

Patient Satisfaction with Primary Healthcare in Kashmir India

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Abstract:-

Purpose: The main objective of this study was to examine the relationship between service expectations, physical environment, communication and information, participation and involvement, Interpersonal relationship between physician and patient, medical-technical competence and patient satisfaction.

Design/Methodology/Approach: This was a quantitative study in which the data were collected from 209 patients visiting primary health centers in Kashmir India.

Findings: Service expectations were found to have a strong positive relationship with patient satisfaction in the study. Patient satisfaction demonstrated a substantial and positive association with the physical environment. Patient satisfaction was linked to participation and involvement in a significant and beneficial way. Patient satisfaction demonstrated a substantial and positive relationship with medical-technical competence.

Originality: In India, studies of patient satisfaction at the primary care level are mostly ignored. While a number of studies have been conducted in India to investigate the determinants of patient satisfaction in tertiary care and big hospitals, studies of patient satisfaction at the primary care level have received less attention.

Keywords:- Patient satisfaction; service expectations; physical environment; communication and information; participation and involvement; physician-patient relationship; medical-technical competence; primary health care; Kashmir India.

I. INTRODUCTION

Over the last two decades there has been a growing concern in how patients experience health care (Larsson, Wilde, & Udén, 1996). During the 1950s, Patient satisfaction studies in health care originated in U.S.A (Ardey & Ardey, 2015). Patient satisfaction is the extent to which a patient is pleased with the medical care received from their provider (Farley et al., 2014). It has emerged as an essential measure in the assessment of healthcare system and in predicting health outcomes, and therefore constitutes an important indicator of the healthcare quality (Cleary & McNeil, 1988; Laschinger, Hall, Pedersen, & Almost, 2005). According to Parasuraman, Zeithaml, and Berry (1988), the primary factor affecting the service quality is the expected service and perceived service. Hence, a decrease in patient satisfaction is seen wherever there is a lag between patient's expectations and services received (Al

Emadi, Falamarzi, Al-Kuwari, & Al-Ansari, 2009). Patient satisfaction is correlated with important outcomes, such as superior compliance, decreased utilization of medical services, less malpractice litigation and better prognosis (Huang et al., 2004). Most of the existing patient satisfaction studies evaluated overall satisfaction levels and paid little attention to satisfaction with specific domains of health care delivery. Domains of satisfaction have been viewed as multidimensional, such as hospital structure, medical processes, and outcome of health care services (Marley, Collier, & Meyer Goldstein, 2004). Empirical evidences verify to the fact that the majority of the Government health facilities in India are very little concerned about the facilities provided to the patients and their families and in turn their satisfaction rate (McKinley & Roberts, 2001). Furthermore, in the developing countries patient's perceptions about health care system is largely ignored due to overburdened health facilities, the health care managers, dissatisfied health care providers, quick health care delivery (Jenkinson, Coulter, Bruster, Richards, & Chandola, 2002; Joshi, Sochaliya, Purani, & Kartha, 2013).

Primary healthcare is the foundation of total healthcare of any country because it reduces the cost and has huge forward linkages with emphasis more on the prevention of the diseases than their curative aspects (Khursheed, 2017). The study of patient satisfaction at primary care level has been generally ignored in India. While a number of studies have been carried out which have explored the parameters of patient satisfaction in tertiary care and large hospitals in India, very little attention has been paid to studies of patient satisfaction at the primary care level (Ardey & Ardey, 2015). Patient's health largely depends on the primary health care sector of the country. Primary care involves a sustained partnership between patients and providers that addresses the bulk of a population's health needs over time. It is essential that primary health care providers are engaged in ensuring that their patients are able to timely access diagnostic, management and rehabilitative services (Bonnie, Brent, Ken, & Philip, 2010). With this background the current study was conducted to evaluate patient satisfaction provided by the primary health centers in Kashmir India.

II. LITERATURE REVIEW AND DEVELOPMENT OF RESEARCH HYPOTHESES

A. Patient Satisfaction

Patient satisfaction assessments provide a direct expression of a patients' perception of their healthcare experiences (Wolosin, 2005). As patient satisfaction with healthcare services is reportedly declining, improving patient satisfaction has drawn a considerable amount of attention to the healthcare industry (Donabedian, 1966). Literature revealed a descriptive profile of factors associated with different levels of satisfaction and dissatisfaction in a total community. A scale was designed to measure patients' attitude towards three components of care: a) professional and technical competence of the physician, b) personal qualities of the physician in his relationship with patient and accessibility to care (cost and convenience) (Hulka, Kupper, Daly, Cassel, & Schoen, 1975). Results of previous studies revealed that sixty percent of the respondents were satisfied with the primary health care services provided (Ali & Mahmoud, 1993). Furthermore, results of previous studies also indicate 83% overall satisfaction (Bhargava et al., 2012). Tranberg et al. (2018), found the association of age with patient satisfaction. Moreover, some studies measured patient satisfaction on different domains and the findings revealed patient satisfaction as multi-factorial and also showed positive relationship with patient satisfaction (Alotaibi, Alazemi, Alazemi, & Bakir, 2015; Paddison et al., 2015; Ricci-Cabello et al., 2018). Furthermore, literature from previous studies revealed that different dimensions influence patient satisfaction and service quality and are significant determinants of patient satisfaction (Batbaatar, Dorjdagva, Luvsannyam, Savino, & Amenta, 2017; Idrees & Mishra, 2017; Javed, Liu, Mahmoudi, & Nawaz, 2019; Kraska, Weigand, & Geraedts, 2017; Mahapatra, Srilatha, & Sridhar, 2001). Several researchers have used these factors' including Physical services (tangibles, environment), doctor-patient communication, and laboratory services to assess the sustainability of healthcare services with a concern of patient satisfaction (Anna, 2017; Jalil, Zakar, Zakar, & Fischer, 2017; Wankar, 2017).

B. Service Expectation

A major aim of modern-day health care is to deliver a high-quality patient centered services that address the expectations of its service users. "Expectation is the root of all heartache" (William Shakespeare quotation) (Stewart, 2018). Patient expectations have been recognized as a factor for patient satisfaction in medical consultation (Berhane & Enquesslassie, 2016). Moreover, Satisfaction is strongly affected by expectation (Hogan, 2000). Literature review of previous studies reported expectation as the central importance of patient satisfaction and also revealed that most of the patient satisfaction theories are based on marketing theories and defined as how well health service fulfills patient expectations (Batbaatar et al., 2017). Some studies concluded that post-consultation also impacts patient satisfaction (Berhane & Enquesslassie, 2016). Therefore, it can be hypothesized that:

H1: There is a significant and positive relation between service expectation and patient satisfaction.

