

Determining Patient's Satisfaction with Medical Care

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Abstract:

The need to achieve patient satisfaction should make medical service providers realize the importance of healthcare marketing. Therefore, Hospitals, Clinics and Medical services should actively determine the needs of health care customers and tailor their services to meet those needs and to attract patients to use these services. The purpose of this paper is to briefly review the literature about how the quality of medical services is perceived and to propose a research model in order to determine the degree of patient satisfaction with medical care. Results showed that trust is the main antecedent of satisfaction in medical care and that improving communication skills and developing better patient rapport skills for dealing with adverse patient behavior are essential determinants of patient's satisfaction.

Introduction

Customer satisfaction is a person's feeling of pleasure or disappointment resulting from comparing product/service's perceived performance or outcome in relation to his or her expectations. As this definition makes clear, satisfaction is a function of perceived performance and expectations. If the performance falls short of expectations, the customer is dissatisfied. If the performance matches the expectations, the customer is satisfied. If the performance exceeds expectations, the customer is highly satisfied or delighted.

Recently, Providers of medical services have awakened to consumer challenges, competition, quality, and the realities of marketing. With these changes, a related and equally important issue has emerged, the client-provider relationship on the overall medical service quality evaluation. Clients are increasingly frustrated with the commercialization of medical service, proliferated bureaucratic health care system and weakened client-provider relationship. (*Astrachan, 1991; Bryant et al, 1998; Sinay, 2002*).

To achieve patient satisfaction, medical service providers should realize the importance of healthcare marketing. Therefore, Hospitals, clinics and medical service providers should make effort to develop relationship marketing with their patients, determining their needs, and tailoring their services to meet those needs.

Clients' definition of medical services quality

To define quality of medical services one must first unravel a mystery; the meaning of quality itself. The quality mystery -something real, capable of being perceived and appreciated, but not subject to measurement- has been puzzling us since the Code of Hammurabi was set down. Two sources were used to provide several general clues: the works of Donabedian and Steffen.

Avedis Donabedian, the leading thinker in modern medical quality assurance, states that "it is useful to begin with the obvious by saying that quality is a property that medical service can have in varying degrees." It follows that an assessment of quality is a judgment whether a specified instance of medical service has this property, and if so, to what extent (*Donabedian, 1980*). This first definition portrays a "metaphysical sense" since it reflects the philosophic tradition of using "quality" in the same sense as "property." Thus, philosophers speak of primary qualities as those properties that depend on person's perceptions.

On the other hand, Grant Steffen defines quality as "the capacity of an object with its properties to achieve a goal". This definition shifts the focus of quality from the property to the capacity to achieve a goal and thus makes the goal the factor that determines quality. It follows, then, that quality can be measured only with reference to a goal. The more completely the goal is achieved, the higher we will judge the quality. Accordingly, quality of medical services is "the capacity of the elements of that service to achieve

legitimate medical and nonmedical goals” set by the patient with the assistance of the physician. Medical goals are determined by the nature of the patient’s illness and nonmedical goals are determined by the needs of the physician and the patient to maintain autonomy. These goals are limited by what is legally permitted, ethically acceptable, and medically possible (*Steffen, 1988*). This second definition of quality portrays a “preference sense” since it implies preference and value. Thus, we prefer things that satisfy our needs, fulfill our expectations, and achieve our goals over those things that do not. Those things that we prefer have quality, some having more quality than others do.

This preferential sense must be distinguished from the metaphysical sense proposed by Donabedian. Quality in the metaphysical sense is identical with the properties of an object and does not imply preference. In contrast, quality in the preferential sense is identical not with the properties to achieve a goal, this goal being a state of affairs that is preferred to other states.

It is very obvious that clients, individually and collectively, contribute in many ways to the definition of medical service quality. One way is by influencing what is included in the definition of “health” and “health services” (*Donabedian, 1980*). It is generally believed that clients tend to have a broader view of these things and, as a result, they expect more from the medical services than the medical services are willing or able to give. Clients contribute very heavily to the definition of medical service quality with their values and expectations regarding the management of the interpersonal process. In this context, clients are the primary definer of what quality means.

Client satisfaction in medical services

Client satisfaction is of prime importance as a measure of the quality of medical services because it gives information on the provider’s success at meeting those client values and expectations, which are matters on which the client is the ultimate authority. The measurement of satisfaction is, therefore, an important tool for research, administration, and planning. The informal assessment of satisfaction has an even more important role in the course of each practitioner-client interaction, since it can be used continuously by the practitioner to monitor and guide that interaction and, at the end, to obtain a judgment on how successful the interaction has been (*Donabedian, 1980*).

