2.1: Introduction

Chapter 2 is an overview of Health Care Providers Participation in OPD Management to improve patient satisfaction in tertiary care hospitals. The review covers the patient satisfaction, Physician Patient Relationship and service quality in healthcare organization. The literature review explores the different risks associated with Patient satisfaction, healthcare provider satisfaction and quality improvement. The scope of the literature review extends to the work of founding theorist of trust, peer-reviewed articles, books and journals. Literature reveals a significant gap related to healthcare provider participation in OPD management with Patients satisfaction.

Past research mostly conducted on Patient satisfaction, Physician satisfaction and quality improvement in Hospitals but lacked validation efforts for these models. Although reference to literature show a gap of intensive research effort around healthcare provider participation in management of OPD for patient satisfaction conducted over last decade. The study was based on sufficient solid theories and concepts to bridge the gap and investigate about patients’ satisfaction and Quality care provided in outpatient department with participation of healthcare providers. Plans of action ensure proper utilization of level of care and facilities provided in OPD. An extensive literature search was conducted approximately 122 peer-reviewed articles and Books were reviewed.

Review of work on Health Care Providers Participation in OPD Management with Special Reference to Tertiary Care Public & Private Hospitals is difficult Subject because it is basically a matter of personal trait, tacts, and ability of the management concerned. It is not easy to just jump on conclusions by defining briefly the outpatient department management. OPD conditions differ from place to place, management to management, time to time.

2.2: A Brief Overview:

Outpatient is defined as: A person given diagnostic, therapeutic or preventive service through the hospital’s facilities and who, at the time is not
registered as an inpatient in the hospital as said by Sakharkar (2009). The care provided by doctors, nurses and support staff is important determinants of patient satisfaction with healthcare. Their skill, experience, warmth, responsiveness and courtesy are covered under this dimension Process of clinical care the experience of the patient with clinical processes (treatment processes and outcomes of care) in the hospital is covered in this dimension, since they are critical indicators of patient satisfaction with medical care Administrative procedures. This dimension examines the experience of the patient with the administrative (admission, process and exit procedures) in the hospital, as these procedures are critical indicators of patient satisfaction with overall medical care Safety indicators. Overall experience of medical care received this dimension measures the patient’s experience with the hospital on the whole, the likelihood of patient’s recommending the hospital to a family member or friend, care expected and received at the hospital, quality of care in this hospital with respect to other comparable hospitals. As discussed by Duggirala, Rajendran, & Anantharaman, (2008).

Regarding satisfaction parameter analysis, no significant differences were noted between public and private hospitals in relation to doctors behavior, nurses behavior, getting appointment at a convenient time, doctor tests to find out wrong, doctors examination procedure, hours of service, doctors interest, information sharing about disease, communication, receptionists behaviour, nurses’ attitude, emergency treatment, courteous manner and time spent by doctors with the patients. On the other hand significant differences were noted about cleanliness, environmental quietness, staff care, access to doctor, doctors explanation, nurses activity, faith and confidence in the doctors, doctor advice over the telephone, facilities for dealing with emergencies, nurses’ attention, waiting room, receptionists behaviour, medical tests and doctors competency, as revealed by Ekram, Rahman, Salim, & Haque, (2008). In developed countries with high GDPs and literacy rates patients are not fully aware of their medications. They do not know how early detection and treatment can prevent problems in the future. Hence patient awareness is a very useful tool to improve the care provided by the hospital according to Alam, Aman, & Hafizullah, (2011).
As Table 2.1 B.M. Sakharkar (2009) discussed following Policies and Procedures for smooth functioning of OPD

<table>
<thead>
<tr>
<th>Clinics</th>
<th>Types of Patients</th>
<th>Examination &amp; treatment</th>
<th>Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Functions</td>
<td>2. Paying</td>
<td>2. Laboratory investigation</td>
<td>2. Duties</td>
</tr>
<tr>
<td>6. Referrals</td>
<td></td>
<td>6. Accident injuries</td>
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<tr>
<td>7. Consultations</td>
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<td>7. Fractures</td>
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<tr>
<td>8. Inter-relationship</td>
<td></td>
<td>8. Injuries</td>
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<tr>
<td>10. Records</td>
<td></td>
<td>10. Records</td>
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<tr>
<td>11. Evaluation of care</td>
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<td>11. Follow-up</td>
<td></td>
</tr>
<tr>
<td>12. Timings</td>
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<td></td>
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<tr>
<td>13. Drugs</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>14. Suppliers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Equipments and supplies</td>
<td>Records</td>
<td>General</td>
<td></td>
</tr>
<tr>
<td>1. Inventory</td>
<td>1. Identification</td>
<td>1. Safety and security</td>
<td>1. Safety and security</td>
</tr>
<tr>
<td>5. Accounting</td>
<td></td>
<td>5. Housekeeping</td>
<td>5. Housekeeping</td>
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<tr>
<td>10. Sterilization</td>
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Table 2.1: Policies and Procedures of OPD

Mandokhail, Keiwkarkna, & Ramasoota (2007) observed that hospital autonomy is an attempt to achieve the following objectives of improving communication and reducing administrative complexity, thereby improving government’s responsiveness to local needs, enhance effectiveness and efficiency of management by allowing greater discretion, increase accountability to the public, improve resource mobilization for national and local development policies, and improve local knowledge of development priorities, achieve political objectives such as self-reliance, self determination, and democratization. Patient satisfaction
surveys are an instrument in monitoring hospital’s quality of care in relation to cost and services. Patient satisfaction studies inform planning as part of range of assessment indicators used to compare different activities of organizing or providing health care. Patient satisfaction is vital for hospitals and other health organizations, it would be appropriate to uncover the issue and determine the factors influencing the satisfaction.

As said by Mpinga, & Chastonay, (2011) Patient satisfaction in their more technical aspects, have a potential political, social and ethical impact, which strengthens their usefulness as a monitoring tool of the right to health. Patient satisfaction builds on ethical and moral foundations. The principles of autonomy (free choice, participation, etc.), beneficence and non malfeasance (scientific soundness, technical competency, capacity to empathy, etc.) should be respected by health professionals and be an integral part of the mechanisms of implementation and surveillance quality of care and basic rights of patients. Perhaps patient satisfaction could be considered in the future as a right to health indicator, making its contribution in monitoring the progress states, achieved in regard to implementing the right to health for the populations they are in charge of. Indeed patient satisfaction studies do yield valuable information on accessibility / inaccessibility to quality health care as well as on true/fake patient participation, adequate/inadequate circulation of information and appropriate/ inappropriate allocation of resources, ultimately being of interest to health policy decision makers. Hospital efforts to improve the climate of physician-hospital relationships strategies to improve physician satisfaction or to reduce tensions with the medical staff, or both, may not be successful in terms of increased admissions. Physicians with greater levels of social psychological commitment to a hospital are no more likely than the less committed either to remain loyal to that hospital in terms of admitting patients, or even to remain with the hospital. Administrators desiring more admissions through physician-hospital relationship and focus on increase convenience to save the physician's time. Such programs should begin by encouraging physicians new to the community to locate their offices near the hospital, the climate of physician-hospital relationships is unimportant. Poor relations with physicians may involve significant externalities, such as lower morale
and higher turnover. As stated by Burns & Wholey (1992) that poor relations may harm physician-hospital communication and the quality of joint decision making. Kao, Green, Zaslavsky, Koplan, & Cleary, (1998) has shown that Patient trust scale in table of article relationship between method of physician payment and patient trust.

<table>
<thead>
<tr>
<th>How much do you trust your physician(s)</th>
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<tbody>
<tr>
<td>1. To put your health and well-being above keeping down the health plan’s cost?</td>
</tr>
<tr>
<td>2. To keep personally sensitive medical information private?</td>
</tr>
<tr>
<td>3. To provide you with information on all potential medical options and not just options covered by the health plan?</td>
</tr>
<tr>
<td>4. To refer you to a specialist when needed?</td>
</tr>
<tr>
<td>5. To admit you to the hospital when needed?</td>
</tr>
<tr>
<td>6. To make appropriate medical decision regardless of health plan rules and guidelines?</td>
</tr>
<tr>
<td>7. Judgment about your medical care?</td>
</tr>
<tr>
<td>8. To perform necessary medical test and procedures regardless of cost?</td>
</tr>
<tr>
<td>9. To offer you high quality medical care?</td>
</tr>
<tr>
<td>10. To perform only medically necessary test and procedures?</td>
</tr>
</tbody>
</table>

**Table 2.2: Patient trust scale**

Andaleeb, Siddiqui & Khandakar (2007) said that the ability to satisfy customers is vital for a number of reasons. For one, today’s buyers of health care services in developed countries are better informed, a condition that is being driven by greater levels of information available to them. These buyers are therefore more discerning, knowing exactly what they need. Customer satisfaction is also a valuable competitive tool; hospitals that are customer focused have been able to increase capacity utilization and market share. Recent research has shown that service satisfaction can significantly enhance patients’ quality of life and enable service providers to determine specific problems of customers, on which corrective action can then be taken. Patients’ voice ought to derive similar changes in the developing countries. Health care providers’ empathy and understanding of patients’ problems and needs can greatly influence patient satisfaction. Patients desire doctors to be attentive and understanding towards them. This reflects service providers’ empathy...
the more empathy received from the service provider, the greater the satisfaction of the patients.

Mpinga & Chastonay (2011) also explained that over time and years the concept of patient satisfaction shows an evolution towards complexity, while becoming more operational. Indeed patient satisfaction studies have proved of value as a health indicator and allowed the implementation of improvement strategies in the health sector based on “the voice of the patient”, thus becoming a potential right to health indicator. Mead & Bower (2000) elucidated that `patient-centred' 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. The doctor patient relationship encompassed by the concept of `patient-centeredness' and to assess the advantages and disadvantages of alternative methods of measurement, conceptual dimensions are identified which includes bio psychosocial perspective; `patient-as-person'; sharing power and responsibility; therapeutic alliance; and `doctor-as-person'.

Feldman, Novack & Gracely (1998) looked at specific aspects of managed care, such as gate keeping and capitation, to assess physicians’ views. To gain more information about the impact of managed care, they developed a survey to assess the attitudes of primary care physicians on how managed care affects (1) physician-patient relationships, (2) their abilities to carry out their ethical obligations to patients and quality of care. There is widespread agreement that trust between patient and physician is important for high-quality health care. It has been suggested that trust in physicians has deteriorated over recent decades. One reason for this deterioration could be decreasing continuity. To improve trust is to improve continuity. This could be encouraged through financial incentives by providing higher reimbursement to physicians or lower copayments to patients when a visit is made to one’s regular physician or by allowing patients to keep their regular physician efforts to improve continuity can improve the relationship between a patient and his/her physician and may improve the quality and outcomes of care is suggested by Mainous, Baker, Love, Gray & Gill, (2001).
2.3: Patient Satisfaction and its importance in OPD:

According to Irwin & Richardson (2006) patient-focused or patient-centered care is not a new concept, but its value has been overlooked in preference to the physician-led, technology-based, disease-centered model that has prevailed in medicine for the last 50 years. Patient-focused care is often defined by what it is not: technology centered, doctor centered, hospital centered, and disease centered. Today, patient-focused care can be thought of as a merging of the patient education, self-care, and evidence-based models of medical practice. Patient-focused care takes the best points from each of these models and divided into broad areas of intervention: communication with patients, partnerships, health promotion, and physical care (medications and treatments). Patient-focused care, therefore, requires an appreciation of a variety of issues: patients’ expectations, beliefs, and concerns regarding their disease and an understanding of their personal circumstances; the motivation to provide information regarding diagnosis, pathology, treatments, and prognosis; the ability to find a common ground on what the problem is and agreeing on management; and the knowledge to utilize the best medical evidence to inform treatment decisions.

