

## THE COMPARISON OF DIFFERENCES BETWEEN SERVICE PROVIDERS AND CUSTOMERS' (PATIENTS') VIEWS ON THEIR EXPECTATIONS, AN EXPERIMENT IN HEALTH SECTOR

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### ABSTRACT

*This study aims to determine whether customer (patients) and service providers (dentists) have different views on customers' (patients') expectations from treatment for transitioning to more customer (patient)-centered management. The surveys were conducted with 78 dentists and 481 patients in the offices of a private healthcare facility. The surveys asked participants to make two different assessments. One was to assign importance scores to the criteria, and the other was to rank the criteria by importance. Both ratings were considered in a way that supported each other. Patients strongly and significantly assigned higher importance to three criteria than physicians. These were ratings of treatment cost, minimal wait time, and rapid treatment and outpatient care. Compared to previous studies, measurements were made through two different assessments and analyses based on more criteria. Patients were found to give higher importance to three aspects than physicians: assessing the cost of treatment (care), minimal wait time and rapid intervention, and outpatient care.*

**Keywords:** Customer Satisfaction, Patients Expectations, Patient Satisfaction, Patient-Centered Management.

**JEL Codes:** M31, N30, P46.

## MÜŞTERİLERİN BEKLENTİLERİ ÜZERİNDE MÜŞTERİLERLE HİZMET GÖRENLERİN GÖRÜŞ AYRILIKLARININ KARŞILAŞTIRILMASI; SAĞLIK SEKTÖRÜNDE BİR UYGULAMA

### ÖZET

*Bu arařtırmanın amacı daha fazla müşteri (hasta) odaklı bir yönetime geçiş için; müşterilerle (hastalarla) hizmet görenlerin (hekimlerin), müşterilerin beklentileri hakkındaki farklı bakış açlarına sahip olup olmadıklarını ortaya koymaktır. Özel bir sağlık kurumunun şubelerinde 78 doktor ve 481 hasta ile anketler yapılmıştır. Anketlerde katılımcılardan iki farklı değerlendirme yapmaları istenmiştir. Birisi kriterlere önem notu verilmesi diğer ise kriterlerin önem sırasına sokulmasıdır. Böylece önceki*

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*çalışmalara göre daha fazla kriter üzerinden iki farklı değerlendirme ve analiz yoluyla ölçüm yapılmıştır. Her iki değerlendirme birbirlerini destekleyecek şekilde dikkate alınmıştır. Hastalar güçlü ve anlamlı şekilde 3 kritere hekimlerden daha yüksek bir önem atamaktadırlar. Bu alanlar tedavinin maliyetlerinin değerlendirilmesi, minimum bekleme süresi ve hızlı işlem ve ayakta karşılanmadır.*

**Anahtar Kelimeler:** *Müşteri Memnuniyeti, Hasta Beklentileri, Hasta Memnuniyeti, Hasta Merkezli Yönetim.*

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## 1. INTRODUCTION

While customer focus has long been considered a necessity for organizational success, it is an accepted fact that it is not easy to implement. The healthcare sector is one of the sectors where concepts such as customer (patient) orientation and customer loyalty have been discussed relatively recently. There are numerous studies on this topic. For example, Deloitte conducted a study called "Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS)" in the same region and hospitals with similar characteristics between 2008 and 2014. In this study, the return on assets (ROA), which shows the success of healthcare organizations with the highest scores (9 and 10) on the customer (patient) experience measure, was 4.7, while the rate of organizations with an experience score of 6 and below was only 1.8 ([www2.deloitte.com](http://www2.deloitte.com), 2021).

On the other hand, 69% of leaders in highly competitive healthcare organizations report that improving patient experience is one of the top two priorities for the organization, while only 35% report being a member of a team focused on patient experience (sage-growth, 2019). It will be extremely useful to take a detailed and comparative look at the relationship between patients and physicians, representing the demand and supply sides, to evaluate customer orientation in healthcare. This is because the phase in which customer orientation takes shape, or in other words, the moment of truth, is the moment in which patient and physician face each other. At this stage, it can be said that the more satisfied the patient is or the more their expectations are met, the stronger the customer orientation will be. However, patients' preferences do not always coincide with physicians' preferences. Therefore, the best treatment can be delivered only when patients' preferences are fully explored, understood, and even incorporated into this clinical decision-making process (Solomon et al., 2003). In this study, the dental field, where esthetic and physical procedures are effective, was chosen as the research area to show the differences in opinions between patients and physicians.

## **2. LITERATURE REVIEW**

### **2.1. Patient-Centered Care**

In the broadest sense, patient-centered care is not physician-centered, disease-centered, hospital-centered, or technology-centered and is organized around the patient (Erdoğan and Kırılmaz, 2020). In a report published by the Institute of Medicine in 2000, patient-centered healthcare was defined as safer, more effective, patient-centered, timely, efficient, and equitable care that respects and responds to individual patients, such that all clinical decisions should be guided by patient values (Boissy, 2020).

Patient-centered care is not easy to perform because each patient has a unique perception, emotion, and behavior (Richardson, 2009). On the other hand, each patient's unique experience with healthcare services makes the patient experience a rich resource with invaluable information for healthcare service design (Lee, 2019). In this regard, care providers need to know the drivers of the patient experience as the factors that matter to patients, and their impacts differ. For example, while steps that require financial investment, such as providing private rooms, are a profitability factor for most hospitals, more cultural actions, such as improving communication between patients and caregivers, can also reduce overall healthcare costs and improve medical outcomes (Merlino and Raman, 2013).

