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Doctor–Patient Communication and Patient Perceptions of Service Quality in Hospitals from Faridabad and Gurgaon

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Abstract

Service quality and effective doctor–patient communication are critical determinants of patient satisfaction and healthcare outcomes. This study examines how demographic and institutional factors influence patients' perceptions of hospital service quality and communication practices in Faridabad and Gurgaon. Using primary data collected from 507 patients across public and private hospitals, the study employs cross-tabulation and Chi-Square analysis to assess associations between service quality perception, marital status, family dependents, region, gender, age, and hospital type. The findings reveal statistically significant associations between marital status and service quality perception, notable age-based and institutional differences in doctor–patient communication, and consistently higher satisfaction levels in private hospitals. Younger and unmarried patients exhibit greater quality orientation, while older patients and public hospital users report relatively lower communication satisfaction. The study highlights the need for differentiated service strategies, improved communication training, and patient-centered care models to enhance healthcare service delivery across diverse patient segments.

Keywords: *Service Quality, Doctor–Patient Communication, Patient Satisfaction, Hospital Management, Healthcare Services*

1. Introduction

Healthcare service quality has emerged as a central concern for hospital administrators, policymakers, and healthcare practitioners. Beyond clinical outcomes, patients increasingly evaluate hospitals based on interpersonal communication, responsiveness, empathy, and overall service experience. Doctor–patient communication, in particular, plays a decisive role in shaping patient satisfaction, treatment adherence, and trust in healthcare systems. In rapidly urbanizing regions such as Faridabad and Gurgaon, the coexistence of public and private healthcare institutions presents varied service experiences. Differences in infrastructure, staffing patterns, patient volume, and management practices may significantly influence patient perceptions. Furthermore, demographic factors such as age, marital status, gender, and family responsibilities shape expectations and evaluations of healthcare services. This study seeks to empirically examine how these demographic and institutional factors influence patient perceptions of service quality and doctor–patient communication in hospitals of the study area.

Service quality in healthcare is a multidimensional construct encompassing technical competence, interpersonal behavior, accessibility, and communication effectiveness (Dagger et al., 2007). Previous studies have demonstrated that patient satisfaction is strongly linked to communication clarity, empathy, and time spent with physicians (Ha & Longnecker, 2010). Demographic characteristics such as age and marital status significantly influence healthcare expectations. Younger and unmarried patients tend to adopt a consumer-oriented approach, placing greater emphasis on efficiency, transparency, and communication (Meesala & Paul, 2018). Conversely, older patients often value emotional reassurance and personalized interaction, and dissatisfaction arises when these needs are unmet (Hojat et al., 2011). Institutional factors also play a critical role. Private hospitals generally outperform public hospitals in perceived service quality due to lower patient loads, better infrastructure, and stronger service orientation (Bleich et al., 2009). However, communication gaps persist even in private healthcare settings, underscoring the need for continuous quality improvement (Doyle et al., 2013). Despite extensive research, limited empirical work compares service quality clusters and communication perceptions across demographic and institutional variables within the NCR region. This study addresses this gap.

2. Research Methodology

2.1 Research Design

The present study adopts a **descriptive and analytical research design**. The descriptive component enables systematic documentation of patients' perceptions regarding service quality across public and private hospitals, while the analytical component facilitates examination of relationships between demographic variables and service quality perception clusters. Such a design is appropriate when the objective is to identify patterns, associations, and differences within a defined population without manipulating the study environment (Kothari, 2004; Malhotra & Dash, 2016). This design has been widely used in healthcare service quality studies in India to understand patient satisfaction, service delivery gaps, and perceptual differences across regions and hospital ownership structures (Andaleeb, 2001; Rao et al., 2011).

2.2 Data Collection

The study primarily relies on primary data, collected through a structured questionnaire developed after an extensive review of existing healthcare service quality literature. The questionnaire comprised close-ended questions designed to capture patients' demographic profiles and their perceptions of service quality dimensions. Data were collected from 507 patients, of which 251 respondents were from Faridabad and 256 respondents were from Gurgaon, covering both public and private hospitals. Respondents were approached at hospital premises after availing healthcare services, ensuring that perceptions reflected recent service experiences.

Primary data collection through structured questionnaires is considered reliable for measuring service quality perceptions in healthcare settings, particularly in developing country contexts like India where patient feedback plays a crucial role in healthcare evaluation (Andaleeb, Siddiqui & Khandakar, 2007; Chahal & Kumari, 2012).

