Published in Consumer Behavior in the Health Marketplace: A Symposium Proceedings, Ian M. Newman, Editor, Nebraska Center for Health Education & University of Nebraska-Lincoln, 1976.

SOME DETERMINANTS OF POST-PURCHASE SATISFACTION AMONG MEDICAL CARE CONSUMERS

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Consumer behavior in the health marketplace is an interesting subject. One of the interesting things about studying medical care is that different people experience different results after having the same health care. For example, in the Massachusetts presidential primary that took place some time ago, one of the voting machines somehow got hooked up to an X-ray device, and, as a result, three voters were exposed to doses of radiation. One of the exposed was a conservative, one was a liberal, and one was an independent. They were immediately rushed to one of the major Boston medical centers where a physician gave them a thorough examination and said to all three of them, "I'm sorry folks, but the three of you will be dead in two weeks." The conservative ran out to spend the two weeks praying for salvation, the liberal decided to spend the two weeks raising hell and trying to live as much as possible, but the independent ran out to look for another doctor.

So, post-purchase satisfaction is important because it shapes the patient's subsequent behavior. But, there are also several reasons why post-purchase satisfaction is important to health care management. These are summarized in Figure I.

First, providers, whether they like it or not, are more and more often finding themselves in a competitive environment. Success therefore is not automatic. Some providers have to compete to get and keep patients. From a business perspective if you are in the fee-for-service business, you want to insure that your patients are satisfied enough to come back. If you are operating an HMO or any other prepayment plan, you need to keep your patients satisfied enough to keep their memberships.

Even if a provider does not have these direct concerns, there are some image factors of concern. Providers have to be concerned about

FIGURE I

Importance of "Post-purchase" Satisfaction

For Provider Success

- Insure Patient Return on Next Appropriate Occasion (Fee-For-Service)
- Stay Enrolled (HMO)
- "Image"
  - For Attracting New Patients
  - For Funding
- Minimize Malpractice Suits

For Patient "Success"

- Maximize Chances that a Prescribed Regimen Will Be Followed
- Insure Return For Needed Follow-Up Examination or Treatment

attracting new patients, and/or maintaining the kind of reputation in the community that facilitates the seeking of funds or of facilities when and if they are needed. For instance, the question of whether a town wants a large medical facility or whether a medical facility can expand in a given town may be related to the townspeoples' perceptions of the quality of the service the facility is perceived as providing. Among other factors that we do not like to talk about much are malpractice suits. It may be that the degree to which a patient perceives himself or herself to be satisfied with care is a determinant of whether or not that patient later initiates suit.

A second set of factors has to do with patient rather than provider success. No matter how good the diagnosis and no matter how good the treatment, there are very often some things that the patient will have to do as part of the care process. The physician wants to maximize the chances that any prescribed regimen or any prescribed treatment is actually going to be followed and the chances that patients will return for follow-ups when they are supposed to.

I would now like to discuss some rather interesting studies which relate to those factors that appear to affect patients' satisfaction with medical care. After reviewing these studies, I would like to raise questions for further research and study. These are areas that we do not know much about but which, if we knew more about, would enable us to design our systems to provide more patient satisfaction, with the concomitant benefits just discussed.

The first thing we might look at are the dimensions or range of the medical care experiences which concern people. Zyzanski et al.,[1] in a study entitled "Scale for the Measurement of 'Satisfaction' with Med-

ical Care" examined the factors that seem to affect people's satisfaction with the health care system. They developed three categories of factors related to patient satisfaction. These are shown in Figure II.

FIGURE II.

"Satisfaction" with Medical Care

Professional Competence

People do not know how many mistakes doctors really make.
Today's doctors are better trained than ever before.
Doctors rely on drugs and pills too much.
Given a choice between using an old reliable drug and a new experimental one, many doctors will choose the new one.
When doctors do not cure mildly ill patients, it is because the patients do not cooperate.
Doctors can help you both in health and in sickness.

Personal Qualities

You cannot expect any one doctor to be perfect.
A doctor's job is to make people feel better.
Doctors act like they are doing you a favor by treating you.
Many doctors treat the disease but have no feeling for the patient.
Doctors should be a little more friendly than they are.