Kistler, Walter, Mitchell & Sloane, (2010) discussed regarding Patient perceptions of medical mistakes, health care professionals can better understand patients’ satisfaction with the current health care system. Although patient perceptions of mistakes likely encompass broader concepts than the strict definition of medical error, these perceptions have been shown to affect care regardless of whether a true adverse event has occurred. Psychological and emotional harm can result from perceived mistakes whether or not they would be defined as errors or adverse events by the medical community. Perceptions of mistakes have been shown to play a role in patient satisfaction, which is linked to physician trust and medication adherence. Thus, even though patient perceptions of medical mistakes may not always represent true adverse events, they nonetheless may influence patient satisfaction, regimen adherence, and other outcomes and therefore deserve study. According to Ostermann, Bertram, & Büs singer (2010) the nature of the environment in which a medical staff does their work plays an important role in job satisfaction and performance. Several studies already investigated the relationship
between the milieu in which health professionals work and the impact on job satisfaction. They proved that poor work environment is associated with reduced job satisfaction, absenteeism, somatic complaints, burnout and depression. Moreover, poor work environment might also influence the work performance negatively, and might also promote negative and cynical attitudes towards patients and colleagues, which in turns will have an impact on the patients’ satisfaction and their relatives’ satisfaction.

As discussed in the article Resolving disagreements in the patient-physician relationship: tools for improving communication in managed care by Levinson, Gorawara-Bhat, Dueck, Egener, Kao,Kerr, C, & Kemp-White, (1999). Conversed on types of disagreement shown in following table 2.3 below.

<table>
<thead>
<tr>
<th>Category and Type of Disagreements</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allocation of resources Length of stay in hospital</td>
<td>Patient expects that the physician should allow longer stay than guidelines recommend for the condition.</td>
</tr>
<tr>
<td>Specialty referral</td>
<td>Patient wants to see specialist who is not medically essential.</td>
</tr>
<tr>
<td></td>
<td>Patient wants to see out-of-panel specialist.</td>
</tr>
<tr>
<td>Request for test or treatment</td>
<td>Patient requests expensive tests to “rule out” disease.</td>
</tr>
<tr>
<td></td>
<td>Patient requests non-formulary drugs.</td>
</tr>
<tr>
<td></td>
<td>Patient request the physician “bend the rules” to authorize uncovered services.</td>
</tr>
<tr>
<td>Access to care Time limitations</td>
<td>Patient waited and expects long visit</td>
</tr>
<tr>
<td>Calls to the physician answered by assistant</td>
<td>Patient expects physician rather than assistant</td>
</tr>
<tr>
<td>Financial arrangements what the physician charges</td>
<td>Patients are uncomfortable asking about fees</td>
</tr>
<tr>
<td>Disclosure of incentives</td>
<td>Patients worry that financial incentives influence decisions.</td>
</tr>
</tbody>
</table>

Table 2.3: Types of Disagreement patient-physician Relationship

Qidwai, Dhanani & Khan, (2003) reported that Health care providers are coming under increasing pressure to demonstrate that they incorporate the views of users when planning
and evaluating services. Within the rapidly changing climate of primary care, there is an increasing need to evaluate the reactions of patients to real and proposed changes in practice. It has been shown that there are areas of patient dissatisfaction, which can be focused by hospital managers, in order to improve service quality. Mismatch between patient expectation and the service received is related to decreased satisfaction.

It has been demonstrated that patients benefit from physicians who keep the focus on them. Patient waiting time is an issue that has remained a factor in the determination of patient satisfaction. Major portion of a patient visit time is consumed in activities other than actually seeing a physician. It is important for health services planners to ascertain an acceptable waiting time for patients which, if achieved, may lead to overall satisfaction.

The style and efficacy of leadership, interestingly, does not show much direct relation to feelings of burnout, although previous healthcare research has shown a relationship to job satisfaction the following popper user interface control may not be accessible. Tab to the next button to revert the control to an accessible version. The relatively slight influence of leadership may be specific to ward nursing teams. Leadership in such teams is distributed across a number of people, including: the ward manager (the person rated in this project), consultant psychiatrist(s), senior qualified nurses who are in charge of shifts when on duty, and managers at a higher level than ward staff in several layers up to the top management team of the healthcare organisation. In addition, the shift system means that the nursing team never meets as a whole with the ward manager, and communication downwards is easily fractured. This may well be why staff having clarity among themselves about the organisation and rules may be so central in the resulting model is stated by Bowers, Nijman, Simpson & Jones (2011).

Health care that establishes a partnership among practitioners, patients, and their families (when appropriate) to ensure that decisions respect patients’ wants, needs, and preferences, and that patients have the education and support they need to make decisions and participate in their own care. Exploring the patients’ main concerns, emotional, and information needs, finding common ground, and
enhancing the continuing relationship between patient and doctor. The Picker approach to assessing patients’ experience defines dimensions of patient-centred care. Access; respect for patients’ values, preferences and expressed needs; coordination and integration of inpatient services; Information, communication, and education; physical comfort; emotional support and alleviation of fear and anxiety. Involvement of family and friends; Transition and continuity after discharge: ‘‘There are at least three important and distinct domains of patient centredness: communication, partnership, and health promotion all is observed by Groene, Lombarts, Klazinga, Alonso, Thompson & Suñol, (2009).

Qidwai, Ali, Baqir & Ayub, (2005) expressed their views that In today’s age of growing demand for autonomy and respect for patient, we should not be surprised at the finding that a majority of our study subjects want to be involved in decisions concerning their treatment. The majority also wants written feedback on their visit. This shows that there is clearly a shift from a paternalistic medical practice that exists, a more autonomy based model of medical practice. We need to prepare our medical community to adjust to such changes that are taking place today in doctor-patient relationship. Fan, Burman, McDonellc & Fihn, (2005) observed Patients’ satisfaction with their medical care is predictive of their decisions regarding choice of health care plans, compliance with prescribed regimens and clinical outcomes. Several patient characteristics have been associated with general patient satisfaction including demographic factors, socioeconomic status, and general health status. In addition to patient characteristics, satisfaction is also influenced by the manner in which health care is delivered. The type of health care setting and characteristics of the medical provider, such as experience, age, and gender, are related to patients’ satisfaction. Health care delivery that may impact patient satisfaction is continuity of care. A sustained partnership over time between a clinician and patient is considered a fundamental component of primary care. This longitudinal relationship ideally leads to a bond between clinician and patient, characterized by trust and a sense of responsibility. There is evidence that continuity of care is associated with improved outcomes such as fewer emergency department visits and hospitalizations, improved management of chronic diseases such as diabetes, and use of preventive services.
Perneger, Etter, Raetzo, Schaller & Stalder, (1996) revealed that outpatient clinic care provided by interns and residents in a teaching hospital is comparable in quality to care provided by more experienced physicians in private practice. Only frequent changes of physicians, inherent in this type of institution, were considered as a drawback by some respondents. On the other hand, clinic administrators were aware of difficulties in getting appointments and with waiting times. At the present time, the hospital clinic is revising its procedures for obtaining and scheduling appointments. This indicates that patients do not blindly endorse the care they receive, and also suggested that the care provided at a teaching hospital outpatient clinic may be rated as good as care received from independent fully trained physicians, and that a managed health care plan may cause substantial dissatisfaction among members forced to consult designated gatekeepers. Most importantly, this comparison led to quality improvement interventions in both settings in which patients expressed relative dissatisfaction with specific aspects of care.

Patient perceptions of medical service quality provided by solo and group practices, Lin, Xirasagar & Laditka, (2004) hypothesized that the superior resource base of group practices would translate into better customer service. Patient perceptions are to influence future decisions to avail the clinic’s services, satisfaction with the clinic, and behavioural intent to return to the clinic and recommend it to friends and relatives. The findings have policy implications for governments, and management implications for office-based physicians. Office practice-based care is more economical, geographically and logistically more accessible, and potentially offers better continuity of care and outcomes for ambulatory conditions. Seeking to reform health systems need to evaluate service quality in solo versus group practices from a quality and strategic marketing perspective.

Sultana, Riaz, Rehman & Sabir, (2009) suggested that quality of health care showed that efficient delivery of Primary Health Care through the existing health system will lead to improved health conditions by reducing morbidity, maternal and infant mortality and population growth rate. Nurses need to know the factors influencing the patient satisfaction in order to improve the quality of health care. Every human being carries a particular set of thoughts, feelings and needs. By getting to know the patients a little more to get their views on the care, one ought to
come closer to what the patients consider as good care. A study by Bhuttacharya showed that although the unit under study provides satisfactory health care services in terms of technical quality, responsiveness, general cleanliness and food, certain areas need improvement namely communication, toilet facilities, facilities for attendants as well as behavior and attitude of paramedical staff. To determine the level of patient satisfaction in relation to medical facilities and performance of medical and paramedical staff in tertiary care hospitals in order to improve the health status of the community.

Cheng, Yang & chiang, (2003) agreed that there is room for improvement and that more items may be needed; however, this might be a good starting point to investigate patient perception of the clinical performance of hospitals and their recommendation of a hospital. The ideal quality indicator measures a specific aspect of the quality of health care and nothing else. Unfortunately, this is often not the case, particularly for outcome indicators, which often reflect a variety of patient characteristics that are not under the provider’s control. According to Perneger, (2004) patients who complained even when they receive the best care, and of patients who are thankful and uncomplaining even in the worst conditions. Comparisons of mean satisfaction between health care providers who do not serve the same profile of patient population may be biased. Satisfaction often mistrusted by providers, particularly by those who are fairly poor in comparison with others, and are therefore not used to improve care.

