

## ‘WHY PATIENTS PREFER PRIVATE HOSPITAL‘

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### ABSTRACT

Patient satisfaction is a very important means that of activity the effectiveness of health care delivery and quality of medical aid. It denotes the extent to that general health care wants of the patient are met to their necessities. Millions of Indians forced to turn to crippling expensive private healthcare because of lack of quality medical services in public institutions across the country. Private Doctors were the most important single source of treatment in both rural and urban sectors,” said the National Sample Survey Office (NSSO) survey of over 3.3 lakh households across India released this week. Although there too most tending expenses are paid out of pocket by patients and their families, instead of through insurance, because it is assumed that private sectors are being more efficient and provide better treatment to satisfy patients than public hospitals. There are few studies done thus far to live patient satisfaction privately hospitals in Madhya Pradesh. This study was designed to assess the patient satisfaction relating to the services provided privately hospital of Indore (MP) India. During this study eighty five respondents selected conveniently were asked to fill structured survey form to report their satisfaction with their stay in private hospital services of Indore town. The results confirms that quality of care, accountability and various services are main reason for patients preference in private hospitals.

**KEYWORDS:** Patient Satisfaction, Private Hospital, Public Hospital, Out of Pocket Expenses, Quality of Care

### INTRODUCTION

The overall Indian healthcare market is worth around US\$ 100 billion and is expected to grow to US\$ 280 billion by 2020, a Compound Annual Growth Rate (CAGR) of 22.9 per cent. The hospital and diagnostic centers attracted Foreign Direct Investment (FDI) worth US\$ 4.09 billion between April 2000 and September 2016, according to data released by the Department of Industrial Policy and Promotion (DIPP). India also offers vast opportunities in R&D as well as medical tourism. In India, the development assistance for health for a population of 1.3 billion is a total of \$650 million out of which the majority is provided for child and newborn care (\$230 million) and maternal health (\$110 million)<sup>a</sup>. Today, hospitals area unit a vital facet of society having the tremendous responsibility to promote the health of the community it serve With ever-increasing stress on specialization and tertiary care, primary care has become the poor relation in modern-day medication. Despite recent developments in the India healthcare sector, there is still

Great concern about the quality of healthcare services in the country. Health care service is the combination of tangible and intangible aspect with the tangible aspect dominating the intangible aspect. Though the services (consultancy, diagnosis etc) offered by the doctor's are completely intangible. The tangible aspect can include the building, the décor, etc. Efforts are made by the hospitals to tangibles the service being offered by them.

The Health sector comprises of the followings;

- Medical care providers like physicians, specialist clinics, nursing homes, hospitals.
- Diagnostic service centers and pathology laboratories.
- Medical equipment manufacturers.
- Contract research organizations (CRO's), pharmaceutical manufacturers
- Third party support service providers (catering, laundry).

Traditional practitioners of health care have contributed to the medicinal needs of society. Prior to independence the healthcare in India was in shambles with large number of deaths and spread of infectious diseases. After independence the Government of India laid stress on Primary Health Care and through sustained efforts the health care system showed improvement across the country. The government primary, secondary or tertiary health care initiative was not enough to meet the demands of the growing population. Alternate sources of finance were critical for the sustainability of the health sector.

## REVIEW OF LITERATURE

Studies of Patient Satisfaction in health care originated in the USA during the 1950s. Patient satisfaction is defined as “an evaluation of distinct health care dimensions” (Linder-Pelz, 1982) Patient satisfaction regarding health care is a multidimensional concept that now becomes a very crucial health care outcome. A meta-analysis of satisfaction with medical care revealed the following aspects for patient satisfaction and overall performance of an organization: overall quality, trust, reputation, continuity, competence, information, organization, facilities, attention to psychosocial problems, humaneness and outcome of care (Hall & Dorman, 1988, p. 935). Patient satisfaction is predicted by factors relating to caring, empathy, reliability and responsiveness (Tucker and Adams, 2001). Ware et al. (1978) identified dimensions affecting patient evaluations, including physician conduct, service availability, continuity, confidence, efficiency and outcomes.