Cost/Convenience

You may have to wait a little, but you can always get a doctor.
It is easier to go to the drugstore for medicine than to bother with a doctor.
In an emergency, you can always get a doctor.
Doctors try to have their offices and clinics in convenient locations.

Source: Stephen J. Zyzanski, Ph.D., Barbara S. Hulka, M.D., and John C. Cassel, M.D., "Scale for the Measurement of "Satisfaction" with Medical Care: Modifications in Content, Format and Scoring," *Medical Care*, July 1974, Vol. XII, No. 7.

Under the heading of professional competence, they included items that reflect patients' perceptions of the physician's current knowledge, training, and judgement. The second category had to do with the physician's personal qualities, as opposed to professional qualities. Hence they looked for the degree to which physicians show interest, empathy, and concern for the patient; they are really affective factors. The third category of factors were less professionally or personally related but have to do with the costs and convenience of the system.

Now, one might look at this array of factors as describing the range of feelings or predispositions that consumers bring to any given

medical care situation because, all of us, based on our past experiences or even lack of experience, have some general feelings about the system. We have general feelings about what physician's personal competences are, what their professional competences are, how they treat us, and what the cost and convenience aspects of the care system are. These predispositions may directly bear on the post-purchase satisfactions a patient feels after a given episode of treatment. For example, it is likely that those who complain the most about quality of care are those who brought to the care situation some rather negative feelings about the physician's professional competence. Those who complain about the affective dimension of any given aspect of care may be those people who have brought with them some pre-existing feelings about the degree to which physicians are (or are not) personally interested in patients.

Other uses of these factors could include attempting to identify those people who are likely to join a prepayment plan or HMO, versus

FIGURE III

Evaluation of Medical Care in the Area

Continuity of Care
- A good doctor for the whole family
- Able to see the same doctor
- Regular medical exam
- Doctor interest when well

Cost of Care
- Doctor care at reasonable cost
- Reasonable hospital cost
- Care for the poor
- Good care for the elderly

Availability of Services and Facilities
- Prescriptions day and night
- Medical advice from druggist
- Ambulance or rescue squad
- Transportation to doctor

Availability of Quality Medical Care
- Good care for children
- Good hospitals nearby
- Medical care in emergencies
- Specialists available

Source: John E. Ware, Jr., W. Russell Wright, Mary K. Snyder, and Godwin C. Chu, *Consumer Perceptions of Health Care Services; Implications for the Academic Medical Community*, The Rand Paper Series.

those people who would rather use a fee-for-service organization. Perhaps these or similar dimensions might even be used to identify those people who are likely versus those not likely to follow a given treatment regimen, holding other factors constant. This particular study concentrated on developing the scales and really did not look at the relationship between the scales and post-purchase satisfaction so we might proceed next to a study that looked more specifically at that relationship.

Ware et al.,[2] looked at the dimensions people use to describe medical care. Figure III shows the dimensions that resulted: continuity, costs, availability of services and facilities, and availability of quality medical care.

This set of dimensions also may provide some input to understanding how satisfied people are with their care after receiving it because availability factors certainly should affect people's expectations. For instance, if a patient felt that there was not quality medical care available in the area he or she might be satisfied with a lower level of personal care or a less satisfactory personal experience than if

FIGURE IV.

Beliefs about Physician Behavior

Thoroughness
- Examines carefully
- Thorough Physical examination
- Careful exam before diagnosis
- Lets you tell him everything

Surgical Prudence
- Surgery only if necessary
- Explains why surgery necessary

Humaneness
- Treats you with respect
- Keeps record of your problems
- Explains when and how to take Rx
- Posts medical diplomas
- Orders necessary tests

Use of the Health Care System
- Uses specialist when in doubt
- Checks on allergies
- No unnecessary drugs
- Uses area health services

Preventive Measures
- Discourages drinking
- Discourages smoking
- Helps with family problems
- Gives advice about food

Female Health Care
- Gives Pap test annually
- Examines breasts annually

Use of Medication
- Often gives shots
- Frequent antibiotics

Information Giving
- Explains side effects of drugs
- Explains medication
- Explains nature of illness
- Tells how to avoid illness

Source: John E. Ware, Jr., W. Russell Wright, Mary K. Snyder, and Godwin C. Chu, *Consumer Perceptions of Health Care Services: Implications for the Academic Medical Community*, The Rand Paper Series.

he or she felt that the quality of care available in the area was very high.

