

1986

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Recommended Citation

Christensen, Donald E. and Thomas E. Giese. "The Assessment and Application of Patient Satisfaction Variables in Marketing a Psychiatric Practice." E.C.R.S.B. 86-3. Robins School of Business White Paper Series. University of Richmond, Richmond, Virginia.

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A PSYCHIATRIC PRACTICE

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Abstract

As the health care industry becomes increasingly more competitive, marketing functions will take on increasingly more importance. At the core of the marketing concept is the pursuit of customer satisfaction, or, for medical services, patient satisfaction. This study reports on the administration of a 33-item patient satisfaction questionnaire to the consumers of services in four outpatient offices of a large, group private psychiatric practice. Data are analyzed descriptively and recommendations are made for improvements of service delivery based on the findings of the survey.

INTRODUCTION

This paper presents a study of patient satisfaction conducted in four outpatient offices of a private psychiatric practice. The study was based on information collected by the administration of a 33-item questionnaire before the patient's appointment during the first two weeks of October, 1985. The questionnaire was developed from a body of literature on the dimensions of patient satisfaction and its assessment through survey methods.

The study was designed to accomplish three purposes: first, to globally assess the degree of satisfaction patients have with the psychiatric practice and its delivery of mental health services; second, to identify the various dimensions of patient satisfaction/dissatisfaction; and third, to gather information that would be of valuable for general practice administration and management functions. A final goal was to base recommendations for changes in service delivery and other marketing decisions on the empirical findings of this study. Given the fact that this questionnaire was designed to gather information about the satisfaction needs of the practice's patients, it was assumed that it could lead to patient/customer-based changes in service delivery.

The data are treated to both a descriptive, statistical analysis and an item analysis. Interpretations of the findings incorporate marketing concepts, specifically the marketing mix, professional service marketing principles, and consumer/patient satisfaction theory. Principles of patient management and information regarding the organization of the target practice and the nature of the services offered in each of the four outpatient offices was an integral aspects of the interpretation of the data.

BACKGROUND

Marketing and Health Care

Marketing concepts and strategies have until recently been quite foreign to health care and medical services. There are numerous reasons for this lack of acceptance of marketing by professionals. Among these are a general disdain of commercialism among professionals, legal and ethical codes of the professions, and the erroneous equating of marketing with selling or advertising, and a perceived lack of need for the marketing of professional services (Bloom, 1984; Kotler and Connor, 1977; O'Connor, 1978).

Recently, however, the professions have begun to turn to marketing, and the topic of marketing professional services has become a very contemporary issue. Three reasons for this increased interest in marketing among the professions have been cited: (1) loosening of legal sanctions and changes in professional codes of ethics; (2) increased competition from an overabundance of professionals in many disciplines; and (3) the declining public image of professionals and the changing expectations of clients (Bloom, 1984; Kotler and Connor, 1977).

Many approaches to marketing exist for professional service firms. Kotler and Connor (1977) differentiate between minimal (passive) marketing, which has traditionally been practiced by professionals, and hard-sell marketing, which emphasizes a sales rather than a marketing orientation. In contrast to these two approaches, Kotler and Connor develop a concept of "professional marketing," which they describe as consisting of "organized activities and programs by professional services firms that are designed to retain present clients and attract new clients by sensing, serving, and satisfying their needs through delivery of

appropriate services on a paid basis in a manner consistent with creditable, professional goals and norms" (Kotler and Connor, 1977, p. 72).

The retention of present patients and attraction of new patients is becoming an increasingly important issue in the health care industry. The number of practicing health care professionals continues to increase at the same time that cost control mechanisms, such as Diagnostic Related Groups and prepaid health plans, have emerged, with the effect of decreasing hospital usage rates and placing increasingly lower caps on insurance-covered medical care. The consumers of health care services are increasingly better informed and educated about the most effective ways to utilize medical services, and have a wider array of choices of both payment mechanisms, places to obtain health related services, and providers of health care. Where once there was only a family physician who worked out of his office and was the gatekeeper for hospitalization, and who was usually reimbursed on a fee for service basis, there are now numerous medical specialists and allied medical professionals in private practice; hospitals, urgent care facilities, large group practices and specialty care centers; and a wide variety of prepaid and preferred provider systems of health care coverage in addition to the fee for service-based insurance coverages.