Alexander W. Chessman, Amy V. Blue, Gregory E. Gilbert, Maura Carey, G. Mainous (2003) studied medical student's interpersonal & communication skill as a fundamental dimensions of their clinical competence. They conducted a comparative study applying correlation between structural clinical examination & clinical practice examination and patient satisfaction was measured. Their study indicates that measures of student's communication and interpersonal skills in one clinical performance setting are not consistent with similar measures in another setting.

Allan Smith, Ilona Juraskova, Phyllis Bulow, Caroline Miguel, Anna-Lena Lopez, Sarah Chang, Richard Brown, Jurg Bernhard (2010) in their study found that Cognitive and emotional aspects of Sharing Decision and Managing emotions in oncology consultations have different effects on various patient outcomes. It is important that doctors focus on both sharing decisions and managing emotions in consultations. Communication skills training addressing both these areas may be an effective way to improve diverse patient outcomes.

Amy P. Abernethy, James E. Herndon II, Jane L. Wheeler, Meenal Patwardhan, Heather Shaw, H. Kim Lyerly, and Kevin Weinfurt (2008) in their paper titled ‘Improving Health Care Efficiency and Quality Using Tablet Personal

Computers to Collect Research' - came with the conclusion that Patients supported e/Tablets as: easy to read (94 percent), easy to respond to (98 percent), comfortable weight (87 percent). Generally, electronic responses validly reflected responses provided by standard paper data collection on nearly all subscales tested

Bull SA, Hu XH, Hunkeler EM, Lee JY, Ming EE, Mark son LE, et al. (2002) in their paper titled "Discontinuation of use and switching of antidepressants: Influence of patient physician communication" came with the conclusion that A doctor who offers support, empathy, and clear and complete explanations at every step can help alleviate these to a significant extent. Good communication also enhances adherence to long term therapy.

C.F.Quirt,W.J. Mackillop,A.D. Ginsburg, L.Sheldon, M.Brundage, P.Dixon, L.Ginsburg (1997) in their paper titled "Do doctors know when their patients don't? A survey of doctor -patient communication in lung cancer" concluded that before devolving responsibility for a medical decision to the patient, the doctor should : first ascertain that this is the patient's preferred role in the decision process; second, decide the minimum set of facts that a patient need to understand in order to make a substantially autonomous decision; third, provide the patient with the key information in a form which he or she can understand:& forth ask explicit questions to ensure that the patient understands the issues, & if he or she does not, back up & try again.

ClaramitaM,SusiloAP,Kharismayekti M, Dalen Jv, VieutenCv, (2013) In their study titled "Introducing a partnership doctor -patient communication guide for teachers in culturally hierachial context of Indonesia." concluded that Despite general comprehension of the principles of partnership doctor -patient communication,teachers still had a difficulty reflecting it to Southeast Asian culture & teaching the concept in their chapters. However, teachers proposed an adapted guide with a simpler structure, tailored to their clinical environment,characterized by high patient load & limited time for doctor patient communications

C. Scott Smith, Magdalena Morris, Francine Langois-Winkle, William Hill, Chris Francovich (2010) in their study titled" A pilot study using Cultural Consensus Analysis to measure Systems-Based Practice performance" concluded that the correlation between patient satisfaction cumulative scores and the difference in patient and resident cultural consensus analysis rankings on 'goals' was -0.527 (less difference between residents' and patients' value ranking correlates with higher satisfaction). The correlation with 'changes' was -0.351. The correlation between nursing satisfaction cumulative scores and the difference in nursing staff and resident cultural consensus analysis rankings on 'goals' was -0.086. The correlation with 'changes' was -0.415.

Dugdale D, Epstein R, and Pantilat S,(1999) in their study titled " Time and the Patient-Physician Relationship" examine the effects of limiting time on the Patient-Doctor relationship & review the effects that are attributable to managed care. They offer recommendations for teaching medical students and residents skills that will help establish and maintain their Patient-Doctor relationships in the face of time pressure.