2.3 Sampling Technique

A stratified convenience sampling technique was employed for the selection of respondents. Initially, the population was stratified based on hospital location (Faridabad and Gurgaon) and hospital type (public and private) to ensure adequate representation across key strata. Within each stratum, respondents were selected using convenience sampling based on accessibility and willingness to participate. This approach allowed the study to capture heterogeneity in patient perceptions across regions and healthcare delivery systems while remaining feasible under time and operational constraints. Stratified sampling enhances representativeness, while convenience sampling is commonly adopted in hospital-based studies due to practical limitations in accessing patients (Kothari, 2004; Kumar, 2019). Similar sampling approaches have been used in Indian healthcare service quality studies where access to a comprehensive patient sampling frame is limited (Chakraborty & Majumdar, 2011; Gupta & Rokade, 2016).

2.4 Tools of Analysis

The collected data were coded, tabulated, and analyzed using **Statistical Package for the Social Sciences (SPSS)**. Both descriptive and inferential statistical tools were applied to fulfill the study objectives.

The following statistical tools were used:

- **Cross-tabulation**: To examine the distribution of service quality perception clusters across demographic variables such as age, gender, marital status, region, and hospital type.
- **Pearson Chi-Square Test**: To assess the existence of statistically significant associations between categorical variables, particularly demographic characteristics and service quality clusters.
- **Likelihood Ratio Test**: Used as a robustness measure to validate the Chi-Square test results, especially in cases of smaller expected cell frequencies.
- **Linear-by-Linear Association**: Applied to identify trends and directional relationships between ordinal variables.

These tools are widely used in healthcare and social science research to analyze categorical data and test associations between variables (Field, 2018; Pallant, 2020). Their application is well documented in Indian hospital service quality research, particularly for examining patient perception and satisfaction levels (Rao et al., 2011; Gupta & Rokade, 2016).

2.5. Research Analysis

The study used a descriptive and analytical research design based on primary data collected through a structured questionnaire from patients in public and private hospitals, selected using stratified convenience sampling. Data were analyzed using SPSS, employing cross-tabulation to describe distributions and inferential statistics—including Pearson's Chi-Square test, Likelihood Ratio test, and Linear-by-Linear Association—to examine associations and trends between demographic variables and service quality perception clusters.

3. Results and Discussion

3.1 Service Quality Clusters and Marital Status Across Hospital Regions

The distribution of patients' service quality perceptions across marital status and hospital regions. The results indicate noticeable differences in how married and unmarried patients evaluate hospital service quality in both Faridabad and Gurgaon. Across both regions, unmarried patients constitute a larger proportion of the Quality-Oriented Patients cluster, accounting for 148 out of 234 patients in this category. In contrast, married patients are more evenly distributed across the Quality Seekers and Acceptable Patients clusters. This pattern suggests that unmarried patients exhibit higher service expectations and are more inclined to critically assess hospital service dimensions such as responsiveness, communication clarity, and procedural efficiency. From a behavioral perspective, unmarried patients are often younger, more independent in healthcare decision-making, and more exposed to digital and consumer-oriented service standards. Prior studies have shown that such patients tend to adopt a consumer mindset toward healthcare services, leading to higher scrutiny and stronger quality orientation (Dagger et al., 2007; Meesala & Paul, 2018). Table 1.

Table 1**:** *Distribution of Service Quality Clusters Across Marital Status and Regions*

Service Quality Cluster	Marital Status	Faridabad	Gurgaon	Total
Quality Seekers	Married	30	32	62
	Unmarried	36	32	68
Acceptable Patients	Married	36	35	71
	Unmarried	39	33	72
Quality-Oriented Patients	Married	48	38	86
	Unmarried	62	86	148
Total		**251**	**256**	**507**

3.2. Association Between Marital Status and Service Quality Perception

To statistically validate the relationship between marital status and service quality perception, a Chi-Square test was conducted. The results are shown in Table 2. The Pearson Chi-Square value of 7.459 with a p-value of 0.024 indicates a statistically significant association between marital status and service quality perception at the 5 percent level. The Likelihood Ratio confirms this association, while the Linear-by-Linear Association further demonstrates a significant directional trend. These results confirm that marital status plays a meaningful role in shaping patient perceptions of hospital service quality. Unmarried patients are significantly more likely to fall into the Quality-Oriented cluster, whereas married patients tend to evaluate services as acceptable rather than exceptional. Similar findings have been reported in healthcare satisfaction literature, where family responsibilities, time constraints, and pragmatic healthcare usage influence evaluation patterns among married individuals (Alrubaiee & Alkaaida, 2011; Chahal & Kumari, 2010).

