b) Front office conversation

The front office staff's professionalism impacts on patient satisfaction and the patient's overall experience. Front office factors that influence patient satisfaction in private hospitals and their impact on overall health care service perception. Front desk characteristics and the pay collection process influence patient attitude and

satisfaction. Relationships exist between front office employees' empowerment and patient satisfaction in hospital settings (Nguyen, 2019).

c) Contact details issuing

One of the communication strategies is this: That indicates that the doctor gives the patient, his or her contact information in case of an emergency or after the patient contacts them. These days, the majority of native medical professionals use this approach. The patient will be satisfied because of this. This strategy is followed not only in the indigenous sector but also in law, marketing, management, and education (Beaver et al., 2010).

d) Telephone reminding

Patients are satisfied with telephone reminders for their next clinic visit or health care visit. According to some studies, the majority of patients were content with the attitude and communication abilities of the care providers (Ahmed et al., 2011), which is one of the aspects covered in the aforementioned information. This is novel in the context of Sri Lankan traditional medicine. That is Patients' future expectations from the aforementioned sector.

e) Availability and accessibility

Discipline, the cost of medical care, the accessibility of doctors, the length of service hours, and the location of the wards are some of the satisfaction factors. According to some studies, the patients had a positive experience because doctors were available in the wards and because the service hours were convenient (Ahmed et al, 2011). This is appropriate for all medical treatments. Relationships exist between the accessibility of health care services and patient satisfaction, considering factors such as distance, waiting time, and service quality (Takbiri et al., 2020), which are important for improving access to health care services for people with disabilities and their impact on their satisfaction and health care outcomes.

f) Infrastructure development

The various aspects of environment satisfaction include a welcoming setting, cleanliness, facilities and services, a beautiful building, and the hospital's convenient location (Ahmed et al., 2011) Surveys of patient satisfaction conducted on a regular basis give hospital management and staff information about the caliber of services provided. In developed nations, these surveys have become standard practice as a component of total quality management. The patient-provider relationship, in-patient services, hospital amenities, and accessibility to care were all rated favorably by patients, while waiting times and treatment costs were not. Patients and their loved ones voiced complaints about long wait times for ultrasound and other radiological investigations, missed folders, missing laboratory results, and delayed appointments (Gajida, 2010) While patients in developed nations have strong consumer protection groups that call for high-quality care (Iliyasu et al., 2010), patients in developing nations use conventional or alternative treatments without complaining about the care they receive.

A relationship exists between health infrastructure development and patient satisfaction. Influence of health facility infrastructure on patient satisfaction relationship between health care infrastructure and quality of service, including patient satisfaction. Impact is on healthcare infrastructure, health system responsiveness and patient satisfaction. Patient satisfaction can be measured in a direct or indirect manner. In the indirect method, patients from alternative health care delivery systems and the general population are sampled through regular field surveys. The direct method is to conduct exit interviews with patients and ask them to rate their satisfaction with their interactions with particular healthcare facilities or providers. The direct method is less time-consuming and provides data for total quality management (Iliyasu et al., 2010). In the Sri Lankan indigenous medical context, both methods are not applied.

The Second Dimension Intrinsic Vs. Extrinsic Factors

Intrinsic factors are the factors those are closely dealing with patient satisfaction

1) **Intrinsic Factors** (Patients and factors are closely related.)

a) patient previous experience

The various characteristics of patient awareness include prior hospital experiences, knowledge of diseases, and awareness of patient rights. Some studies have found a connection between prior experience and satisfaction (Ahmed et al., 2011). Increased patient satisfaction is not always a result of complementary and alternative medicine's (CAM) general characteristics. There are some characteristics of complementary medicines that can be problematic or have negative effects (Bhalero et al., 2013). Patients' perceptions of care, including their previous experiences, relate to hospital quality and safety measures and overall satisfaction (Isaac et al., 2010). Found a relationship between patient's prior hospitalization experiences and their satisfaction with the discharge process. The patient's prior experience with hospital influence led to their evaluations of the care they received (Hude Quan et al., 2005). The patient's previous experience and expectations shape their satisfaction and interaction with health care providers (Kornelsen et al., 2016). Patients with hospital care, including the influence of patients previous health care experiences (Levy et al., 2009), and the patient's symptoms, diagnostic labels, and prior experience influence the rating of patient satisfaction (Hude Quan et al., 2006).

b) Patients acceptance

Patients with chronic diseases use complementary and alternative medicine (CAM) at a high prevalence. Patients with diabetes mellitus (DM), human immunodeficiency virus (HIV), and epilepsy who used CAM rated it highly for convenience, effectiveness, and safety. Given the possibility of an interaction between CAM and allopathic medications, a history of CAM use must be obtained (Bhalero et al., 2013). Determinants of patient acceptance of a web-based disease management program for

heart failure have an impact on patient satisfaction (Ahmed et al, 2011). Physician's emails relate to their satisfaction and communication. Impact is on e-health technologies on the quality and safety of health care services, which can indirectly affect patient satisfaction. Patient acceptance is tele-health in the management of type 2 diabetes mellitus and its impact on patient satisfaction (Rastogi, 2020).

c) patients mentality

In developed nations, 50% of acute liver failure is brought on by drug-induced liver damage. The use of some of homeopathic and Ayurvedic medications has been linked to liver damage (Dalal et al., 2017). This case describes the first known instance of *Kanchanar gugulu* and *Punarnava mandura* causing drug-induced liver damage (Dalal et al., 2017). People believe that all herbal remedies cause the above-mentioned issue, which has contributed to their dissatisfaction with the use of indigenous medicines.