Edward E. Bartlett, Marsha Grayson, Randol Barker, David M. Levine Archie Golden & Sam Libber (1984) in their study at John Hopkins institute, found that quality of interpersonal skills influenced patient outcomes more than quantity of teaching and instruction. Secondary analyses found that all the effects of physician communication skills on patient adherence are mediated by patient satisfaction and recall. These findings indicate that the physician might pay particular attention to these two variables in trying to improve patient adherence, and that enhancing patient satisfaction may be pivotal to the care of patients with chronic illness.

G. Calap Alexander, Lawrence P. Casalino, David O. Meltzer (2003) "Patient physician communication About Out-Of-Pocket costs" concluded that among respondents, both patients & physician believed that discussion of out of pocket cost were important, yet these discussions occurred infrequently. Physician communication with patients about out of pocket costs may be an important yet neglected aspect of current clinical practice.

Han Z. Li, Zhang, Young-Ok Yum, Juanita Lundgren, Jasrit S. Pahal (2008) in paper titled "Interruption & patient satisfaction in resident-patient consultations" concluded that resident made significantly more interruption than patients specially in categories of intrusive interruption. High correlations were found between residents & Patients on all three categories of interruptions, providing unequivocal support of Communication-Accommodation theory.

Howard B. Beckman, Melissa Wendland, Christopher Mooney, Michael S. Krasner, Timothy E. Quill, Anthony L. Suchman, and Ronald M. Epstein. (2012) "The Impact of a Program in Mindful Communication on Primary Care Physicians". Concluded that the program significantly improved indicators of patient-centered care (e.g. Empathy, Psychosocial Orientation) while also enhancing Physicians' well-being (e.g. decreased Burnout, improved Mood). These changes were mediated by changes in physicians' mindfulness.

Huma Ahmed, Anam Qurush and Maleeha Anwar (2012) in a paper titled "Doctor Patient Relationship in Tertiary Care Hospitals of Pakistan" concluded that Doctor patient relationship involves all those ethical issues which we face daily in hospitals, and when we talk about Tertiary care /Teaching hospitals, then we talk about the highest Ethical values prevailing in the medical profession.. As evident in medical student that they don't pay attention on clinical side while studying for the foreign exams as they intend to practice and learn the practical aspects only after they get residency abroad. Work load in teaching hospitals both in OPD and emergency departments increases the work pressure on doctors while their practical output immensely lowers down resulting sometimes in frustration and chaos from the Patient side.

Katherine L. Kahn, Honghu Liu, John L. Adams, Wen-Pin Chen, Diana M. Tisnado, David M. Carlisle, Ron D. Hays, Carol M. Mangione, and Cheryl L. Damberg (2003) studied "Methodological Challenges Associated with Patient Responses to Follow-up Longitudinal Surveys Regarding Quality of Care, concluded that overall response rates were 54 percent and 63 percent for patients with chronic disease. Patient demographics, health status, use of services, and satisfaction with care in 1996 were all significant predictors of response in 1998, highlighting the importance of analytic strategies (i.e., application of non response weights) to minimize bias in estimates of care and outcomes associated with longitudinal quality of care and health outcome analyses. Process of care scores weighted for non response differed from un weighted scores (p<.001). Stability of responses across time was moderate, but varied by survey item from fair to excellent.

Kathleen M. Mazor, Brian E. Clauser, Terry Field, Robert A. Yood, and Jerry H. Gurwitz (2002) in their paper titled "A Demonstration of the Impact of Response Bias on the Results of Patient Satisfaction Surveys" came with the conclusion that positive correlation was found between mean patient satisfaction rating and response rate in the actual patient satisfaction data. Simulation results suggest response bias could lead to overestimation of patient satisfaction overall, with this effect greatest for physicians with the lowest satisfaction scores.

Kevin J. O'Leary, Tiffani A. Darling, Jennifer Rauworth and Mark V. Williams (2013) Impact of hospitalist communication-skills training on patient-satisfaction scores concluded that Patient satisfaction did not significantly

improve after a communication-skills training program for hospitalists. Because of the small sample size, larger studies are needed to assess whether such a program might truly improve patient satisfaction.

Languets WA, Each P, Kiss A, Wismar B (1998) conducted a study on "Improving communication skills: A randomized controlled behaviorally oriented intervention study for residents in internal medicine." concluded that Good communication is an art that is so far acquired, developed and improved by experience. However, it can also be taught, and assessed, by means of structured programs.