### **2.2. Research on Patient Expectations**

Well-designed healthcare service is designed according to the experiences of both patients and providers, based on patient activities, as both contribute to the creation of a shared value (Lee, 2019). Therefore, healthcare organizations have developed various approaches to uncover the drivers of the patient experience. According to a study conducted by Sage-Growth (2019) with 100 healthcare executives in the U.S., 93% of healthcare organizations use phone calls, 90% use electronic health records, and 80% use patient portals to understand and improve the patient experience. Only 35% of these organizations use a centralized CRM program, 70% conduct additional training for staff and physicians to improve patient interactions, and 32% have a dedicated senior manager whose sole role is to improve the healthcare consumer experience. As a result of these detailed studies, how the patients feel about their experiences and why they feel that way are understood. The Cleveland Clinic, for example, found in one study that patients initially wished for more smiles. However, upon an in-depth examination, it was found that patients' real expectations were not that staff members looked happy. Patients are concerned that staff hides negative information about themselves when they seem unhappy or grumpy (Merlino and Raman, 2013).

El-Haddad et al. (2020) found three conceptual domains in their study to provide general and categorical outcomes for patient expectations and patient satisfaction. These are outcomes related to the patient's health, the physician himself, and the expectations of the healthcare system. Patients may have independent expectations concerning these three areas. The first of these three areas is primarily the

most basic expectation. The expectation of a patient who cannot receive treatment means that their expectation is not met. However, the relationship or perception dimension of this variable is quite low. Therefore, the second and third domains are more important to healthcare managers and practitioners. According to Armstrong (1991), courtesy, sufficient information, and emotional support have been added to patients' expectations after years of believing that they turn to physicians only to treat their diseases in a passive situation.

According to Pulia (2011), the most effective phrase summarizing the results of numerous studies on what patients want is: patients want fast/effective care from an empathetic and well-communicating physician. However, this simple phrase is deceptive in the author's opinion because the patient's condition contains subjective components that vary from patient to patient. Nevertheless, some general points can be made:

- Patients want minimal wait and initial intervention time. Moreover, their ideas in this direction are very demanding. This time generally consists of mandatory obligations such as the duration of registration. The most logical approach is to explain the estimated time and its reasons. A pessimistic determination of the duration can reduce the negative impact of the delay while increasing patient satisfaction in case of early completion. An apology should be given in the event of a delay.

- The second important point for patients is empathy. Although empathy is a subjective situation, greeting by standing up, effective listening, dedicating adequate time, and having open body language are generally signs of empathetic behavior (Pulia, 2011).

According to Press Ganey's (2019) study conducted with 1.3 million patients and 73,221 physicians, the top three reasons for patient loyalty are teamwork, respect, and courtesy. The most important reason in the emergency department setting is that patients care about the staff (Bean, 2019). Bidmon et al. (2020) evaluated 84,680 studies on a public rating site (PRWs-Physician-Rating website), rating 7083 physicians in Germany, and showed what patients value when visiting a physician. According to the authors' findings, improvements in physician friendliness and sincerity had the strongest increasing effect on patient satisfaction. In contrast, negative features in waiting rooms, long wait times, and technical deficiencies in medical equipment had the strongest reducing effect. Zeh et al. (2021) and Dierks and Bitzer (1999) state that patients expect to be treated personally and viewed from a holistic perspective. Moreover, Maassen et al. (2017) stated that psychiatric patients wanted to be heard without being judged.

As can be seen, the most important determinant of the patient-centered approach is the relationship between the patient and the physician. Therefore, this relationship is addressed separately in this study.

### **2.3. Research on Patient-Physician Communication and Relationship**

Many studies have shown that the aspects of the physician-patient relationship that increase compliance increase patient satisfaction and recovery rates (Stewart et al., 1979). Furthermore, no matter how knowledgeable a physician is, he or she cannot help the patient if he or she does not have good communication with the patient (Asnani, 2009). Like many other authors, Lazare et al. (1972) found that the main reason for treatment dropout was that the patient's expectations were not met because the therapist (physician) did not know exactly what they wanted, i.e., their views on the subject did not match.

Physician-patient communication is a fundamental necessity that encompasses complex health behaviors (Henry et al., 2013). In their study, Zimmerman et al. (2020) found that most patients generally believed that having physicians or nurses know their personal information during the treatment process would improve their relationship and increase the quality of care. They also view the use of their names as positive. However, according to the authors, very little importance is given to physicians' personal communication with patients during treatment. On the other hand, the patient-physician relationship is more than a service relationship between the company and the customer; it is therapeutic. In other words, this relationship is focused on attention and care before service and requires attachment, respect, and compassion (Torie, 2014). The patient-physician relationship is much more complex than what the term "partnership" can meaningfully cover, and there is no single ideal model that fits everyone in this relationship. Communication is shaped according to illness, patient, and the moment (Salmon and Young, 2005). According to Press Ganey's data, the three most important factors in patient-physician interactions are trust in the provider (physician), teamwork in the hospital, and staff members showing care about the patient (Keckley, 2019). Knowing that the physician truly cares about the patient increases the trust relationship between them, and the trust relationship improves the harmony between them. The development of harmony leads to better treatment (Hurst, 2011). Although the factors that increase trust in the physician vary according to the sociocultural context, they are based more on conceptual reasons such as the physician's reputation or treatment guarantee than on objective criteria such as the physician's competence. Additionally, feeling comfortable with the physician and the physician's communication skills significantly affect trust in the physician (Gopichandran and Chetlapalli, 2015).