As a system of healthcare medicine, Ayurveda has its own theories and special ways of treating patients. It was widely used in south Asian nations during the ancient era, but as a result of colonization and its subsequent decline in popularity, allopathic medicine quickly replaced Ayurveda as the primary form of healthcare. Ayurveda's standing as a superior treatment for various illnesses, particularly the most prevalent lifestyle diseases like obesity, hypertension, diabetes, and heart disease, has somehow returned to the healthcare market today (Suhail & Srinivasulu, 2021).

According to the researcher's survey, it is clear that the Ayurvedic healthcare sector is highly service-oriented and that there are more in-person interactions between patients and service providers during treatment times. Here, rather than drug quality, personal judgments are what healthcare consumers use to determine how well a service is provided. Five key performance-based service quality model (SERVPERF) dimensions include tangible, dependability, responsibility, assurance, and empathy (Suhail & Srinivasulu, 2021). Patient mindset can influence physician behavior and decision-making, which can have an impact on patient satisfaction.

Patient characteristics and mindsets influence patient perception and satisfaction with outpatient care. The placebo effect and patients' mindsets can impact their response to treatment and overall satisfaction (Zion & Crum, 2018). Mindset of patient's responses to disease management programs leads to influence on patient satisfaction. Influence of patient expectations, which are closely related to mindset, on clinical outcomes and patient satisfaction. Impact of hospitalist mindset, communication, and patient encounters and the potential implications for patient satisfaction (Anna Lembke et al., 2021).

2) Extrinsic Factors (Patients and factors are not closely related.)

a) Environment cleanliness of treatment place

In foreign countries, hospital cleanliness using visual and microbial environmental monitoring relates to patient satisfaction. Patient satisfaction is associated with hospital cleanliness, quality of care, and patient outcomes (Gajida, 2010). The cleanliness of the hospital environment impacts the patient's outcome and overall satisfaction. Relationship is between hospital cleanliness and clinical outcomes, which can influence patient satisfaction. Measurement of hospital cleanliness, particularly related to hard surfaces, and its implications for patient safety and satisfaction. Role of hospital cleanliness is as a quality indicator. Patient perception of hospital cleaning and it correlates with their overall experience and patient satisfaction (Issac, 2010).

b) Back ground music

The effects of background music on patient anxiety during a urological examination have a potential impact on patient satisfaction. The effects of music therapy on health-related outcomes, including potential implications for patient experience (Mandel et al., 2007), the patients and their relatives experiences with music in the health care environment impact satisfaction (Leslie Bunt et al., 2018). The effect of health music on pain and anxiety in colorectal surgery patients leads to potential influence on overall satisfaction. The use of music in health care settings and the

integration of music can influence patient experience and satisfaction. The effect of music on post-operative pain and anxiety and its potential impact on patient satisfaction the role of music and sound in the healing arts, including its potential impact on patient-centered care (Mandel et al., 2007).

c) Environment smell

The impact of hospital environments on patient experiences, including the role of sensory factors such as smell, Impact of odors in a health care environment, particularly in a geriatric ward, and their influence on patient satisfaction (Zhang et al., 2019). Smoking is ban in a hospital environment and its potential effects on patient satisfaction. The effect of ambient odor on pain perception can have implications for patient behavior and satisfaction. The influence of environmental odor on pain perception, which can be indirectly related to patient satisfaction, The effect of odor on the perception of pain and its potential relevance to patient behavior and satisfaction Impact of hospital environment odor on patient well-being, proving insight into patient satisfaction (Zhang et al., 2019).

d) Ventilation

Patient perception of the indoor environment in health care facilities, including aspects related to ventilation (Dimitroulopoulou et al., 2023). The effects of air quality on hospital employees health, which can indirectly impact patient experience (Abbas Shaughnessy et al., 2016). Air quality in health care facilities and its implications for human health, including patients experiences relationship between ventilation rates and health, which can influence the patient's behavior (Sundell et al., 2011). Air quality and comfort in hospital rooms with the displacement ventilation system and its potential impact on patient satisfaction. Influence of ventilation on airborne particles and microbial contamination in a hospital ward, which can relate to patient satisfaction. Noise and ventilation are impact on patients' sleep quality, which can indirectly affect patient experience. Indoor air quality and impacts on health at tertiary care hospitals are providing patient wellbeing (Sundell et al., 2011).

e) Noise of the environment

Noise levels in acute care settings, including their impact on patient experience and satisfaction, impact of noise in hospitals on patients, including its effects on sleep, stress, and satisfaction. Noise pollution in hospitals and its impacts on patients, leads to patient satisfaction (Hsu et al., 2012). Effects of hospital noise on the sleep quality of patients and implications for patient satisfaction. Noise pollution in an adult intensive care unit its impact on patient satisfaction. Hospital noises on patients sleep and their potential relationship to overall satisfaction (Spence, & Keller, 2019).

f) Packaging

The impact of medication packaging on medication adherence and treatment outcome in older adults with hypertension, which can influence patient satisfaction, Medication packaging is a resource for improving medication management in older adults, which can affect the patient experience. Influence of medication packaging on patient safety, including its potential role in medication errors and its implications for patient safety. The relationship between medication packaging and patient compliance can have an impact on patient satisfaction. Medication packaging and its influence on dialogue during medication administration with older patients, which can relate to patient satisfaction, medication packaging and its impact on patient compliance, which can have implications for patient satisfaction (Brain et al., 2014).