Fujimori M, Shirai Y, and colleges(2014)"Effect of Communication Skills Training Program for Oncologists Based on Patient Preferences for Communication When Receiving Bad News: A Randomized Controlled Trial" concluded that At the follow-up survey, the performance scores had improved significantly, in terms of their emotional support ( $P = .011$ ), setting up a supportive environment ( $P = .002$ ), and ability to deliver information ( $P = .001$ ), Patients who met with oncologists after they had undergone the CST were significantly less depressed than those who met with oncologists in the CG ( $P = .027$ ). However, the CST program did not affect patient satisfaction with oncologists' style of communication. CST program based on patient preferences is effective for both oncologists and patients with cancer. Oncologists should consider CST as an approach to enhancing their communication skills.

Meryn S.(1998) "Improving doctor patient communication." Concluded that lack of communication can lead to treatment discontinuation and therapeutic failure. This can extend to depression and despair, or to anger and complaints. Most complaints in health care systems, both public and private, arise from poor communication. Very few people can judge the quality of a doctor's examination, diagnosis, or prescription. Obviously, relatively few complaints originate in poor performance in these areas. On the other hand, good communication can play a significant part in avoiding complaints and malpractice claims.

MohammadrezaHojat, Daniel Z. Louis, Fred W. Markham, Richard Wender, Carol Rabinowitz, and Joseph S. Gonnella,( 2011) "Physicians' Empathy and Clinical Outcomes for Diabetic Patients " concluded that Empathy, an essential component of the physician-patient relationship, may be linked to positive patient outcomes. Published reports also suggest that indicators of empathic engagement in patient care, such as Physician-Patient Communication, Verbal interaction (e.g., positive talk), nonverbal cues (e.g., appropriate touch, eye contact, bodily posture, gestures), as well as length of the encounter can lead to increased patient satisfaction These findings indicated that the physicians' degree of empathy was a unique and significant contributor to the prediction of good control of hemoglobin A1c for diabetic patients, beyond the contributions of gender and age of the physicians and patients, and type of patients' health insurance.

Moira A. Stewart (1995) in their paper titled "Effective Physician-Patient Communication and Health Outcomes: A Review" concluded that Most of the studies reviewed demonstrated a correlation between effective physician-patient communication and improved patient health outcomes. The components of effective communication identified by these studies can be used as the basis both for curriculum development in medical education and for patient education programs. Future research should focus on evaluating such educational programs.

Michelle Mourad, Andrew D. Auerbach, Judith Maselli, Diane Sliwka, ( 2011) "Patient Satisfaction With a Hospitalist Procedure Service: Is bedside Procedure Teaching Reassuring to Patients" concluded that Patients are highly satisfied with procedure performance by supervised trainees, and many patients were reassured by physician communication during the procedure. These results suggest that patient experience and teaching can be preserved with a

hospitalist-supervised procedure service.

Nicola Mead, Bower P(2000) in their study titled “Patient-Centeredness: a conceptual framework and review of the empirical literature, concluded that ‘patient-centered’ approach is increasingly regarded as crucial for the delivery of high quality care by doctors. However, there is considerable ambiguity concerning the exact meaning of the term and the optimum method of measuring the process and outcomes of patient-centred care. Five conceptual dimensions are identified by them are: bio psychosocial perspective; ‘patient-as-person’; sharing power and responsibility; therapeutic alliance; and ‘doctor-as-person’. Two main approaches to measurement are evaluated: self-report instruments and external observation methods.

Partridge MR, Hill SR.(2000) in paper titled” Enhancing care for people with asthma: the role of communication, education, training and self management” Concluded that a doctor with these skills is more likely to have happy, satisfied patients, than an equally technically competent doctor who does not bother about communication.

Sally Thorne, John L. Oliffe, Kelli I. Stajduhar (2012) “Communicating shared decision-making: Cancer patient perspectives” concluded that patients located what they considered effective or ineffective communication approaches within the context of who they are as people, and the uniqueness of their particular experience. They therefore organize our conceptualizations about their perceptions of shared decision-making within the context of two interrelated themes: experiencing the communicative environment, and negotiating decisional processes. In their efforts to move beyond traditional paternalism, shared decision-making has been widely advocated as best practice in cancer communication.