Patients do not fully express their feelings in their relationship with the physician. The least expressed thoughts are about the diagnosis of the treatment and concerns about its future success, and the patient's opinion about the mistakes made (Barry et al., 2000). Internationally, however, the most common patient complaint is physicians' communication skills (Montini et al., 2008). In one of the seminal first articles on physician-patient relationships, Peabody (1927) stated that, in the physician-patient relationship, the physician can be generous with time, sympathy, and understanding, but that the important thing is to establish a personal connection and that the indispensable prerequisite is to show

interest in the patient. According to the author, an illness in a human being is never like an illness in an animal. There are emergencies in which a physician deals only with the disease. However, it is a fact that the patient's mental (emotional) state is affected by the disease and influences the disease. A physician who neglects this is like a scientist who neglects important variables in an experiment.

According to Champion et al. (1992), three main areas set the assessment agenda between physicians and patients: physical, emotional, and social. While patients and physicians equally emphasized the physical agenda, the emotional agenda was more prominent among patients than physicians. According to Emanuel and Dubler (1995), an ideal patient-physician relationship is expressed in the 6 Cs (choice, competence, communication, compassion, continuity, and (no)conflict of interest). Choice (giving patients the right to participate and choose), competence (theoretical and practical knowledge, experience, etc.), communication (listening, understanding, and communicating to the patient the level of knowledge desired, being able to give a good explanation), compassion, continuity, and overlap of interest (the patient's interests should come first when the physician's interests overlap with the patient's interests). According to many authors, the trust that needs to be established between patient and physician depends on realizing this 6C.

In their study with both patients (640 patients) and physicians (300 physicians), McBride et al. (1994) compared the importance of both groups in terms of competencies using seven competencies established by the Pew Association of Vocational Commissions at a relatively early time. While the most important skill for patients is diagnosing and treating the disease, communication is second. Ethical behavior ranks third. On the other hand, when the same patients rated their physicians, they gave the highest score to ethical behavior and the weakest score to communication's assessment of the cost of treatment. The comparison of patients' and physicians' ratings is shown in Table 1.

**Table 1. Comparison of Importance, Perf.Qua., Training Ratings**

Competency	Importance Ratings of Participants (Very Important %)	Importance Ratings of Physicians (Very Important %)	Participants' Ratings of Their Physicians	Training Ratings of Physicians (Excellent %)
Communication with patient	98	92	48	26
Diagnosing and treating the disease	99	98	51	67
Ethical behavior	98	77	60	31
Promoting preventive care	93	73	46	10
Correct use of technology	85	61	51	12

Source: McBride et al. (1994)

Table 1 shows that the order of importance of patients and physicians is similar. The main difference in ranking is that patients place more importance on technology than physicians. However, looking at the specific ratings, it can be seen that patients do not receive the communication satisfaction they expect from physicians. Similarly, physicians think that the level of education they receive on this topic is low.

Petrie et al. (2005), in their study of open-ended questions in a pain center, found that patients usually expect a good explanation or understanding following the expectation of relief from their pain. In one of the most recent studies on this topic, Zeh et al. (2021) conducted interviews with patients. They presented a qualitative study that classified patients' expectations of healthcare providers into two groups, basic (important) and minor (less important), by analyzing the data obtained. These expectations are presented in Table 2.

**Table 2. Patients' Expectations from the Healthcare Provider**

Key Expectations	Small Expectations
Competency of the physician, empathetic and accurate understanding of the patient, and Short-term treatment (short wait time) and dedicating sufficient time	Treating the patient not only physically or symptomatically but also from a holistic perspective Providing accurate information (using understandable terms, effective listening, eye contact, etc.)
Being fully aware of the patient's situation (difficulties, feelings, etc.)	Application of not only traditional treatment methods (use of medications, etc.), but also other treatment methods (massage, physiotherapy, etc.) Transparency about the expected duration of treatment, especially in case of delays Non-discrimination between patients (mainly for the insured, etc.)

Source: Zeh et al. (2021).

### 3. METHOD

#### 3.1. The Purpose of the Study

The study aims to compare the opinions of physicians (dentists) and patients to understand patients' expectations, which are very important for patients' experiences in healthcare. These expectations are addressed in two areas. The first area is expectations in general, and the second is expectations related to communication. In this way, it is hoped to create an awareness that will enrich the perspective of healthcare managers and, in particular, physicians.

#### 3.2. The Significance of the Study

There are very few studies that compare patients' and physicians' opinions about patient expectations. In a sense, this study is important in demonstrating the historical change, even though it is specific to the dental field, as it reviews and updates previous studies. Moreover, the importance of attitudes and behaviors as practical cues in the sub-items of communication was demonstrated.