C. Physical Environment

Physical environment measures the patient's perception about the service quality in regard to the healthcare physical services. This measure includes: The cleanliness and maintenance of the facility, technological capability, diagnostic test rooms, blood banks, wards, beds, ambulance services, waiting rooms, and operation theatres (Ko, Zhang, Telford, & Enns, 2009). Fadda (2019) concluded that Structure or physical environment is essential in affecting the healthcare delivery process and health care outcomes. The medical facilities can use the physical environment to promote patient satisfaction with the services and perception of quality (Andrade, Lima, Pereira, Fornara, & Bonaiuto, 2013). Furthermore, forming a pleasant environment strongly facilitates the patients to make a full recovery (Dijkstra, Pieterse, & Pruyn, 2006). Therefore, it can be hypothesized that:

H2: There is a significant and positive relation between Physical Environment and patient satisfaction.

D. Communication and Information

"Effective communication is defined as active listening, appropriate questioning, provision of adequate instructions and relevant information to the patient" (Platonova, Kennedy, & Shewchuk, 2008). Communication plays the most important role between the provider and the patients (Itri, Yacob, & Mithqal, 2017). The main three goals of physician-patient communication create a good interpersonal relationship, facilitates exchange of information, and includes the patients in decision making (Arora, 2003; Bredart, Bouleuc, & Dolbeault, 2005; Lee, Back, Block, & Stewart, 2002). Previous studies showed that communication between patients and their healthcare providers can affect patient outcome and behaviour (Stewart, 1995).

Davidson and Mills (2005) highlighted the importance of assessing the patient perception of care and the quality and content of communication of information at various stages of illness. In an ideal world, physicians should collaborate with their patients to provide the best care as physicians tend to make decisions based on quick assessments, which may be biased (Feudtner, 2007). This requires the physicians to take time or set up opportunities to offer and discuss treatment choices to patients and share the responsibility and control with them (Arora, 2003; Lee et al., 2002). Successful information exchange ensures that concerns are elicited and explored and that explanations of treatment options are balanced and understood to allow for shared decision making (Arora, 2003; Kindler, Szirt, Sommer, Häusler, & Langewitz, 2005; Lee et al., 2002; Minhas, 2007). The literature of previous studies showed significant and positive relationship between physician's communication behavior and patients' overall satisfaction (Clever, Jin, Levinson, & Meltzer, 2008; Finefrock et al., 2018). Therefore, it can be hypothesized that:

H3: There is a significant and positive relation between Communication and Information and patient satisfaction.

E. Participation and Involvement

The patients' ability to participate and be actively involved had an influence on their perception of satisfaction (Gäfvert & Ek, 1996; Ottosson, Hallberg, Axelsson, & Loven, 1997). Patient participation began with patient participation groups (PPGs). The first group was established in 1972. Reedy (1970) defined patient participation as, "It is essential to realize that all families whose personal and corporate health are embodied within the practice are themselves an integral part of the organization and that operational considerations must include the patient group as a functioning and dynamic integer of the whole organisation" (Wilkie, 2018). Patient participation in their care may reduce the risk of medical errors by providing health care providers information about their Medical conditions (Weingart et al., 2007).

Furthermore, Patient participation *pertains to the patients' involvement* and role in decision making in matters relating to their own treatment and care; and is often used in relation to concepts such as patient involvement, partnership, and patient control (Storm & Edwards, 2013). The literature of previous studies revealed patient's participation and involvement in their own treatment, a primary concern as it strengthens patient's roles and leads to improved hospitalization process and could further enhance treatment outcome in the vulnerable population (Kolovos, Kaitelidou, Lemonidou, Sachlas, & Sourtzi, 2016). Therefore, it can be hypothesized that:

H4: There is a significant and positive relation between Participation and Involvement and patient satisfaction.

F. Interpersonal relation between Physician-Patient

The Physician-patient relationship is a foundation of medical care. Stronger Physician-patient relationships are associated with better patient outcomes (Snyderman & Work, 2019). To provide the patient with high quality care, there needs to be a healthy Physician-patient relationship (Donahue, Ashkin, & Pathman, 2005; Ward, 2018). Effective communication and interpersonal skills of a doctor, tend to gather a proper history from the patient, which guides the right examination and then treatment (Ha & Longnecker, 2010). Trust is also a key characteristic of the Physician - patient relationship. Patients' trust in their doctors has been

recognized to be more significant than treatment satisfaction in predictions of patient adherence to recommendations and their overall satisfaction with care (Lee et al., 2002). The literature revealed that E-mail has the potential to improve the doctor-patient relationship as a result of better communication (Leong, Gingrich, Lewis, Mauger, & George, 2005). Furthermore, research (Lings et al., 2003; Platonova et al., 2008) found that patient trust and interpersonal relationship with the Primary care physician were major predictors of patient satisfaction. Moreover, the literature of previous studies concluded that the longer continuity of care was associated with greater patient satisfaction. The study found that participants with less than one year continuity were not satisfied with the concern shown by their physician, those with one to two years continuity were more satisfied with the quality of care received (Donahue et al., 2005). Therefore, it can be hypothesized that:

H5: There is a significant and positive relationship between Physician-Patient interpersonal relationship and patient satisfaction.

G. Medical-Technical Competence

"Competence refers to a person's underlying characteristic that is causally related to the performance of a job" (Boyatzis, 1982). Lane (1998) defined competence as "the ability to perform a specific task in a manner that yields desirable outcome". Health workers acquire competence over time (Bonnie et al., 2010). Literature revealed that effective management of healthcare providers is associated with increased patient satisfaction (Bhakta & Marco, 2014). Furthermore, literature of previous studies concluded that differences in patient satisfaction levels could be influenced by different perspective on prioritized skills (Cheng, Yang, & Chiang, 2003; Murakami, Imanaka, Kobuse, Lee, & Goto, 2010). Hence, competence strongly influences patient's service quality assessments. If the service provider's competence is perceived high, then satisfaction level also increases (Andaleeb, 1998). Therefore, it can be hypothesized that:

H6: There is a significant and positive relation between Medical-Technical competence and patient satisfaction.