Chompikul & Sermsri,(2008) observed that improving the quality of OPD services at health centres. Most patients highlighted the need to improve the discipline of health care workers, provide training programs for health providers, and provide continuing education for experienced health providers to keep up with updated knowledge, technology and work practices. The health care services should be continually improved by the health center because it is the basic service. The health center should encourage the training programs for the health providers; provide the continuing education for the experienced health provider to keep up work updated knowledge and technology. According to Forkan & Dhaka, (2011) a service received by different customers of outpatient department (OPD) has created opportunity. Objective was to examine the reliability and effectiveness of
considered customer satisfaction drivers of OPD of square hospital limited and depending on this result have an idea about private healthcare industry. Different drivers of customer satisfaction, i.e., appointment desk, customer service, nurse station, waiting room, and doctors’ service met standards for internal scale reliability except registration desk. Variables or items under each driver loaded on single summated scale considered for every driver except appointment desk and waiting room.

Jadhav, Lokhande, Naik, Rajderkar, Suryavanshi & Bhyoe, (2011) stated that in recent years, much attention has been paid to improve health care and decrease inequalities within health care systems. As well as addressing key areas such as structure, process, and outcome, which are normally taken from the provider's viewpoint, it is also necessary to address the patient's perspective. Patient-reported outcomes are an increasingly popular method of assessing the patient's experience within the health care system. It is thus an essential part of quality assessment to include patient satisfaction as an ultimate end point to health care quality. Net, Sermsri & Chompikul, (2007) observed two ways communication with politeness and friendliness during the provision of service to patients and the establishment of good communicator model are also recommended in order to increase patient satisfaction level. Considering health service providers as internal customers, patient satisfaction study should be conducted in parallel with the satisfaction of service providers with their job in order to better understand the concerns of the service providers that make patients dissatisfied so that these concerns can be solved accordingly.

Cheah, Giloi, Chang & Lim, (2012) revealed one of the main contributing factors which influences the Safety Satisfaction of health care providers is job satisfaction. Job satisfaction affects nurses’ retention and turnover, their morale level, productivity, commitment, and performance, which in turns affects patients’ safety. A health and safety survey showed a majority of nurses indicated that perception on working conditions interfered with their ability to deliver quality care. These respondents also reported that health and safety concerns influenced their decisions about the kind of nursing work performed and their continued practice in the field of nursing. In addition, the respondents also stated that the perception of
unsafe working conditions may hinder recruitment and retention of qualified staff. It is important to gauge how healthcare workers perceive the issues of safety and health in their workplace. Evidence shows that the work nature of health workers, involving long working hours and overtime, can create stress and work-personal life imbalance. Inadequate nursing staff, poor working environment, and lack of management support impact patient safety and health care delivery. Increasing work pressure results in decrease in morale and productivity of nurses. Monitoring nurses’ working conditions and improving the organizational climate of hospitals is likely to improve nurses’ safety and hospital profitability and the quality of patient care delivered.

Traditionally, the focus of medical care has been restricted to diagnosis and treatment of disease and not on patient experience during the course of treatment. Medical outcome in terms of morbidity and mortality is considered as the main indicator of quality. However, these outcomes poorly assess various issues of importance to the patient. Patient satisfaction involves physical, emotional, mental, social, and cultural factors. It is determined by the quality of care provided and the patient’s expectations of the care. Patient involvement in decision making by means of an audit has emerged as an effective tool for quality assurance in health services as discussed by Gupta & Gupta, (2011).

Mekonnen, Mariam, Kedir & Kabew, concluded that Patient satisfaction was lowest with the sanitation and the lack of explanation about the procedures. The hospital administrators should work on the enhancement of services. Hospital administration needs to work with laboratory units in designing & concerted effort to improve the cleanliness. Provision of relevant information to patients who use the laboratories is also needed. Additional resources need to be directed to laboratory services in these hospitals. Ongoing training of laboratory staff members needs to be provided. Finally, patient satisfaction should be viewed as an important issue in health care organizations and further studies on the subject of patient satisfaction are recommended.

Assefa & Mosse, (2011) discussed about Client satisfaction that is the level of satisfaction that clients experience having used a service. It therefore reflects the
gap between the expected service and the experience of the service, from the client’s point of view. Measuring client or patient satisfaction has become an integral part of hospital/clinic management strategies across the globe. Moreover, the quality assurance and accreditation process in most countries requires that the satisfaction of clients be measured on a regular basis. Asking patients what they think about the care and treatment they have received is an important step towards improving the quality of care, and ensure local health services are meeting patients’ needs. It is an established fact that satisfaction influences whether a person seeks medical advice, complies with treatment and maintains a continuing relationship with practitioners. The leading theorist in the area of quality assurance has emphasized that Client satisfaction is of fundamental importance as a measure of the quality of care 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.

Patient Satisfaction with Nursing Care is the outmost requirement as per Sharma & Kamra (2013). Improving the nurses’ interpersonal skills could increase patients' satisfaction which was likely to have a positive effect on treatment adherence and health outcome. The overall patient satisfaction with nursing care was high in selected public as well as private hospitals. However, patient satisfaction with nursing care was high in all the dimensions of nursing care in private hospitals as compared to government hospitals. Furthermore it was found that patient satisfaction with nursing care in medical, surgical, orthopaedic and maternity wards was not significantly different in selected public and private hospitals. However, it was found communication and emotional support dimension of nursing care needs improvement to further enhance patients' satisfaction with nursing care in selected public and private hospitals. Therefore, it is recommended to plan and implement the training programs needed for nurses to improve their knowledge and skills of communication and use of emotional support measures for the patients.

Khattak, Alvi, Yousaf, Shah, Turial & Akhter, (2012) observed that the concept of patient satisfaction is not new. Patients are one of the main stakeholders among the ever expansive modern world of medicine. A wealth of medical literature supports the notion that there have been unprecedented shifts in the traditional
“Doctor-Patient” relationship. Patient satisfaction forms an essential component of many policy level decisions. Changes in patient care trends have been seen in developing countries recently. Patient satisfaction is a complex, multidirectional issue that needs to be approached from several different angles. In another article Afzal, Khan, Rizvi, & Umer conferred that Paramedic staff needs to know the factors influencing the patient satisfaction in order to improve the quality of health care. Measurement of patient satisfaction is expected to play an increasingly important role in the growing push toward accountability among health care providers overshadowed by measures of clinical processes and outcomes in the quality of care equation. Patient satisfaction finding regarding inpatient and ambulatory care play a significant role in hospitals’ strategies and tactics in delivering patient services. Every human being carries a particular set of thoughts, feelings and needs. By getting to know the patients a little more to get their views on the care, one ought to come closer to what the patients consider as good care. Patient compliance is very important for successful treatment outcome and since clinical outcome is always attributed to the provider and never to the patient, the patient compliance with treatment becomes all the more crucial.

Kuteyi, Bello , Olaleye, Ayeni & Amedi, (2010) they also revealed that Patient’s confidence in the doctor significantly contributed to overall satisfaction levels. Our findings that information provision, the patient’s confidence in doctor their communication with patients and, to a large extent, patients’ adherence emphasize, among other things, that good interpersonal / communication skills are essential to gain a patient’s trust. Patient’s confidence in the doctor and the doctor’s communication skills predicted patient satisfaction and, to a large extent, patients’ adherence emphasis, among other things, that good interpersonal/communication skills are essential to gain a patient’s trust, in agreement with the findings of other researchers. Patient’s confidence in the doctor, information provision by the doctor and the doctor’s communication skills predicted patient satisfaction and adherence. This shows the importance of the doctor’s role in influencing patient satisfaction, a direct determinant of patient adherence to the physician’s advice and, consequently, favourable health outcomes. Doctors have the means, namely effective physician-patient interaction, to influence the outcome of the medical consultation.
Acharyulu, Ramaiah (2011) discussed that Indian healthcare provider needs to be benchmarked to international quality and efficiency standards to provide the quality service to the patients to meet the expectation. Outpatient department is the Patients’ first point of contact in the Hospital. It is the shop window of hospital. The service quality provided by this department would makes or mars the hospital image. A quality OPD service can reduce the load and also improve the perception of the patients and his/her attendants about the hospital. In the today’s’ healthcare competitive environment it is very important to provide the quality OPD services to the patients. Many quality Gurus and scholars has been given many definitions of quality by focusing on the identification and satisfaction of customer needs and requirements.

Rajinder (2010) thrashed out important reasons to visit government hospitals are charges, geographical proximity, recommended by their friends or relatives. Majority of patients had not utilized the services earlier for any other disease. Patients are found to be dissatisfied with the doctors’ check-up. Majority of patients say doctor visit on alternative day to check the patient in their room/wards and nurse visits whenever the medicine is to be given. Majority of patients purchased medicine from the chemist shop in the market. Mostly patients were found dissatisfied with the hygiene and overall condition of the basic amenities. Half of the patients were satisfied with the recovery since admission in the hospital. Majority of patients were satisfied with various diagnostic services provided by hospitals. Mostly patients did not lodge complaint against the behaviour of staff and quality of services. Hameed, Keiwkarnka, Sirisook & Smitasiri, (2005) discussed about overall human relations of the nurses in the hospital was found to be reasonably good, however, there was a room for improvement. The hospital may encourage the nurses to improve their human relations and reward them with financial incentives. Overwork reduced the level of human relations among the nurses. The hospital may ensure that the nurses work an adequate number of hours and enough staff is available to provided relief in their working hours and shift duties. Level in the hierarchy seems to influence the human relations among the nurses. Timely promotions and proper job structure will improve their performance in terms of human relation.
Haldar, Sarkar, BisoI & Mondal, (2008) thought that healthcare providers and programmes in our country have overwhelming emphasis on quantitative aspect of service delivered, which means that, in a quest to chase runaway targets, neglect the concept of quality of care, which is also a right of clients. Healthcare providers and programmes worldwide have increasingly recognized that the quality of care they provide determines their overall success in attracting the clients and meeting their needs, and the quality improvement initiative has been started because poor quality is costly - to clients, to programmes and to the society overall. People’s perception about quality of care often determines whether they seek and continue to use services. Being intangible in nature, the perception directly affects the quality rating in service. So, there are attempts to scale and measure this perception. OPD is the window to any health system and OPD care indicates the quality care of hospital reflected by patient’s perception in terms of satisfaction to the services they are provided.

Ahmad, (2010) observed that satisfaction is a psychological state resulting when the emotion surrounding disconfirmed expectations is coupled with consumer’s prior feelings about the consumption experience. While Patient satisfaction has been defined as the degree of congruency between a patient’s expectations of ideal care and his /her perception of the real care him /her receives. Patient satisfaction represents a key marker for the quality of health care delivery and this internationally accepted factor needs to be studied repeatedly for smooth functioning of the health care systems. A better appreciation of the factors pertaining to client satisfaction would result in implementation of custom made programs according to the requirements of the patients, as perceived by patients and service providers. Patient is the best judge since he/she accurately assesses and his /her inputs help in the overall improvement of quality health care provision through the rectification of the system weaknesses by the concerned authorities.