#### 3.3. The Scales

As mentioned earlier, this study compared opinions about patient expectations in two different areas. One is expectations in general, and the other is expectations in communication. For general expectations, McBride et al. (1994) relied on seven competencies established by the Pew Association of Vocational Commissions. However, as a recent addition to the criteria of this study, Zeh et al. (2021)



added the factor of speed and timing to the basic expectations in their study. Thus, timing, which has been emphasized in many studies in the literature, was taken into consideration. The eight criteria that emerged are:

1) Diagnosis and treatment of the disease, 2) Communication, 3) Ethical behavior, 4) Collaboration with other healthcare professionals, 5) Promoting preventive care, 6) Use of technology, 7) Evaluation of the cost of care for the patient, 8) Minimal wait times and rapid response.

The main study to be considered on communication, which is the second examination area, is the study by Pulia (2011). The behaviors discussed in this study under empathy are: Greeting by standing up, effective listening, allowing sufficient time, and open body language. In addition to these criteria, in the study by Zeh et al. (2021), which is effective and up-to-date, the criteria of "being fully aware of the patient's situation (difficulties, feelings, etc.)," one of the basic expectations, and "using understandable expressions and giving a good explanation" and "eye contact" which are among the secondary expectations in the same study, were added. Lastly, "being good-humored" was added, which is very important in communication and was highlighted in the study (Merlino and Raman, 2013). Thus, the criteria to be tested in "communication" are as follows:

1) Greeting by standing up, 2) Effective listening, 3) Allowing sufficient time, 4) An open body language, 5) Being fully aware of the patient's situation (difficulties, feelings, etc.), 6) Using understandable expressions and giving a good explanation, 7) Eye contact, 8) Being good-humored.

Although the questions were the same for patients and physicians, two separate survey forms were used. A 5-point Likert scale was used in the study. Furthermore, participants were asked to rank competencies (criteria) in two different areas in order of importance from 1 to 8.

### **3.4. Research Population and Sample**

The study was conducted in a total of 8 different branches of a private dental hospital chain, whose name is kept confidential and has branches in different cities in Turkey. The total number of current patients that can be actively evaluated in this hospital chain (the number of patients who came to the clinic within two years, the average time a patient comes to the clinic) is about 5,000 people. The total number of physicians in the Istanbul branches of the chain is about 100. For the number of samples, the table prepared by Yavan (2014) and Yavan (2021) using previous researchs was used to calculate the sample size. According to this table, the number of samples at a confidence level of 95% is 370 for patients with a population of 5000 and 80 for physicians with a population of 100. The study was conducted in February-March 2022. In the study, random sampling was used, and surveys were collected from all patients and physicians in the hospital on the study days. Initially, 559 surveys were collected through in-person interviews with 481 patients and 78 physicians.



### 3.5. Statistical Method(s)

Data were analyzed with a confidence level of 95% using the statistical software packages SPSS 26.0 and AMOS 21.0. For categorical (qualitative) variables, frequency and percentage (n (%)), mean, standard deviation (S.D.), median statistics of numerical evaluation, and significance criteria are reported. The Chi-square test and Mann-Whitney test were used in the study. The Chi-square test is used to determine the relationship between two categorical variables. The Mann-Whitney test compares two groups concerning a quantitative variable. In the study, the Chi-square test was used in the order of importance in the group (physician/patient), and the Mann-Whitney test was used to compare the significance and the level of evaluation by group, sex, and age.

### 3.6. Ethical Approval and Consent to Participate

Approval for this study was obtained from the Ethics Committee of the University (Hamidiye Bilimsel Araştırmalar Etik Kurulu). Permission was obtained from the participants within the framework of ethical approval. The Certificate (it's that is 07.02.2022, the number is 99859) was attached.

## 4. FINDINGS

**Table 3. Distribution of Demographic Characteristics**

		Physician	Patient	Total
Branch	Bağcılar	15 (22.4)	69 (18)	84 (18.6)
	Bakırköy	8 (11.9)	68 (17.7)	76 (16.9)
	Çamlıca	10 (14.9)	65 (16.9)	75 (16.6)
	Fatih	10 (14.9)	11 (2.9)	21 (4.7)
	Mecidiyeköy	13 (19.4)	43 (11.2)	56 (12.4)
	Pendik	10 (14.9)	69 (18)	79 (17.5)
	Şerifali	1 (1.5)	59 (15.4)	60 (13.3)
Age	Under 20	0 (0)	32 (8.5)	32 (7.2)
	20-29	35 (53.8)	89 (23.5)	124 (28)
	30-39	25 (38.5)	101 (26.7)	126 (28.4)
	40-49	4 (6.2)	69 (18.3)	73 (16.5)
	50 and older	1 (1.5)	87 (23)	88 (19.9)
Sex	Male	31 (47)	175 (46.5)	206 (46.6)
	Female	35 (53)	201 (53.5)	236 (53.4)
Experience in the profession (years)	Less than 5	27 (41.5)	x	27 (41.5)
	5-10	26 (40)	x	26 (40)
	More than 10	12 (18.5)	x	12 (18.5)
Educational Status	Primary Education	x	36 (14.6)	36 (14.6)
	High School	x	67 (27.2)	67 (27.2)
	Associate Degree	x	10 (4.1)	10 (4.1)
	Bachelor's Degree	x	115 (46.7)	115 (46.7)

Master's Degree	x	17 (6.9)	17 (6.9)
PhD Degree	x	1 (0.4)	1 (0.4)

The demographic characteristics of the respondents were given according to the patient, physician, and total.