However, client satisfaction also has some limitations as a measure of quality. Clients generally have only a very incomplete understanding of the science and technology of care, so that their judgments concerning these aspects of care can be faulty. Moreover, clients sometimes expect and demand things that it would be wrong for the practitioner to provide because they are professionally or socially forbidden, or because they are not in the client’s best interest. For example, if the patient (client) is dissatisfied because his unreasonably high expectations of the efficacy of medical science have not been met, one could argue that the practitioner has failed to educate the patient. And when the patient is dissatisfied because a desired service has been denied, the grounds for that denial could be of questionable validity, especially if it is assumed that the primary responsibility of the

practitioner is to the individual client, and that the client is, ultimately, the best judge of his own interests, provided that he is mentally unimpaired and properly informed. These limitations do not lower the validity of patient satisfaction as a measure of quality, but they are the best representation of certain components of the definition of quality, namely, those which pertain to client expectations and valuations (*Donabedian, 1980*).

The clients' view of Medical Service Quality

People are seldom asked to say what they think the quality of medical service means. What is good doctor, or clinic? What is a bad one? What does the respondent like and dislike about his doctor, clinic, and so on? From these opinions about the attributes of providers, inferences must be drawn about the ingredients of "goodness" in the care they give. In order to make the task simpler, the respondent is often given a list of attributes and asked to rank all these or select some. When this is done, the questioner's view of the boundaries and content of the concept of quality may be imposed on the respondent. Moreover, the respondent's answers are influenced by his interpretation of the language in which the choices are presented.

Much of the literature on client views of the good doctor or clinic pertains to the relative importance of the technical management of illness as compared to the management of the relationship between the client and the practitioner. In the early 1950s, Rose Laub Coser (1956) conducted "standardized interviews" with 51 patients at a hospital. When Coser asked "what is your idea of a good doctor?" the answers given by the patients seemed to classify them into two distinct groups. A little more than half of the patients saw the good doctor as one who provided kindness, love, and security. He "talks nice, shows interest, makes you feel good, so all-knowing and all-powerful that you can rest secure in his safe-keeping." On the other hand, the remaining patients focused on the doctor's scientific and professional competence. Also Coser asked "what makes a good patient?" and again a little more than the half thought that a good patient should be to some degree autonomous, whereas almost all the rest thought that the patient should be totally submissive. In addition, those who defined goodness in technical-professional terms saw the patient as rather autonomous and the others, who defined doctor's goodness in terms of kindness, personal interest, and care, saw the patient as submissive.

Later on, Friedson (1961) interviewed patients about their reasons for liking and disliking certain doctors, and for continuing to receive care from one but not from another. Friedson concluded that "patients assume that all doctors possess a minimal competence" and they are concerned only with degrees of competence. The patients defined quality in terms of certain behaviors on the part of the physician, or attributes of his care, which they felt denoted personal interest or competence. In addition, these two traits were, themselves, interrelated, since they were necessary conditions to a highly individualized application of medical knowledge to each patient condition, in a manner that took account of the patient's needs, expectations, and preferences.

The attributes of good care identified by Friedson were further studied in several researches. Cartwright (1967) interviewed patients to define the appreciated qualities for

doctors. Majority of the responses showed the most appreciated qualities related to the manner or personality of the doctor and the way they looked after the patient.

Another study by Sussman et al (1967) confirmed that the attributes of interpersonal and communication skills were highly ranked by patients. Their results corresponded to the findings of Cartwright in showing an emphasis on the management of the interpersonal process, and to the findings of Coser in revealing two different orientations.

Quality assessment

1- Quality as a comparison between Expectations and Performance

Lewis and Booms (1978) claimed that service quality involves a comparison of expectations with performance. In line with this, Gronross (1982) developed a model in which he contends that clients compare the service they expect with perceptions of the service they receive in evaluating service quality. He postulated that two types of service quality exist: technical quality, which involves what the client is actually receiving from the service, and functional quality, which involves the manner in which the service is delivered. Furthermore, Tarantino (2004) stressed on the fact that patients' satisfaction is truly measured based on two factors, their expectations of the service and their perceptions of the actual service they received.