Sarah L. Clever, Lei Jin, Wendy Levinson, and David O. Meltzer ( 2003) in their paper titled “Does Doctor–Patient Communication Affect Patient Satisfaction with Hospital Care?” results of an Analysis with a Novel Instrumental Variable came out with the findings that there was a significant positive relationship between overall satisfaction and overall ratings of attending physician’ communication behaviors, with an increase in overall satisfaction of 0.58 points on a 5-point scale for each 1-point increase in overall attending’ communication behaviors, Po.001. This relationship was maintained but attenuated in the IV regression, with a coefficient of 0.40, p5.046. Although they found that the relationship between patient communication ratings and overall patient satisfaction may be confounded by patient-level factors, but they nevertheless continue to find evidence of a statistically significant and sizable relationship between physicians’ communication behaviors and overall patient satisfaction after controlling for such factors. These results support the hypothesis that physicians’ communication behaviors are associated with overall ratings of satisfaction.

Silvina Santana, Berthold Lausen, Maria Bujnowska-Fedak, Catherine Chronaki, Per EgilKummervold,Janne Rasmussen( 2012), in a paper titled ‘Tove Sorensen Online Communication Between Doctors and Patients in Europe: Status and concluded that Use of the Internet to communicate with a known health professional is still rare in Europe. Legal context, health policy issues, and technical conditions prevailing in different countries might be playing a major role in the situation. Interest in associated health services is high among citizens and likely to increase.

Susan Williams, JohnWeinnan & Jeremy Dale (1998) in the paper titled “Doctor –patient communication & patient satisfaction; a review, concluded that there is evidence that doctors general information provision during consultations is positively related to patients satisfaction. Patient information provision has also been found to positively associate with patient satisfaction, but not excessive talking. There are mixed & often contradictory findings on the

relationships between specific topics of Information provision & patient satisfaction. For example, Time spent on talking about a patients history has been found to be both negatively& positively related to patient satisfaction.

Teresa Pawlikowska, Wenjuan Zhang, Frances Griffiths, Jan van Dalen and Cees van der Vleuten ( 2011) "Verbal and non-verbal behavior of doctors and patients in primary care consultations – How this relates to patient enablement" and concluded that Consultations that were regarded as patient-centered or verbally dominated by the patient on RIAS coding were considered enabling. Socio-emotional interchange (agreements, approvals, laughter, legitimization) was associated with enablement. These features, together with task-related behavior explain up to 33% of the variance of enablement, leaving 67% unexplained. Thus, enablement appears to include aspects beyond those expressed as observable behavior.

Timothy J. Gallagher, Paul J. Hartung, Holly Gerzina, Stanford W. Gregory Jr., Dave Merolla (2005) in paper titled "Further analysis of a doctor–patient nonverbal communication instrument" the reliability and validity of the relational communication scale for observational measurement (RCS-O) using a random sample of 80 videotaped interactions of medical students interviewing standardized patients (SPs). The RCS-O is a 34-item instrument designed to measure the nonverbal communication of physicians interacting with patients. The instrument was applied and examined in two different interview scenarios. In the first scenario (year 1), the medical student's interview objective is to demonstrate patient-centered interviewing skills as the SP presents with a psychosocial concern. In the second scenario (year 3), the student's interview objective is to demonstrate both doctor-centered and patient-centered skills as the SP presents with a case common in primary care. In the year 1 scenario, 19 of the 34 RCS-O items met acceptable levels of inter-rater agreement and reliability. In the year 3 scenario, 26 items met acceptable levels of inter-rater agreement and reliability. Factor analysis indicated that in both scenarios each of the four primary relational communication dimensions was salient: intimacy, composure, formality, and dominance.