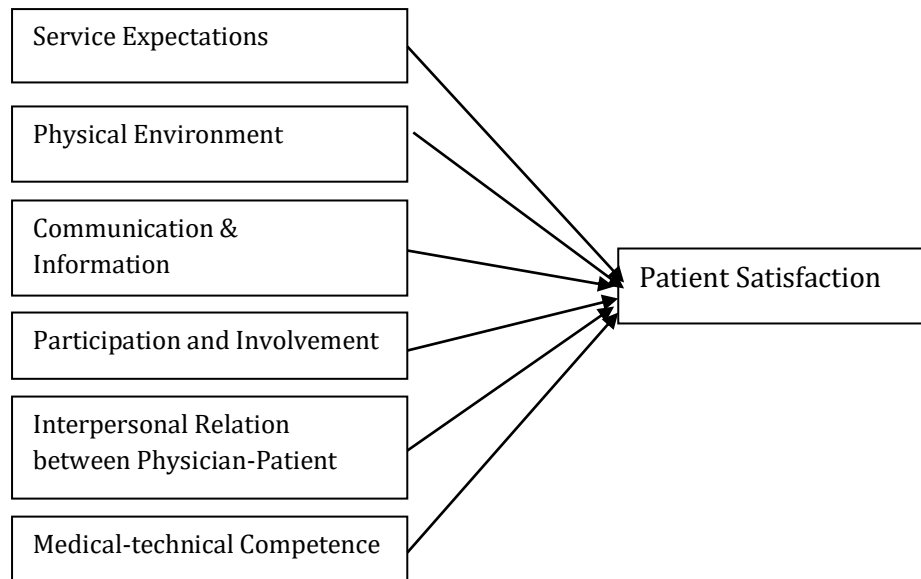


Fig. 1: Research Framework

III. METHODOLOGY

A. Data collection Procedure and Sampling

The present study was a cross sectional study and data were collected from the patients visiting to the primary health centers in district Srinagar, Budgam and Ganderbal in the month of June-October 2018. A non-probability convenience sampling was used to collect the data for the study. Convenience sampling is the most frequently used technique in quantitative studies. The data were collected in the form of a set of questionnaires and drop off / Pickup method was used to collect the information from the respondents. According to (MacLennan, Langley, & Kypri, 2011), drop off / pick up method reduces interviewer bias effects and social desirability effects and exploits the benefit of leaving respondents alone and in their owntime. All the primary health centers were approached and requested to provide access of patients for drop off / pick up of survey questionnaire. In total around 500 questionnaires were dropped at the primary health centers reception area and at the end of the survey 224 filled questionnaires were received (response rate of 44.8%). After thorough scrutiny of the filled questionnaires, 209 were found fit to use for dataanalysis. Studies identified that, for structural equation model (SEM) with the PLS approach, it is suggested that minimum sample size should be at least five times of number of observations, however, it is also suggested that more acceptable ratio is 10:1(Hair, Anderson, Babin, & Black, 2010).

B. Measurement

All

theitemsweremeasuredonfivepointsLikertscalei.e.,(1)strongly ydisagree to (5) strongly agreed except basic information. For service expectation, six items(Ware Jr, Snyder, Wright, & Davies, 1983), communication and information,three items(Larasanty, Cahyadi, Sudarni, & Wirasuta, 2019), interpersonal relation between doctor-patient, five items(Ayalew et al., 2017), medical-technical competence, six items(Alaloola & Albedaiwi, 2008) were adapted from.Five items for the physical environment were adapted from(Sadjadian, Kaviani, Yunesian, & Montazeri, 2004). Two items for participation and involvement were adapted from(Chang, Tseng, & Woodside, 2013).

C. Data Analysis and Findings

The study respondents were males 49.3% and females 50.7%. The majority of the respondents were highly educated that include diploma holders, graduates, postgraduates, and professional degree holders (74.6). Rest has primary education (12.9%) and HSC level (12.4%). The respondents of the study were almost evenly distributed in different age group except the age group of 61 and above. The 61 and above age group represent 3.8% of total respondents. The age group which holds maximum number of respondents was 41-50 years with 25.8% of representation.

Socio-demographic Factors	Categories	Frequency	Percentage
Age	< 20 Years	17	8.1
	21-30 Years	47	22.5
	31-40 Years	45	21.5
	41-50 Years	54	25.8
	51-60 Years	38	18.2
	61 and above	8	3.8
Gender	Male	103	49.3
	Female	106	50.7
Marital Status	Married	132	63.2
	Single	55	26.3
	Divorced	10	4.8
Education	Widow	12	5.7
	Primary	27	12.9
	HSC level	26	12.4
	Graduation level	68	32.5
	Diploma level	25	12
Occupation	Post-Graduation level	41	19.6
	Professional level	22	10.5
	Agriculturist	10	4.8
	Business	38	18.2
	Employee	32	15.3
	Professional	47	22.5
	House wife	39	18.7
	Student	23	11
	Retired person	11	5.3
	Other	9	4.3
Income (per month)	Upto Rs. 5,000	25	12
	Rs 5,001-10,000	6	2.9
	Rs 10,001-15,000	28	13.4
	Rs 15,001-20,000	48	23
	Rs 20,001-25,000	43	20.6
	Rs. 25,001 and above	59	28.2
Number of Visits (past year Including today's visit)	1 visit	25	12
	2 visits	36	17.2
	3 visits	49	23.4
	4 visits	44	21.1
	5 visits or more	36	17.2
	Not sure	19	9.1

Table 1: Socio-Demographic Profile of Respondents (N=209)

D. Assessment of Measurement Model

Except for two items, all of the factor loadings exceeded the recommended value of 0.708 set by Hair Jr, Sarstedt, Hopkins, and Kuppelwieser (2014). The average variance extracted (AVE) of these items' latent variables was higher than the recommended value of 0.50. The AVE of all

variables ranged from 0.516 to 0.864, above the recommended value of 0.50, while the CR ranged from 0.823 to 0.946, exceeding recommended value of 0.70. by Hair Jr et (2014). The loadings, CR, and AVE for the items and constructs are summarised in Table 2.

Construct	Mean(SD)	Item	Factor Loadings	CR	AVE
Service Expectation (SE)	3.300 (0.707)	SE1	0.764	0.908	0.622
		SE2	0.79		
		SE3	0.787		
		SE4	0.849		
		SE5	0.756		
		SE6	0.781		
Physical Environment (PE)	3.572(0.621)	PE1	0.629	0.841	0.516
		PE2	0.785		
		PE3	0.766		
		PE4	0.733		
		PE5	0.666		
Communication and Information (CI)	3.634(0.778)	CI1	0.617	0.823	0.613
		CI2	0.886		
		CI3	0.821		
Patient's Participation and Involvement (PPI)	3.561(0.828)	PPI1	0.936	0.927	0.864
		PPI2	0.922		
Interpersonal Relation between Physician-Patient (IPR)	3.434(0.662)	IPR1	0.800	0.898	0.639
		IPR2	0.791		
		IPR3	0.741		
		IPR4	0.83		
		IPR5	0.831		
Medical-technical Competence (MTC)	3.093(0.752)	MTC1	0.732	0.914	0.641
		MTC2	0.844		
		MTC3	0.87		
		MTC4	0.797		
		MTC5	0.847		
		MTC6	0.702		
Patient Satisfaction (PS)	3.37(0.904)	PS1	0.850	0.946	0.746
		PS2	0.845		
		PS3	0.883		
		PS4	0.867		
		PS5	0.898		
		PS6	0.837		

Table 2: The Results of Measurement Model and Descriptive Analysis

The Heterotrait-Monotrait (HTMT) ratio was used to test the model's discriminant validity. The discriminant validity of the model was determined using a conservative level of 0.85 (HTMT.85) in this study. Table 3 demonstrates

that the model's discriminant validity was established as all of the HTMT.85 criterion's results fell below the critical value of 0.85.