McCabe, C. (2004) shared his experience that nurses are not good at communicating with patients, nurses can communicate well with patients when they use a patient-centred approach. However, health care organizations do not appear to value or recognize the importance of nurses using a patient-centred approach when communicating with patients to ensure the delivery of quality patient care. Another reason why nurses may not communicate in a patient-centred way is that they do not
know what patients value about nurse–patient interactions. This lack of evidence also limits the way in which nurses are educated in relation to how to communicate in a patient centred way. Unless health care organizations and nurses recognize the importance of communicating in a patient centred way in order to deliver good quality care, the task centred approach to patient care as experienced by the participants in this study will continue.

It has been stated by Kao, Davis & Koplan, (1998) that trust is a fundamental aspect of the patient-physician relationship. Health service shown that payment methods may have an impact on clinical decision making, no studies that have examined whether patients' beliefs about how their physician is paid affect their trust in the physician. It is assessed how patients thought their physicians were paid and whether their perceptions were accurate & examined whether availability of a choice of physicians, length of patient-physician relationship was related to the patients' trust in their physician. Many doctors equate professionalism with autonomy-to be left alone to do what they want, not only medically but financially. Because of their specialized knowledge, professionals are uniquely positioned to supervise the work of their peers, to protect consumers against failures of professionalism. If health care reform is to succeed, it must consciously and energetically promote these qualities in the medical profession and among other health care providers. Any health care system that undermines these qualities will leave the public unhappy and rebellious and will fail to establish a stable, politically viable alternative to the present system this is observed by Blumenthal, (1994).

2.4: **Medical Profession and its significance in Tertiary care Hospitals:**

Physicians are truly making decisions based on the patient's best interest or are unduly influenced by economic incentives. These circumstances lead to the potential for disagreements and conflict in the patient-physician relationship. Levinson, Gorawara-Bhat, Dueck, Egener, Kao, Kerr & Kemp-White, (1999) convened a group of individuals including patient representatives, leaders from health care organizations, practicing physicians, communication experts, and medical ethicists, to articulate the types of disagreements emerging in the patient-physician relationship as a result of managed care. The doctor–patient relationship has evolved since the times of paternalistic medicine and with it so has the definition
of what it means to be an autonomous decision maker. It suggests that the preferred relationship recognizes patient autonomy, not as control, but as an active role in treatment decision-making within the context of a shared relationship with a trusted provider as described by Deber, Kraetschmer, Urowitz & Sharpe, (2007).

As said by S.A.Kelkar (2010). Leader must have personal perception. Leader must create innovative systems to provide feedback from the results. Leader must create daily operational systems which address the work structure, human capabilities, and improvement activities. In figure 2.1, we find Visionary Leadership.

![Figure 2.1: Leadership: Schematic](image)

Trust in medical care focuses on two questions: (1) is the physician competent to make a diagnosis and provide treatment; and (2) will the physician act in the best interest of the patient? Most patients must depend on the physician for the information they need to answer those questions. This results in an unbalanced relationship. Physicians rely on professionalism to safeguard patients from their dependency. However, one believes that patients and health care purchasers are challenging the effectiveness of professionalism. Managed care happens to be one form of challenge, but it is a symptom of general unrest with health care delivery, not the causative agent. Any institution that expects to restore and enhance trust in medical care must satisfy the two questions listed above at an individual level as observed by Newcomer, (1997).
Hall, Dugan, Zheng & Mishra, (2001) said that there is pressing need to increase the rigors of thought and the amount and quality of information bearing on trust. The rapidly developing body of work on trust in the medical setting to propose a detailed conceptual framework and summarize the limited empirical evidence to date, doing so reveals several insights. First an explicit conceptual framework is an important aid to analyze of truth especially considering its subtle and paradoxical nature. Therefore it is essential that definition and distinctions be clearly articulated. Second, it is critical to take a rigorously empirical approach since many casual assumptions about trust and its causes and effects do not bear up under scrutiny. This often happens because we overlook the fact that trust originates from fundamental psychological attributes of seeking care in state of anxiety rater than from variable physician characteristics or patient personalities. Taking trust as the object of law and ethics knowing more about what condition produce trust and distrust and why this matters helps to craft the structure and financing of healthcare delivery in manner that supports and enhance trust. It includes the choice of providers encouraging better communication and more time with patients and using trust measure to monitors delivery system.

The providers of Health care services are becoming increasingly committed to the satisfaction of users’ requirements. Regarding public health, the majority of services are not motivated by profit; the system operates at a low degree of competitiveness and, therefore, quality programs are either not a priority or are focused on quantification of quality aspects that are more related to efficiency and effectiveness than to total quality. Mechanisms of evaluation of health services are tools of utmost importance in the depiction of what should be desirable and economically accessible health system for the country and essentially requires discussion on quality, Series of questions about the elements that form quality as a mandatory requirement for health services, positioning user satisfaction as an important element within that definition. This is a major component of quality and care, considered a goal to be reached. Satisfaction measurement is a relevant instrument for administration and planning, in addition to playing an important role in the interaction between service provider and user, since satisfaction reflects judgment of the quality of provided care as reported by Oliveira, Arieta, Temporini
& Kara-José (2006). Patient privacy, location of the hospital, financial cost of treatment, and respect is important. Above all Outpatients, doctors’ behaviour has the largest effect followed by medicine availability, hospital infrastructure, staff behaviour is of enormous important as said by Rao, Peters, & Bandeen-Roche, (2006).

Hall, Camacho, Dugan & Balkrishnan, (2002) stated that people encounter a range of different providers; they naturally choose to remain with those in whom they have the most trust. Therefore, any side-by-side assessment of physicians in general and one’s current physician is likely to produce higher ratings for the latter. Trust in physicians in general has a number of limitations that merit further investigation, trust should have a controlled intervention design use more objectively assessed or independently observed measures of the correlates of trust, and include a larger and more diverse sample. Trust in physicians and medical institutions deserve deeper and more rigorous study, for it is a vital aspect of health care relationships that may mediate many important behaviours and outcomes. As discussed by Kulkarni & Satyashankar (2009) the output of care provided to outpatients is measured in any one of the following ways:

1. Number of outpatients visits
2. Number of finished episodes of outpatient care
3. Number of procedures

Doctors treating low income outpatients spend more time with patients, undertake primary checkups. If he is unable to make him well, he will advise him future course of action. In urban hospitals, the doctors expect the patients to bring medical reports from in-house facilities and his role is limited to prescribing tablets or recommending him to another specialist doctor.

Patients are categorized under the three groups for payment.

i. Government employees
ii. Individuals whose bills are processed and paid by third parties
iii. Patients themselves directly or indirectly. In case of the first category, the overall load depends upon budget provisions. In case of the second, some sort of controls is exercised. Financial resources serve as a limiting factor for the third.
Hall, Zheng, Dugan, Camacho, Kidd, Mishra & Balkrishnan, (2002) stated that Physician trust exhibits a strong association with satisfaction, having enough choice in selecting one’s physician, willingness to recommend the physician, no desire to switch physicians, no prior dispute with the physician, and not seeking second opinions. Physician trust has a weaker, but still significant, association with length of time with a physician, total lifetime visits with the physician, insurer trust, and membership in managed care. These correlations are all consistent with prevailing conceptual theories of trust, and there were no expected associations that were not observed. The overlap between trust and satisfaction is much stronger for the single-item measure of satisfaction, which directly assesses satisfaction in the physician, than with the more general measure of satisfaction with care received from all sources.

McCaig, Hooker, Sekscenski & Woodwelln (1998) reported that the structure and process of health care delivery in hospital outpatient departments, especially in teaching hospitals, are undergoing rapid change in ways that are likely to increase the use of physician assistants and nurse practitioners in these settings. For example, in an attempt to generate future savings from the deployment of a more balanced physician supply, the Council on Graduate Medical Education has recommended a reduction in the number of specialist positions in hospital-based graduate medical education programs. Mean while, other changes in graduate medical education are shifting greater proportions of primary care medical residents from hospitals to community settings, which will contribute to increased demand for PAs and NPs in hospital OPDs. Patients seen in OPD visits have been shown to differ from those seen in physicians' offices in demographic characteristics; for example, OPDs provide a disproportionate amount of care to people of colour and to Medicaid recipients. The present study was designed to determine whether PA-NP hospital OPD visits differ from hospital OPD visits to all types of medical practitioners in terms of factors such as patient characteristics, tests and procedures performed or ordered, and medications prescribed.

Bramesfeld, Wedegärtner, Elgeti & Bisson (2007) said that the Patients' opinions and views are increasingly being recognized as major indicators of how well health services and health systems are performing, as well as providing
guidance for further service improvement? The service users' view is particularly relevant when trying to make health services more responsive to users' expectations. In the context of the World Health Report 2000, WHO developed the concept of health system responsiveness as a parameter for a health care system's ability to respond to service users' legitimate expectations of non-medical issues in mental health care? The concept that relates to patient orientation and showing respect for persons in mental health care consists of eight domains: autonomy, confidentiality, communication, dignity, social support, attention, basic amenities and choice.

According to Donabedian, (1992) Consumers appeared in many roles on the health care stage: often as patients, at other times as past or future clients, and at all times as citizens. As patients, they can influence the quality of health care, subtly and not so subtly, but always being constrained to maintain a friendly relationship with the doctors on whom so much of their welfare depends. As consumers move further and further away from this position of relative dependency, they can become more outspoken, more assertive, even contentious; and it is proper that they should become so, provided the purpose is always constructive. When health care professionals and consumers present a united front It is necessary, that individual practitioners be always completely open and truthful with their patients about the ways in which public policy shapes what they are able to do. How else could patients act intelligently in their other role: as citizens in a democracy? Similarly, our professional associations must come to be regarded as the most truthful, most impartial sources of information on matters of public policy pertinent to health and health care.

In Patient Relationship Management: Kelkar (2010) observed that Healthcare is not optional; it comes unexpected and unplanned, Healthcare being a booming business, the competition is bound to increases, In view of growing consumer awareness, the healthcare is increasingly becoming consumer driven, Although the healthcare is a services (and not a product), patients expect a good degree of consistency in the treatment provided, Bad news travels faster than the good news, Marketing programs, therefore, involves identifying “potential customers” and building a relationship with them, i.e. these programs are not directed at “identified customers” Patients expect the same level of “services” that
they received during their encounter (as likely prospect) with the “marketing program”. Knowing about the patient’s expectations is the key to “getting and keeping” a patient.

The outpatient services provide the main linkage of the hospital with the community. Francis & de Souza (2004) suggested that Location of OPD should be near the main roads and close to main hospital entrance, but with sufficient space to provide for parking, etc and to prevent noise and dust pollution.

1. Separate from inpatient wards and other departments, but connected with them.
   - Can function more efficiently in terms of scheduling and communications.
   - Easier for patients to find their way around.
   - Less patient and attendant traffic through central hospital.
   - Kept closed when not in use, and
   - Easier to expand, should a need arise.

2. Disadvantage of physically separate outpatient and inpatient departments.
   - Certain specialized diagnostic facilities may be available only in the inpatient section of the respective specialty thus inconveniencing patients,
   - Some outpatient facilities are required for use also by inpatients,
   - A separate facility may require duplication of certain services that could otherwise be shared, satellite laboratories, and
   - Distance between inpatient and outpatient facilities may cause inconvenience to doctors who have responsibilities in both areas.