**Table 4. Comparison of the Importance Levels of General and Communication-related Criteria by Group**

Criteria	Physician		Patient		Total		p	
	Median	Mean±sd	Median	Mean±sd	Median	Mean±sd		
General Criteria	Diagnosing and treating the disease	5	4.93±0.26	5	4.86±0.43	5	4.87±0.41	0.268
	Communication	5	4.81±0.4	5	4.87±0.35	5	4.86±0.36	0.134
	Ethical behavior	5	4.88±0.33	5	4.76±0.54	5	4.78±0.51	0.088
	Collaboration with other healthcare professionals	4	4.37±0.65	5	4.63±0.72	5	4.59±0.72	0.000*
	Promoting preventive care	4	4.36±0.71	5	4.64±0.64	5	4.6±0.66	0.000*
	Use of technology	4	4.19±0.76	5	4.64±0.71	5	4.57±0.73	0.000*
	Evaluation of the cost of care for the patient	4	3.9±0.8	5	4.59±0.68	5	4.49±0.74	0.000*
	Minimal wait time and quick response	4	4.04±0.91	5	4.74±0.56	5	4.64±0.67	0.000*
Criteria Related to Communication	Greeting by standing up	3	3.33±1.13	5	3.92±1.43	4	3.83±1.4	0.000*
	Effective listening	5	4.82±0.42	5	4.74±0.63	5	4.76±0.6	0.693
	Allowing sufficient time	5	4.69±0.61	5	4.73±0.63	5	4.73±0.63	0.333
	An open body language	4	4.34±0.71	5	4.58±0.74	5	4.55±0.74	0.001*
	Being fully aware of the patient's situation	4	4.36±0.69	5	4.65±0.64	5	4.61±0.66	0.000*
	Using understandable expressions and giving a good explanation	5	4.88±0.37	5	4.8±0.52	5	4.81±0.51	0.246
	Making eye contact	5	4.52±0.59	5	4.62±0.77	5	4.6±0.75	0.013*
Being good-humored	5	4.73±0.54	5	4.78±0.57	5	4.77±0.56	0.241	

\*p<0.05: there is a significant difference; p>0.05: there is no significant difference; Mann-Whitney test

There is a statistically significant difference between physicians and patients regarding collaboration with other healthcare professionals, promotion of preventive care, use of technology, evaluation of the cost of care for the patient, minimum wait time, and importance of rapid intervention (p<0.05). For patients, collaboration with other health professionals (4.63), promotion of preventive care (4.64), use of technology (4.64), evaluation of the cost of the patient's care (4.59), minimum wait time, and rapid intervention (4.74) are more important.

There is a statistically significant difference between physicians and patients in the importance of the criteria "greeting by standing up" (3.92), "open body language" (4.58), "being fully aware of the patient's situation" (4.65), and "making eye contact" (4.62), which are related to communication ( $p < 0.05$ ). Patients rated greeting by standing up (3.92), open body language (4.58), being fully aware of the patient's situation (4.65), and the criterion of making eye contact (4.62) as more important. The difference in the other criteria was not significant ( $p > 0.05$ ).

**Table 5. Comparison of the Importance Ranking of General and Communication-related Criteria by Group**

Criteria	Physician		Patient		Total		p	
	Median	Mean±sd	Median	Mean±sd	Median	Mean±sd		
General Criteria	Diagnosing and treating the disease	1	1.94±1.56	2	3.4±2.72	2	3.18±2.63	0.001*
	Communication	3	2.7±1.31	3	3.67±2.41	3	3.53±2.31	0.040*
	Ethical behavior	2	2.7±1.53	4	4.29±1.95	4	4.05±1.97	0.000*
	Collaboration with other healthcare professionals	5	5.42±1.44	5	5.15±2.16	5	5.19±2.07	0.534
	Promoting preventive care	6	5.36±1.64	5	5.11±1.97	5	5.15±1.92	0.511
	Use of technology	6	5.7±1.69	5	4.98±2.09	5	5.08±2.05	0.011*
	Evaluation of the cost of care for the patient	8	6.85±1.67	5	4.77±2.25	5	5.08±2.3	0.000*
	Minimal wait time and quick response	5	5.33±1.78	4	4.39±2.3	4	4.53±2.25	0.002*
Criteria Related to Communication	Greeting by standing up	8	7.04±1.97	7	5.67±2.75	8	5.87±2.69	0.000*
	Effective listening	2	3.09±2.07	4	4.28±2.24	4	4.1±2.25	0.000*
	Allowing sufficient time	4	4.4±1.87	4	4.34±2.13	4	4.35±2.09	0.802
	An open body language	6	5.45±1.8	5	4.85±2.07	5	4.94±2.04	0.028*
	Being fully aware of the patient's situation	5	4.54±2.18	5	4.49±2.25	5	4.5±2.24	0.785
	Using understandable expressions and giving a good explanation	2	2.84±1.72	4	3.95±2.16	3	3.78±2.13	0.000*
	Making eye contact	5	4.88±1.88	5	4.37±2.23	5	4.44±2.18	0.077
Being good-humored	4	3.72±1.81	3	3.63±2.37	3	3.65±2.3	0.366	

\* $p < 0.05$ : there is a significant difference;  $p > 0.05$ : there is no significant difference; Mann-Whitney test

There is a statistically significant difference between physicians and patients in the order of importance of general criteria such as diagnosis and treatment of the disease, communication, ethical behavior, use of technology, evaluation of the cost of care for the patient, minimal wait time, and rapid intervention ( $p < 0.05$ ). While physicians prioritize diagnosis and treatment of the disease (1.94), communication (2.7), and ethical behavior (2.7), patients prioritize the use of technology (4.98), evaluation of the cost of care for the patient (4.77), minimal wait time, and rapid intervention (4.39).