This highly competitive environment has fostered an increasing reliance on marketing concepts to attract new patients. Yellow pages advertising for medical services is now an accepted standard. Newspaper, magazine, radio and television advertising is also now commonplace. Shopping center based dental offices have begun to appear, bringing the office to where the customers are. Coupons for free medical evaluations and check-ups are frequently included in direct mail Valu Pak offerings. One alcoholism treatment program even offers

a money-back guarantee if relapse occurs within one year after successful completion of the alcohol treatment program.

The Role of Patient Satisfaction

In contrast to selling and advertising oriented approaches, the marketing concept places the customers' needs, wants and satisfactions in a position central to all other efforts. "In essence, the marketing concept is a customer's needs and wants orientation backed by integrated marketing efforts aimed at generating customer satisfaction as the key to satisfying organization goals" (Kotler, 1984, p. 22). Thus, the satisfaction of customers' needs is paramount in a marketing-based organization. This orientation is consistent with the objectives of the medical profession.

Medical Economics, a journal for private practice physicians, devoted a special issue to the results of a national patient survey conducted in 1982. Findings from this survey underscore the critical importance of maintaining and fostering patient satisfaction in a highly competitive and cost conscious environment. To quote from the lead article: "Patients are becoming more and more difficult to please. They expect more than ever from their doctor. And when they are not satisfied, they are more willing than ever before to try a new physician" (Medical Economics, May 1983, p. 8).

In support of this statement, the survey results indicate that in 1963, only 38% of the patient respondents said that they had ever quit a doctor because they were dissatisfied with something about him or his staff. That minority rose to 44% in 1969, and it jumped to 52% in a 1976 survey. The results of the most recent 1982 survey indicate that 59% of the respondents have switched doctors because of dissatisfaction.

Patient satisfaction impacts medical practice in other ways besides direct loss of patients. The same Medical Economics survey reports that almost half the patients polled stated that they chose their doctors on the recommendations of other patients. Thus, satisfied customers are valuable influence agents who influence future patients.

The Concept of Patient Satisfaction

Patients are consumers of health care services. To some degree, then, patient satisfaction should have some conceptual similarities to consumer satisfaction. One widely accepted theory of consumer satisfaction is that it occurs as the result of a comparison process: customers have certain expectations from a transaction or purchase, and they then compare what they expected to receive with what they actually receive, which results in a state of disconfirmation, which may be either positive or negative. Positive disconfirmation is achieved when actual experience surpasses expectations; negative disconfirmation is achieved when actual experience does not live up to expectations. Satisfaction, then, is viewed as a function of both expectations and resulting disconfirmation, and the level and direction of disconfirmation influence satisfaction (Oliver, 1980).

METHOD

The Instrument

The questionnaire utilized in this study was designed to assess those aspects of patient satisfaction shown to be important from previous studies cited in the literature, as well as those which are unique to the psychiatric practice under study.

The questionnaire was developed in a series of stages. First, a pool of statements was generated, borrowing heavily from those in instruments used by Hulka, Ware, and others cited in the literature. This process resulted in 53 statements about the office-based service delivery and treatment aspects of the practice.

Next, this initial pool of statements was reviewed by selected clinicians, administrative staff, and business colleagues of the author. Certain statements were rejected due to irrelevance or redundancy; others were revised or reworded; and many were accepted as initially drafted. The remaining 43 statements were put into an initial draft of a questionnaire, with instructions for indicating agreement or disagreement with each statement. This initial draft was once again reviewed by clinicians and professional colleagues.