Study by Tabish (2001) showed that obviously the nursing need of the patients will influence the total workload of the unit; and, where patients are segregated by speciality for example medical, surgical, orthopaedic, paediatric, and other specific wards, experience will dictate the particular nursing and other skills required. Even so, there can be considerable variations; one surgeon, for instance, may insists on elaborate preoperational procedures which may not be considered necessary by another, and it is essential to recognize such factor and cater for them. The resources of the unit must also be organized to ensure that the patient’s total needs are
met. These needs are not confined exclusively to the physical and the home conditions, fear of the feature, and may other equally important concerns must be taken into account if a sense of confidence and security is to be imparted to the patient.

Faulkner, Saltrese-Taylor, O'Brien, Williams, Collins & Frankel, (1995) they also stated that Outpatient department perceived that there was a large proportion of re-attending patients who could appropriately have been seen by the GP, but in many cases they were equivocal in judging the appropriate site of care and acting upon these judgments. There will doubtless always be come discrepancy between the aggregate of clinicians' opinions and their clinical actions. The method of review demonstrated in this study can help prioritise conditions which may be candidates for development of alternative care arrangements across the primary/secondary care interface. Jha (2011) observed that in country like India where we find majority of our population insensitive to the health problem, it is imperative that both the public and private hospitals play a meaningful role by sensitising the masses. Quality an important consideration in the healthcare services and therefore we make a strong advocacy in favour of conceptualisation of Total Quality Management. Poverty and insensitivity are the two important barriers depriving the Indian masses of getting the quality healthcare services. The mounting demographic pressure makes it essential that the Hospital Services Consultancy Corporation assigns due weightage to the qualitative-cum-quantitative transformation so that a large number of our population get the quality healthcare services.

Brazier, (1967) reported that the most important point of all is that hospital staff should never forget that they work to provide a service for sick people. All who come into contact with patients should treat them as human beings, not cases. This has been said so often in so many surveys and reports that it seems tedious to make the point again. Yet it remains true. Unless it is taken to heart by all, many of our new hospitals will be no better than our old despite improved surroundings. The acceptance of the outpatient department as an essential part of the health services meant that it was used by a section of the community who were inclined to be critical. Signs of growing criticism became apparent by the increasing number of letters in the press finding fault with such aspects as waiting time. In the last few years the Patients' Association has been formed which seeks redress for complaints
made by members of the public about conditions in hospital, but until recently no one had formulated the basic needs for a congenial and efficient outpatient department. Various surveys mainly concerned with the investigation, diagnosis and treatment of a patient rather than the organization of the outpatient department.

The study conducted by Furstenberg, also observed that outpatient care of the chronically ill poor patient has always been inadequate, though one still occasionally hears the misstatement: It's the poor and not the middle class that get good medical care when they come to the hospital. Outpatient Department has been that the care of the Chronically-ill poor is less than adequate. That care, too often, has been the central source of service has been the outpatient department. Typically, the patient receives episodic care, rarely indicated continuous care and, almost never, home care. Despite administrative controls, the patient too often has no personal physician. The physician seeing the patient has no real involvement in his total care unless the patient is the subject of a special study in a special clinic or suffers with an especially interesting illness. Usually when the patient is out of the physician's sight he is out of the physician's mind. This is a commentary on the organization of medical care for the poor. I consider my own efforts at outpatient administration largely palliative in the area of medical care; the fact that the chronically ill poor also may receive poor care from private practitioners gives me no satisfaction.

Soufi, Belayachi, Himmich, Ahid, Soufi, Zekraoui & Abouqal, (2010) observed that Patients’ satisfaction is an important indicator for quality of care. Measuring healthcare quality and improving patient satisfaction have become increasingly prevalent, especially among healthcare providers and purchasers of healthcare. This is mainly due to the fact that consumers are becoming increasingly more knowledgeable about healthcare. Cho, Lee, Kim, Lee & Choi, (2004) explained that auxiliary service quality dimensions such as non-physicians care is important for satisfaction formation of outpatients during their early visits to health organization. Patient satisfaction influences patient retention rate and effectiveness of medical care doctor–patient relationship may, in the long run, emerge as the most significant factor in bringing about patient satisfaction and loyalty Therefore, everyone in the organization needs to become part of an institution-wide commitment to
patient satisfaction, because quality management is not the monopoly of top administrators. The relation between outpatient satisfaction and frequency of visits is not positively linear, but rather U-shaped. Hospital management should be aware that repeat visits to the hospital do not necessarily reflect patient loyalty resulting from patient satisfaction. It seems that policymakers and hospital management should look at the level of satisfaction with discretion. They should consider the patient's conditions and care situation when interpreting the satisfaction data for decision-making purposes.

2.5: Physician Patient Relationship its importance in Healthcare Setting:

Stewart, (1995) reported that Patient health outcomes can be improved with good physician-patient communication. The studies reviewed here suggest that effective communication exerts a positive influence not only on the emotional health of the patient but also on symptom resolution, functional and physiologic status and pain control. When taking a history, physicians should ask a wide range of questions, not only about the physical aspects of the patient's problem, but also about his or her feelings and understanding of the problem, expectations of therapy and perceptions of how the problem affects function. Patients need to feel that they are active participants in care and that their problem has been discussed fully. Patients should share in decision making when a plan for management is formulated. They should be encouraged to ask questions and given clear verbal information supplemented, when possible, by emotional support and written information packages. Agreement between patient and physician about the nature of the problem and the course of action appears to bode well for a successful outcome.

According to Coddington & Fischer (2001) the average health care CEO and chief operating officer have to “get much more into the game” with respect to technological innovation, particularly in the IT area. To a lesser degree the same is true with developing a more in-depth understanding of consumerism and various market segments. Most senior health care managers need a self-taught crash course in new technology and marketing strategies, beginning with e-health care. How are the Web sites of those using “best practices” organized to handle inquiries from patients with questions about cardiac problems? What are the best ways of integrating “bricks and clicks” initiatives into women’s health programs?
Acknowledge Discomfort and Uncertainty: These days, discomfort, uncertainty, and stress hang over most health care settings most of the time. Common sources of stress include physicians’ income losses, nurses’ problems in achieving new productivity targets, and managers’ problems in increasing productivity in a very tight labour market. These and other immediate problems must be acknowledged and dealt with. However, pressing current problems cannot be used as an excuse not to deal with key change issues, such as consumerism and technology. Similarly, consumerism and technology cannot be used to delay addressing the other pressing problems.

Park. K (2011) told that information is needed for day to day management of the health system. The information comes from many sources- both formal and informal. The information system should be tailored according to the management needs of the individual health services. The functions of an information system consist of collection, classification, transmission, storage, retrieval, transformational and display of information. A good information system provides data for monitoring and evaluation of health programmes and gives the requisite feedback to health administrators and planners at all levels, computers can play role in improving the health information system.

Tsai, Wang, Liao, Lu, Sun, Lin & Breen, (2007) stated that Outpatients' perceptions of the physical environment of waiting areas, there is still room for improvement via customizing patients' specific characteristics and demands. In addition to evaluating various dimensions of the physical environment, we also examined the effects that outpatient socio-demographics and visiting backgrounds had on patient satisfaction with respect to the physical environment of waiting areas. Gender, age, visiting frequency, and visiting time were all related to patient satisfaction. Furthermore, these factors should be considered when redesigning more comfortable and customized medical care environments in the future.

Patient ratings concerning hospitals' technical competence and physicians' interpersonal skills seemed to be good predictors for patient satisfaction and patient recommendation of a hospital. Yet, perceived technical competence and interpersonal skills had different magnitudes of effect on patient satisfaction and recommendation. Notably, it was found that technical aspect of care is more important than
interpersonal skills in determining patient recommendation of a hospital, key point show the effects of perception on patient satisfaction and recommendation of a hospital.

Gené-Badia, Ascaso, Escaramis-Babiano, Sampietro-Colom, Catalán-Ramos, Sans-Corrales & Pujol-Ribera, (2007) expressed that patient’s confidence in the physician and the physician’s knowledge of the patient. Also of note was that the dimension of individualised clinical care was independent of the dimension of team coordination. An evaluation of the care provided by physicians found that only two dimensions contributed independently to the final output of the care: one was related to the structure (management and organisation of the team) and the other was related to the process of clinical care. Prasanna, Bashith & Sucharitha, (2009) stated that Health care has two connotations (a) health care programs and (b) medical care organizations. Medical care organizations are mainly providing curative care. They are attractive and high-tech oriented and they should be cost effective. In recent years, quality assurance has emerged as an internationally important aspect in the provision of health care services. The health care system depends on availability, affordability, efficiency, feasibility, and other factors. Consumer satisfaction is recognized as an important parameter for assessing the quality of patient care services. Satisfaction regarding the attitude of providers toward these services is expected to affect treatment outcome and prognosis. There is a need to analyze the health care system as often as possible. Consumer satisfaction regarding medical care organizations tertiary care hospital is important in the provision of services to patients. Consumer satisfaction with regard to clinical care such as the approach of the doctor, examination, education on taking medication, availability of services, waiting time, and cost provided in the outpatient department.

Doyle, Reed, Woodcock & Bell, (2010) revealed that hospital trusts are required to develop quality indicators and collate detailed feedback from patients in addition to the annual inpatient survey to measure these. To make best use of resources, additional data collection should focus on those aspects of care of most importance to patients locally. This demonstrates a statistical technique that can help to identify such priority areas by showing those aspects of care most strongly associated with the overall rating of care. The analysis uses national level data to
demonstrate how this can be achieved. This shows the importance to patients of being treated with dignity and respect, and good communication between staff and between staff and patients. The staff working in hospital should be motivated in terms of careful and enthusiastic services (the director of hospital and nurse staff must wonder around hospital during the rush hours). Improving the actual performance of the hospital in order to serve the patients expectations as much as possible, community participation should be encouraged more by the hospital administration, providing the chances to the patients in sending their recommendations or constructive comments via postcards or sms by monthly offering the motivations such as special awards to the most useful recommendation or randomly selected for the fortune participants, lack of sufficient number of the sitting facilities were also a complaint point and the providers may consider appropriate measures to resolve the issue, the treatment seeking time may be shortened by displaying all instructions clearly as to avoid unnecessary delay caused by ignorance, it is recommended that not only the opinion from the patient side for improving the service of medicine OPD but there should also be the opinion and needs of the providers as stated by Mandokhail, (2007).

Sodani, Kumar, Srivastava & Sharma, (2010) explained how to improve quality of care at public health facilities: Hospital administrators to increase the patient satisfaction at public health facilities: Efforts should be made to reduce the patient load at the higher level facilities so that doctors and other staff can give more attention and time to the patients; Efforts are also needed to strengthen infrastructure and human resources at the lower level health facilities, to improve the services at public health facilities of the state resulting in the more satisfaction of patients availing such public health facilities.