		1	2	3	4	5	6	7
1	CI							
2	IPR	0.479						
3	MTC	0.49	0.616					
4	PE	0.375	0.575	0.541				
5	PPI	0.347	0.548	0.676	0.547			
6	PS	0.391	0.496	0.739	0.544	0.761		
7	SE	0.627	0.511	0.404	0.352	0.85	0.402	

Table 3: The Results of Discriminant Validity Analysis (HTMT_{0.85} Criterion)

E. Assessment of the Structural Model

The R2 measures the coefficient of determination and the level of significance of the path coefficient in PLS, and it is used to assess the structural model's goodness (Hair, Ringle, & Sarstedt, 2011). R2 should be between 0.02-0.12 weak, 0.13-0.25 moderate, and 0.26 above considerable, according to Cohen (2013). (Hair et al., 2011) qualified these values, claiming that a high R2 is contingent on the research setting. The R2 value for endogenous construct

patient satisfaction was 0.590, indicating that six exogenous variables, namely service expectation, physical environment, communication and information, patient participation and involvement, interpersonal relationship between physician and patient, and medical-technical competence value of 0.85, can explain 59 percent of the variance of the construct patient satisfaction.

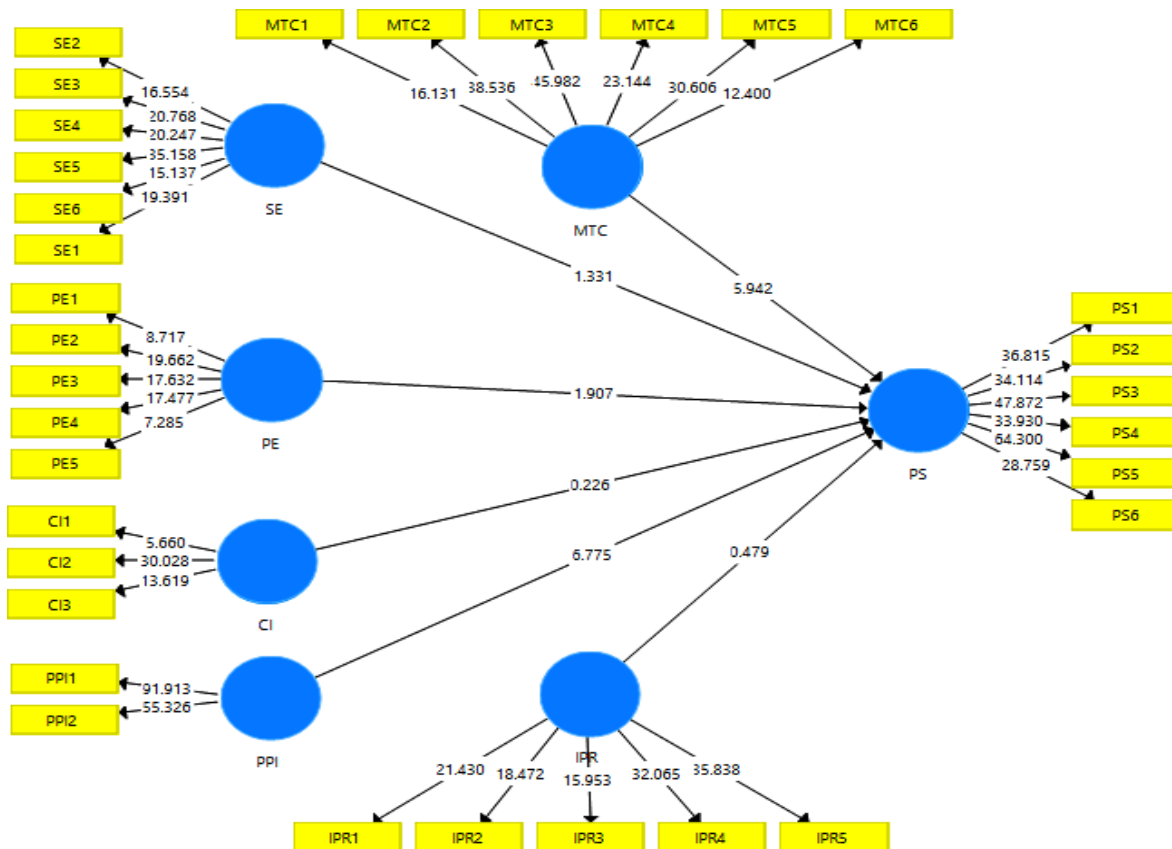


Fig. 2: Output of Structural Model Analysis

The path coefficient was significant for the relationship between service expectation and patient satisfaction ($\beta = 0.081$, $p < 0.10$), Physical environment and patient satisfaction ($\beta = 0.115$, and $p < 0.05$), Patient participation

and involvement and patient satisfaction ($\beta = 0.391$ at $p < 0.01$), medical-technical competence and patient satisfaction ($\beta = 0.375$ at $p < 0.01$). Therefore, H1, H2, H4, and H6 were supported (See Table 4).

Hypothesis	Relationship	Beta	SE	T- Value	P-Value	Decision	Effect size	VIF	R ²
H1	SE -> PS	0.081	0.061	1.331	0.092	Supported	0.011	1.488	0.590
H2	PE -> PS	0.115	0.06	1.907	0.028	Supported	0.023	1.416	
H3	CI -> PS	0.014	0.061	0.226	0.410	Not supported	0.000	1.401	
H4	PPI -> PS	0.391	0.058	6.775	0.000	Supported	0.222	1.678	
H5	IPR -> PS	-0.032	0.066	0.479	0.316	Not supported	0.001	1.759	
H6	MTC -> PS	0.375	0.063	5.942	0.000	Supported	0.181	1.899	

Table 4: Assessment of Structural Model

(SE= Service Expectation; PE= Physical Environment; CI= Communication and Information; PPI= Participation and Involvement; IPR= Interpersonal Relation; MTC= Medical-Technical Competence; PS=Patient Satisfaction).

R2 was used to evaluate the model's prediction accuracy. Furthermore, the Q2 value of the Stone-Geisser model can be used to establish the model's predictive significance. A Q2 score greater than zero implies that the model correctly predicted the endogenous construct data points (Hair, Sarstedt, et. al., 2014). Table 5 shows the results of Q2 and GoF. As advised by the authors, the study

used global goodness-of-fit (GoF) for the SEM (Tenenhaus, Vinzi, Chatelin, &Lauro, 2005). The GoF value was estimated using the criteria of Wetzels, Odekerken-Schröder, and Van Oppen (2009), which can be used as a cut-off for the global validation of the PLS model. The study model's GoF value of 0.625 was higher than Akter and Hani's (2011) cut-off value of 0.36 for big R2 effect size.

Endogenous construct	Predictive relevance (Q2)	GoF
Patient Satisfaction	0.404	0.326

Table 5: Results of blindfolding, GoF

IV. DISCUSSION AND IMPLICATIONS

The study found that service expectation is affected by the various factors of patient satisfaction. The findings also revealed that the patients possessing higher satisfaction with services received from the primary health centers will have a positive perception about primary health care services in terms of medical services received and treatment sought. However, the inadequacy of tools made it unable to capture the role of the fulfillment of expectation in the health care sector (Marimon, Gil-Doménech, & Bastida, 2019). Moreover, the findings also indicate that patients seeing a doctor of their choice, pharmacy services, dispensing of drugs, and guidance on health education, medical equipment and services as one of the important features of service expectation. The identification of these services could enable administrators to improve these aspects of service delivery ensuing to the study. It also suggests that there are certain aspects of service provision which patients rate with high importance when judging a service. Furthermore, the findings of the study verify that service expectations create a positive perception among patients receiving medical care in primary health centers and had an influence on patient satisfaction and it should be taken into account in potential improvements.