Ware et al.,[3] also developed several factors relating to patients' beliefs about physician's behavior and then looked at these in relationship to satisfaction. Figure IV shows these belief factors.

Here we are getting down to specific factors and specific behaviors in a treatment or a diagnostic episode. For instance, you note thoroughness—examines carefully, gives a thorough physical, gives a careful exam before diagnosis, plus tells you everything; humaneness—treats you with respect, keeps record of your problems, explains when and how to take the prescription; information giving—explains side effects of drugs, explains medication, explains nature of illness, and tells how to avoid illness. Of course, not every episode of treatment or diagnosis is going to include all of these behaviors, but every episode is going to include some of them; this study identified some of the relationships between positive evaluations of physicians on these dimensions and the level of satisfaction.

This study considered frequency of use of the care system—these were self reported behaviors; heavy users seem to have more favorable perceptions than light users of both the physician-patient relationship and the quality of service. Now one can interpret a finding like this in several ways: one could argue that experience causes satisfaction; heavier user have certainly had more experience, or one can say that heavier users usually have more problems and thus are much more in need of help. Therefore, they tend to accept and weigh positively *any* episode that appears to be of any help.

Comparing the determinants of satisfaction between discretionary care and required care is interesting. Changing physicians and coming in for check-ups are behaviors unrelated to actual health status but were related very strongly to patients' perceptions of physician behavior and patients' beliefs as to whether they were getting from the physicians what they wanted. This study found that the more thorough the physician and the more the physician gave information, the more likely patients were to be satisfied. The lower the physician was rated on these items, the more likely patients were to change physicians. But when behavior is nondiscretionary among people who went to the physician because they were actually sick, the relationship between satisfaction and these particular dimensions of physician behavior was not nearly as strong.

These results suggest a rather intriguing possibility: *The various dimensions consumers use to evaluate their medical care may change with the severity of the condition for which they are seeking care.* Specifically, where care sought is either preventive or for treatment of a very "mild" illness, the more salient determinants of satisfaction may be the affective or interpersonal relationship components of the experience. But, where care is being sought for a more

severe illness, then the focus changes and the perceived medical competence of the physician becomes the more salient determinant of satisfaction. But, there is an important *caveat* in this statement: Some (or even many) patients may have little confidence in their ability to evaluate a physician's medical competence. These patients will then tend to focus on affective measures (in which they have more confidence), using these measures as predictors of the physician's medical competence. Then, in both cases, the focus is on the affective components of the patient's experience, although for different reasons. So, we are beginning to concentrate on some things that do not necessarily relate to "professional" measures of the quality of medical care. If a physician were looking at the quality of diagnosis and the quality of treatment, the physician would look at factors such as symptoms discovered, processes by which they were discovered, and treatment. Here we are concentrating on an entirely different dimension: what a medical care consumer thinks is a satisfying episode. We are concentrating on factors relating to affective behavior—the relationship between the physician and the patient. Two studies, among many, illustrate the importance of affective factors in consumer satisfaction with pediatric care.

The whole question of pediatric care itself gets more important as society considers HMO's and prepayment in general. It is usual in many families that parents are more concerned about their children's medical care than they are about their own. Children are usually on a schedule of regular visits to the pediatrician while parents' visits are usually limited to those occasions when somebody is sick (except for women, who have routine gynecological examinations). Thus the perceived quality of and satisfaction with the pediatric care may be a very important determinant of whether the family signs up with a given HMO. So it is important to know what affects satisfaction with pediatric care.

Korsch et al.,[4] studied an emergency clinic at a Los Angeles hospital. These investigators looked at walk-in visits encompassing a variety of pediatric problems. They wanted to examine the relationship, if any, between doctor and patient, (in this case really between doctor and parent, invariably mother) and satisfaction with the visit. Their procedure involved tape recording the whole visit and category-coding everything that was on the tape for later computer analysis. They also interviewed the mothers to determine their feelings about the quality of the care their children received. The findings were very interesting.

