The Doctor-Patient Relationship: Participation, Compliance and Satisfaction

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Abstract

This conceptual paper aims to contribute to the services marketing literature by investigating the doctor-patient relationship through the theoretical lens of relationship marketing and the co-creation paradigm. With a clear link between satisfaction, health outcomes and the adherence to therapeutic suggestions proposed in the literature, patient satisfaction is likely to benefit not only individual health service providers but potentially the health care system as a whole. Hence, this paper conceptualises the drivers of such satisfaction, with a particular focus on the relationship between participation, compliance and satisfaction within the medical encounter, leading to a conceptual model for future empirical research. The paper provides relevant measurements and concludes with a research agenda.

Keywords: doctor-patient relationship, participation, compliance, satisfaction, health services
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Introduction

Increases in competition amongst health care services have led organisations to consider marketing strategies and alternative methods to maintain patients and increase the number of patients they serve (O’Conner and Shewchuck, 1995). To achieve this objective, patient satisfaction with the health service provision, namely the quality of the interaction with the doctor, has been described as a critical factor to consider (Hausman, 2004). However, given the association between satisfaction, health outcomes and the adherence to therapeutic suggestions (DiMatteo, Taranta and Friedman, 1980; Bartlett Grayson, Barker, 1984), the relevance of satisfaction appears to go beyond benefits for individual health service providers. A lack of adherence, or non-compliance, can lead to death and significant health care costs (Mojtabai and Olfson, 2003). Another concept shown to reduce health care costs and increase health outcomes is patient participation (Vernarec, 1999).

The identification of customers as ‘partial employees’ (Bowen, 1986), interlinked with the co-creation paradigm, has recognized the customer as a means for value enhancement and to increase productivity (Lovelock and Young, 1979), thereby including the customer in the creation of the service delivery. For customers to positively experience intangible services, Bowen (1986) acknowledges that equipping service providers with interpersonal skills can influence satisfaction. In addition, building long-term relationships with customers is considered essential for the economic survival of most service firms today (Berry, 1995; Heskett, Jones, Loveman, Sasser and Schlesinger, 1994). As such, the physician is the key in maintaining and enhancing relationships with patients.

While individual studies have considered satisfaction, compliance and participation individually in a services context, calls to empirically examine the concept of participation and its influence on satisfaction have essentially gone ignored (Ennew and Binks, 1999; Kellog, Youngdahl and Bowen, 1997). Hence, this paper aims to (1) develop a conceptual framework explaining the relevance of doctor and patient participation in encouraging patient compliance and satisfaction, as well as (2) establish a relevant research agenda. It contributes to the existing literature by integrating separate services and relationship marketing concepts into a consistent framework, which is complemented by an outline of relevant measurements to be used in a health context. This paper is structured as follows. The medical encounter will first be introduced, followed by a brief literature review relating to the concepts of participation, compliance and satisfaction. This will lead to the development of a conceptual framework before the paper concludes with a research agenda.

The Medical Service Encounter

Medical service is defined by Orava and Tuominen (2002, p. 677) as “a health care service intended to influence a person’s health, directly or indirectly, through procedures executed by medically educated personnel”. It is characterised by a high level of interaction between the doctor and patient (Lovelock, 1979), and has been shown to include (1) one-on-one interactions (2) frequent encounters with the same physician (3) intimate exchanges (4)
variability across encounters and (5) the requirement of patient cooperation to achieve successful health outcomes (Hausmann, 2004; Johnson and Zinkhan, 1991; Waitzkin, 1985).

As this service context is high in credence, patient evaluations are complex (Alford and Sherrell, 1996; Shostack, 1987), which implies that the relationship between the service provider and consumer is key (Crosby, Evans and Cowel, 1990). As the doctor-patient relationship is often ongoing, it lends itself to strong emotional bonds being formed, subsequently driving the patient to evaluate the service based on feelings and emotions (Shemwell, Yavas, Bilgin, 1998). This bond may be the result of information sharing between the patient and physician (Carman, 2000; Johnson and Zinkham, 1991). In highly participative services, outcomes emerge from the collaboration of service employees and customers (Zeithaml, Parasuraman and Berry, 1985). Hence, the quality of the service is in part dependent on the quality of the interpersonal collaboration of the relationship.