Parasuraman et al (1988) defined service quality as "a global judgment, or attitude, relating to the superiority of the service." They link the concept of service quality to the concepts of perceptions and expectations as follows: "Service quality is viewed as the degree and direction of discrepancy between clients' perceptions and expectations" (*Parasuraman et al*, 1985). They developed an instrument known as SERVQUAL for measuring customers' perceptions of service quality (*Parasuraman et al* 1988 & 1991). Additionally they developed a model of service quality based on the magnitude and directions of five "gaps," which include client expectations-experiences discrepancies in addition to differences in service design, communications, management, and delivery (*Zeithaml et al*, 1988). The five gaps are:

- Gap 1: Difference between client's expectations and management's perceptions of these expectations.
- Gap 2: Difference between management's perceptions of clients' expectations and service quality specifications.
- Gap 3: Difference between service quality expectations and service quality delivery.
- Gap 4: Difference between service quality and the influence of external communications on clients' expectations.
- Gap 5: Difference between clients' expectations and clients' perceptions of service delivery, which is caused by the combined influences of Gaps 1 to 4.

Later on, Parasuraman et al (1994), published a model in which consumers have a “zone of tolerance” bounded by adequate and desired service levels. If a service encounter does not meet their minimal performance criteria, then they become dissatisfied and develop a negative image of the service.

2- Quality Evaluations in Medical Services

According to Donabedian (1988), the measurement of effective medical service system is described in terms of “Structure, processes, and outcomes.”

- Structure denotes the attributes of the settings in which care occurs. This includes the attributes of material resources, human resources, and organizational structure.
- Process denotes what is actually done in giving and receiving care. It includes the patients’ activities in seeking care and carrying it out as well as the physician’s activities in making a diagnosis and recommendation or implementing treatment.
- Outcome denotes the effects of care on the health status of patients and population. Improvement in the patient’s knowledge and salutary changes in the patient’s behavior are included under a broad definition of health status, and so is the degree of the patient’s satisfaction with care.

Research Model Development:

In medical care literature, perceptions are defined as patients’ beliefs concerning the medical services received or experienced. Expectations are defined as desires or wants of the patients or in other word what they feel an ideal standard of performance the physician should offer rather than would offer. These expectations may be based, in part or total, on past relevant experiences, including those gathered vicariously. For example, one may form expectations about a visit to a physician from one’s own experience or by observing or being informed about someone else’s experience.

In computing medical service-quality gaps, a modified version of the SERVQUAL is more appropriate due to the unique characteristics of physicians and physician-client relationship. For example, physicians typically have advanced degrees, meet credential requirements, and often hold equity positions in their organizations.

The interactive nature of medical services indicates a need to examine the perceptions of both parties involved in the service encounter. Overall, physicians’ perceptions most directly affect the design and delivery of the services offered, whereas clients perceptions more directly determine evaluation of the service delivered. Hence, both parties are very important and must be considered if a more thorough understanding of service quality is to be gained.

Potential gaps that relate to expected and experienced service and represent both sides of the service exchange should have a significant impact on the service evaluation. In general, these gaps include:

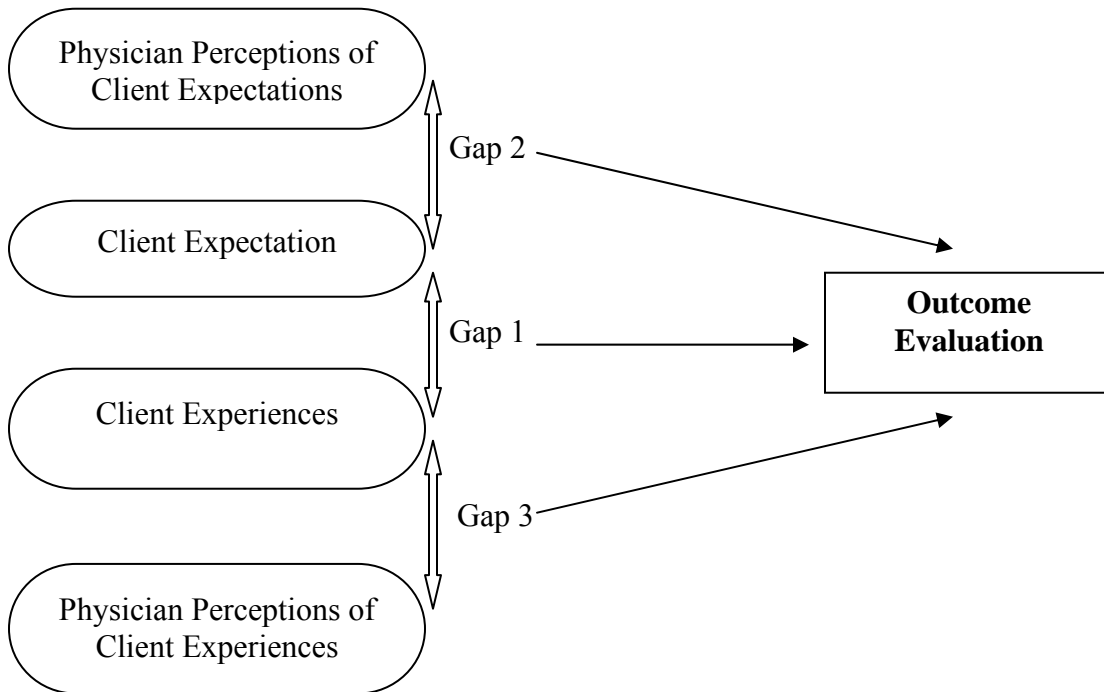
- An intra-client gap between client expectations and client experiences and,
- Client-physician gaps between client expectations and physician perceptions of those expectations, as well as between client experiences and physician perceptions of those experiences.