In Ayurvedic medicine, the evaluation of the actual service received by patients is used to determine the level of patient satisfaction and service quality. General satisfaction, technical quality, interpersonal manner, communication, financial aspects, time spent with doctors, accessibility, and convenience (Suhail & Srinivasulu, 2021).

By examining patient satisfaction with allopathic, Unani, and Siddha forms of medicine, it will be possible to clearly understand how patients feel about traditional or herbal medicine. The study also demonstrates patient awareness of and familiarity with unorthodox and Ayurvedic treatments (Jegajeevandram & Ganesh, 2019).

The development of various herbal research fields, from extraction techniques to isolation and identification methods, the design and use of bioassays for efficacy testing, dosage form design, and the study of pharmacokinetic, pharmacodynamics, toxicological, and pharmacological modes of action, calls for healthy competition with the currently in place traditional health care systems. Another area of the herbal medicine industry that has received attention recently is the use of forensic studies in regulatory aspects and international marketing strategies (Satrupa & Mitra, 2011). If foreign marketing techniques were implemented in the domestic medical industry, patient satisfaction would rise.

A major but largely unexplored area in the study of herbal drugs is the alteration of environmental conditions during the cultivation or growth of medicinal plants, improper agricultural practices used during cultivation and harvesting, mistakes made during drying, and improper post-harvest storage conditions. The secondary metabolite concentration is also impacted by conditioned drying, processing, post-harvest storage, production steps like extraction and final processing before packaging, and transportation (Satrupa & Mitra, 2011). If you take into account the aforementioned elements that boost patient satisfaction,

Aspects of quality control simultaneously find adulteration. That is a common and serious issue; quality control, safety, and efficacy research on herbal drugs is therefore a major thrust area of research today (Satrupa & Mitra, 2011). Adulteration results in lower quality, which makes patients unhappy. Thin-layer chromatography (TLC), high-performance liquid chromatography (HPLC), capillary electrophoresis (CE), and others are techniques for analyzing the active ingredient as well as adulteration (Satrupa & Mitra, 2011).

Modern methods for isolating medicinal compounds, pharmacological testing procedures, and advancements in plant tissue culture techniques for the production of more secondary metabolites are all regarded as important issues today. Low-cost plant tissue culture bioreactors are being created specifically for the commercialization of phyto-constituents. Herbal drug side effects will be reduced

through technology (Satrupa & Mitra, 2011). Tissue culture technology is a crucial component of plant growth for pharmaceutical production. Herbs from anthills are beneficial for making drugs, according to Ayurveda. Whether or not metabolites change during natural growth and tissue culture Science produces beneficial results for society, but traditional methods still appeal to people's minds.

In cultivated medicinal plants, pesticides play a part in controlling plant growth and the production of secondary metabolites. However, adverse effects can also result from adulteration, substitution, contamination, and misidentification, lack of standardization, improper preparation and/or dosage, and inappropriate labeling and/or advertising. Some toxic heavy metals and unreported drugs, including Glibenclamide and Mefenamic acid, have been discovered in some Chinese and Indian traditional herbal products. Patients experience serious side effects when mixing Western medications. Once the aforementioned issue is identified, no amount of effective medication will satisfy the patient (Satrupa & Mitra, 2011). Now that people are aware of these issues, numerous steps are being taken, including forensic identification and regulations, to address them. Not only does it highlight negative effects, but today's society also values drug-drug and drug-excipient interactions (Satrupa & Mitra, 2011). In Sri Lanka, pesticide usage is increasing, which causes collateral damage to the human body and leads to dissatisfaction in patients.

Studies on herbal drug stability are now regarded as important. Herbal medications are typically administered as pills, decoctions, syrups, tablets, or capsules. The high moisture content, bacterial and fungal contamination, chemical instability, improper harvesting, and storage conditions are damaging causes. Raw materials used to make herbal drugs are physically instable. Active constituents' biodegradation is frequently facilitated by high moisture content. These frequent sources of instability can be reduced by using proper drying conditions that take into account the way that active ingredients break down, the drug's nanoparticle coating, the use of chelating agents, and the formulation of emulsions and suspensions, among other factors (Satrupa & Mitra, 2011). Drug dosage forms and drug instability are factors that affect

patient satisfaction. Patients are satisfied with some dosage forms, such as syrups. Some of the dosage forms are unsatisfactory, such as *Perunkaya churna* (Ramanathan, 2000). Patients were not satisfied due to drug instability and some irritable dosage forms.

Once more, the main cause of the low bioavailability of water-soluble phyto-constituents is poor in vivo absorption. Therefore, methods to improve phytochemical bio-availability and stabilize the bioactive extract with a minimum shelf life of over a year are crucial research areas. Different novel drug delivery systems, such as polymeric nanoparticles, nano capsules, liposomes, phytosomes, Nano emulsions, microspheres, transferosomes, and ethosomes, had been reported to extend the product's shelf life and enhance and prolong the biological efficacy of the herbal medicine (Satrupa & Mitra, 2011). Patient dissatisfaction with herbal medications is caused by the slow onset of drug action. In order to solve that issue, new drug formulations are required. Adding new technologies can help with drug development.