The researchers found that the most important overall satisfaction factor for patients is the environment (Gu & Itoh, 2015), which is consistent with the present study. The Physical environment of a health facility could potentially affect patient satisfaction (Adhikary et al., 2018). However, other researchers explained that patients are more concerned about some particular aspects of the physical environment which in turn had an impact on patient satisfaction (Bouchard, 1993). A good physical environment has a significant effect on a patient's emotional processes and social wellbeing. An inappropriate physical environment and crowdedness make the centers uncomfortable and displeasing to patients. However, leaders and managers need to pay special attention to enhancing and improving the patient satisfaction. The built environment can contribute to reducing errors, infections, etc. Moreover, it can enhance privacy, comfort, and control. Therefore, if a physical environment is clean and healthy it will help patients to reduce their stress levels and would help them in their personal recovery and recuperation. Healthcare stakeholders and management must form strategies to increase the level of patients satisfaction.

The Lack of communication, the non-availability of proper information related to the patients affects satisfaction level (Ghosh, 2014). Therefore, lack of essential services, emergency services, non-availability of doctors, lack of competency in technical staff, lack of infrastructure, lack of communication skills, non-availability of medicines, the behavior of doctors are major concerns to be focused on. The researchers in context with healthcare facilities other than India, argued that good communication skills, medicine adherence, and information are the important predictors of patient satisfaction and have a positive relationship with patient satisfaction. However, the findings of these studies are inconsistent with the present study (Abioye Kuteyi,

Bello, Olaleye, Ayeni, & Amedi, 2010; Clever et al., 2008; Nasir, Ariffin, & Yasin, 2018; Norhayati & Azlina, 2017), due to the lack of health facilities in the context of Kashmir. The primary focus of patients is to get proper treatment facilities at the primary level, communication is required at a point when patients get the appointments for consultation according to their demand. Communication information generally improves health outcomes however, it does not guarantee better physical outcomes unless a patient is satisfied with the quality of care received (Jiang, 2019). Patient satisfaction with the medical staff is highly dependent on the patient being able to freely communicate with their Physician. Improvement of Physician–Patient communication is important to maintain the bond between the doctors and the patient for the achievement of the optimal level of health of the people.

The findings of the present study predicted that patients who preferred to be more involved in decision making and information-seeking with their physicians would be more satisfied and had a positive relationship with patient satisfaction. However, results also showed that patients with strong preferences for decision-making would be more satisfied when physicians engage them in more information giving. In other words, patients with a strong desire to be more involved in making treatment and diagnostic decisions with their doctors tend to be more satisfied when their physicians supplied them with more information about medical conditions and treatment implications. Therefore, these results directly imply that patient participation and involvement are important predictors of patients satisfaction. Researchers explained that little research has been performed on health outcomes of intervention aiming to increase patient participation in general practice visits among patients suffering from symptom-based complaints (Sanders et al., 2013). Physicians in primary health centers may not realize the importance of patient participation in patient satisfaction, which in turn contributes to the whole notion of effective services. Sebai, Milaat, and Al-Zulaibani (2001) stated that health professionals have no vocational training for primary care. Furthermore, Al-Osimy (1994) points out that many physicians do not attend training sessions. Communication problem hinders effective participation.

Better health outcomes are expected by making patient participation and involvement in treatment, diagnosis, and decision making a reality, which would be more than just an ethical vital and in turn it may enhance patient satisfaction with health care services received in primary health care services. Therefore, it would benefit healthcare organizations to train medical professionals in this method and to include it in their practical guidelines.

Researchers in public health argued that interpersonal relationship between doctor-patient is associated with patient satisfaction and has been considered an important determinant of patient satisfaction (McLeod, Tamblyn, Benaroya, & Snellmd, 1994; Sullivan, Stein, Savetsky, & Samet, 2000), however, others argue that patient-physician fit is a predictor of visit satisfaction, which in turn is associated with patient satisfaction. In healthcare, patients

are becoming increasingly concerned about making the right choices about making the correct healthcare choices as their burden of healthcare costs continues to increase (Krupat, Yeager, & Putnam, 2000). Trusting a regular doctor and consultation with that regular doctor has been found as a predictor of patient satisfaction. However, these findings are inconsistent with the present study, because patients visiting primary health centers in Kashmir hardly find regular doctors for consultation. Moreover, there is a lack of manpower in health care facilities. Healthcare delivery in Kashmir needs major changes to make it comprehensive, effective and investing in health should be made the top priority. The most important and intense need is to restructure the health services by applying epidemiological principles including Healthcare needs assessment.

The findings also revealed that patients would prefer doctors who are accurate in diagnosis and treatment and in turn would be highly satisfied. Therefore, the more clinical and technical competency the more would be the quality care and that would result in increased patient satisfaction. These patients would recommend the same doctor to other family members, friends, and relatives.

The study provides a few interesting findings for practicing managers and the outcomes can be helpful to develop strategies and improve services for the service providers. The contributions made by the academic study should be practical and free from the complexity that can be implemented easily in the actual environment. This can be done by identifying the important factors that would be helpful to understand the overall scenario.

V. CONCLUSION, LIMITATIONS AND FUTURE RECOMMENDATIONS

In conclusion, based on the conceptualization of the research framework for the study, the researcher in the current study determined that service expectation, physical environment, participation and involvement, and medical-technical competence have a significant influence on patient satisfaction. The research added to the body of healthcare literature by analyzing patient satisfaction with features of primary health centers to better understand the components of patient care most associated with patient satisfaction. Analyzing patient satisfaction surveys consistently identifying the needs of patients is important because research indicates that patients are more likely to seek regular healthcare, engage in preventative care, and follow physician health recommendations if they are satisfied with their health care.

Although the research has considerable practical implications, the research study has a few limitations. The study was performed on patients visiting primary health centers in three districts of Kashmir. Therefore, the study findings can only associate with patients visiting from three districts of Kashmir and cannot be generalized to the patients visiting from the other districts of Kashmir.

The study used a non-probability convenience sampling method. However, by using this technique, the opportunity to participate is not equal for all qualified individuals in the target population (Suen, Huang, & Lee, 2014). The probability sampling could be used for the sampling due to the unavailability of sample frame. The use of a probability sample could draw attention to the generalizability of the study findings. The data were collected from only ten selected primary health centers providing services to patients visiting. Therefore, caution should be given to generalizing the findings on other primary health centers not included in this study. Future studies could be performed on the secondary and the tertiary level and the findings of the study could be compared to develop a better understanding of the satisfaction of patients. To conduct a qualitative study to explore patient satisfaction and dissatisfaction with patient care variables. Additional studies dealing with patient satisfaction such as the utilization of health services, compliance with medical regimens are needed to examine to which these factors are affected by the level of patient satisfaction. This study has identified the relationship of variables with patient satisfaction from the point of view of patients. Further studies should be done to evaluate the health care provider's satisfaction. Different research designs should be used in order to check for the validity of the collected data.