Valerie Jenkins and Lesley Fallowfield (2001) "Can Communication Skills Training Alter Physicians' Beliefs and Behavior in Clinics?" concluded that Physicians who attended the course showed significantly improved attitudes and beliefs toward psychosocial issues compared with controls ( $P = .002$ ). This improvement was reflected in the analysis of the videotaped recordings of their communication behaviors with patients. Expressions of empathy were more likely for the course group at T2 than the controls ( $P = .02$ ), as were open questions ( $P = .001$ ), appropriate responses to patient cues ( $P = .005$ ), and psychosocial probing ( $P = .041$ ). These objective findings were supported by physicians' self report of changes in communication style during interviews with patients., thus increasing the likelihood that such skills will be used in the clinical setting.

William B. Brinkman, Sheela R. Geraghty, Bruce P. Lanphear, Jane C. Khoury, Javier A. Gonzalez del Rey, Thomas G. DeWitt, & Maria T. Britto (2006) carried out a study on "Evaluation of Resident Communication Skills and Professionalism: A Matter of Perspective?" Parent and attending physician ratings were similar on most items, but attending physicians indicated that they frequently were unable to observe the behaviors of interest. Nurses rated residents lower than did attending physicians on items that related to respecting staff (69% vs 97%), accepting suggestions (56% vs 82%), teamwork (63% vs 88%), being sensitive and empathetic (62% vs 85%), respecting confidentiality (73% vs 97%), demonstrating integrity (75% vs 92%), and demonstrating accountability (67% vs 83%). Nurse responses were higher than attending physicians on anticipating post discharge needs (46% vs 25%) and effectively planning care (52% vs 33%).

**Objectives:** To study the patient satisfaction with the services provided in private hospitals

## RATIONALE

This study is undertaken with the aim to find out the level of patient satisfaction related to different parameters of quality health care including the prescription at private health facilities in the Indore city, a centrally placed, business capital of one of the biggest Indian state - Madhya Pradesh. Since research on patient satisfaction can be an important tool to improve the quality of services. Patient satisfaction with the healthcare services largely determines their compliance with the treatment and thus contributes to the positive influence on health.

## RESEARCH METHODOLOGY

The study was carried in private hospitals of Indore city where structured questionnaire was administered personally. The questionnaire which carried standardized scale used in various international studies to measure Patient satisfaction with services provided in private hospitals..They are anchored on 5 point Liker scale where 1 is completely satisfied,2 is somewhat satisfied,3 is neutral, 4 is somewhat dissatisfied and 5 is completely dissatisfied. Questionnaire was administered to patients who had at least 3 days of hospitalization during last 6 months. For getting quality data questionnaire was administered to adult literate patients only.

Pilot study has been conducted and questionnaire has been tested (in Hindi translation also )on the data of 40 respondents. After the pilot study few suggestions were received from the respondents like language of questions which is incorporated and improved the questionnaire

**HYOTHESIS:** To study the patient satisfaction with the services provided in Private hospitals One sample Z test is applied using following services of Private hospital that includes (Accommodation, Cleanliness, Equipment, Overall Nursing Services, Nursing attention and responsiveness, Explanation of test, treatment and procedure by nursing staff, Overall rating of Physician Services Ability of Physician to Diagnose Problems(ailment),Thoroughness of examination by Physician ) with Hypothesis no 16 to Hypothesis no 24 and their summery with results is mentioned here.

Hypothesis1: The patients are satisfied with the accommodation and physical facilities of the Private Hospitals.	Null hypo Rejected	Zvalue8.254
Hypothesis 2: The patients are satisfied with the cleanliness of the Private Hospitals.	Rejected	1.83
Hypothesis 3: The patients are satisfied with the equipment's of the Private Hospitals.	Rejected	8.52
Hypothesis 4: The patients are satisfied with the overall nursing services of the Private Hospitals.	Rejected	7.34
Hypothesis 5: The patients are satisfied with the nursing attention and responsiveness to needs of the Private Hospitals.	Rejected	6.9
Hypothesis 6: The patients are satisfied with the explanation of procedure, test and treatment by nursing staff of the Private Hospitals.	Rejected	6.53
Hypothesis 7: The patients are satisfied with the overall rating of the physician services of the Private Hospitals.	Rejected	8.07
Hypothesis 8: The patients are satisfied with the ability of the physician to diagnose problems (ailment) in the Private Hospitals.	Rejected	8.01
Hypothesis 9: The patients are satisfied with the thoroughness of examination by the physicians of Private Hospital.	Rejected	7.78