**Participation**

Discussions related to the relevance of collaboration in the service delivery process are mirrored in the co-creation paradigm, which describes value as being created by cooperating with service providers (Claycomb, Lengrick, Hall and Inks, 2001). Two streams in the marketing literature, namely services marketing and relationship marketing, have provided prolific discussion and insight into co-creation, leading to its inclusion in the service-dominant logic (Vargo and Lusch, 2004a; Bendaupi and Leone, 2003). In this context, the consumer is described as a ‘partial’ employee, helping to create the service, therefore ensuring their own satisfaction (Bitner, Faranda, Hubbert, and Zeithaml, 1997). Unless the customer acts, the service provider cannot effectively deliver the service outcome (Bitner et al., 1997). Participation has been defined as “the degree to which the customer is involved in producing and delivering the service” (Dabholkar 1990, p. 484). Hence, a purchase involves both consumption and production on the part of the customer (Bowen, 1986). Different types of participation have been identified as; firm production, joint production and customer production (Meuter and Bitner, 1998). The medical encounter involves joint production where both the doctor and patient provide input into the service creation and delivery. Hence, unless the patient participates, for example through information exchange by disclosing descriptions of symptoms, the doctor cannot effectively deliver the service outcome (Firat, Dholakia and Venkatesh, 1995). While much of the medical literature considers participation solely in the context of decision making, participation is here acknowledged as going beyond a single process in the medical encounter, consisting of an active verbal statement or response which has the potential to significantly influence the doctor-patient interaction and the doctor’s behaviour (Street and Millay, 2001).

**Compliance**

While compliance also relates to an action on part of the patient, it is distinct to participation in that it is a passive response rather than a proactive involvement of the customer in the services context. Compliance has been described as the extent to which the patient follows their doctor’s orders (Trostle, 1988). The examination of compliance is important as non-compliance results in billions of dollars being lost each year in health care costs (Mojtabai and Olfson, 2003) and has been linked to a number of societal problems, such as obesity and smoking. In efforts to increase compliance, studies have shown that manipulating and trying to alter patient behaviours and attitudes have failed (Grandinetti, 1998). While the medical literature has suggested educating the patient on health benefits of medications and the risks.
of non-compliance (Levins, 1998), such education attempts have also been found as unsuccessful (O’Conner and Shewchuck, 1995).

Antecedents of compliance were identified by Dellande, Gilly and Graham (2004), who were seeking to determine and relate providers’ characteristics and consumers’ attributes to compliance and outcome. Their study extended Bowen’s (1986) work in the area of participation by determining that the facilitating variables of participation are in fact also the antecedents of compliance. The antecedents and nature of the relationships among the variables are that role clarity leads to ability, which in turn leads to motivation (Dellande et al, 2004). Other practices which have been found to facilitate compliance are extensive interaction and reimbursement for compliance (Giuffrida and Gravelle, 1998).

However, as these practises are too time-consuming and costly, the doctor-patient interaction instead has been identified as a means to improve compliance (Lutfey and Wishner, 1999). Multiple studies using social cognitive theory have shown that interpersonal interactions between the doctor and patient elicit increased compliance (Hughes, 2003; Loden and Schooler, 2000). This may be due to the social function of the exchange where overtime the patient grows fond of the doctor and wishes to please them by following their directions (Menon, Deshpande, Zinham and Perri, 2004). Nevertheless, the study of Hausman (2004) contradicts this, as her results did not confirm a direct effect of interpersonal interaction on compliance. In an earlier study however, Hausman (2001) found the interpersonal elements of open communication and participative decision-making to lead to improved compliance. While Hausman (2001) suggests patient participation to be more effective in achieving compliance than communication, further research is required to link participation and compliance with satisfaction. Furthermore, the perceptions of the doctor’s active participation within the medical encounter remains to be investigated.

**Satisfaction**

Satisfaction is an important outcome of a service encounter, as it is related to customer retention and positive word of mouth (Goodwin and Gremler, 1996). The literature describes it as a multi-dimensional construct, including satisfaction with the process and satisfaction with the outcome (Brown and Swartz, 1989, Gronroos, 1984). The former relates to the manner in which the service is delivered, while the latter is an evaluation on what the customer actually receives. This distinction is particularly relevant in a health context. As a patient’s ability to evaluate technical quality has been questioned (DiMatteo and Hays, 1980), satisfaction is included in this study as a multi-dimensional construct; to allow patients to assess satisfaction with the process and outcome of the encounter. This inclusion has been made due to the medical encounter having high levels of credence, making it difficult for patients to evaluate the service. As such, it is known that patients express satisfaction with different aspects of care (Kane, Maciejewski and Finch, 1997), with a focus on the interpersonal elements of the relationship, particularly social bonds with the doctor, to evaluate their satisfaction of the service (Shemwell, Yavas and Bilgin, 1998).