There is a statistically significant difference between physicians and patients in the importance of greeting the patient by standing, listening effectively, using open body language, using understandable expressions, and giving a good explanation ( $p < 0.05$ ). While physicians considered the criteria of listening effectively (3.09), using understandable expressions, and giving a good explanation (2.84) to be more important, patients considered the criteria of standing up (5.67) and open body language (4.85) to be more important. The difference in the other criteria was not significant ( $p > 0.05$ ).

**Table 6. Relationship of the Importance Ranking of the General Criteria with the Group**

Criteria	Priority order	Physician	Patient	Total	p
Diagnosing and treating the disease	1	34 (50.7)	157 (41.1)	191 (42.5)	0.000*
	2	21 (31.3)	58 (15.2)	79 (17.6)	
	3	6 (9)	18 (4.7)	24 (5.3)	
	4	3 (4.5)	16 (4.2)	19 (4.2)	
	5	0 (0)	41 (10.7)	41 (9.1)	
	6	0 (0)	6 (1.6)	6 (1.3)	
	7	0 (0)	22 (5.8)	22 (4.9)	
	8	3 (4.5)	64 (16.8)	67 (14.9)	
Communication	1	12 (17.9)	93 (24.3)	105 (23.4)	0.000*
	2	18 (26.9)	79 (20.7)	97 (21.6)	
	3	25 (37.3)	42 (11)	67 (14.9)	
	4	7 (10.4)	24 (6.3)	31 (6.9)	
	5	1 (1.5)	45 (11.8)	46 (10.2)	
	6	3 (4.5)	22 (5.8)	25 (5.6)	
	7	1 (1.5)	43 (11.3)	44 (9.8)	
	8	0 (0)	34 (8.9)	34 (7.6)	
Ethical behavior	1	15 (22.4)	21 (5.5)	36 (8)	0.000*
	2	20 (29.9)	52 (13.6)	72 (16.1)	
	3	18 (26.9)	90 (23.6)	108 (24.1)	
	4	5 (7.5)	49 (12.9)	54 (12.1)	
	5	4 (6)	61 (16)	65 (14.5)	
	6	3 (4.5)	42 (11)	45 (10)	
	7	2 (3)	43 (11.3)	45 (10)	
	8	0 (0)	23 (6)	23 (5.1)	
Collaboration with other healthcare professionals	1	0 (0)	27 (7.1)	27 (6)	0.007*
	2	2 (3)	29 (7.6)	31 (6.9)	
	3	4 (6)	32 (8.4)	36 (8)	
	4	10 (14.9)	50 (13.1)	60 (13.4)	
	5	20 (29.9)	75 (19.6)	95 (21.2)	
	6	15 (22.4)	47 (12.3)	62 (13.8)	
	7	11 (16.4)	47 (12.3)	58 (12.9)	

	8	5 (7.5)	75 (19.6)	80 (17.8)	
Promoting preventive care	1	1 (1.5)	24 (6.3)	25 (5.6)	0.134
	2	1 (1.5)	28 (7.3)	29 (6.5)	
	3	8 (11.9)	24 (6.3)	32 (7.1)	
	4	12 (17.9)	54 (14.1)	66 (14.7)	
	5	9 (13.4)	71 (18.6)	80 (17.8)	
	6	19 (28.4)	79 (20.7)	98 (21.8)	
	7	11 (16.4)	60 (15.7)	71 (15.8)	
	8	6 (9)	42 (11)	48 (10.7)	
Use of technology	1	1 (1.5)	22 (5.8)	23 (5.1)	0.150
	2	3 (4.5)	40 (10.5)	43 (9.6)	
	3	2 (3)	40 (10.5)	42 (9.4)	
	4	8 (11.9)	43 (11.3)	51 (11.4)	
	5	16 (23.9)	74 (19.4)	90 (20)	
	6	12 (17.9)	55 (14.4)	67 (14.9)	
	7	15 (22.4)	57 (14.9)	72 (16)	
	8	10 (14.9)	51 (13.4)	61 (13.6)	
Evaluation of the cost of care for the patient	1	2 (3)	39 (10.2)	41 (9.2)	0.000*
	2	0 (0)	42 (11)	42 (9.4)	
	3	1 (1.5)	41 (10.8)	42 (9.4)	
	4	3 (4.5)	32 (8.4)	35 (7.8)	
	5	7 (10.4)	81 (21.3)	88 (19.6)	
	6	7 (10.4)	39 (10.2)	46 (10.3)	
	7	11 (16.4)	50 (13.1)	61 (13.6)	
	8	36 (53.7)	57 (15)	93 (20.8)	
Minimal wait time and quick response	1	2 (3)	58 (15.3)	60 (13.4)	0.000*
	2	2 (3)	36 (9.5)	38 (8.5)	
	3	3 (4.5)	42 (11.1)	45 (10.1)	
	4	19 (28.4)	73 (19.2)	92 (20.6)	
	5	10 (14.9)	44 (11.6)	54 (12.1)	
	6	8 (11.9)	41 (10.8)	49 (11)	
	7	16 (23.9)	34 (8.9)	50 (11.2)	
	8	7 (10.4)	52 (13.7)	59 (13.2)	

\*p<0.05 significant relationship, p>0.05 no significant relationship; chi-square test

For the general criteria, there is a statistically significant relationship between the order of importance of the criteria of diagnosis and treatment of the disease, communication, ethical behavior, collaboration with other health professionals, evaluation of the cost of care for the patient, minimum wait time, and rapid struggle and the group (p<0.05). The criteria are given in order of importance. For other criteria, the relationship is not significant (p>0.05).