The Third Type of Dimension: Internal Vs. External Treatments

According to drug usage mode, drugs are dividing as two kinds, such as external and internal. The drug used on body surface is called external and the drug swallowed is called internal drug.

1) Internal Treatment

a) Taste of the drugs

Strongly bitter medicinal plants are used as therapeutic and appetizing agents. By contrasting the threshold bitter concentration of an extract material with that of quinine hydrochloride, the bitterness is ascertained (Pradhan et al., 2015). The role of taste and smell in drug administration leads to sensory aspects can influence patient acceptance and satisfaction. Insights into taste masking methods cause their implications for patient experience. Improve medication acceptance among children

and adolescents, which can impact the patient satisfaction. Taste and odor mask bitter drugs, and sensory aspects can reduce patient acceptance. Flavor and formulation on drug production can have implications for patient satisfaction. Taste masking strategies are used in pharmaceuticals, and they can impact the patient experience (Ranjit, 2002).

b) Smell of the drugs

The sensory aspects of pediatric pharmaceuticals, its taste and smell, and their implications for medication acceptance. Taste and smell change in cancer patients, highlighting the relevance of sensory aspects in medication experience. Medication and administration by caregivers at home for children with cancer, including sensory aspects of medication and their impact on caregivers home care experience. Medication acceptance is among elderly patients, encompassing sensory aspects and potential effects on satisfaction. Sensory aspects of medication and administration in geriatric patients (aged patients), which can be influenced aged patients' experience and satisfaction (Paliwel et al., 2021).

c) Gastric irritation

Most of the drug ingredients are spices in indigenous medicine, and because of that, they irritate the gastric mucosa. But some of the ingredients are antagonists of that action, and the drug with *Anupana* also prevents that irritation in any way. Gastric irritation causes patient dissatisfaction (Pararajasekaram, 2016).

d) Integration of medical systems

Studying patient satisfaction with both conventional and Ayurvedic medicine is very common worldwide. A recent study found that both conventional and complementary medicine were used with high patient satisfaction (>90%). Gastrointestinal disorders (24.3%), hair and skin disorders (21.8%), menstrual issues (19.4%), musculoskeletal disorders (13.9%), headaches (6.1%), and metabolic and

endocrine disorders (4.8%) were the most common complaints in Bangladesh (Snigdha et al. 2020).

It is clear that the high cost and side effects of modern medicine are having a negative impact on patient satisfaction. Additionally, consumers think Ayurvedic medicines are safe because they are affordable and made from natural ingredients. That could be the cause of the relatively higher patient satisfaction with Ayurvedic treatment. To aid in disease prevention and promote wellness, Ayurvedic therapy aims to integrate and balance the body, mind, and spirit. Due to their high patient satisfaction rate, lack of adverse drug reactions unlike modern medicine, and cost-effectiveness, traditional medicines should therefore receive more attention (Snigdha et al., 2020).

2) External Treatment

External application therapy of Indigenous medicine causes following beneficial effect and changes in body soothing effect, cosmetic improvement, no drug interaction, safety usage for kidney failure patient, Applicability for Coma patient, Applicability for Paralysis patient and Safety usage for small infant/elders.

For the above-mentioned reasons, the external treatment of indigenous medical systems caused more patient satisfaction. Impact of medication adherence on hospitalization risk and health care cost, which could be indirectly related to patient satisfaction (Sokol et al., 2005) adverse drug reactions and medication errors, which can be affected patient experience (Mekonnen et al., 2018). Pharmacological aspect of drug therapy for aged population, could be able to impact on patient satisfaction and wellbeing. Medication adherence, pharmacy education and related policies, those are considering as their implications for patient satisfaction (Bell et al., 2010).

In the 21st century, lifestyle-related illnesses have been grown to be a significant health concern. If strategies to encourage lifestyle behavior changes are incorporated into the overall clinical management of their clients, physiotherapists, who are committed to providing the best care, can make significant contributions to society (Pang, 2012). Due to the highly competitive market environment, physiotherapists

face many difficulties. Although some doctors tend to decrease the number of patients they refer to physical therapy, other professionals, like Ayurvedic and homeopathic practitioners, effectively market their services to potential clients. Patient satisfaction has become a factor of crucial importance as market competition has increased. In other words, patient satisfaction can help determine how likely it is that they will follow their treatment plan (Tennakoon & Zoysa, 2014).

The technical workforce in the field of public health includes licensed physicians, registered nurses, and lab technicians, as well as occasionally other professionals with backgrounds in healthcare management, health policy, economics, and law. A unique indigenous group of medical professionals known as the AYUSH (Ayurveda, Yoga, Unani, Siddha, and Homoeopathy) doctors play a significant role in providing healthcare, particularly in the Indian and Sri Lankan public healthcare systems. India is the only nation that has legalized these traditional medical practices alongside the allopathic or modern medical system (Samal & Pratap, 2013).

Following a combined treatment of orthopedic pain management and local Ayurvedic therapy for osteoarthritis of the knee joint, noticeably positive results were found on the visual analog scale and the patient satisfaction index. Conservative treatment cannot correct a fixed joint deformity, but Ayurvedic therapy improves patients' functional outcomes and levels of patient satisfaction (Saoji, 2015).