Needleman, Buerhaus, Mattke, Stewart & Zelevinsky, (2002) stated that in OPDs, although most patients were satisfied with waiting room facilities but were highly dissatisfied with toilet facilities and supply of drinking water. With regards to helpfulness of OPD staffs and consultation by doctors, the level of satisfaction was poor. Most of these patients were dissatisfied with OPD staffs with respect to their willingness to listen and help with their problems and with doctors and dispenser for their failure to provide ‘medication instruction’ and warning about side effects.
However, the level of satisfaction varied with sex, females being significantly more satisfied than males and also inversely related to the level of education and income. Health care facilities of the country, suggesting that little improvement has occurred with respect to services provided in OPDs Strategic planning, proper monitoring and accountability will be needed to improve quality of OPD services particularly with respect to reducing waiting time, improving waiting room and toilet facilities, making OPD staffs more caring and responsive to patients problems, improving availability of drugs and investigation facilities and ensuring doctors’ and pharmacists’ consultation.

Henderson, J.W.(2011) said that the market for hospital services have some important factors served to transform hospitals into the Modern medical institutions they have become today- The germ theory of diseases, Advances in Medical technology & increased urbanization. These changes have been accompanied by a dramatic change in patient expectations. No longer do patients seek a caring environment exclusively, they have come to expect a cure. Diseases were seen as having specific causes, rather than being viewed as disequilibria or the result of moral turpitude. Centralized Medical care bringing the patient to the practitioner, become a necessity. New hospital technology, especially advances in surgical & diagnostic imaging provided physicians with the tools that would revolutionize medical intervention. Another factor is urbanization, also played an important role in the centralization of Medical facilities. Migration to the urban centers meant more one-person households & fewer extended-family living arrangements. People could no longer count on treatment at home. Home was an apartment building or boarding house & likely inappropriate for convalescence, without family nearby patients had no one to serve as caregiver anyway.

According to Ahmad, Nawaz, Khan, Khan, Rashid & Khan,(2012) Medical diagnostic facilities in hospitals are used by different types of patients: outpatients who have made an appointment in advanced. A common policy in hospitals is to serve emergency patients as soon as possible, and to reserve certain time slots in which inpatients are served. The amount of this capacity reserved for inpatients has a large impact on the performance of the facility: if it is chosen too large it will affect throughput of the facility, whereas if it is chosen too small it will lead to large
costs due to inpatients staying in the hospital while waiting for service. It is therefore important to determine the schedule that constitutes the optimal trade-off and waiting costs, they developed a model to determine this optimal schedule. The number of patients in the diagnostic facility using a generating-function approach we derive performance measures to determine the schedule that maximizes average daily profit. Instead of maximizing profit it is as well possible to plot an efficient frontier of schedules and subsequently decide which schedule to be chosen.

Vermeulen, Bohte, Elkhuizen, Bakker & Poutré, (2008) revealed that by allowing patient to choose timeslots over a range of costs, the patient can schedule their appointments. The approach is designed with its practical application in mind, furthermore, the experimental results are robust for a wide range of scenarios, and clarify the potential effectiveness within a real scenario. The scheduling problem one can consider is inherently distributed; there is always a trade-off between objectives of different departments and between departments and patient preferences. This will include a more detailed patient preference model, such that individual preferences can be considered and valued, and the cost range of scheduling will be dependent on individual patient attributes. Cost-based approach for complex local scheduling, including online optimization of the cost-function parameters this approach allows a hospital or department to set a desired level of efficiency versus fulfilling patient preferences.

Trachtenberg, Dugan & Hall, (2005) reported that patient trust might be more consistent with a deferential style of patient-physician interaction in which patients are passive, in contrast to assertive patient questioning or limitation of physician authority which might be indicative of patient distrust. If so, then pursuing active patient involvement might lead to lower trust, or promoting trust might lead to more passive patients, either of which might compromise optimal treatment relationships and health outcomes. At a minimum, it is a conceptual puzzle how these views of desirable attributes of medical relationships can coexist without each taking account of the other view. There certainly are sceptics of patient trust who warn that, contrary to conventional wisdom, too much trust might be negative and that patients, for their own good, should be encouraged to trust less to avoid the dangers of paternalistic medicine, especially in managed care settings.
2.6: **Physician Satisfaction its impact on Outpatient Department:**

Quality assurance has emerged as an internationally important aspect in the provision of health care services as per Ashrafun & Uddin, (2011) the expectations of the public increased day by day and they have started questioning the adequacy of patient care not only for quantity of service rendered but also for the quality that is provided by the hospitals. Studies in the developing world have showed a clear link between patient satisfaction and a variety of explanatory factors, among which service quality has been prominent. Patient satisfaction is undoubtedly a useful measure, and to the extent that it is based on patients’ accurate assessments, it may provide a direct indicator of quality care.

Patient satisfaction has emerged as an increasingly important parameter in the assessment of quality of health care; hence, healthcare facility performance can be best assessed by measuring the level of patient’s satisfaction. As revealed by Umar, Oche & Umar (2011) completely satisfied patient believes that the organization has potential in understanding patient needs and demands related to health care. A study in the United Kingdom concluded that, patient satisfaction is directly correlated with waiting times to see a doctor while another study found that, because of prolonged waiting times, a substantial number of patients left outpatient departments.

Warren, Weitz & Kulis, (1998) Physicians practice changed dramatically in the last twenty years, context has changed to such an extent that regardless of age or years in practice, many physicians accept a somewhat more collaborative relationship with patients as the norm rather than invidiously comparing their positions to those of physicians in some ideal past. Physicians now accept it as the rules at least in areas in which high percentages of patients belong to such plans. As a side-effect, physicians may now view the entrepreneurial aspects of medical practice-owning or renting one's office or equipment-as an unnecessary nuisance rather than as a professional prerogative. Similarly, physicians now accept that patients will seek medical knowledge and desire to participate in medical decisions and thus do not find such patients an impediment to work satisfaction. However, whether changes in patient physician relationships have had little effect on physician satisfaction because physicians have learned to manage such patients without
spending much time or giving up clinical autonomy or because physicians have concluded that educated patients are easier to work with and have better outcomes.

Chuck, Nesbitt, Kwan & Kam, (1993) observed that despite recent negative publicity about medical careers, most physicians in our respondent group were satisfied with their jobs. This global satisfaction is important as it has been associated with increased physician retention and could arguably lead to higher morale, enhanced productivity, and improved quality of care. It is encouraging that most respondents also felt that their job was fun. This suggests that whereas the recent demoralization of the medical profession is definitely real, perhaps its severity and effect on individual physicians have been overstated. Fun at work demonstrated the strongest correlation with overall job satisfaction suggests that efforts directed at helping physicians to derive enjoyment from their work may be of paramount importance if the goal is to improve overall job satisfaction.

Wallace, Lemaire & Ghali, (2009). Stated that Physicians are important citizens of health-care systems, and evidence indicates that many physicians are unwell. Physicians who are affected by the stresses of their work may go on to experience substance abuse, relationship troubles, depression, or even death. Physicians’ stress, fatigue, burnout, depression, or general psychological distress negatively affects health-care systems and patient care. Thus when physicians are unwell, the performance of the health-care system can be sub optimum. The corollary is that physician wellness might not only benefit the individual physician, but also be vital to the delivery of high-quality health care.

Burns, Andersen & Shortell, (1990) articulated that the hospitals and physicians may still actively pursue these new types of exchanges, regardless of their limited ability to affect the quality of physician-hospital relations. Hospitals might pursue economic strategies simply to control physicians rather than to achieve some harmonious integration. Organization theorists have long argued that organizations seek to reduce uncertainty, including uncertainty over such inputs as labor, in order to gain control over their environments. Hospitals might also pursue normative strategies for reasons that have nothing to do with integration. For example, hospitals may feel that medical staff involvement in decision making
improves the quality of decisions. Alternatively, institutional theorists argue that organizations must conform to widely shared norms about appropriate structural arrangements in order to gain legitimacy. Two such norms, historically, have been professional involvement in hospital governance and avoidance of the corporate practice of medicine. Because for-profit hospitals are commonly suspected of putting pecuniary goals ahead of community service, they may go to extreme lengths to avoid any appearance of evil by placing physicians on the board and not placing any physicians on salary. These arguments may explain why hospitals pursue control strategies that have little effect on physician satisfaction and conflict.

According to Goes & Zhan, (1995) Involving physicians in hospital governance seems to have the greatest potential for improved occupancy, while financial integration may be the best strategy for containing hospital costs. However, a strategy of encouraging direct physician ownership in hospitals comes with substantial performance risks attached, and this may be the reason California hospitals are rapidly abandoning the strategy. Moreover, the attractiveness of the strategic options varies depending on hospital characteristics like size or system membership. Larger hospitals that encourage physician ownership apparently enjoy higher margins and lower costs, but may sacrifice occupancy in the process. Physician governance seemingly provides greater benefits among hospitals linked to networks or systems. Managers should consider carefully their operating context and which outcomes they desire most to influence, and they should adjust their strategic choices accordingly.

Burns, Andersen & Shortell, (1993) stated that Hospitals and physicians will need to develop new relationships that enable them to assume risk for providing care to defined populations, as purchasers hold them jointly responsible for the costs and quality of care provided. These relationships will occur outside of the traditional medical staff organization. These new practice arrangements and methods of compensation likely will have important impacts on hospital/physician relations. To the degree that these new models provide management and support services to physician groups, they may serve to lessen some of the traditional hospital/physician conflicts over ancillary services and equipment purchases observed here. To the degree that they provide practitioners with information on cost, quality, and
patient outcomes, these new models also may reduce conflicts over competitive issues concerning professional autonomy and resource use. More traditional conflicts also may be mitigated by increasing use of contracts with primary care physicians and groups who will form the hub of the new provider networks.

Succi & Alexander, (1999) monitored that many hospitals are actively pursuing strategies that integrate physicians into their management and governance structures. Despite expectations that these strategies improve hospital efficiency, empirical studies have failed to provide consistent evidence that physician involvement in hospital management and governance improves hospital efficiency and examines factors that may moderate the relationship between physician participation in hospital management and governance and hospital efficiency.

According to Sarkar & Chatterjee, (2011) some of the suggestions made by the clients for betterment of the hospital were:

- Physicians devote more time for examinations, explanation of patients’ quarries and day to day condition to the patient.
- Hospital must arrange more facilities for investigations
- Nursing staff should receive some training for improving their behavior and attitude.
- Group D and other hospital staffs should be available and sensitive enough
- Waiting time and place in OPD including cleanliness both in the outdoor, indoor bathroom should be improved.

Health services provided by this referral teaching hospital, which needs to be addressed by the hospital management authority and plans for better management of health problems to meet the patients expectations and fewer unsatisfied patients.