REFERENCES

- [1.] Abioye Kuteyi, E., Bello, I. S., Olaleye, T., Ayeni, I., & Amedi, M. (2010). Determinants of patient satisfaction with physician interaction: a cross-sectional survey at the Obafemi Awolowo University Health Centre, Ile-Ife, Nigeria. *South African Family Practice*, 52(6), 557-562.
- [2.] Adhikary, G., Shawon, M. S. R., Ali, M. W., Shamsuzzaman, M., Ahmed, S., Shackelford, K. A., . . . Levine, A. (2018). Factors influencing patients' satisfaction at different levels of health facilities in Bangladesh: Results from patient exit interviews. *PLoS one*, 13(5), e0196643.
- [3.] Al-Osimy, M. H. (1994). Evaluation of primary health care in Riyadh, Saudi Arabia. *Journal of family & community medicine*, 1(1), 45.
- [4.] Akter, S., & Hani, U. (2011). Complex modeling in marketing using component based SEM.
- [5.] Al Emadi, N., Falamarzi, S., Al-Kuwari, M., & Al-Ansari, A. (2009). Patients' satisfaction with primary health care services in Qatar. *Middle East Journal of Family Medicine*, 7(9), 4-9.
- [6.] Alaloola, N. A., & Albedaiwi, W. A. (2008). Patient satisfaction in a Riyadh tertiary care centre. *International journal of health care quality assurance*.
- [7.] Ali, M. E. S., & Mahmoud, M. E. A. (1993). A study of patient satisfaction with primary health care services in Saudi Arabia. *Journal of community health*, 18(1), 49-54.
- [8.] Alotaibi, M., Alazemi, T., Alazemi, F., & Bakir, Y. (2015). Patient satisfaction with primary health-care services in Kuwait. *International journal of nursing practice*, 21(3), 249-257.

- [9.] Andaleeb, S. S. (1998). Determinants of customer satisfaction with hospitals: a managerial model. *International journal of health care quality assurance*.
- [10.] Andrade, C. C., Lima, M. L., Pereira, C. R., Fornara, F., & Bonaiuto, M. (2013). Inpatients' and outpatients' satisfaction: The mediating role of perceived quality of physical and social environment. *Health & place*, 21, 122-132.
- [11.] Anna, S. (2017). How the physical environment of a hospital affects patient health. Retrieved from <https://today.mims.com/how-the-physical-environment-of-a-hospital-affects-patient-health>
- [12.] Ardey, R., & Ardey, R. (2015). Patient perceptions and expectations from primary health-care providers in India. *Journal of family medicine and primary care*, 4(1), 53.
- [13.] Arora, N. K. (2003). Interacting with cancer patients: the significance of physicians' communication behavior. *Social science & medicine*, 57(5), 791-806.
- [14.] Ayalew, M. B., Taye, K., Asfaw, D., Lemma, B., Dadi, F., Solomon, H., . . . Tsega, B. (2017). Patients'/clients' expectation toward and satisfaction from pharmacy services. *Journal of Research in Pharmacy Practice*, 6(1), 21.
- [15.] Batbaatar, E., Dorjdagva, J., Luvsannyam, A., Savino, M. M., & Amenta, P. (2017). Determinants of patient satisfaction: a systematic review. *Perspectives in public health*, 137(2), 89-101.
- [16.] Berhane, A., & Enquesslassie, F. (2016). Patient expectations and their satisfaction in the context of public hospitals. *Patient preference and adherence*, 10, 1919.
- [17.] Bhakta, H. C., & Marco, C. A. (2014). Pain management: association with patient satisfaction among emergency department patients. *The Journal of emergency medicine*, 46(4), 456-464.
- [18.] Bhargava, A., Thakur, A., Mishra, B., Taneja, J., Dogra, V., & Loomba, P. (2012). Patient satisfaction survey of microbiological tests done in GB Pant Hospital. *International journal of health care quality assurance*.
- [19.] Bonnie, S., Brent, E., Ken, B., & Philip, E. (2010). Primary Care-Family Practice: Wait Time Expert Panel. *online*, at: <http://www.ontla.on.ca/library/repository/mon/17000/272629.pdf>.
- [20.] Bouchard, L. (1993). Patients' satisfaction with the physical environment of an oncology clinic. *Journal of Psychosocial Oncology*, 11(1), 55-67.
- [21.] Boyatzis, R. E. (1982). *The competent manager: A model for effective performance*: John Wiley & Sons.
- [22.] Bredart, A., Bouleuc, C., & Dolbeault, S. (2005). Doctor-patient communication and satisfaction with care in oncology. *Current opinion in oncology*, 17(4), 351-354.
- [23.] Chang, C.-W., Tseng, T.-H., & Woodside, A. G. (2013). Configural algorithms of patient satisfaction, participation in diagnostics, and treatment decisions' influences on hospital loyalty. *Journal of Services Marketing*.
- [24.] Cheng, S.-H., Yang, M.-C., & Chiang, T.-L. (2003). Patient satisfaction with and recommendation of a hospital: effects of interpersonal and technical aspects of hospital care. *International Journal for Quality in Health Care*, 15(4), 345-355.
- [25.] Cleary, P. D., & McNeil, B. J. (1988). Patient satisfaction as an indicator of quality care. *Inquiry*, 25-36.
- [26.] Clever, S. L., Jin, L., Levinson, W., & Meltzer, D. O. (2008). Does doctor-patient communication affect patient satisfaction with hospital care? Results of an analysis with a novel instrumental variable. *Health services research*, 43(5p1), 1505-1519.
- [27.] Cohen, J. (2013). *Statistical power analysis for the behavioral sciences*: Academic press.
- [28.] Davidson, R., & Mills, M. (2005). Cancer patients' satisfaction with communication, information and quality of care in a UK region. *European Journal of Cancer Care*, 14(1), 83-90.
- [29.] Dijkstra, K., Pieterse, M., & Pruyn, A. (2006). Physical environmental stimuli that turn healthcare facilities into healing environments through psychologically mediated effects: systematic review. *Journal of advanced nursing*, 56(2), 166-181.
- [30.] Donabedian, A. (1966). Evaluating the quality of medical care. *The Milbank memorial fund quarterly*, 44(3), 166-206.
- [31.] Donahue, K. E., Ashkin, E., & Pathman, D. E. (2005). Length of patient-physician relationship and patients' satisfaction and preventive service use in the rural south: a cross-sectional telephone study. *BMC family practice*, 6(1), 40.
- [32.] Fadda, J. (2019). Quality of Healthcare: A Review of the Impact of the Hospital Physical Environment on Improving Quality of Care *Sustainable Building for a Cleaner Environment* (pp. 217-253): Springer.
- [33.] Farley, H., Enguidanos, E. R., Coletti, C. M., Honigman, L., Mazzeo, A., Pinson, T. B., . . . Wiler, J. L. (2014). Patient satisfaction surveys and quality of care: an information paper. *Annals of emergency medicine*, 64(4), 351-357.
- [34.] Feudtner, C. (2007). Collaborative communication in pediatric palliative care: a foundation for problem-solving and decision-making. *Pediatric Clinics of North America*, 54(5), 583-607.
- [35.] Finefrock, D., Patel, S., Zodda, D., Nyirenda, T., Nierenberg, R., Feldman, J., & Ogedegbe, C. (2018). Patient-centered communication behaviors that correlate with higher patient satisfaction scores. *Journal of patient experience*, 5(3), 231-235.
- [36.] Gäfvert, A., & Ek, A. (1996). Home nursing patients' expectations and satisfaction—a qualitative study. *Nurs Sci Res Nordic Count*, 16, 19-24.
- [37.] Ghosh, M. (2014). Measuring patient satisfaction. *Leadership in Health Services*.
- [38.] Gu, X., & Itoh, K. (2015). Factors behind dialysis patient satisfaction: exploring their effects on overall satisfaction. *Therapeutic Apheresis and Dialysis*, 19(2), 162-170.
- [39.] Ha, J. F., & Longnecker, N. (2010). Doctor-patient communication: a review. *Ochsner Journal*, 10(1), 38-43.