3.3. Service Quality Perception and Number of Family Dependents

Table 3 examines how service quality perception varies with the number of family dependents across regions. Patients with up to four dependents constitute the largest share across all service quality clusters, particularly within the Quality-Oriented Patients group. As the number of dependents increases beyond four, the proportion

of Quality-Oriented Patients declines sharply. This trend suggests that patients with larger family responsibilities may prioritize accessibility, affordability, and continuity of care over premium service attributes. Existing research indicates *Table 2. Chi-Square Test Summary: Association Between Marital Status and Service Quality Perception*

Statistic	Value	df	p-value
Pearson Chi-Square	7.459	2	0.024
Likelihood Ratio	7.489	2	0.024
Linear-by-Linear Association	5.196	1	0.023
Valid Cases	507		

that family burden and caregiving responsibilities significantly influence healthcare expectations and satisfaction levels (Bleich et al., 2009; Aiken et al., 2012).

Table 3. Distribution of Service Quality Clusters Across Number of Dependents and Regions

Service Quality Cluster	Number of Dependents	Faridabad	Gurgaon	Total
Quality Seekers	Up to 2	27	26	53
	3–4	30	28	58
	5–6	6	5	11
	More than 6	4	4	8
Acceptable Patients	Up to 2	22	22	44
	3–4	34	32	66
	5–6	12	12	24
	More than 6	5	4	9
Quality-Oriented Patients	Up to 2	56	53	109
	3–4	50	55	105
	5–6	7	8	15
	More than 6	2	3	5
Total		**251**	**256**	**507**

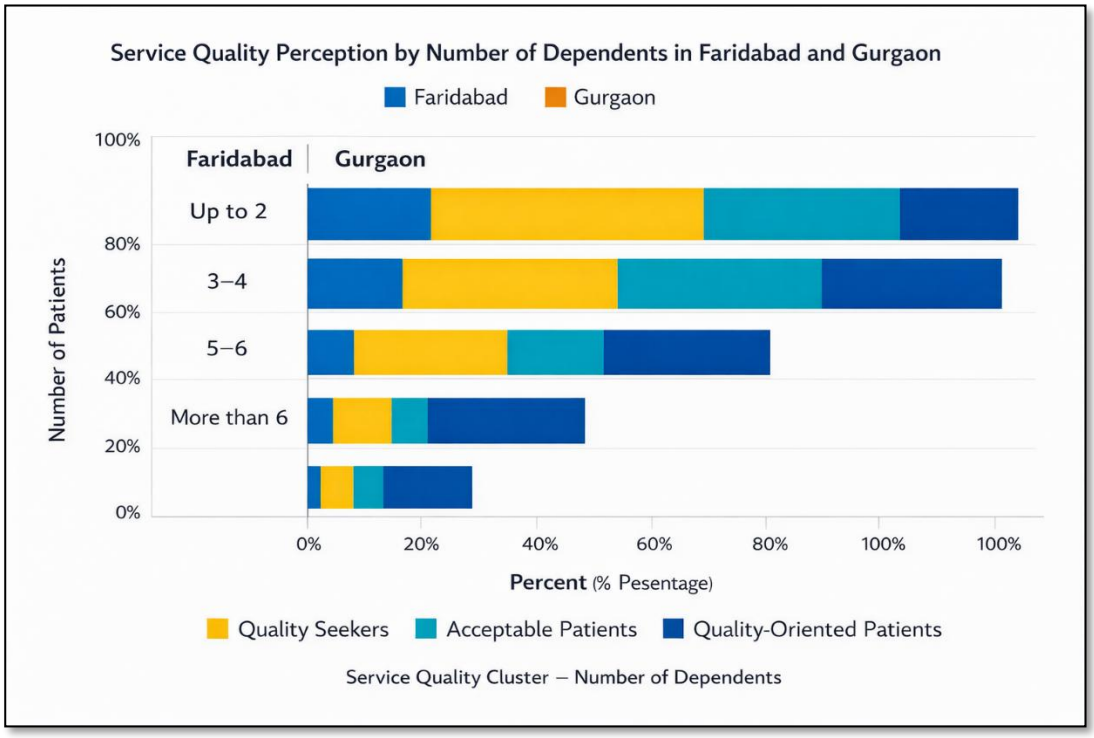

Figure 1: Distribution of Service Quality Clusters Across Family Dependents

3.4. Doctor–Patient Communication Across Regions

Table 4 presents patient evaluations of doctor–patient communication across Faridabad and Gurgaon. Overall, communication quality is rated positively, with 58.4 percent of patients reporting either Excellent or Good experiences. Gurgaon marginally outperforms Faridabad in both categories, suggesting relatively better communication practices. However, nearly one-fifth of respondents across both regions report Poor or Very Poor communication, indicating a persistent communication gap. Prior studies emphasize that ineffective doctor communication can negatively impact patient trust, adherence, and perceived quality of care (Street et al., 2009; Ha & Longnecker, 2010).