The final version of the questionnaire was then constructed. This version consisted of 31 statements which patients were asked to respond to by indicating their agreement or disagreement on a 5-point Likert scale. In addition, as suggested by Rusley (1985) and Stamps (1984), two open-ended questions were included so that patients could register complaints or compliments about the practice if they so wished.

Administration and Data Collection

The method of data collection was unaided completion of the survey by patients at four separate offices. All patients, at the time of their appointment, were asked to participate in the study. They were told that the practice was conducting a survey for self-evaluation purposes, and that their participation in the study would be very helpful and appreciated. When completed, the respondents (patients) placed the questionnaire back into an envelope and deposited

it in a box at the receptionist's station. This method of data collection resulted in a high return rate of usable completed surveys.

RESULTS

Analysis of Instrument

The design of the present instrument utilized a marketing perspective. This was accomplished by using the concept of the marketing mix: Product, Place, Price, and Promotion. Questions were analyzed and categorized as to which element of the marketing mix they incorporated. The Product concept was further subdivided into core Product and augmented Product, with core Product including the caring and curing aspects of psychiatric service, and augmented Product including other office-based or business-related services aimed at providing convenience or comfort to the patient. The Place concept included statements about location or physical facilities. Price statements incorporated cost or billing/collection practices. The Promotion factor included only one statement having to do with referral.

The results of this analysis and categorization of questionnaire statements can be seen clearly in Table 1. An understanding of this table is important, since much of the subsequent analysis stems from these data. Here, each question is rephrased to clarify the dimension or concept it is assessing. The categories which the factor falls into is listed next, with 1A being the core Product, or medical service dimension, 1B being the augmented Product, or office service dimension, 2 being Place, 3 being Price, and 4 being Promotion.

According to this schemata, 14 (45%) of the statements on the questionnaire, measured medical/psychiatric service variables, and 7 items (23%) of the questionnaire, assessed office-related service aspects. Five items (16%) of the

questions, assessed Place variables. Four items (13%) of the statements, tapped the Price dimension, and one item addressed the Promotion variable.

Analysis

The analysis of the data proceeded in three stages. The first stage was directed at assessing the overall level of satisfaction patients felt toward their involvement with the practice. This was a global measure of satisfaction and utilized mean item scores. The analysis was conducted for the total patient sample, and then for each of the four offices sampled. In this way, offices could be ranked according to the level of satisfaction their patients expressed. A complete analysis of the total and all four offices cannot be made because of limitation of space.

A second level of analysis looked at the various degrees of satisfaction the patients expressed, and the dimensions or characteristics of the practice with which they felt most or least satisfied. This analysis utilized rank ordering of items and item analysis. Once again, the analysis was conducted for the total patient sample, and then each separate office. Finally, the responses to the open-ended questions were categorized and analyzed.

It should be emphasized that the purpose of this study was to provide applications-oriented information. It was not conducted as a theoretical or hypothesis-testing study. The data analysis proceeded in such a way as to be easily replicated in a medical practice environment. Thus, descriptive statistics (e.g., means) were utilized almost exclusively. No statistical tests were conducted on the data. Relative differences were analyzed. Whether or not these differences were statistically significant was not considered particularly germane to the purpose of this study.