The gaps proposed are: See Figure 1.

Gap1: Client expectations-client experiences

Gap2: Client expectations-physician perceptions of client expectations

Gap3: Client experiences-physician perceptions of client experiences



(Fig.1)

Implicit in these gaps are the following hypotheses to be tested:

H1: the level of positive client evaluation of the clinical service is inversely related to gap1

H2: the level of positive client evaluation of the clinical service is inversely related to gap2

H3: the level of positive client evaluation of the clinical service is related positively to gap3

Gap1 hypothesized to be related to positive client evaluation because it measures the difference between client expectations and experiences, a standard approach to determine satisfaction and assessing an encounter.

Gap2 and Gap3 are hypothesized to be related to positive client evaluation because they reflect differences between client's expectations/experiences and the physician's perceptions of them. The physician would design, develop, and deliver the service offering on the basis of his/her perceptions of client expectations. Likewise, modifications to the service offering would be affected by the physician's perceptions of client experiences. Whether these experiences exceed, match, or are below expectations can have a profound effect on future client-physician relationships. For example, if a physician exceeds the client's expectations, a true person-to-person bonding relationship often is initiated or furthered, which in turn builds client loyalty and may also encourage referrals. Therefore, one can argue that gaps in either of these gaps areas can directly influence positive client evaluation.

In addition, examining the relationships between medical service quality, patient satisfaction, and patient intention to return for the same medical service provider in case a need arises should be considered. The following three additional hypotheses are to be tested:

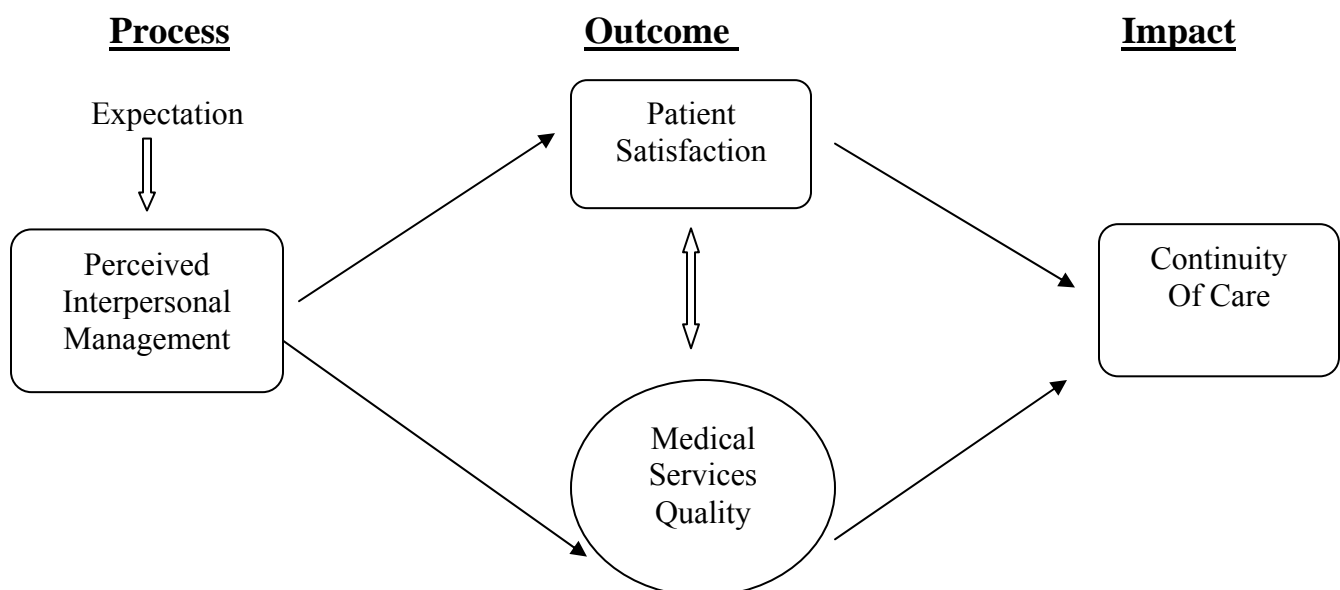
H4: client satisfaction is an antecedent of medical service quality.