## RESULTS AND DISCUSSIONS

- Result shows that the null hypothesis is rejected, hence it can be said that the patients are satisfied with the accommodation and physical facilities of the Private Hospitals. The reason might be that private hospitals are like big hotels investing lot of money on infrastructure and physical facility to satisfy the needs of paying patients
- Result shows that the null hypothesis is rejected, hence it can be said that the patients are satisfied with the cleanliness of the Private Hospitals. The reason behind this might be that private players are investing substantial amount of money on physical facility in which cleanliness is related to hygiene and important satisfaction indicator for paying patients.
- Result shows that the null hypothesis is rejected, hence it can be said that the patients are satisfied with the equipments of the Private Hospitals. The reason behind this might be that private players are investing substantial amount of money on infrastructure and physical facility in same manner they are investing huge amount on high tech and modern equipment to get competitive advantage of their rival.
- Result shows that the null hypothesis is rejected, hence it can be said that the patients are satisfied with the overall nursing services of the Private Hospitals. The reason behind this might be that private players are investing substantial amount of money on infrastructure and physical facility in same manner they are investing on qualified and trained nurses and make their availability round the clock.
- Result shows that the null hypothesis is rejected, hence it can be said that the patients are satisfied with the nursing attention and responsiveness to needs of the Private Hospitals. The reason behind this might be due to growing awareness of consumerism and intense competition it becomes essential to recruit responsive, efficient and trained nurses in private hospitals by their owners.
- Result shows that the null hypothesis is rejected, hence it can be said that the patients are satisfied with the explanation of procedure, test and treatment by nursing staff of the Private Hospitals. since crowd is less so it becomes easy for them to explain test, procedure and treatment to admitted patients individually since sometimes patients are unaware of test /diagnosis requirements to go empty stomach or not and also access to lab.
- Result shows that the null hypothesis is rejected, hence it can be said that the patients are satisfied with the overall rating of the physician services of the Private Hospitals. One reason for this is due to the fact that physicians in private hospitals are also experienced and qualified in their respective fields or expertise to treat global patients.
- .Result shows that the patients are satisfied with the ability of the physician to diagnose problems (ailment) of the Private Hospitals. The reason behind this might be that private hospitals are set either by corporate groups employing most qualified doctors or by well experienced doctors after long practicing, for them diagnosis would not be a big issue.
- Result shows that null hypothesis is rejected hence it can be said that the patients are satisfied with the thoroughness of examination by the physicians of the Private Hospitals. The reason behind this might be that Since private hospitals are equipped with most modern hi-tech medical equipment for diagnosis and treatment of diseases and are employing experienced doctors

### Limitations

- The data is collected through convenience sampling, where sample is not representative of population. Thus the findings of study are not generalized to the entire population.
- Respondents (which are patients in the study) were not in comfortable position where one can expect they will respond after understanding each question thus affecting the quality of data.
- Some of the respondents were not well versed with English or Hindi thus it is likely that they may have responded without proper understanding.
- Sample size is limited further affecting the generalization of the findings.

### Scope for Future Studies

- Study is confined to Indore city only it can be extended to other important cities/metros of India in both government and private hospitals.
- To make results more representative for future studies sample size would be increased.
- Future Survey may also be conducted using experimental studies with modern instruments to measure communication both verbal and non verbal cues.
- Cross sectional studies may be conducted in future to check communication effect on gender like male doctor communicating with female patient or even male doctors and elderly patients or say doctors communicating with child patients.

### CONCLUSIONS

One should not forget the Dr SamleePlianbangchang remark who is Regional Director, WHO South-East Asia Region that” Patients, as human beings, come to health facilities with their own expectation for care. Care of not only their “body”, but also their “mind “and “soul”. They (the patients) expect fair treatment from the health care systems.”

The research conducted on the patients satisfaction of the services of private hospitals was done in Indore city. In the study it was found that patients are satisfied with the services provided in the private hospitals, because they find efficient and quality services there. There is a strong need from government to take strong initiative to control out of pocket expenses and malpractices in these hospitals.

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