The *Pancha Karma* therapy is used by Ayurveda in its treatments. *Pancha Karma* therapy employs a number of procedures for the body's renewal, purification, and extension of longevity. The five actions that make up *Pancha Karma* are used to remove toxins from the tissues of the body. They are the *Vamana* (forced therapeutic emesis using some medications), the *Virechana* (purgation through the use of powders, pastes, or decoction), the *Vasti* (use of enemas prepared from medicated oils or decoction), the *Rakta mokshana* (detoxification of blood), and the *Nasya* (administration of medicines like decoctions, oils, and fumes through the nasal route). This includes two different types of medications: internal and external

(Jaiswal & William, 2017). This provides the patient with satisfaction, longevity, and relief from illness.

Conclusion

In conclusion, the literary research conducted aimed to achieve three primary objectives which are related to the patient satisfaction with the indigenous medical system in Sri Lanka. The study focused on identifying both clinical and non-clinical factors influencing patient satisfaction, as well as intrinsic and extrinsic factors contributing to the overall satisfaction level. Additionally, the research delved into understanding internal and external treatment-related factors that play a role in shaping patients' perceptions of the indigenous medical system.

The findings from the literature review shed light on a multifaceted understanding of patient satisfaction within the context of the indigenous medical system in Sri Lanka. Clinical factors such as the effectiveness of treatment, the competence of healthcare providers, and the accessibility of services were explored, alongside non-clinical factors like communication, cultural sensitivity, and the overall patient experience. In the realm of clinical factors, the dynamics between healthcare providers and patients play a pivotal role in shaping the overall satisfaction within the indigenous medical system in Sri Lanka.

The doctor-patient relationship serves as a cornerstone, influencing the entire treatment journey. The quality of this relationship extends to interactions with therapists, attendants, and dispensers, forming a collective experience that significantly impacts patient contentment.

The time spent with doctors during consultations and treatment processes emerges as a critical factor. Adequate time allocation fosters a sense of attention and personalized care, contributing positively to patient satisfaction. The post-treatment relationship, privacy plans, preparative processes, and the personal hygiene of healthcare providers further influence the overall patient experience.

Technical skills exhibited by doctors and therapists are carrying substantial weight in patient satisfaction, as proficiency in traditional healing methods contributes to treatment efficacy. The attention given by doctors during and after the treatment process, coupled with clear instructions and equitable thinking, shapes patients' perceptions of the quality of care they receive. Empathy, a cornerstone of effective healthcare, is also a key determinant of patient satisfaction, reflecting the compassionate nature of healthcare providers within the indigenous medical system.

Beyond the clinical sphere, non-clinical factors also significantly contribute to patient satisfaction. Communication channels, such as telephone conversations and interactions at the front office, serve as touch points that influence patient perception. The issuance of contact details and telephone reminders enhance accessibility and follow-up care, reinforcing a patient-centric approach.

The availability and accessibility of healthcare services, along with ongoing infrastructure development, form crucial components of non-clinical factors. These aspects not only impact the convenience of seeking medical care but also contribute to a perception of the overall quality of healthcare facilities.

In conclusion, the comprehensive analysis of both clinical and non-clinical factors within the indigenous medical system in Sri Lanka reveals a multifaceted landscape that influences patient satisfaction. The intricate interplay between doctor-patient relationships, technical competencies, communication channels, and healthcare infrastructure collectively shapes the patient experience, providing valuable insights for improving the quality of care within the indigenous medical context.

The distinction between intrinsic and extrinsic factors allowed for a nuanced analysis of patient satisfaction. Intrinsic factors, such as the perceived quality of care and the effectiveness of traditional treatments, were contrasted with extrinsic factors like the physical environment of healthcare facilities, administrative processes, and socio-economic considerations. This comprehensive approach provided insights into

the diverse aspects that contribute to the overall satisfaction of patients with the indigenous medical system.

Furthermore, the investigation into internal and external treatment-related factors aimed to pinpoint specific elements within the healthcare delivery process that significantly impact patient satisfaction. Internal factors encompassed the actual treatment procedures, the competence of practitioners, and the availability of resources, while external factors delved into aspects such as the accessibility of healthcare facilities, waiting times, and the overall infrastructure.

The insights gained from this research could be able to inform healthcare practitioners, policymakers, and researchers in enhancing the quality of care and patient experience within the indigenous medical system. The relative nature of indigenous medical practices and their effect on patient satisfaction are highlighted in the literature review. Different nations take different approaches, and it is important to comprehend these differences in order to develop strategies that work. The study recognizes that various nations adopt a range of approaches and follow different healthcare trajectories. The study clarifies the relative standing of Sri Lanka's health activities by contrasting these tactics, suggesting possible areas for development. The fact that health activities in Sri Lanka are currently relatively low, especially in the indigenous medical sector, should be emphasized in the conclusion. This prepares the ground for an improvement and call to action.

The above mention reasons, through the literature, traditional medicine of Sri Lanka and its external application therapies reflect positive and negative impact on patient satisfaction and human health. Further studies need for patient satisfaction and relative finding for clear detail elaboration.

References

Ahmad, I., Nawaz, A., Khan, S., Khan, H., Rashid, M. A., & Khan, M. H. (2011). Predictors of patient satisfaction. *Gomal Journal of Medical Sciences*, *9* (2).