**Conceptual Framework**

Reciprocal self disclosure has been found to contribute positively to commercial exchange satisfaction (Crosby, Evans and Cowles, 1990). Similarly, receiving positive expression may be perceived as the employee’s, in this case the doctor’s, eliciting effort which has had a
strong impact on customer satisfaction (Bitner, Booms and Tetreault, 1990; Bitner, Booms and Mohr, 1994). Hence, doctor participation is expected to increase patient satisfaction. Furthermore, it is anticipated that when one party openly communicates, the other party will respond similarly. Hence, relationship building in the form of smiling and positive verbal utterances of support is suggested to lead to the patient responding in the same manner. Furthermore, if the doctor divulges information, this may lead to the patient becoming actively engaged in the encounter and start to participate in their treatment. Thus, we propose doctor participation to foster patient participation.

When considering participation on the patient side, it has been established that customers will only participate in a relationship if they anticipate benefits from that relationship (Ford, 1990). As they anticipate benefits, even if they are not satisfied with the outcome, they may still maintain the relationship as they may enjoy the interpersonal elements of the relationship, helping to satisfy the patient through the way in which the service is delivered. Also, participation has been identified as an antecedent of satisfaction (Ennew and Binks, 1999), thus leading to this link to be included in the conceptual framework.

The interpersonal elements of support and encouragement the doctor provides are likely to increase compliance. This is supported by earlier studies that have shown that caring and friendliness is positively linked to increased compliance behaviour (Korsch, Gozzi and Francis, 1968), as are interpersonal elements (Giuffrida and Gravelle, 1998). In line with this stream of thought, doctor participation is expected to increase compliance, as is patient participation (Hausmann, 2004). Compliance, in turn, has been found to directly influence satisfaction (Dellande et al., 2004). Attributes of the doctor-patient relationship and outcomes of the service exchange are presented in Figure 1.

The model is developed from the patient’s perception. Given that patient satisfaction reflects intentions and actual future use of the service, it is important to research the relationship from the patient side (Woodside, Frey and Daly, 1989). As the patient’s ability to evaluate technical quality has been questioned (DiMatteo and Hays, 1980), satisfaction has been included as a multi dimensional construct to allow patients to assess satisfaction with the process and outcome of the encounter as is known patient’s express satisfaction with different aspects of care (Kane, Maciejewski and Finch, 1997).

**Figure 1. Conceptual Framework**
While the measurement of all variables included in the conceptual framework can be based on existing scales, various levels of refinement will be required to ensure meaningful measurement in the health services context. The two concepts of participation require the most significant change, using Bettencourt’s (1999) development of a customer voluntary performance measure, originally developed for a retail context. The measurement of satisfaction as proposed here requires a differentiation between satisfaction with the process and outcome, with existing scales requiring some refinement (Oliver and Swan, 1989 a,b). Hausman’s (2001) measure of compliance is proposed for use in related future studies, as it has previously successfully been employed in a medical service context. Additionally, while these are not included in the model, potential moderating variables might taken into account, including demographic variables, condition severity, health knowledge (Jayanti and Burns, 1998) and relationship orientation (Palmatier, Scheer, Evans and Arnould, 2008).

Conclusions and Research Agenda

The importance of the interpersonal elements in services selling has been recognised as a source of competitive advantage in relationships. However, the knowledge of participation influencing satisfaction is scant. While individual studies have considered satisfaction, compliance and participation individually in a services context, calls to empirically examine the concept of participation and its influence on satisfaction have essentially gone ignored (Ennew and Binks, 1999; Kellog, Youngdahl and Bowen, 1997). This article proposes that the effect of participation by both parties involved in the medical encounter will influence compliance behaviour and psychological outcomes in the form of satisfaction. It contributes to the existing literature by integrating separate services and relationship marketing concepts into a consistent framework, which is complemented by an outline of relevant measurements to be employed in future health services research.

Based on the conceptualisation introduced in this paper, future research should empirically test the influence of participation on satisfaction, particularly taking into account how the doctor’s level of participation influences the patient’s participation and, in turn, satisfaction. Furthermore, with researchers either focusing on compliance or participation, the interplay between these two related yet distinct concepts requires further investigation. In particular, researchers may test whether compliance or participation have a stronger effect on satisfaction; to determine whether doctors should focus on one or the other. Similarly, further research should investigate the affect of satisfaction on compliance, to determine whether patient’s satisfied with the medical encounter comply. The inclusion of additional outcome measures, such as word-of-mouth behaviours may also be confirmed in this context.

In addition, future research should determine the importance of the service evaluation from a process or outcome perspective in the medical encounter, for example by examining which dimension of satisfaction impacts on relevant outcome variables, such as retention or word of mouth. Further research should also endeavour to gather data from both the doctor and patient as research on the service encounter has almost entirely focused on the role of the employee (Kelley, Donnelly and Skinner, 2001), and thus on one side of the service encounter. Furthermore, attempts should be made to consider whether the consumer wishes to engage within a relationship with the service provider and how such need for a relationship moderates the conceptual model provided in this paper.
References