**Table 7. Relationship of the Importance Ranking of Criteria Related to Communication with the Group**

Criteria	Priority order	Physician	Patient	Total	p
Greeting by standing up	1	2 (3)	61 (16.1)	63 (14.1)	0.002*
	2	4 (6)	22 (5.8)	26 (5.8)	
	3	0 (0)	24 (6.3)	24 (5.4)	
	4	3 (4.5)	12 (3.2)	15 (3.4)	
	5	1 (1.5)	28 (7.4)	29 (6.5)	
	6	3 (4.5)	21 (5.5)	24 (5.4)	
	7	5 (7.5)	34 (8.9)	39 (8.7)	
	8	49 (73.1)	178 (46.8)	227 (50.8)	
Effective listening	1	20 (29.9)	65 (17)	85 (18.9)	0.001*
	2	14 (20.9)	32 (8.4)	46 (10.2)	
	3	7 (10.4)	53 (13.8)	60 (13.3)	
	4	11 (16.4)	49 (12.8)	60 (13.3)	
	5	6 (9)	67 (17.5)	73 (16.2)	
	6	1 (1.5)	30 (7.8)	31 (6.9)	
	7	6 (9)	57 (14.9)	63 (14)	
	8	2 (3)	30 (7.8)	32 (7.1)	
Allowing sufficient time	1	4 (6)	46 (12)	50 (11.1)	0.522
	2	6 (9)	42 (11)	48 (10.7)	
	3	14 (20.9)	52 (13.6)	66 (14.7)	
	4	11 (16.4)	66 (17.2)	77 (17.1)	
	5	13 (19.4)	56 (14.6)	69 (15.3)	
	6	9 (13.4)	54 (14.1)	63 (14)	
	7	6 (9)	29 (7.6)	35 (7.8)	
	8	4 (6)	38 (9.9)	42 (9.3)	
An open body language	1	3 (4.5)	27 (7.1)	30 (6.7)	0.144
	2	3 (4.5)	42 (11)	45 (10)	
	3	3 (4.5)	32 (8.4)	35 (7.8)	
	4	9 (13.4)	56 (14.7)	65 (14.5)	
	5	12 (17.9)	63 (16.5)	75 (16.7)	
	6	12 (17.9)	60 (15.7)	72 (16.1)	
	7	21 (31.3)	66 (17.3)	87 (19.4)	
	8	4 (6)	35 (9.2)	39 (8.7)	
Being fully aware of the patient's situation (difficulties, feelings, etc.)	1	10 (14.9)	59 (15.4)	69 (15.4)	0.056
	2	7 (10.4)	36 (9.4)	43 (9.6)	
	3	5 (7.5)	34 (8.9)	39 (8.7)	
	4	6 (9)	44 (11.5)	50 (11.1)	
	5	8 (11.9)	73 (19.1)	81 (18)	
	6	18 (26.9)	46 (12)	64 (14.3)	

	7	11 (16.4)	55 (14.4)	66 (14.7)	
	8	2 (3)	35 (9.2)	37 (8.2)	
	1	19 (28.4)	59 (15.4)	78 (17.4)	
	2	15 (22.4)	64 (16.8)	79 (17.6)	
	3	14 (20.9)	55 (14.4)	69 (15.4)	
Using understandable expressions and giving a good explanation	4	4 (6)	47 (12.3)	51 (11.4)	0.006*
	5	8 (11.9)	61 (16)	69 (15.4)	
	6	6 (9)	33 (8.6)	39 (8.7)	
	7	1 (1.5)	38 (9.9)	39 (8.7)	
	8	0 (0)	25 (6.5)	25 (5.6)	
	1	2 (3)	47 (12.4)	49 (11)	
	2	5 (7.6)	55 (14.5)	60 (13.5)	
	3	12 (18.2)	50 (13.2)	62 (13.9)	
Making eye contact	4	9 (13.6)	36 (9.5)	45 (10.1)	0.134
	5	10 (15.2)	57 (15)	67 (15)	
	6	12 (18.2)	55 (14.5)	67 (15)	
	7	12 (18.2)	46 (12.1)	58 (13)	
	8	4 (6.1)	34 (8.9)	38 (8.5)	
	1	7 (10.4)	103 (27)	110 (24.5)	
	2	13 (19.4)	62 (16.2)	75 (16.7)	
	3	12 (17.9)	37 (9.7)	49 (10.9)	
Being good-humored	4	14 (20.9)	38 (9.9)	52 (11.6)	0.003*
	5	9 (13.4)	54 (14.1)	63 (14)	
	6	6 (9)	28 (7.3)	34 (7.6)	
	7	5 (7.5)	20 (5.2)	25 (5.6)	
	8	1 (1.5)	40 (10.5)	41 (9.1)	

\*p<0.05 significant relationship, p>0.05 no significant relationship; chi-square test

For the communication-related criteria, there is a statistically significant relationship between the group and the order of importance of greeting by standing up, effective listening, using understandable expressions, and a good explanation, and being good-humored (p<0.05). The criteria are given in order of importance. For other criteria, the relationship is not significant (p>0.05).