H5: client satisfaction has a significant impact on patient's behavioral intention.

H6: Medical service quality has a significant impact on patient's behavioral intention.

Proposed conceptual model of Medical Service Quality:

(Fig.2)



Research Design:

To address the model developed based on the literature review, a survey technique was followed. The key determinants of patient satisfactions were determined via focus groups and questionnaires.

The questionnaire were be based on past researches in the medical area (*Ware et al, 1975; Donabedian, 1980; Brown and Swartz, 1989; Rubin et al, 1990; Badrick, 1996; James, 2002; Tam, 2004; Gummerus et al, 2004; Tarantino, 2004; and Willging, 2004*)

The questions developed were tested through focus group techniques. In this case, three groups of 10 participants each (6 regular patients, 2 medical staff, 2 physicians) convened in a round table discussion in the presence of a moderator (the researcher who has reviewed the literature extensively). The meeting was for two hours and the purpose was to discuss the elements of the questionnaire proposed by the moderator who has listed the questions based on the literature. The moderator did not interfere but stimulated the discussion and then summed up the results of the three meetings into one single questionnaire.

In addition, care was taken to include statements that correspond to the ten critical dimensions of service quality proposed by Zeithaml et al (1990). Those critical dimensions or evaluation criteria that patients use in assessing service quality are:

- 1) *Courtesy*: Politeness, respect, consideration, and friendliness of physicians and medical staff.
- 2) *Access*: Approachability and ease of contact.
- 3) *Communication*: Keeping patients informed in the language they can understand and listening to them.
- 4) *Understanding*: Making the effort to know patients and their obligations.
- 5) *Empathy*: Caring, individualized attention provided to patients.
- 6) *Reliability*: Ability to perform the promised service dependably and accurately.
- 7) *Tangibles*: Appearance of physical facilities, equipment, staff, and communication material.
- 8) *Responsiveness*: Willingness to help patients and provide prompt service.
- 9) *Competence*: Possession of the required skills and knowledge to perform the service.
- 10) *Assurance*: Knowledge and courtesy of physicians and their ability to convey trust and confidence.

These evaluation criteria are a function of the expectations patient bring to the service situation, and experiences patient received during the encounter. Expectations reflects what the patient hopes to receive, while experience reflects what the patient perceive is getting. See Appendix 1.

Data Analysis

Descriptive Profile:

A total of 800 questionnaires were distributed to a convenient selection of patients (750) and physicians (50). A total of 700 completed and useable questionnaires (654 patients and 46 physician), 87.50% were used for the analysis. The remaining 100 questionnaires were not used for the analysis because they were more than 15% incomplete.

Patients' Perceived Expectation and Experience in Relation to Medical Service Quality:

Underpinned by the disconfirmation paradigm, the patients' expectations or satisfaction in relation to the Medical Service attributes were measured by asking the respondents to rate: 1-Expectations / 2-Experiences. The statements in the questionnaire are rated on a 5-point Likert scale ranging from "Strongly Disagree = 1" to "Strongly Agree = 5"

Reliability was measured by the Cronbach's alpha. First results showed a weak reliability for the 42 items present in the questionnaire. However, narrowing down the items to 21 intercorrelated variables, resulted in a strengthened reliability of 0.779 Cronbach's alpha:

Hypothesis testing

H1: the level of positive client evaluation of the clinical service is inversely related to gap1 (client Expectation-client experience).