Roter & Hall, (2004) observed that Medical care translates into better clinical outcomes depends on much else besides simply whether the physician seems to be doing the “right” things. Patients must also respect the physician’s judgment and be willing to follow through on the physician’s suggestions and on their own good intentions (regarding, for example, self-care, lifestyle, and medication adherence). Little or nothing is known about how male and female
physicians compare on these kinds of outcomes. However, only for patient satisfaction is there evidence bearing on this question, and here the literature is mixed. Physicians who are skilful may achieve time efficiencies that allow the delivery of quality, patient-centered care in even-more-restricted time frames. Physicians have the capacity to improve their communication skills in meaningful ways through self-awareness, self-monitoring, and training. The potentially powerful impact of patient reciprocation of both communication style and affect in the medical visit is especially important to recognize, as recognition could help create positive exchanges and defuse negatively spiralling interaction patterns. Promotion of patient-centered medicine is key to the nation’s future quality-of-care agenda and to the advance of medicine, both as healing art and as science.

Koehler, Fottler & Swan, (1992) observed about equity in the health services, physician develops a model that focuses on the importance of the mutual satisfaction of both patient and physician to the success of the health care encounter. The degree of satisfaction with the encounter influences a number of related outcomes, including the retention of both patients and physicians, the quality of health care, and cost containment. Equity theory is used to explain the advantages to physicians of striving for mutually satisfying health care exchanges. The dimensions of patient and physician satisfaction are presented and linked together, and the outcomes of these mutually satisfying linkages are discussed.

Koehler, Fottler & Swan, (1992) conferred that Hospitals are particularly susceptible to pressure from their medical staffs not to fall behind other similar hospital in the region, either in the non-technological aspects of their facilities (such as attractiveness and personal service) or the clinically more important aspects of the technological capacity. In many ways, this pressure from medical staffs for hospital to keep abreast of newest developments in technology is a good influence and has probably been one of the reason hospitals has been so well equipped and resourced with technology ;at the same time, this influence can be overdone ,with costly results for the hospital.

It should also be stressed that many of the requirements with regard to technology and pharmaceuticals may be set by accrediting and licensing agencies on
the one hand and insurance, contracting, and legal pressures on the other. Quite aside from the influence of their medical staff, hospitals and clinics are faced with growing array of regulatory, compliances, and legal issues affecting everything from quality of care, patient safety, laboratory management, privacy of information, and range of services available. Many of these pressures can only be met by increased use of newer technologies or approaches to patient care, each of which carry organizational impacts of their own. One of the most interesting impacts on health care organizations is the use of new technology and products in a marketing and business development sense.

McKinstry, (2000) revealed that patients are more satisfied and more likely to comply with treatment when doctors allow them to express their concerns and ideas in the consultation is powerful. Some authors have suggested that patients should routinely be involved in decision making in consultations and this concept has been accepted by those involved in the training of general practitioners. There is, however, little evidence that patients find shared decision making acceptable, to determine patients' preferences for participation in decision making in consultations for different types of medical problems.

According to Madhiwalla & Roy, (2006) Doctors and almost all the patients felt that many problems would be resolved if patients were treated with more respect. A senior doctor felt that doctors should make an effort to be friend of patients'. One has to pay attention to repeated complaints from a patient. A casualty officer noted that doctors who are given lessons in communication could manage most situations. However some situations may arise where the advice would not be useful. Several suggestions emerged in terms of hospital management. Senior doctors said that the current atmosphere of fear and distrust must be addressed. Doctors should not have to run around to collect equipment, staff who are responsible for maintaining stocks and ensuring their availability should be made more accountable, the design of the hospital ensure that patients don’t have to walk a lot and wait for long periods, which adds to their frustration and suffering. Suggestions were made about improving the conditions in which residents live and work. These included providing them with better accommodation, ensuring that they
get breaks for eating and resting, and providing counselling for residents with personal problems or difficulties in adjusting to a new city and environment.

Mache, Vitzthum, Nienhaus, Klapp & Groneberg, (2009) observed that job satisfaction may increase if physicians experienced more opportunities to advance their careers, team spirit, and better supervision is important. Relationship between job resources such as interpersonal relationships, cooperative arrangements and teamwork and higher job satisfaction, Reducing sources of interpersonal conflict and promoting teamwork should rate high on the list of hospital managers' priorities. Other variables associated with specific dimensions of job satisfaction. For example, the pressure of quantitative demands and heavy workload reduce satisfaction significantly. In summary, efforts to restructure hospitals, without regard to the effect on working conditions could potentially have dire consequences for physicians' job satisfaction, encouraging them to seek work elsewhere.

Cousin, Schmid Mast, Roter & Hall, (2012) Participants’ attitudes toward caring and sharing in physician’s communication style predicted their satisfaction with physicians who communicated in a low caring or in low sharing way. More caring physician communication style led to higher satisfaction regardless of participants’ attitudes toward caring. However, satisfaction with physicians’ high or low sharing communication style was influenced by the participant’s attitude toward sharing. Physician adoption of a high caring communication style is likely to optimize patient satisfaction regardless of variation in patient attitudes toward caring. However, the same cannot be said of high sharing. Consequently, we suggest that physicians incorporate high caring into routine practice style with confidence that all patients will benefit. The adoption of a high sharing or low sharing communication style, however, is more problematic and physicians may need to consider how to best align this aspect of their communication style to individual patient preference.

Zhang & Feng, (2011) underlined the importance of the psychological attitude at work, indicates that several, but not all dimensions of both job satisfaction and burnout syndrome prove to be relevant factors affecting physicians' turnover intention. In particular, it suggests that there may be partial mediation
effects of occupational burnout, mainly through emotional exhaustion, within the impact of job satisfaction on turnover intention, among Chinese physicians in urban state-owned medical institutions, who experience a moderate degree of turnover intention with significant differences according to location. This signifies that enhancements in job satisfaction can be expected to reduce physicians’ intentions to quit by the intermediary role of burnout as well as the direct path. It is hoped that these findings will offer some clues for health-sector managers to keep their physician resource motivated and stable.

According to Pearson & Raeke, (2000) the importance of trust in patient-physician relationships is not questioned, but our understanding of it has depended largely on the passionate thoughts and anecdotes of physicians who cherish the special bond they feel with their patients. For practicing clinicians and for those who teach medical students and residents, the elements of physician behaviour that foster trust can continue to reflect the instincts of physician-theorists: competence, compassion, reliability, integrity, and open communication. A widely accepted empirical conceptualization and understanding of trust is yet to come. In recent years, other complex and once believed intangible concepts, those of “satisfaction” and “health status,” have yielded to rigorous qualitative and quantitative research, and investigators and policy leaders now have standardized instruments with which to measure these concepts in a wide variety of health care settings.

Witman, Smid, Meurs & Willems,(2011) revealed that the doctor sees a patient. Like a detective the doctor looks for complaints and symptoms that point the way to a disease that has to be cured. To acquire, preserve and develop this disposition, the doctor has to see many patients and acquire experience, because ‘every patient is different’. ‘Seeing patients’ means passing through the whole medical trajectory, from examining and diagnosing to treating. Doctors in the lead should also remain wise men. Therefore they have to stay active in clinical practice and should avoid being considered as managers who ‘coincidentally’ happen to be doctors. They need sufficient support from the non-medical management to bridge the gap between two worlds. However, tools and instruments of the management world need to be provided to them selectively, otherwise they risk being seen as defector to the management world by their medical colleagues and thus losing their
ability to influence their colleagues. The selection of the counterpart of the doctor in the lead, the non-medical manager, is also an important factor.

Thom, (2001) articulated that physician-patient relationship is recognized as having an essential role in the process of medical care, providing the context in which caring and healing can occur. Patient trust in the physician has been proposed as a key feature of this relationship. There are several potential benefits to patient trust, including increased satisfaction, adherence to treatment, and continuity of care. Trust may also be associated with lower transaction costs, such as those incurred by a need to reassure patients (eg, ordering additional tests and referrals) or by inefficiencies due to incomplete disclosure of information by the patient. Despite the apparent importance of patient trust, relatively little is known about what physician behaviours are most strongly associated with it. A previous study,1 using patient focus groups, identified categories of physician behaviours that increased patients’ trust: thoroughly evaluating problems, indicating an understanding of the patient’s experience, expressing care for the patient, providing appropriate and effective treatment, communicating clearly and completely, building partnership, and demonstrating honesty and respect.

Stephan & Kaluzny (2008) stated that aims for any health care systems which are safe, effective, patient-centered, timely, efficient, and equitable. Achieving these six aims will require considerable leadership in addition to alignment of incentives among individuals, health care teams, health organizations, and the purchasers, payers and regulators of health care services. The desired outcomes of safety, effectiveness, efficiency, personalization of care, timeliness of care, and equitable care are most immediately a function of high performing patient-centered teams operating within an organization designed to facilitate the work of those teams. This is referred as “care system”.

2.7: Service Quality in Healthcare Organization:

According to the S.M.Jha (2011) the perception of total quality management makes it clear that in the hospital services for quality management is essential. fair blending of technical quality, functional quality and infrastructural quality is made possible. While blending the hospital managers bear the responsibility of identifying
the changing needs and requirements of patients, increasing levels of expectations of patients and attendants and making it sure that the services offered by hospitals would fulfil in totally the same. figure 2.2, mention different dimensions of TQM.

Parasuraman, Zeithaml, & Berry, (1985) stated that what features a service must have in order to meet consumer needs, and what levels of performance on those features are needed to deliver high quality service. Service marketers may not always understand what consumers expect in a service. Variety of factors-resource constraints, market conditions, and management in-difference-may result in a discrepancy between management perceptions of consumer expectations and the actual specifications established for a service.

Even when guidelines exist for performing services well and treating consumers correctly, high quality service performance may not be a certainty. Executives recognize that a service firm's employees exert a strong influence on the service quality perceived by consumers and that employee performance cannot always be standardized. Advertising and other communications by a firm can affect
consumer expectations. Communications can affect not only consumer expectations about a service but also consumer perceptions of the delivered service. Ensuring good service quality is meeting or exceeding what consumers expect from the service. Judgments of high and low service quality depend on how consumers perceive the actual service performance in the context of what they expected.

Levels of trust appeared to be relatively low patient physician relationship—at least compared with other indicators of public views such as public satisfaction levels. The inadequacies of satisfaction indicators have been well documented not least the propensity to under represent levels of dissatisfaction. Those with limiting longstanding illness (overrepresented in this survey) are sometimes portrayed as ‘lay experts’ and may be more aware of the inadequacies and limitations of healthcare provision. However, there was no evidence that those with longstanding illness were more likely to report higher levels of distrust as reported by Calnan, & Sanford (2004).

Aarts, Ash, & Berg, (2007) Analyzed the workflow to reduce errors and improve the quality of care can lead to the next step of rethinking the workflow. According to Growth, the revolutionary impact of IT is that it makes possible new coordination mechanisms and thereby new forms of organization. The interviewees from the health maintenance organization described how their information system enabled them to design targeted programs for patients with specific health problems such as diabetes. The information system, which is an integration of an electronic medical record and a physician order entry system, allows identification of patients who have been diagnosed with, for example, diabetes and use of order sets and assessment of disease specific outcomes.