First of all, they found that satisfaction was not related to any demographic or diagnostic factors. They found, however, that there were some rather strong relationships between satisfaction with the visit and satisfaction with the care. These relationships fell strongly into the affective domain. Figure V summarizes the findings.

FIGURE V.

Pediatric Outpatient Emergency Clinic

Parent Satisfaction NOT related to

Parent social class
Education
Doctor seen
Visit length
Specific Diagnosis

Satisfaction Decreased with

Unfriendliness and uncommunicativeness of physicians
Disconfirmation of expectations to learn cause of disorder
Failure to give expected treatment (X-ray, injection, medication, etc.) or failure of cure

Source: B. Korsch, E. Gozzi, V. Francis, "Gaps in Doctor-Patient Communication," *Pediatrics* 42, pp. 855.

Overall, 76 percent of the mothers interviewed were satisfied with the care their child received, but examination of the various dimensions of the relationship between mothers' feelings and their satisfaction were very interesting. Among mothers who rated the physician as friendly, 83 percent were satisfied. Among those who rated the physician as business-like, 60 percent were satisfied, and among mothers who believed that the physician understood their concern for the child, 83 percent were satisfied. Among those who believed the physician did not understand their concern, only 32 percent were satisfied. Eighty-six percent of those who liked their physician's communication skills were satisfied while only 25 percent of those who did not were satisfied.

There was also some relationship between the care or treatment expected versus the care received and the level of satisfaction. If the mother expected that the child would get medicine but the child did not get medicine, only 51 percent of the mothers were satisfied. Among those who expected reassurance but did not get reassured, only 36 percent were satisfied. Mothers who were not told the cause of illness or its diagnosis and who wanted more explanation than they were given were not satisfied.

When the investigators analyzed the tapes, they found that, by and large, the interaction between physician and mother was controlled by the physician. Physicians did not listen to mothers very much, and they tended to use medical jargon wherever possible. Not listening to mothers may be a mistake, for several reasons. First, the tapes indicated that mothers were pretty good diagnosticians. Most often, they had a reasonable idea of what was wrong with the child.

Second, mothers tended to blame either themselves or environmental factors that were at least somewhat under their control. Mothers, for example, would feel it was their fault that the child caught a cold as a result of being out in the rain, that they should not have let the child out without a raincoat, rubbers and hat.

As a result of guilt, mothers were anxious about diagnosis and treatment, and they tended to restrict the child's activities after the physician's visit more than the physician suggested. Perhaps this latter finding is as much a reflection of mother's perception that the physician did not really care that much as it is a reflection of her guilt. Mother said, "Doc, do I have to keep the child in?," and the doctor said "Oh, it doesn't matter very much, let him out." And what really went through the mother's mind is "Well, this doctor doesn't seem to be very much interested in the whole episode, and therefore I really ought to keep the child in."

These findings suggest that there is considerable room for improving post-purchase satisfaction with pediatric care, for all of the reasons mentioned at the beginning of the talk.

An interesting longitudinal study was conducted in a pediatric ambulatory clinic in Boston in the years 1964–1968. Patients who used the Boston Children's Hospital Emergency Clinic were divided into three groups: an experimental group to whom comprehensive care was offered; an attention control group who got the same interviews as the comprehensive care people but who didn't get comprehensive care; and a non-attention control group who were not interviewed during the project, but only at the beginning and end. This study measured attitudes before and after the project's life and also measured some of the quantifiable dimensions of care. Figure VI shows some of the salient findings.[5]

There seems to be a relationship here between how long the consumers have to wait for care and how satisfied they are with that care. The control group had a much higher proportion of dissatisfied consumers, and the measures taken suggest that people in the control groups had to wait much longer than the comprehensive care group. This illustrates in part that people are pretty reasonable in their expectation.

One of the reasons for trying to increase patient satisfaction is to get your patients to return when they need to. One could argue whether it is necessary for people to use a physician in all of these situations or not, but the data suggest that, over-all, the group receiving comprehensive care felt they would use a doctor at the clinic for each of the situations listed to a much greater extent than the people who did not receive comprehensive care. So comprehensive care does enhance the chances of repeat visits. It also can build a feeling that the physician should be used in a wider selection of situations.