- [40.] Hair, J. F., Anderson, R. E., Babin, B. J., & Black, W. C. (2010). *Multivariate data analysis: A global perspective* (Vol. 7): Upper Saddle River, NJ: Pearson.
- [41.] Hair, J. F., Ringle, C. M., & Sarstedt, M. (2011). PLS-SEM: Indeed a silver bullet. *Journal of Marketing theory and Practice*, 19(2), 139-152.
- [42.] Hair Jr, J. F., Sarstedt, M., Hopkins, L., & Kuppelwieser, V. G. (2014). Partial least squares structural equation modeling (PLS-SEM). *European business review*.
- [43.] Hogan, B. (2000). Patient satisfaction: expectations and experiences of nursing care. *Contemporary nurse*, 9(3-4), 275-283.
- [44.] Huang, J.-A., Lai, C.-S., Tsai, W.-C., Weng, R.-H., Hu, W.-H., & Yang, D.-Y. (2004). Determining factors of patient satisfaction for frequent users of emergency services in a medical center. *Journal-Chinese Medical Association*, 67(8), 403-410.
- [45.] Hulka, B. S., Kupper, L. L., Daly, M. B., Cassel, J. C., & Schoen, F. (1975). Correlates of satisfaction and dissatisfaction with medical care: a community perspective. *Medical Care*, 648-658.
- [46.] Idrees, M., & Mishra, S. (2017). A Study on Patient Satisfaction and Perception towards Health Care Facilities with Special Reference to Jammu and Kashmir. *International Journal of Emerging Technologies and Innovative Research*, 4(3), 12-19.
- [47.] Itri, J. N., Yacob, S., & Mithqal, A. (2017). Teaching communication skills to radiology residents. *Current problems in diagnostic radiology*, 46(5), 377-381.
- [48.] Jalil, A., Zakar, R., Zakar, M. Z., & Fischer, F. (2017). Patient satisfaction with doctor-patient interactions: a mixed methods study among diabetes mellitus patients in Pakistan. *BMC health services research*, 17(1), 155.
- [49.] Javed, S. A., Liu, S., Mahmoudi, A., & Nawaz, M. (2019). Patients' satisfaction and public and private sectors' health care service quality in Pakistan: Application of grey decision analysis approaches. *The International journal of health planning and management*, 34(1), e168-e182.
- [50.] Jenkinson, C., Coulter, A., Bruster, S., Richards, N., & Chandola, T. (2002). Patients' experiences and satisfaction with health care: results of a questionnaire study of specific aspects of care. *Quality and safety in health care*, 11(4), 335-339.
- [51.] Jiang, S. (2019). How does online patient-provider communication heal? Examining the role of patient satisfaction and communication experience in China. *Health communication*, 34(13), 1637-1644.
- [52.] Joshi, K., Sochaliya, K., Purani, S., & Kartha, G. (2013). Patient satisfaction about health care services: a cross sectional study of patients who visit the outpatient department of a civil hospital at Surendranagar, Gujarat. *Int J Med Sci Public Health*, 2(3), 659-663.
- [53.] Khurshed, H. (2017). Empirical analysis of determinants of patient satisfaction: A case study of primary health centres. *Journal of Global Economics*, 4(234), 2.
- [54.] Kindler, C., Szirt, L., Sommer, D., Häusler, R., & Langewitz, W. (2005). A quantitative analysis of anaesthetist-patient communication during the pre-operative visit. *Anaesthesia*, 60(1), 53-59.
- [55.] Ko, H. H., Zhang, H., Telford, J. J., & Enns, R. (2009). Factors influencing patient satisfaction when undergoing endoscopic procedures. *Gastrointestinal endoscopy*, 69(4), 883-891. e881.
- [56.] Kolovos, P., Kaitelidou, D., Lemonidou, C., Sachlas, A., & Sourtzi, P. (2016). Patients' perceptions and preferences of participation in nursing care. *Journal of Research in Nursing*, 21(4), 290-303.
- [57.] Kraska, R. A., Weigand, M., & Geraedts, M. (2017). Associations between hospital characteristics and patient satisfaction in Germany. *Health Expectations*, 20(4), 593-600.
- [58.] Krupat, E., Yeager, C. M., & Putnam, S. (2000). Patient role orientations, doctor-patient fit, and visit satisfaction. *Psychology and Health*, 15(5), 707-719.
- [59.] Lane, D. S. (1998). Defining competencies and performance indicators for physicians in medical management. *American journal of preventive medicine*, 14(3), 229-236.
- [60.] Larasanty, L. P. F., Cahyadi, M. F., Sudarni, N. M. R., & Wirasuta, I. M. A. G. (2019). Patient satisfaction with pharmaceutical care services provided at primary-level and secondary-level health facilities in Indonesia's health coverage system. *Journal of Health Research*.
- [61.] Larsson, G., Wilde, B., & Udén, G. (1996). *Patienters syn på vård: En litteratursammanfattning*: Socialstyrelsen.
- [62.] Laschinger, H. S., Hall, L. M., Pedersen, C., & Almost, J. (2005). A psychometric analysis of the patient satisfaction with nursing care quality questionnaire: an actionable approach to measuring patient satisfaction. *Journal of nursing care quality*, 20(3), 220-230.
- [63.] Lee, S. J., Back, A. L., Block, S. D., & Stewart, S. K. (2002). Enhancing physician-patient communication. *Hematology*, 2002(1), 464-483.
- [64.] Leong, S. L., Gingrich, D., Lewis, P. R., Mauger, D. T., & George, J. H. (2005). Enhancing doctor-patient communication using email: a pilot study. *The Journal of the American Board of Family Practice*, 18(3), 180-188.
- [65.] Lings, P., Evans, P., Seamark, D., Seamark, C., Sweeney, K., Dixon, M., & Gray, D. P. (2003). The doctor-patient relationship in US primary care. *Journal of the Royal Society of Medicine*, 96(4), 180-184.
- [66.] MacLennan, B., Langley, J., & Kypri, K. (2011). Distributing surveys: Postal versus drop-and-collect. *Epidemiology*, 22(3), 443-444.
- [67.] Mahapatra, P., Srilatha, S., & Sridhar, P. (2001). A patient satisfaction survey in public hospitals. *J Acad Hosp Adm*, 13, 11-15.
- [68.] Marimon, F., Gil-Doménech, D., & Bastida, R. (2019). Fulfilment of expectations mediating quality and satisfaction: the case of hospital service. *Total Quality Management & Business Excellence*, 30(1-2), 201-220.
- [69.] Marley, K. A., Collier, D. A., & Meyer Goldstein, S. (2004). The role of clinical and process quality in achieving patient satisfaction in hospitals. *Decision Sciences*, 35(3), 349-369.