Table 1
Summary of Questionnaire Results

	<u>Item Dimension</u>	<u>Category^a</u>	<u>Mean Percentage</u>				
			K ^b	P	N	C	Total
1.	Convenience of location	2	2.12	1.93	1.77	1.84	1.93
2.	Friendliness of receptionist	1B	1.42	1.27	1.09	1.31	1.29
3.	Prompt and courteous service by receptionist	1B	1.53	1.45	1.19	1.40	1.41
4.	Ambience of waiting area	2	1.83	1.86	2.00	1.60	1.82
5.	Comfort of waiting area furniture	2	1.72	1.61	2.12	1.49	1.73
6.	Promptness of therapist	1B	1.75	1.59	1.86	1.63	1.71
7.	Availability of therapist	1A	1.96	1.75	1.52	1.84	1.78
8.	Understanding of therapist	1A	2.02	1.64	1.35	1.45	1.65
9.	Size of fees	3	2.88	3.00	2.27	2.61	2.71
10.	Clarity of billing statement	3	2.64	3.05	2.55	2.29	2.63
11.	Amount of specific advice by therapist	1A	3.19	2.88	2.05	2.89	2.79
12.	Availability of emergency services	1A	2.35	1.84	1.95	1.96	2.04
13.	Receiving needed help	1A	2.26	1.84	1.40	1.69	1.83
14.	Respect of privacy	1A	1.75	1.55	1.36	1.53	1.56
15.	Explanation of payment policies	3	1.92	2.19	1.63	1.74	1.87
16.	Competence of therapist	1A	1.66	1.41	1.29	1.16	1.40
17.	Therapists returning calls	1A	2.05	1.68	1.67	1.55	1.76
18.	Refer friends to practice	4	1.85	1.59	1.38	1.38	1.58
19.	Filing of insurance forms	1B	1.62	1.58	1.81	1.43	1.61
20.	Convenience of appointment times	1B	1.59	1.55	1.83	1.49	1.61
21.	Thoroughness of evaluation and treatment	1A	2.05	1.88	1.38	1.52	1.74
22.	Clarity of therapist's explanations	1A	1.97	1.63	1.62	1.67	1.74
23.	Comfort and trust in therapist	1A	2.05	1.89	1.64	1.44	1.78
24.	Competence of operators	1B	1.75	1.82	1.95	1.86	1.84
25.	Use of charge card	1B	2.45	2.64	2.11	2.75	2.49
26.	Fairness of payment policy	3	2.02	2.26	1.90	1.83	2.01
27.	Range of services	1A	1.98	1.66	1.64	1.80	1.79
28.	Feeling of reassurance derived from therapy	1A	2.25	1.98	1.50	1.77	1.90
29.	Explanation about medications	1A	2.39	1.89	2.06	1.48	1.96
30.	Parking	2	1.54	2.80	4.14	1.46	2.41
31.	Association with psychiatric hospital	2	<u>2.43</u>	<u>2.21</u>	<u>1.78</u>	<u>1.98</u>	<u>2.12</u>
Mean Item Rating			2.03	1.93	1.80	1.74	1.89

(a) Marketing Categories: 1A=Care Product; 1B=Augmented Product; 2=Place, 3=Price; 4=Promotion

(b) K=Kempsville Office; P=Portsmouth Office; N=Norfolk Office; C=Chesapeake Office

Overall Level of Satisfaction

Patients were asked to indicate their agreement/disagreement with each item on the questionnaire along a five-point scale of agreement. For most of the items, agreement represented satisfaction. Eight of the items (#8, 9, 10, 11, 17, 22, 29, 30), however, were scored in the opposite direction so that agreement represented dissatisfaction. These eight items were recoded so that satisfaction ratings for all items were in the same direction. A mean satisfaction rating was then calculated for each item across all respondents, and then separately for patients from each individual outpatient office. The lower the number (e.g., 1.00), the higher the degree of satisfaction. Ratings of 1.00 to 2.00 would suggest satisfaction; a rating of 3.00 would suggest neutrality or indifference; ratings of 4.00 to 5.00 would indicate dissatisfaction. Finally, a mean item rating was calculated for all respondents, and then separately for each office. This mean item rating represents a global measure of satisfaction. These data are summarized in Table 1.

As can be seen from Table 1, the total patient sample is quite satisfied with their involvement with the practice. The summary mean item rating for the total sample is 1.89, representing a global satisfaction between highly satisfied (= 1.00) and satisfied (= 2.00). Individual item means range from 1.29 (item #2) to 2.79 (item #11). No mean item scores are in the range of dissatisfaction.

Because of the limitation of space, only the overall results will be discussed. However, it can be seen that there was some variation in satisfaction among the four outpatient offices.