Adults are also sensitive to some of the same factors in their own

FIGURE VI

Pediatric Ambulatory Clinic—
Comprehensive Care

	Experimental (Comprehensive Care)	Contact Control
Percent Dissatisfied because of Long Wait	6	23
Mean Waiting Time in Waiting Room	7 min.	35 min.
Mean Waiting Time in Examining Room	9 min.	18 min.
Percent of Mothers Saying they would use a Doctor . . . For		
Child temperature = 103	66%	37%
Child Physical Exam	49	25
Family Diarrhea	47	30
Immunizations	43	14
Chronic Disease	43	12
Child Poisoning	24	7
Child Needs Stitches	15	2

Source: Joel J. Alpert, M.D.; John Kosa, Ph.D.; Robert J. Haggerty, M.D.; Leon S. Robertson, Ph.D.; and Margaret C. Heagarty, M.D., "Attitudes and Satisfactions of Low-Income Families Receiving Comprehensive Pediatric Care," *American Journal of Public* Health 60 (March 1970): 499–506.

care. A study of women's perceived preferences for male versus female gynecologists again shows the importance of the affective dimension.[6]

This study included a sample of several hundred women who were given a self-administered questionnaire. Some findings are shown in Figure VII. Among the questions asked was "Would you prefer a female gynecologist?," and this was studied in relation to whether the respondent considered gynecological exams more or less difficult than other types of medical exams. Women who said "yes, a gynecological exam is more difficult than other kinds of exams" were more likely to say they would prefer a woman rather than a man as their gynecologist. (The population studied were predominantly using male gynecologists because there simply were not any women available.) The second part of Figure VII looked at the question "Do you think your gynecologist is understanding of women's psychological problems?", and again there was a relationship between the perception that the gynecologist was or was not understanding of these problems and the preference of a woman versus a man. This study indicated that there was no relationship between the age of the woman, her education, or any other demographic factors and preference for male or female gynecologist. There was a

FIGURE VII.

Preference for Male vs. Female Gynecologists

For Me, a GYN exam is

	More Difficult	Same	Less Difficult
Prefer Woman GYN	47%	49%	4%
DO NOT Prefer Woman GYN	37%	58%	5%

My GYN is Understanding of Women's Psychological Problems

	Yes	No Opinion	No
Prefer Woman GYN	47%	23%	30%
DO NOT Prefer Woman GYN	58%	14%	28%

Source: Esther Haar, M.D., Victor Halitsky, M.D., and George Sticker, Ph.D., "Factors Related to the Preference for a Female Gynecologist," *Medical Care*, Vol. 13 No. 9, Septermber 1975.

very weak relationship between satisfaction and patients' belief as to whether the gynecologist was professionally competent or not. Again, however, it is the affective dimension that came out most strongly.

Women who found the exam difficult felt that a woman gynecologist would be more sensitive, more understanding and more willing to deal with gynecological problems. Similar comments did not come from women who felt that they did not have any particular problems with gynecological examinations. What does this mean? It's obviously an indication or a suggestion that gynecologists could pay more attention to the affective part of the physician-patient relationship. Gynecological care is probably second only to pediatric care as a determinant of whether a family will use a given HMO.

Finally, let me report on a more general study of the relationship between satisfaction and use of either a fee-for-service physician or a comprehensive health maintenance program. This study, conducted in an "Eastern city," looks at some of the dimensions and measures of satisfaction between those who were subscribers to Blue Cross/Blue Shield (and thus had their own personal or family physician) and those using a prepaid practice. Figure VIII presents some of the main findings.[7]

The comprehensive health plan really begins to look at institutional care on a whole range of dimensions. For virtually every dimension, from warmth to personal interest to privacy to time, the prepaid plan seems to come out a little more poorly than the fee-for-

FIGURE VIII.