Askarian, M., Khalooee, A., & Emroodi, N. N. (2006). Personal hygiene and safety of governmental hospital staff in Shiraz, Islamic Republic of Iran. *EMHJ-Eastern Mediterranean Health Journal, 12 (6), 768-774, 2006*.

Banerjee, S., & Mitra, A. (2012). Changing landscape of herbal medicine: technology attributing renaissance. *International Journal of Pharmacy and Pharmaceutical Sciences*, *4*(1), 47-52.

Beaver, K., Williamson, S., & Chalmers, K. (2010). Telephone follow-up after treatment for breast cancer: views and experiences of patients and specialist breast care nurses. *Journal of Clinical Nursing*, *19*(19-20), 2916-2924.

Bell, J. S., Enlund, H., & Vainio, K. (2010). Medication adherence: a review of pharmacy education, research, practice and policy in Finland. *Pharmacy Practice*, *8*(3), 147.

Bhalerao, M. S., Bolshete, P. M., Swar, B. D., Bangera, T. A., Kolhe, V. R., Tambe, M. J., ... & Thatte, U. M. (2013). Use of and satisfaction with complementary and alternative medicine in four chronic diseases: a cross-sectional study from India. *The National Medical Journal of India*, *26*(2), 75-77.

Bhanu, P. (2010). Patient satisfaction. *Journal Cutan Aesthet Surg. Sep-Dec, 3*(3),151-155.

Brody, H. (1982). The lie that heals: the ethics of giving placebos. The doctor patient relationship revisited, Journal of general internal medicine.

Castillo-Pérez, S., Gómez-Pérez, V., Velasco, M. C., Pérez-Campos, E., & Mayoral, M. A. (2010). Effects of music therapy on depression compared with psychotherapy. *The Arts in Psychotherapy*, *37*(5), 387-390.

Coulter, A., & Magee, H. (2003). *EBOOK: The European Patient Of The Future*. McGraw-Hill Education (UK).

Dalal, K. K., Holdbrook, T., & Peikin, S. R. (2017). Ayurvedic drug induced liver injury. *World Journal of Hepatology*, *9*(31), 1205.

Deepa, L. S., Mallika, K. J., & Girish, K. J. (2018). Development and Validation of Patient Satisfaction Questionnaire for Inpatient Department of Ayurvedic Teaching Hospitals. *Journal of Ayurveda Physicians & Surgeons (JAPS)(EISSN 2394-6350)*, *5*(1).

Dimitroulopoulou, S., Dudzińska, M. R., Gunnarsen, L., Hägerhed, L., Maula, H., Visualisation, R. S., ... & Haverinen-Shaughnessy, U. (2023). Indoor air quality guidelines from across the world: An appraisal considering energy saving, health, productivity, and comfort. *Environment International*, 108127.

Duffy, P., & Baldwin, H. (2013). Recovery post treatment: plans, barriers and motivators. *Substance abuse treatment, prevention, and policy*, *8*(1), 1-12.

Eiser, A. R., & Ellis, G. (2007). Cultural competence and the African American experience with health care: The case for specific content in cross-cultural education. *Academic Medicine*, *82*(2), 176-183.

Elwyn, G., Frosch, D., Thomson, R., Joseph-Williams, N., Lloyd, A., Kinnersley, P., ... & Barry, M. (2012). Shared decision making: a model for clinical practice. *Journal of General Internal Medicine*, *27*, 1361-1367.

Epstein, R. M., & Street Jr, R. L. (2001).The four habits model of validation of an instrument to assess the communication skills of primary care physician , Academic medicine 2001

Epstein, R. M., & Street Jr, R. L. (2007). Patient-centered communication in cancer care: promoting healing and reducing suffering.

Epstein, R. M., Franks, P., Fiscella, K., Shields, C. G., Meldrum, S. C., Kravitz, R. L., & Duberstein, P. R. (2005). Measuring patient-centered communication in patient–physician consultations: theoretical and practical issues. *Social Science & Medicine*, *61*(7), 1516-1528.

Ferguson, W. J., & Candib, L. M. (2002). Culture, language, and the doctor-patient relationship.

Filkins, B. L., Kim, J. Y., Roberts, B., Armstrong, W., Miller, M. A., Hultner, M. L., ... & Steinhubl, S. R. (2016). Privacy and security in the era of digital health: what should translational researchers know and do about it?. *American journal of translational research*, *8*(3), 1560.

Fitzpatrick, R., & Hopkins, A. (1983). Problems in the conceptual framework of patient satisfaction research: an empirical exploration. *Sociology of health & illness*, *5*(3), 297-311.

Fox, J.G., & Storms, D.M. (1981). A different approach to socio demographic predictors of satisfaction with health care. *Social Science & Medicine. Part A: Medical Psychology & Medical Sociology, 15*(5), 557-564.

Gajida, A. U. (2010). Patients' satisfaction with services obtained from Aminu Kano Teaching Hospital, Kano, Northern Nigeria. *Nigerian journal of clinical practice*, *13*(4).

Gallagher, A. (2017). Care ethics and nursing practice. *Key concepts and issues in nursing ethics*, 55-68.

Garjani, A., Rahbar, M., Ghafourian, T., Maleki, N., Salimnejad, M., & Aghajani, H. (2009). Relationship of pharmacist interaction with patient knowledge of dispensed drugs and patient satisfaction. *EMHJ-Eastern Mediterranean Health Journal, 15 (4), 934-943, 2009*.