Several variables were taken and cross-tabulated in order to get the Chi-square test. The combination of variables and their results shows the cross-tabulation to have a significance level of almost 0 which indicates that these variables are highly interrelated; however they are positively related thus we **reject H1**.

H2: the level of positive client evaluation of the clinical service is inversely related to gap2 (client expectations-physician perceptions of client expectations).

The Pearson's chi-square test shows that there is a strong relationship between the variables; however, if we look at the cross-tabulation and examine the raw percentages of the variables we can conclude that they are inversely related, and thus we **accept H2**.

H3: the level of positive client evaluation of the clinical service is related positively to gap 3 (Client experiences-physician perceptions of client experiences)

The data analysis through cross-tabulation shows that the level of positive client evaluation of the clinical service is highly related to gap 3, and this relationship is positively related since the clients' expectation increase as the expectation evaluation increase. Therefore, we **accept H3**.

H4: client satisfaction is an antecedent of medical service quality

The chi-square test shows that client satisfaction is highly dependent on medical service quality (level of significance is 0.00), thus, we **accept H4**.

H5: client satisfaction has a significant impact on patient’s behavioral intention. Once again we have used the chi- square test to test the null hypothesis (H5), and we can see that client satisfaction has a highly significant impact patient’s behavioral intentions, since the correlation indicator is very high ($0.0 < 0.05$). Therefore, we **accept H5**.

H6: Medical service quality has a significant impact on patient’s behavioral intention. After doing the cross tabulation to test H6, we concluded that medical service quality is highly correlated to patient’s behavioral intention (level of significance is almost 0.00). Thus, we **accept the null hypothesis H6**.

Factor Analysis

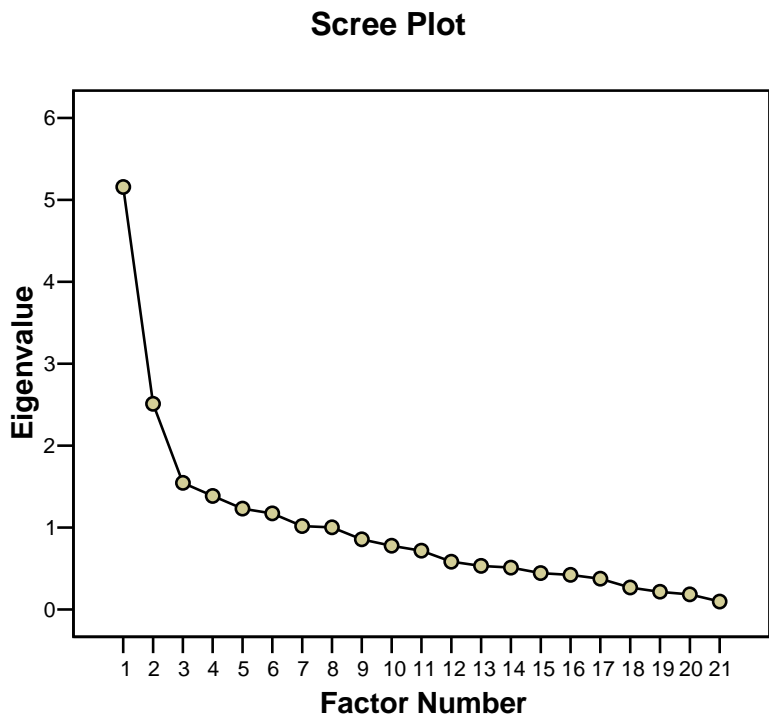
The variance explained by the initial solution, extracted components, and rotated components is displayed. This first section of the table shows the Initial Eigenvalues. The Total column gives the eigenvalue, or amount of variance in the original variables accounted for by each component. *Table 1.*