Table 4. Overall Doctor–Patient Communication Ratings by Region

Communication Quality	Faridabad	Gurgaon	Total
Excellent	65	72	137
Good	78	81	159
Average	54	58	112
Poor	34	30	64
Very Poor	20	15	35
Total	**251**	**256**	**507**

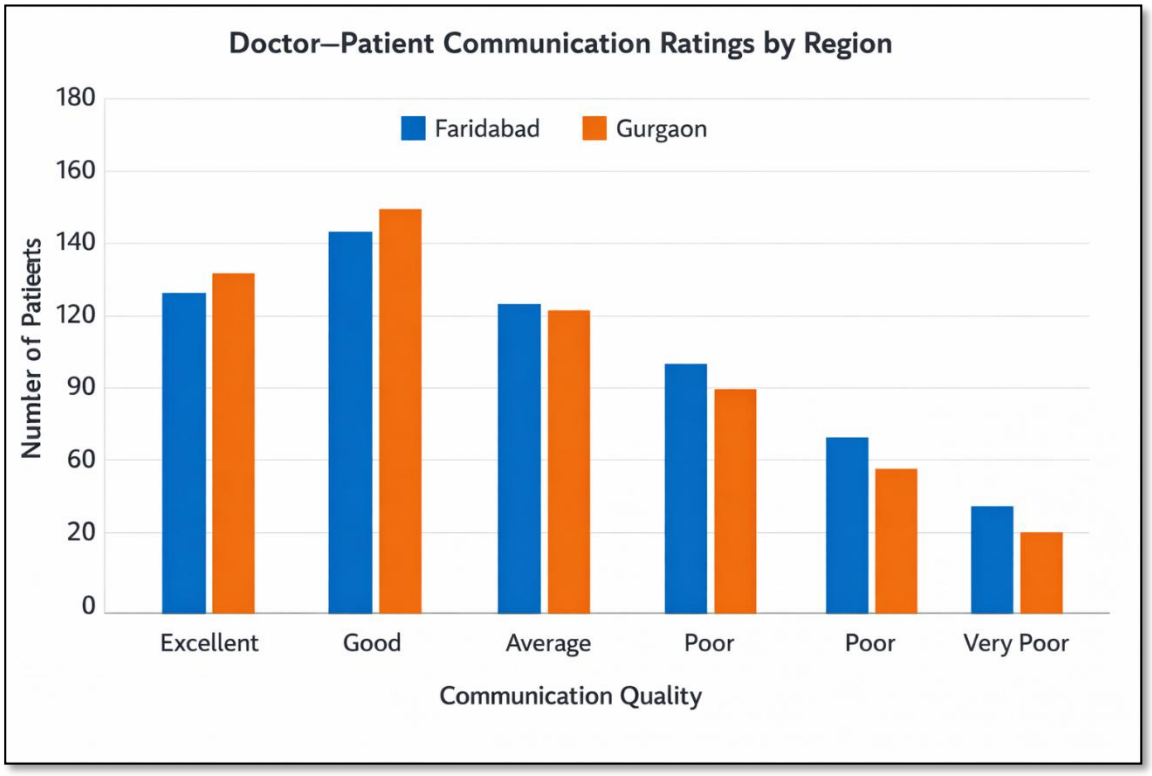

Figure 2: Regional Comparison of Doctor–Patient Communication Quality.

3.5. Gender, Age, and Institutional Differences in Doctor Communication

Doctor–patient communication perceptions are largely **gender-neutral**, with males and females reporting nearly identical satisfaction levels. This suggests that communication quality issues are systemic rather than gender-specific. Age-wise analysis reveals that younger patients (18–45 years) report significantly higher satisfaction levels, while older patients (46 years and above) exhibit greater dissatisfaction. This aligns with evidence that older patients require more empathetic, slower, and family-inclusive communication styles, which are often lacking in high-volume hospital environments (Hojat et al., 2011; Levinson et al., 2010). Private hospitals consistently outperform public hospitals across all positive communication categories, highlighting the role of consultation time, training, and service orientation in communication outcomes.

3.6. Satisfaction With Doctor and Nursing Communication in Private Hospitals

Satisfaction levels with doctor and nursing communication in private hospitals across both regions. Nearly 69 percent of patients report being Very Satisfied or Satisfied with doctor communication, while approximately 65 percent express similar satisfaction with nursing care. Nevertheless, the presence of neutral and dissatisfied responses indicates room for improvement, even in private healthcare settings. Prior literature emphasizes that sustained investment in soft-skill training, empathy development, and workload management is essential to maintain high communication standards (Aiken et al., 2012; Doyle et al., 2013).

10. Conclusion

The study demonstrates that patient perceptions of service quality and doctor–patient communication are shaped by a complex interaction of demographic and institutional factors. While private hospitals and younger patients report higher satisfaction, older patients and public hospital users experience notable communication gaps.

Addressing these disparities through targeted communication strategies and patient-centered care models is essential for improving healthcare service quality and patient trust.

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