Gottschalk, A., & Flocke, S. A. (2005). Time spent in face-to-face patient care and work outside the examination room. *The Annals of Family Medicine*, *3*(6), 488-493.

Hojat, M., Gonnella, J. S., Nasca, T. J., Mangione, S., Vergare, M., & Magee, M. (2002). Physician empathy: definition, components, measurement, and relationship to gender and specialty. *American Journal of Psychiatry*, *159*(9), 1563-1569.

Hsu, T., Ryherd, E., Waye, K. P., & Ackerman, J. (2012). Noise pollution in hospitals: impact on patients. *JCOM*, *19*(7), 301-9.

Ihara, E. (2004). *Cultural Competence in Health Care: Is it important for people with chronic conditions?*. Center on an aging society.

Iliyasu, Z., Abubakar, I. S., Abubakar, S., Lawan, U. M., & Gajida, A. U. (2010). Patients' satisfaction with services obtained from Aminu Kano Teaching Hospital, Kano, Northern Nigeria. *Nigerian journal of clinical practice*, *13*(4).

Isaac, T., Zaslavsky, A. M., Cleary, P. D., & Landon, B. E. (2010). The relationship between patients' perception of care and measures of hospital quality and safety. *Health services research*, *45*(4), 1024-1040.

Jagajeevanram, A. K., & Ganesh, A. A. (2019). Influence Of Attitude On Patient Satisfaction (PS) Towards Government Treatment Of Siddha And Allopathic In Cuddalore District, Tamilandu. *Think India Journal*, *22*(35), 1361-1366.

Jaiswal, Y. S., & Williams, L. L. (2017). A glimpse of Ayurveda–The forgotten history and principles of Indian traditional medicine. *Journal of traditional and complementary medicine*, *7*(1), 50-53.

Kamimura, A., Higham, R., Rathi, N., Panahi, S., Lee, E., & Ashby, J. (2020). Patient–provider relationships among vulnerable patients: the association with health literacy, continuity of care, and self-rated health. *Journal of patient experience*, *7*(6), 1450-1457.

Kanesalinganathan, (2009), Sekarasasekara vaithiya thirattu, Department of Ayurveda, Nawinna, Maharagama. 13-14,31

Keller, S., Tschan, F., Semmer, N. K., Holzer, E., Candinas, D., Brink, M., & Beldi, G. (2018). Noise in the operating room distracts members of the surgical team. An observational study. *World journal of surgery*, *42*, 3880-3887.

Kim, S. S., Kaplowitz, S., & Johnston, M. V. (2004). The effects of physician empathy on patient satisfaction and compliance. *Evaluation & the health professions*, *27*(3), 237-251.

Kiwanuka, F. (2018). Complementary and alternative medicine use: influence of patients' satisfaction with medical treatment among breast cancer patients at Uganda Cancer Institute. *Advances in Bioscience and Clinical Medicine*, *6*(1), 24-29.

Légaré, F., & Witteman, H. O. (2013). Shared decision making: examining key elements and barriers to adoption into routine clinical practice. *Health affairs*, *32*(2), 276-284.

Linder-Pelz, S. (1982). Toward a theory of patient satisfaction. *Social science & medicine*, *16*(5), 577-582.

Mandel, S. E., Hanser, S. B., Secic, M., & Davis, B. A. (2007). Effects of music therapy on health-related outcomes in cardiac rehabilitation: a randomized controlled trial. *Journal of Music Therapy*, *44*(3), 176-197.

Matusitz, J., & Spear, J. (2014). Effective doctor–patient communication: an updated examination. *Social work in public health*, *29*(3), 252-266.

Mekonnen, A. B., Alhawassi, T. M., McLachlan, A. J., & Brien, J. A. E. (2018). Adverse drug events and medication errors in African hospitals: a systematic review. *Drugs-real world outcomes*, *5*, 1-24.

Newsome, P. R. H., & Wright, G. H. (1999). A review of patient satisfaction: 1. Concepts of satisfaction. *British dental journal*, *186*(4), 161-165.

Nguyen, T. T. (2019). *The Effect of AIDET Communications Delivered by Front Desk Staff on Patient Experience and Satisfaction at a Medical Practice* (Doctoral dissertation, Capella University).

Niemiera, E. A. (2017). *The Impact of Portable Music on the Internal World of Young Adults* (Doctoral dissertation, Institute for Clinical Social Work (Chicago)). Niemiera, E. A. (2017). *The Impact of Portable Music on the Internal World of Young Adults* (Doctoral dissertation, Institute for Clinical Social Work (Chicago)).

Ogden, J., Bavalia, K., Bull, M., Frankum, S., Goldie, C., Gosslau, M., ... & Vasant, K. (2004). "I want more time with my doctor": a quantitative study of time and the consultation. *Family practice*, *21*(5), 479-483.

Padmasiri, G.R. (2018). Management of indigenous knowledge in Sri Lanka, with special reference to indigenous medicine. *Information Development, 34*(5), 475-488

Paliwal, Y., Jones, R. M., Moczygemba, L. R., Gendron, T. L., Nadpara, P. A., Parab, P., & Slattum, P. W. (2021). Over-the-counter medication use in residents of senior living communities: A survey study. *Journal of the American Pharmacists Association*, *61*(6), 736-744.