Factor	Initial Eigenvalues			Extraction Sums of Squared Loadings			Rotation Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	5.157	24.559	24.559	4.805	22.879	22.879	3.936	18.743	18.743
2	2.510	11.951	36.510	2.219	10.569	33.448	2.732	13.010	31.753
3	1.544	7.353	43.863	1.010	4.811	38.259	.928	4.420	36.173
4	1.386	6.598	50.461	.915	4.359	42.618	.882	4.201	40.374
5	1.231	5.861	56.322	.711	3.387	46.005	.857	4.082	44.456
6	1.173	5.583	61.906	.635	3.022	49.027	.697	3.319	47.775
7	1.018	4.848	66.754	.511	2.432	51.459	.675	3.212	50.988
8	1.002	4.774	71.528	.394	1.877	53.336	.493	2.348	53.336
9	.856	4.075	75.602						
10	.777	3.702	79.304						
11	.717	3.415	82.719						
12	.583	2.777	85.496						
13	.532	2.532	88.028						
14	.510	2.431	90.458						
15	.444	2.114	92.572						
16	.422	2.008	94.580						
17	.375	1.786	96.366						
18	.268	1.275	97.641						
19	.216	1.026	98.668						
20	.184	.875	99.543						
21	.096	.457	100.000						

Extraction Method: Principal Axis Factoring.

Only eight factors in the initial solution have eigenvalues greater than 1. Together, they account for almost 71% of the variability in the original variables. This suggests that three latent influences are associated with medical service satisfaction, but there remains room for a lot of unexplained variation. However in the cumulative variability the factors are reduced to three only since they only have the eigenvalues greater than one. The cumulative variability explained by these three factors in the extracted solution is about 38%, a difference of 6% from the initial solution.

The scree plot helps us to determine the optimal number of components. The eigenvalue of each component in the initial solution is plotted. **(Fig.3)**



Factor Matrix. Table 2.

VARIABLES	1	2	3
MyDrIsCarefulToExplainWh atIamExpectedToDo			.763
MyDrExaminesMeCarefully BeforeDecidingWhatsWron g	.604		
IHaveCompleteTrustInMyDr	.447		
MyDrTakesRealInterestInM e	.714		
IHaveMyDrSFullAttentionW helSeeHim	.766		
MyDrAlwaysTreatsMeWith Respect	.634		
TheStaff@MyDrOfficeVery FlexibleInDealingWIndividu NeedsAndDesires	.686		
MyDrSOfficeStaffAlwaysAct sInProfessionalManner	.671		
MyDrExplainsALittleAboutM yMedicalProblems	.653		
MyDrIsBetterTrainedThanT heAverageDr	.431	.520	
ComparedToOtherDrsMyDr MakesFewerMistakes	.450	.777	
MyDrKeepsUpOnTheLatest MedicalDiscoveries	.452	.789	
MyDrGivesMeChoicesWhe nDecidingMyMedicalCare	.712	.412	
CRONBACH'S ALPHA	.781	.795	
CUMMULATIVE PER CENT OF VARIANCE	24.6	36.5	43.86

A principle components analysis with varimax rotation was conducted to obtain the dimensions of medical service quality satisfaction. The Kaiser test for eigenvalues greater than one suggests a three-factor solution which explains 38% of the variance. A factor loading of 0.4 was used as a cut off point to eliminate variables with low correlation from each factor and a reliability test was applied to examine the internal consistency of each factor separately. The results show that the value of the cronbach coefficient alpha of the first two variables were 0.781 & 0.911 respectively, indicating that there is good internal consistency among items within each of the two medical service quality satisfaction

dimensions. However, factor 3 has no coefficient alpha since it compromises only one variable.

Factor one is composed of the Dr.'s real interest in the patient, the Dr's full attention to the patient while sitting with him, and the Dr.'s offers of different choices when Medical care is concerned. Factor two Compromises the Dr's continuous follow up on the latest medical technologies, and comparing to other Drs., the Patient's Dr. is viewed to commit fewer mistake than other Drs. While the third factor consists of the Dr.'s carefulness to explain to the patient what is he expected to do. *Table 3.*

Factor 1	Factor 2	Factor 3
My Dr. takes real interest in me	Compared To Other Drs My Dr Makes Fewer Mistakes	My Dr Is Careful To Explain What I Am Expected To Do
I have my Dr's full attention when I see him/her	My Dr Keeps Up On The Latest Medical Discoveries	
The Staff at my Dr's Office are Very Flexible In Dealing with my Individual Needs And Desires		
My Dr's Office Staff Always Acts In Professional Manner		
My Dr Explains A Little About My Medical Problems		
My Dr Gives Me Choices When Deciding My Medical Care		

Conclusions and Implications for future research:

The employment of a modified SERVQUAL instrument had accomplished an "objective" assessment of medical service quality. Much is learned regarding the patient-physician relationship and encounter; (1) Physicians are spending enough time with their patients during the encounter, (2) physicians are answering the patients' questions honestly, completely, and understandably, and (3) physicians are treating patients with respect and are being friendly with them.