Dimensions of Satisfaction

In order to analyze the dimensions of expressed satisfaction, the mean item scores were first rank ordered from lowest score to highest score (representing

high to low satisfaction ratings). The rank ordered items were then divided into the 25% lowest scores (most satisfaction), the 25% highest scores (least satisfaction) and the 50% median scores (average satisfaction). The items in each of these three groupings were then analyzed to assess what aspects of the practice patients were most and least satisfied with.

Total Sample - Table 2 presents the results of this analysis for the total patient sample. The items with the highest level of satisfaction with the practice: friendliness of the receptionist; competency of the therapist; promptness and courtesy of the receptionist; respect of privacy; filing of insurance forms; convenience of appointment times; and the understanding conveyed by the therapist. Three of these items represent medical service, or core Product; four items represent office-based service, or augmented Product items; one item comes from the Promotion category.

The dimensions of the practice with the least level of satisfaction were: fairness of the payment policy; availability of emergency services; association with a psychiatric hospital; parking; use of charge cards; clarity of billing statement; size of fees; and the amount of specific advice given by the therapist. Four of these eight items have to do with payment mechanisms or Price. Two of the items represent medical service, or core Product items, and the last two items reflect Place variables.

By this analysis, the remaining 15 items fall into the category reflecting average satisfaction. Nine of these fifteen items represent medical service, or core Product variables; two items represent office service or augmented Product items; three items reflect Place variables; one item represents a Pricing variable.

Table 2

Rank Order Analysis of Dimensions of Satisfaction: Total Sample

<u>Most Satisfaction</u>			<u>Average Satisfaction</u>			<u>Least Satisfaction</u>		
<u>Item #</u>	<u>Type</u>	<u>Score</u>	<u>Item #</u>	<u>Type</u>	<u>Score</u>	<u>Item #</u>	<u>Type</u>	<u>Score</u>
2	1B	1.29	7	1A	1.78	26	3	2.01
16	1A	1.40	23	1A	1.78	12	1A	2.04
3	1B	1.41	27	1A	1.79	31	2	2.12
14	1A	1.56	4	2	1.82	30	2	2.41
18	4	1.58	13	1A	1.83	25	1B	2.49
19	1B	1.61	24	1B	1.84	10	3	2.63
20	1B	1.61	15	3	1.87	9	3	2.71
8	1A	<u>1.65</u>	28	1A	1.90	11	1A	<u>2.79</u>
				1	2			1.93
				29	1A			1.96
				6	1B			1.71
				5	2			1.73
				21	1A			1.74
				22	1A			1.74
				17	1A			<u>1.76</u>
Mean Item Rating		1.51						1.81
								2.40

Analysis of Open Ended Questions

Patients were asked to respond to two open-ended questions, one soliciting complaints about the practice, and the other soliciting comments about the positive aspects of care given. The respondents offered 178 positive comments about the practice, as opposed to only 62 negative comments.

Positive Aspects - Twenty-eight respondents commented on the personal treatment they received at the practice, that is, that the staff and therapist seemed to care about them personally. Twenty-seven respondents indicated that they liked their therapist. Twenty-six patients commented on the fact that they could see positive results from treatment, and that they felt good about this. In a similar vein, twenty-one patients remarked on the fact that they had gained increased self-understanding/acceptance from therapy. The quality of care and the competence of the therapists received comment from eighteen patients. The friendliness of the staff was listed as a positive aspect of service by seventeen respondents. Other positive comments included: having someone to talk to or listen (10 responses); some positive quality or trait of the therapist, such as his calmness or helpfulness (7 responses); the availability of the therapist (6 responses); some positive quality of the therapeutic relationship (7 responses); and the positive feeling derived from the therapy session (5 responses).

Negative Aspects - The most negative comments were given about the problem with parking (16 responses). All but one of the patients who commented on the parking problem were from one office, where parking is a particularly bad problem. Twelve negative comments reflected dissatisfaction about price factors, either that the billing was difficult to understand, or that treatment was too expensive. Other negative comments had to do with the location of offices (5

responses); lack of evening or Saturday hours (4 responses); difficulty in seeing positive progress in treatment (3 responses); and a desire for the sessions to be longer (3 responses).