Pang, M. Y. (2012). The role of physiotherapy in prevention and management of lifestyle-related conditions. *Hong Kong Physiotherapy Journal*, *2*(30), 43. Parajasekaran, (2016) Pararajasekaram, Provincial department of Indigenous medicine, Northern province, 17

Parimelalakar (1956) Thirukkural, Ed 10, Trinelveli, South India Saiva Siddhantha works publishing society, couplet 950.

Perera, P.K.(2012), April). Current scenario of herbal medicine in Sri Lanka. In *conference proceeding, ASSOCHAM,4th annual Herbal International Summit cum Exhibition on Medicinal & Aromatii Products, Spices and finished products (hi-MAPS),NSIC, Okhla Industrial Estate, New Delhi, India*

Persai, D., Panda, R., Venkatesan, S., Arora, M., & Ahluwalia, J. S. (2014). Does receipt of 5As services have implications for patients' satisfaction in India?. *BMC Family Practice*, *15*(1), 1-7.

Poulsen, J. H., Clemmensen, M. H., Nørgaard, L. S., & Dieckmann, P. (2021). Prospective risk assessments of patient safety events related to drug shortages in hospitals: Three actor-level perspectives. *Exploratory Research in Clinical and Social Pharmacy*, *3*, 100055.

Pradhan, N., Gavali, J., & Waghmare, N. (2015). WHO (World Health Organization) guidelines for standardization of herbal drugs. *International Ayurvedic Medical Journal*, *3*(8), 2238-2243.

Quintana, J. M., González, N., Bilbao, A., Aizpuru, F., Escobar, A., Esteban, C., ... & Thompson, A. (2006). Predictors of patient satisfaction with hospital health care. *BMC health services research*, *6*(1), 1-9.

Ramanathan, (2000), Siddha oudatha pakaviyal, Ayurveda medical officers association, Jaffna Ranjit M.Senaviratne, (2002) Pharmacy, First edtion, M.D.Gunasena & co ltd, 60. Rastogi, S., Singh, N., & Pandey, P. (2020). Telemedicine for Ayurveda consultation: Devising collateral methods during the COVID-19 lockdown impasse. *Journal of Ayurveda and Integrative Medicine*, 100316.'

Samal, J., & Pratap, A. K. (2013). Knowledge and perception regarding the issues, opportunities and practices of public health among Ayurveda interns in India. *South East Asia Journal of Public Health*, *3*(1), 74-76.

Saoji, A., Mahajan, S., & Deshpande, S. (2015). Added advantage of ayurvedic management in a series of 100 cases of osteoarthritis of the knee joint: a shared experience between Orthopaedic and Ayurvedic Faculty. *Egyptian Rheumatology and Rehabilitation*, *42*(1), 7-10.

Shiffa & Fahamiya, 2017, Ilaj Bit Tadbeer (Regimenal therapy in unani medicine),IBH publication,Colombo, 42,60,63

Snigdha, S. A., Alam, M. M., Dilshad, S., Salam, S. A., Biswas, A., & Hawlader, M. D. H. (2020). Level of patient satisfaction at government Unani & Ayurvedic Medical College Hospital in Dhaka, Bangladesh. *Public Health in Practice*, *1*, 100037.

Sokol, M. C., McGuigan, K. A., Verbrugge, R. R., & Epstein, R. S. (2005). Impact of medication adherence on hospitalization risk and healthcare cost. *Medical care*, 521-530.

Spence, C., & Keller, S. (2019). Medicine's melodies: On the costs & benefits of music, soundscapes, & noise in healthcare settings. *Music and Medicine*, *11*(4), 211-225.

Suhail, P., & Srinivasulu, Y. (2021). Perception of service quality, satisfaction, and behavioral intentions in Ayurveda healthcare. *Journal of Ayurveda and integrative Medicine*, *12*(1), 93-101.

Sundell, J., Levin, H., Nazaroff, W. W., Cain, W. S., Fisk, W. J., Grimsrud, D. T., & Weschler, C. J. (2011). Ventilation rates and health: multidisciplinary review of the scientific literature. *Indoor air*, *21*(3), 191-204.

Takbiri, A., Takian, A., Rahimi Foroushani, A., & Jaafaripooyan, E. (2020). The challenges of providing primary health care to Afghan immigrants in Tehran: a key global human right issue. *International Journal of Human Rights in Healthcare*, *13*(3), 259-273. Tennakoon, T., & de Zoysa, P. (2014). Patient satisfaction with physiotherapy services in an Asian country: A report from Sri Lanka. *Hong Kong Physiotherapy Journal*, *32*(2), 79-85.

Ware Jr, J. E., Snyder, M. K., Wright, W.R., & Davies, A.R. (1983). Defining and measuring patient satisfaction with medical care. *Evaluation and program planning*, *6*(3-4), 247-263.

World Health Organization (2019) who global report on traditional and complementary medicine 2019

Zhang, Y., Tzortzopoulos, P., & Kagioglou, M. (2019). Healing built-environment effects on health outcomes: Environment–occupant–health framework. *Building research & information*, *47*(6), 747-766.

Zion, S. R., & Crum, A. J. (2018). Mindsets matter: a new framework for harnessing the placebo effect in modern medicine. *International review of neurobiology*, *138*, 137-160.