## 5. DISCUSSION AND RECOMMENDATIONS

Unlike other studies, this study evaluated general and communication criteria using two different methods. The first is assigning an importance level, and the other determines the order of importance. These two methods are used in a way that supports each other.

First, it is useful to make a comparison with previous studies. It can be noted that there are no major differences in this regard. In fact, in McBride's et al. (1994) study, the first three items were rated as similar by patients and physicians (diagnosis and treatment of the disease, communication, and ethical



behavior) when it came to what patients value, while it was found that only patients expected higher technology use compared to physicians. This study's first three criteria, which physicians and patients value, are similar. However, the expectation of technology use and the criteria of wait time and rapid intervention, promotion of preventive care, and evaluation of the cost of care have higher importance than physicians. The first three criteria with the highest level of importance are similar in evaluating physician-patient communication. These are the use of understandable expressions and good explanations, being good-humored, and effective listening. Making eye contact and allowing sufficient time also have similar importance. On the other hand, the differences according to the two assessment methods are shown in Table 8 and Table 9.

**Table 8. Criteria that Physicians Attach More Importance than the Patients**

	Importance Level	Order of Importance
General Criteria	-	Ethical behavior (2.7)
	-	Communication (2.7)
	-	Diagnosing and treating the disease (1.94)
	-	
	-	
Communication Criteria	-	Effective listening (3.09)
	-	Using understandable expressions and giving a good explanation (2.84)
	-	

**Table 9. Criteria that Patients Attach More Importance to than Physicians Do**

	Importance Level	Order of Importance
General Criteria	Minimal wait times and rapid response (4.74)	Use of technology (4.98)
	Promoting preventive care (4.64)	Evaluation of the cost of care for the patient (4.77)
	Use of technology (4.64)	Minimal wait times and rapid response (4.39)
	Collaboration with other healthcare professionals (4.63)	
	Evaluation of the cost of care for the patient (4.59)	
Communication Criteria	Being fully aware of the patient's situation (4.65)	Greeting by standing up (5.67)
	Making eye contact (4.62)	An open body language (4.85)
	An open body language (4.58)	
	Greeting by standing up (3.92)	

In Table 8, it is noticeable that physicians do not attach more importance to any criterion on the level of importance than patients do. On the other hand, it can be argued that the areas common to both methods have a higher priority, so it would be appropriate to interpret Table 9, which shows the criteria that patients attach more importance to than physicians. Moreover, this picture is more significant in terms of patient orientation. In Table 9, five criteria are the same for both assessment methods. Three of

them belong to the general criteria and two to the communication criteria. However, there is no statistically significant relationship between two of these criteria and their group. Therefore, the remaining three criteria are as follows:

- Evaluation of the cost of care for the patient (4.77)
- Minimal wait times and rapid response (4.39)
- Greeting by standing up (5.67)

Based on these results, the following comments and recommendations can be made for health facility managers and physicians:

- For patient orientation, it is very important to evaluate and explain the necessity of treatments or services to patients, alternative treatments, and their costs from the patients' point of view. Patients expect physicians to choose the treatment that makes the most sense for them and that they will not be forced into excessive and unnecessary care and treatment. Patients want to be sure of this. Since patients do not decide on treatment, it is natural for them to have such a need and expectations. Physicians need to understand this expectation and display a high degree of altruism and evaluate patients' treatment as their treatment.

- In line with the digital age demands, patients need to receive services faster. In particular, setting up an attractive appointment system, keeping appointments, and performing procedures quickly and on time will meet patients' expectations. Appointment coordination and effective time management should be incorporated into the service systems.

- The physician's greeting of patients while standing and open body language (arms at sides, chest slightly forward, etc.) contribute to patient satisfaction. This topic should be given special attention in training content.

## **6. CONCLUSION**

According to the marketing approach, despite increasing competition, healthcare facilities' most important understanding to differentiate themselves from their competitors is patient orientation. The first step of patient orientation is to analyze what patients expect, i.e., to understand their wants and needs properly. There are studies on this topic, but they need to be updated and conducted more specifically. Moreover, it is very difficult for physicians to understand patients fully and for patients to understand physicians for many reasons such as educational differences, information asymmetry, and cultural and social norms that require expertise. This study was conducted using two assessment methods to support each other.

At the end of the study, it was found that there were no profound differences between physicians' opinions about patients' wishes and patients' actual expectations. The disagreements between the two

parties are minor. Nevertheless, several practical recommendations were made to hospital managers and physicians who want to provide better patient services to meet their expectations.

### **6.1. Limitations of The Study and Future Research**

The fact that this research was conducted only in one hospital chain is a limitation of the study. It is necessary to conduct the study in different types of hospitals (branch hospitals, urban hospitals, etc.) and perform analyses for physicians' specialties, especially to provide specific benefits. On the other hand, it will be beneficial to conduct qualitative and quantitative studies.

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