DISCUSSION

The results of this study suggest that patients in the practice are very satisfied with the services they receive. This is evident from the global ratings of satisfaction as measured by the overall mean item rating, as well as the relatively high number and variety of positive comments given in response to the open-ended questions on the survey. This finding of a high degree of patient satisfaction is consistent with the results of other similar studies, and is typical of this type of research (Lebow, 1984).

However, the overall rating of patient satisfaction is the least interesting or important information from this study. As the literature clearly shows, there are numerous dimensions or factors involved in patient satisfaction. An examination of the various aspects of care with which patients in the practice are most satisfied, and perhaps even more importantly, least satisfied, can give the best understanding of how the practice is either meeting or not meeting patients' needs. Lebow (1984) suggests that the generally positive results from patient surveys can be used in public relations or promotional efforts. He also emphasizes that areas of dissatisfaction from surveys are particularly important, since they can serve as the basis for change in service to better meet patients' needs.

Looking first at the positive findings of the study, it appears that patients value prompt, courteous, and friendly service. In this way, they are probably no different from consumers of other types of services. In addition, patients are also purchasing a "product," which is the knowledge and skill of the

professional therapist. It is thus an important finding that patients in all four offices of the practice are highly satisfied with the competency of their therapists. Overall, patients are also very satisfied with the understanding conveyed by their therapists and the respect they feel that is shown toward their right to privacy. Given the sensitive nature of psychiatric problems, these two additional areas of satisfaction are important aspects of "the product." Certainly, all of the positive aspects of the care given by the psychiatrists--friendly, courteous service; competent, understanding therapists; confidential care--could be emphasized in public relations or promotional efforts, plus the effects it has on referral.

Since there were very few areas with which patients expressed dissatisfaction, recommendations for changes in service delivery must come from an examination of those aspects of the practice with which patients expressed least satisfaction. This would be in line with the suggestions made by Lebow for the usefulness and applications of survey findings.

The results of this study reveal that patients expressed least satisfaction with areas related to price and payment mechanisms. This result is consistent with that of Hulka et al. (1975) who found that cost factors were least predictive of patient satisfaction. In particular, the patients in the present study are least satisfied with the size of the fees, the fairness and reasonableness of payment policy, the clarity of the bills, and the acceptance of charge cards as a means of payment. This last item is interesting, since the practice just decided to accept charge cards as a payment mechanism ten months ago. The findings of this survey might suggest a re-evaluation of this policy. It should also be pointed out that in contrast to the relatively low satisfaction with these price variables and payment mechanisms, patients expressed a high degree of satisfaction

with the practice's policy of filing insurance forms for patients. The area of fees and billing may be an area for patient "education."

Certainly, medical care is expensive, and it is not too surprising that patients expressed least satisfaction with aspects of service related to price and payment. However, without a major change in policies, the practice could take a few actions which might be helpful in this area. First, it could help change patients' perceptions of the size of fees by emphasizing the fact that charges are consistent with the usual and customary fees charged for comparable medical service, and consistent with those allowed by all recognized third party insurance carriers. Second, it could re-evaluate the use of credit cards and perhaps change this policy. Third, bills sent to the patients could be presented in a different format so that they clearly indicate what the patient's share (e.g., copayment) is expected to be after insurance payment is received. Statements presently indicate the total amount owed, and this amount continues to appear until the third party insurance reimbursement is received. However, payments from the insurance companies typically do not come in for up to 60 to 90 days after charges are submitted. Meanwhile, patients see their bill increasing in size.