Reports on Satisfaction with Medical Care Among Prepaid Practice and Non-prepaid Practice Subscribers

Measures of Satisfaction	Blue Cross (N = 354) %	Prepaid Practice (N = 356) %	p*
Proportion of respondents receiving services in past year	73	70	NS
Percentage very satisfied among respondents receiving services in past year:			
With amount of privacy in doctor's office	92	86	NS**
With the amount of time the doctor spends with you	82	74	<.05
With the doctor's concern about your health	85	70	<.001
With the doctor's warmth and personal interest in you	83	67	<.001
With the amount of information given to your about your health	81	64	<.001
With the doctor's training and technical competence	93	78	<.001
With the doctor's friendliness	89	79	<.001
With friendliness of nurses, receptionists, etc.	84	81	NS
With quality of medical care received	88	77	<.001
With adequacy of office facilities and equipment	93	84	<.001
With the doctor's willingness to listen when you tell him about your health	86	78	.05

*Statistical significance computed by the χ^2 statistic using the .05 criterion for statistical significance.

**<.07

Richard Tessler, David Mechanic "Consumer Satisfaction with Prepaid Group Practice: A Comparative Study," *Journal of Health and Social Behavior*, Vol. 16, 1 (March 1975): 99.

service option. These findings seem to be related to action. During the time period of the study, 6 percent of the study population switched from the comprehensive prepaid plan to Blue Cross/Blue Shield—and only 1 percent switched from Blue Cross/Blue Shield to the comprehensive plan.

This study also suggests that inertia kept the *switch rate* out of the prepaid plan from being even higher. Now 6 percent doesn't sound like a very high attrition rate. But, this particular plan was marketing through organizations, business organizations, and universities. In other words, rather than selling the plan to people individually, it would have to be sold to the firm or other organization, and that before anyone in the organization signs up for this plan, they are likely to find out whether any of their co-workers are signed up and what their experiences have been. Thus, in a population with organizational connections, the satisfaction of the individual who is enrolled in the plan and can influence other people becomes more important.

Where do we go from here? There are some interesting issues that are worth further exploration, especially for prepaid plans and HMO's. First of all, we have to recognize that the decision is a family decision since it is likely that the whole family will have to participate to make it worthwhile to join. This means that studies of family decision-making, and there are many of those, might be useful to predict the relative influence of husband, wife, and children on the decision to join or not to join. If there are children, as I said before and I really think it is worth emphasizing, it is likely that the pediatric aspect of care will be quite critical to the decision. As we would say in marketing, if it is not the *determinant* attribute, it is probably pretty close to it.

Second, importance of the affective component should be recognized, especially in pediatrics where we are dealing with parents who appear to have some guilt feelings when they bring their children in. We do not know as much as we should know about how guilt is manifested during a particular episode of diagnosis or treatment.

Also, I think we need to try and link in one population and in individual people the following: their general expectations for medical care, their specific expectations on any given visit, and their perceived satisfaction as a result of both the general and specific expectations and as a result of exactly what the provider did and how he or she acted. We really want to know what activites on the part of the provider predict satisfaction in different situations and, importantly, from the health care standpoint, what predicts proper home care and follow-up. If we are concerned about system efficiency, we really have to be concerned about what cuts down unnecessary visits and what brings people in soon enough so that they

can be treated economically, both for themselves and for the system.

Way back in my drugstore days, we used to buy from a firm that had a very interesting slogan which said, "There is no magic in advertising that will overcome the absence of merchandising." If one translates that slogan into medical care terms, it really means that no matter how good you are at attracting patients, you are not going to keep these patients and you are not necessarily going to keep them healthy unless you understand what it is that satisfies them about their care.

This is a two-way process in the sense that there are opportunities for providers to modify their behavior so as to increase patient satisfaction. There are also, I believe, worthwhile opportunities to work with patients so that, first, their expectations about care become more realistic; second, their ability to evaluate care also becomes more realistic; and third, their interaction with physicians becomes more satisfying. Maybe some of you saw Sidney Harris' column in last night's paper: "A doctor I've been seeing has been complaining about the skyrocketing cost of malpractice insurance. I asked how many times in the thirty years of practice he'd been sued. 'Not one,' he admitted. 'Do you ascribe this to your superior skill and talent,' I asked. 'I guess not,' he shrugged; 'just lucky.' 'Just lucky my foot,' I said. 'I'll tell you why you haven't been sued, even when you've made mistakes. It's because you're one of the few doctors who don't try to play God.' 'What do you mean?' 'I mean you level with patients, you tell them what they want and need to know, you don't pretend to be infallible, you try to treat them like intelligent human beings and they appreciate it.' " Again we see the relationship between the affective component and perceived satisfaction with treatment.

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