- [70.] McKinley, R., & Roberts, C. (2001). Patient satisfaction with out of hours primary medical care. *BMJ Quality & Safety*, 10(1), 23-28.
- [71.] McLeod, P. J., Tamblyn, R., Benaroya, S., & Snellmd, L. (1994). Faculty ratings of resident humanism predict patient satisfaction ratings in ambulatory medical clinics. *Journal of general internal medicine*, 9(6), 321-326.
- [72.] Minhas, R. (2007). Does copying clinical or sharing correspondence to patients result in better care? *International journal of clinical practice*, 61(8), 1390-1395.
- [73.] Murakami, G., Imanaka, Y., Kobuse, H., Lee, J., & Goto, E. (2010). Patient perceived priorities between technical skills and interpersonal skills: their influence on correlates of patient satisfaction. *Journal of evaluation in clinical practice*, 16(3), 560-568.
- [74.] Nasir, N., Ariffin, F., & Yasin, S. (2018). Physician-patient interaction satisfaction and its influence on medication adherence and type-2 diabetic control in a primary care setting. *The Medical journal of Malaysia*, 73(3), 163-169.
- [75.] Norhayati, M. N., & Azlina, I. (2017). Patient satisfaction with doctor-patient interaction and its association with modifiable cardiovascular risk factors among moderately-high risk patients in primary healthcare. *PeerJ*, 5, e2983.
- [76.] Ottosson, B., Hallberg, I. R., Axelsson, K., & Loven, L. (1997). Patients 'satisfaction with surgical care impaired by cuts in expenditure and after interventions to improve nursing care at a surgical clinic. *International Journal for Quality in Health Care*, 9(1), 43-53.
- [77.] Paddison, C. A., Abel, G. A., Roland, M. O., Elliott, M. N., Lyratzopoulos, G., & Campbell, J. L. (2015). Drivers of overall satisfaction with primary care: evidence from the English General Practice Patient Survey. *Health Expectations*, 18(5), 1081-1092.
- [78.] Parasuraman, A., Zeithaml, V. A., & Berry, L. L. (1988). Servqual: A multiple-item scale for measuring consumer perc. *Journal of retailing*, 64(1), 12.
- [79.] Platonova, E. A., Kennedy, K. N., & Shewchuk, R. M. (2008). Understanding patient satisfaction, trust, and loyalty to primary care physicians. *Medical Care Research and Review*, 65(6), 696-712.
- [80.] Reedy, B. (1970). Operational problems in group practice. *The Journal of the Royal College of General Practitioners*, 20(Suppl 2), 72.
- [81.] Ricci-Cabello, I., Stevens, S., Dalton, A. R., Griffiths, R. I., Campbell, J. L., & Valderas, J. M. (2018). Identifying primary care pathways from quality of care to outcomes and satisfaction using structural equation modeling. *Health services research*, 53(1), 430-449.
- [82.] Sadjadian, A., Kaviani, A., Yunesian, M., & Montazeri, A. (2004). Patient satisfaction: a descriptive study of a breast care clinic in Iran. *European Journal of Cancer Care*, 13(2), 163-168.
- [83.] Sanders, A. R., van Weeghel, I., Vogelaar, M., Verheul, W., Pieters, R. H., de Wit, N. J., & Bensing, J. M. (2013). Effects of improved patient participation in primary care on health-related outcomes: a systematic review. *Family practice*, 30(4), 365-378.
- [84.] Sebai, Z. A., Milaat, W. A., & Al-Zulaibani, A. A. (2001). Health care services in Saudi Arabia: past, present and future. *Journal of family & community medicine*, 8(3), 19.
- [85.] Snyderman, R., & Work, P. (2019). The Importance of Physician-Patient Relationships Communication and Trust in Health Care.
- [86.] Stewart, M. A. (1995). Effective physician-patient communication and health outcomes: a review. *CMAJ: Canadian medical association journal*, 152(9), 1423.
- [87.] Stewart, M. A. (2018). Stuck in the middle: the impact of collaborative interprofessional communication on patient expectations. *Shoulder & Elbow*, 10(1), 66-72.
- [88.] Storm, M., & Edwards, A. (2013). Models of user involvement in the mental health context: intentions and implementation challenges. *Psychiatric Quarterly*, 84(3), 313-327.
- [89.] Suen, L.-J. W., Huang, H.-M., & Lee, H.-H. (2014). A comparison of convenience sampling and purposive sampling. *Hu Li Za Zhi*, 61(3), 105.
- [90.] Sullivan, L. M., Stein, M. D., Savetsky, J. B., & Samet, J. H. (2000). The doctor-patient relationship and HIV-infected patients' satisfaction with primary care physicians. *Journal of general internal medicine*, 15(7), 462-469.
- [91.] Tenenhaus, M., Vinzi, V. E., Chatelin, Y.-M., & Lauro, C. (2005). PLS path modeling. *Computational statistics & data analysis*, 48(1), 159-205.
- [92.] Tranberg, M., Vedsted, P., Bech, B. H., Christensen, M. B., Birkeland, S., & Moth, G. (2018). Factors associated with low patient satisfaction in out-of-hours primary care in Denmark-a population-based cross-sectional study. *BMC family practice*, 19(1), 15.
- [93.] Wankar, A. D. (2017). Study of determination of laboratory turnaround time in tertiary care hospital in India. *Int. J. Res. Med. Sci*, 2, 1396-1401.
- [94.] Ward, P. (2018). Trust and communication in a doctor-patient relationship: a literature review. *Arch Med*, 3(3), 36.
- [95.] 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.
- [96.] Weingart, S. N., Cleary, A., Seger, A., Eng, T. K., Saadeh, M., Gross, A., & Shulman, L. N. (2007). Medication reconciliation in ambulatory oncology. *The Joint Commission Journal on Quality and Patient Safety*, 33(12), 750-757.
- [97.] Wetzels, M., Odekerken-Schröder, G., & Van Oppen, C. (2009). Using PLS path modeling for assessing hierarchical construct models: Guidelines and empirical illustration. *MIS quarterly*, 177-195.
- [98.] Wilkie, P. (2018). Patient participation in primary care: why is it important? *InnoVait*, 11(8), 452-459.
- [99.] Wolosin, R. J. (2005). The voice of the patient: a national, representative study of satisfaction with family physicians. *Quality Management in Healthcare*, 14(3), 155-164.