A more ambitious response to these payment and price issues might be greater utilization of prepaid insurance plans (e.g., HMO's). HMO's are beginning to capture a greater share of the health insurance market in Tidewater. With these plans, no bills need be sent to the patients, and a low fixed payment is expected at the time of each visit. Based on the findings of the present study, it would appear that these procedures might be more satisfactory to patients. It might be that Center Psychiatrists could incorporate some aspect of a prepaid plan into its own payment policies. For example, patients who are expected to be in long-term therapy could be offered a plan whereby they prepay their

insurance deductible and copayment for, say, six months of appointments. A percentage discount might be offered as an incentive for this prepayment. Statements would not need to be sent to the patients for this length of time, and the practice could deal directly with the insurance company for the balance of the account.

In addition to pricing variables, there were other aspects of care with which the patients expressed lowered satisfaction. Patients indicated that they were least satisfied with the availability of a doctor in case of an emergency. It should be pointed out that this item fell into the least satisfied range for Office A and Office B patients, but not for Office C and Office D patients. This is understandable since Office C and Office D are located in hospital facilities. It would be recommended, then, that all patients, especially those in free-standing outpatient offices, be given a number on their appointment cards which they could call at any time, 24 hours a day, if they have an emergency. In addition, each patient needs to be informed that the practice does have a physician on call, at this number, 24 hours a day, 7 days a week.

Patients were also less satisfied with the association between the practice and psychiatric hospital. Since all the respondents to this survey were outpatients, it is probable that they do not like the connotation of a psychiatric hospital. perhaps it would not be beneficial for the practice to emphasize this rather close professional relationship with this psychiatric hospital. Rather, the practice's provision of outpatient services could be promoted more intensively.

The item with which patients most consistently expressed lowered satisfaction was the one referring to the amount of specific advice and recommendations provided by the therapists. It would appear that patients prefer more direction be given them in therapy. This is a fairly surprising finding, one which would

not have been predicted before this study. However, given the expense of treatment, the feeling and sense of increased tempo in the general culture, the traditional long-term nature of psychotherapy, and the non-directiveness of many therapists, this desire of many patients for more direct, specific advice is understandable. It is as if they were saying "tell me what to do." This, in fact, is what therapists often hear from patients.

Doyle and Ware (1977) point out two strategies for bringing about more favorable perceptions of physicians: "alteration of consumer perceptions without changing the structure or process of care, and improvements in care designed to emphasize those factors that are most important in relation to the satisfaction of consumers" (p. 799). Either of these strategies could be utilized here. On the one hand, patients could be better educated as to the nature of therapy, what they could expect from the therapist in the way of direct advice, and the fact that the purpose of the therapeutic relationship is to help them better understand their underlying motivations and become healthy and autonomous in the management of their lives. Direct advice and recommendations by the therapist would be contrary to these goals. This education process should occur very early in therapy, and should serve to alter patients' perceptions and expectations of therapy.

On the other hand, the practice could develop a program of more directive services. There is a school of therapy which utilizes a more directive, structured approach to work with patients. In fact, short-term, problem-oriented, time-limited therapy is beginning to grow in popularity at the present time, mainly driven by economic forces related to the continual decrease in third party insurance support for longer term therapy. It might be that there is a "market" for this type of therapeutic approach in the patient population, and that an organized program

of directive, short-term therapy would be a marketable product. There appears to be evidence for this in the current data.

Lebow (1984) indicates that one of the potential functions of a patient satisfaction study is to compare the level of satisfaction not only with programs, but also across programs. The data from the four outpatient offices suggest some differences in both degrees of patient satisfaction as well as patterns of satisfaction between the offices. Recommendations for changes based on these data could be valuable for each individual office, and thus for the practice as a whole.

In conclusion, it should be emphasized that the results from this study are in all likelihood not generalizable beyond the sample and practice surveyed. The methodology, however, is generalizable. It was designed to be highly applications oriented. The data were collected in the most efficient, cost effective method possible. The data were analyzed without complicated, sophisticated statistical procedures. Recommendations for change in clinical and business practices followed logically from the results of the data analyses. It would be recommended that this study be replicated periodically in the target practice to continually assess the level and degree of satisfactions patients have with the care provided to them.

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