Findings of this study indicate that high quality medical service can be delivered by hospitals or clinics only when those latter foster a customer oriented marketing culture characterized by emphasis on medical service quality orientation and interpersonal relationship. This can be assured through the following dimensions:

- Systematic, regular measurement and monitoring of nurses and Drs' performance
- Clear focus on patients needs
- A strong linkage between the clinic staffs' behavior and the clinic's image
- The desire to meeting the clinic's expectations on medical quality service
- Emphasis on communication skills
- Staffs' attention to details in their work
- Recognition of employees invaluable assets of the firm
- Frequent interaction between Drs and front line staffs

This research gives importance to the medical service quality and its impact on patients' satisfaction. Still, it has several implications and limitations.

- Additional research is needed on evaluating medical service quality as this study was conducted on medical care provided by physicians and should not be construed as representing the entire medical services.
- The focus of this research is the dyadic interaction between a single physician and a single client, yet often the client's time is spent interacting with support staff and/or multiple physicians.
- SERVQUAL is designed to measure interpersonal quality only. However, interpersonal quality cannot be sustained without accurate diagnoses and procedures. Such technical quality should be the focus of future research.

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Appendix 1: Questionnaire used in the research:

1-Expectations

The following set of statements deal with the opinion of a patient to medical services. The patient will show the extent to which he thinks Clinics or Hospitals offering medical services should possess the features described in each statement.

There is no right or wrong answer; the interest is in the number that best shows the expectations about organizations offering medical services.

- (1) *Strongly disagree*
- (2) *Disagree*
- (3) *Neither agree nor disagree*
- (4) *Agree*
- (5) *Strongly agree*

- Appointments should be made easily and quickly.
- I expect the medical service's fees to be reasonable for the professional service rendered.
- I expect my doctor to keep up on the latest medical technologies.
- I expect my doctor (or nurse) to be sincerely interested in me as a person.
- I expect my doctor to examine me carefully before deciding what is wrong.
- I expect my doctor to explain tests and procedures to me.
- I would like to have more health-related information available in the reception area.
- I would like to have brochures available from my doctor explaining my medical problem and treatment.
- I expect the doctor's office to be open at times that are convenient to my schedule.
- I expect the doctor to be available in an emergency.
- Where my medical care is concerned, my doctor should make all decisions.

2-Experiences

The following statements relate to the feelings about the medical services delivered (mainly related to the Physician). The patient will show the extent to which he believes medical services have the feature described by the statement.

There is no right or wrong answer; the interest is in the number that best shows the perception about medical services.

- (1) *Strongly disagree*
- (2) *Disagree*
- (3) *Neither agree nor disagree*
- (4) *Agree*
- (5) *Strongly agree*

- My doctor hears what I have to say.
- My doctor gives me enough information about my health.
- My doctor gives me brochures explaining my medical problem and treatment.
- My doctor is careful to explain what I am expected to do.
- My doctor is extremely attentive to details.
- My doctor spends enough time with me.
- My doctor examines me carefully before deciding what is wrong.
- I have complete trust in my doctor.
- My doctor takes real interest in me.
- I have my doctor's full attention when I see him/her.
- My doctor always treats me with respect.
- My doctor thoroughly explains to me the reasons for the tests and procedures that are done on me.
- My doctor's staff is friendly and courteous.
- The staff at my doctor's office is very flexible in dealing with my individual needs and desires.

- My doctor's office staff always acts in a professional manner.
- My doctor's staff is more interested in serving the doctor than meeting my needs.
- My doctor prescribes many drugs and pills.
- My doctor orders too many tests.
- My doctor takes unnecessary risks in treating me.
- My doctor's main interest is in making as much money as he/she can.
- My doctor and staff talk as if I am not even there.
- My doctor does not admit when he or she does not know what is wrong with me.
- There are some things about the medical care I receive from my doctor that could be better.
- My doctor explains a little about my medical problems.
- My doctor is better trained than the average doctor.
- Compared to other doctors, my doctor makes fewer mistakes.
- My doctor keeps up on the latest medical discoveries.
- My doctor gives me choices when deciding my medical care.
- My doctor is present during his/her clinic hours.
- I am kept waiting a long time when I am at my doctor's office.
- My doctor's office is conveniently located for me.
- My doctor is on staff at a hospital which is convenient for me.