Landon, B. E., Wilson, I. B., & Cleary, P. D. (1998) stated about conceptual model of the effects of health care organizations there has been a great deal of interest in recent years in developing measures of health care quality that can be used to characterize and study the effects of health plans. However, because of the recent emergence of diverse types of health care organizations, it is often difficult to know which parts of a plan should be combined for analysis purposes. Also, simple taxonomies of health maintenance organizations (eg, staff, independent practice
Goel, Sharma, Bahuguna, Raj, & Singh. (2014). Said that in the modern era, the quality of services provided by the health sector is increasingly being measured by patient’s experiences at the health facility. Several dimensions including behaviour of staff, patient physician interaction coupled with issues of administration of the health facility and physical environment are critical to the issue of patient satisfaction. Patient satisfaction is also a barometer of patient outcome and other health indicators of a facility. A satisfied patient had better adherence to treatment protocols and goes for regular follow up for his illness. Thus understanding of patient expectation and their level of satisfaction is of utmost importance for provision of good quality of health care. Empirical evidences confirm to the fact that most public health facilities in India are very little concerned about the facilities provided to the patients and their families and in-turn their satisfaction rate. The long queues outside the outpatient departments, small and unkempt waiting areas, poor condition of toilets, unsympathetic attitude of doctor and other health care staff bear eloquent testimony to this fact. Public health facilities cover a much broader part of the society and must comply with the patient’s expectations in delivering quality services. The private care providers are only slightly better in terms of the facilities but the exploitative cost of the treatment is a deterrent for a common person in India, where nearly one third of population fall below poverty line. All these concerns make the assessment of patient’s satisfaction with public health system even more important.

Charles, Gauld, Chambers, O'Brien, Haynes, & Labelle (1994) stated that hospital's perspective, clinical staff and managers ought to be interested in patients' views of care because (a) diagnosis and treatment depend on clear communication with and information for patients as well as patient participation in the treatment process, (b) patient satisfaction with care is predictive of future behaviour(e.g., compliance with treatment and intent to return for care), (c) patient preferences can be used by providers to help make choices about ways of organizing and providing care (e.g., scheduling visits and planning discharge), (d) patient satisfaction may be a direct or indirect measure of outcome (e.g., how well a patient is functioning)
"achieving and producing health and satisfaction, as defined for its individual members by a particular society or subculture, is the ultimate validator of the quality of care.

Sofaer, Crofton, Goldstein, Hoy & Crabb, (2005) observed that Nurse and Hospital Staff Communication with Patients, within this domain, three items were most likely to be considered important, across the groups: nurses (1) listening carefully to patients; (2) treating them with courtesy and respect; and (3) explaining things carefully. However, as there is conceptual overlap between courtesy and respect and listening carefully (someone who is not listening can hardly be considered courteous or respectful) some participants thought the courtesy item was less important to include. Listening carefully had a special significance to participants as an indicator of quality. As one participant noted, ‘‘If nurses are not listening carefully, they might miss something. I might mention some little symptom that means nothing to me but is very important.’’ With respect to explanations, several participants commented that they rely on nurses to explain what the doctors have said to them and to communicate treatment plans.

DeJong, Akik, El Kak, Osman & El-Jardali, (2010) discussed that In many developing countries, particularly middle-income countries, constraints related to access to care are lessening with the increased trend towards institutional deliveries (World Health Organization Department of Reproductive Health and Research, 2008). Thus attention is needed to ensure the quality and safety of care received, and in reducing differentials in provision and quality across geographic region, public and private sectors. This appears to be the case in Lebanon where institutional deliveries are nearly universal but problems of quality have been documented; more and better information is needed on how provision relates to health outcomes and how inequities at health system level affect quality. This study makes a first step in rectifying this gap. Lebanon may be exceptional in the degree to which information about maternal health-care provision is lacking, but the problems identified in this research are likely to resonate with other developing countries where the private sector dominates and which lack a comprehensive picture of maternal health-care provision and how health system factors affect it.
Chakravarty, (2011) in his study explained that healthcare managers are under increasing pressure to demonstrate that their services are customer-focused and directed towards providing best possible medical care to the clientele of the hospital. Taking into consideration the resource constraints under which service hospitals must function, it has become essential for hospital managers to understand and measure consumer perspectives, so that any perceived gap in delivery of service is identified and suitably addressed. Healthcare quality has two distinct facets, namely technical quality and functional quality. Technical quality refers to the accuracy of medical diagnosis and procedures, and is generally comprehensible to the professional community but not to the patients. Patients essentially perceive functional quality as the manner in which the services are being delivered. Service quality largely determines consumer satisfaction. A popular definition of service quality is conformance to consumer expectations. The important role played by expectations in consumer’s evaluation of services has been widely acknowledged in the service quality literature. Researchers have generally agreed that expectations serve as reference points in consumer’s assessment of service performance.

Aydin, Hatirli & Ersoy, (2005) discussed about total quality management In health institutions, qualified service and care requires determining the current level of quality, continuous improvement, distributing the responsibilities and activities, satisfying both the inner and outer customers (staff and patients), informing society, labour division, and continuous education in every step and field. In order to be successful, the needs and expectations of the customers would be known. Service or care must be produced and served at minimum cost and maximum quality. TQM focuses on the quality, customer, and process. Every step in the TQM process has to be controlled continuously. The TQM process is a scientific process to help develop the people, improve society, and prevent mistakes before they occur. When a patient comes to a hospital, he comes with a hope and faith that the hospital will do everything possible to relieve his pain and cure his illness at the earliest possible and at a reasonable cost. He is absolutely ignorant of any lurking dangers, hazards or complications that may visit him and nobody ever bothers to warn him. Any unexpected hazard or complication, therefore, comes to him as a painful rude shock, shattering his morale and adding to the misery. It may mean a prolonged hospital
stay, additional unforeseen expenditure or prolonged suffering and sometimes disability or even death of the patient. These situations cause a lot of bitterness and resentment among patients and relatives. Sometimes, there are arguments leading to violent behaviour and sometimes even to law suits or criminal cases against the doctor and the hospital. Most of the times, the hospitals are able to live up to the hopes and faith of the patients, but sometimes they don’t and the patients end up with complications.

According to Joshi.S.K (2012) Hospitals are very unlike other organizations. They work nonstop, round the clock, seven days a week. They are expected to be ever ready and provide the best possible treatment to every patient who walks in or is brought in with any disease at any time, day or night. Hospitals are temporary homes for people seeking care, comfort and cure of their illness.

Kumaraswamy, (2012) observed that in order to enhance the present level of service quality in health care center, the present study identifies some managerial implications for a paradigm shift from medical service to customer zed service in the medical field. Initially, the attitude of the physicians and their behaviour towards the patients has to be enriched by providing continuous and on-going training programmed especially in the case of human psychology. The physician should be impartial, friendly, sympathetic and courteous to patients under all circumstances. Since the service quality of Supportive staffs plays an important role in the Health. The management of health care center should see the attitude of the supportive staffs which is a major cause of the service quality. They should monitor the requirements of the supportive staff through properly designed system and effective efficiency linked incentive plans. The maintenance of green gardens, spacious parking place, bath room facilities and lift facilities should also be focused to increase the patient satisfaction.

Rubin, Pronovost & Diette, (2001) revealed the Process measures Quality of healthcare are highly acceptable because they demonstrate clearly how providers can improve their outcomes. Clinicians are also more accountable for the process of care than its outcomes, which are affected by many other things. As electronic medical records become more common, process measures can be unobtrusively
tracked as part of routine clinical care, which will aid in implementation. Process measures that are incorporated into routine clinical data collection also provide a constant educational reminder to clinicians about the correct process and eliminate duplicative data collection for quality assessment.

Joshi.S.K. (2009) expressed about the evaluation of quality of services in the OPD:

1. **Patient Satisfaction Surveys**: on structured formats conducted periodically (every 3 months) could be the best and the direct feedback.

2. **The Complaints/ Suggestions**: received in the suggestion boxes placed at the prominent places in the OPD, casualty, reception etc.

3. **Monitoring of Entry to Exit Time of patients as well as the time taken at every stage such as registration, waiting for the consultation, time taken in the doctors chambers, time taken for the investigations and for the issue of medicines.**

4. **Improvement of Health Status and public knowledge about health matters (to evaluate the impact of preventive and promotive services).**

5. **Monitoring the OPD workload, overall as well as specialty/doctor wise.** Periodic (monthly) review of OPD records, patient related statistics and the patients’ feedback, can help in evaluating the adequacy of infrastructure and services. It can help in identifying the shortcomings, whatever, so that the corrective measures can be taken.

**2.8: Summary:**

Participation of health care providers is far too often the fundamental part of medical treatment, unnecessary errors for patients. There are lots of reasons for these participation problems. There are lots of things that can be done about them.

But too little actually happens, with regards either to understand these problems or pertaining the readily available solutions, in part because there is no such place to go to gain access to information about either (1) the cause of the problems or (2) the tools available for dealing with them.

The literature separately illustrated that following are important determinants and has its significance in the growth and prosperity of tertiary care hospital.
Review of Literature

- Patient satisfaction
- Physician-Patient Relationship
- Physician Satisfaction
- Quality Service

This study has used questions that focus on potentially variable behaviours of patients and of health care providers in order to identify the determined frequency of patient satisfaction. Therefore, study may find out that with increasing participation of health care providers with management, more patients are satisfied and that health care providers must be capable about the quality work in order to make OPDs successful in Tertiary Care Hospitals. Khan, Hassan, Anwar, Babar, Babar & Khan, (2007) concluded that: 1. Patient satisfaction is a major indicator of quality care. 2. Thus quality of work can be assessed by mapping out patient satisfaction with nursing care. 3. Nursing services is one of the most important components of hospital services which has two major objectives; nursing care of sick patient and prevention of disease and promotion of health. Nurses form a very important group, which is largest single technical group of personal engaged in hospital care next to doctors and consume almost one third of hospital cost.

Findings from this research will highlight on the following
- Patient-physician communication and interaction
- Desired new services and facilities that can enhance the level of care
- Patients’ observations like waiting times, Waiting room and procedure room environment and cleanliness.
- Staff courtesy and compassion.

All the above mentioned points were determined in the research to fill in the gaps and make a research model between health care providers and patient satisfaction. The following research is intended as one small step towards alleviating this access problem. Hopefully, it will make it a little easier for people interested in bridging the participation gaps between patients and health care workers to know where to find useful information on the subject and to increase the rate of patient satisfaction.
The study on Health Care Providers Participation in OPD Management can revolutionize the system. The research questions presented in the study attempts to investigate some of the identified gaps evident in the literature. The next chapter attempts to discuss Research methodology utilizes for current study.