Inter-Relationship Among the Extent of Past Consultations, Recommendation, Satisfaction, and Loyalty in Patient-Doctor Relationship: An Empirical Study

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〈Abstract〉

The present study examines the relative roles of external recommendations and internally felt satisfaction in influencing patient loyalty to a doctor. It establishes that recommendations do result in preliminary loyalty formation in the patient to the doctor, but only until the formation of own experiences; the significance of external sources of recommendation in the determination of patient loyalty becomes insignificant thenceforth. Implications for the doctors are that they should strive at fostering bonds of emotional attachment in their present patients so that they become strongly loyal and spread positive word-of-mouth which could result in the doctor getting new patients as well. Probable extensions of this research are also discussed later in the paper.

Keywords: Patient-doctor relationships, recommendations, patient's prior experiences, own satisfaction development, mediation, patient loyalty, India.

INTRODUCTION

Maintaining customers and sustaining their satisfaction are crucial for all service firms no matter what the particulars of the firm are. The key to a firm's success invariably lies in its ability to retain a base of loyal customers. Dissatisfied customers do not come back, and when they go to the competitor they take their inner-circle with them, too. It is therefore of utmost importance for those in the business of service production and delivery to build and maintain a strong base of loyal customers. It is evident from the existing literature that customer satisfaction leads to customer loyalty (Heskett *et.al.,* 1994) and customer loyalty in turn leads to significant increases in profits. A reduction in customer defection of 5% has been found to boost profits by 25% to 85% in various organizational settings (Reichheld and Sasser, 1990). Loyalty

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generates profitability over time as it reduces operating cost per customer and increases customer spending over time; loyal customers provide free advertising by way of positive word of mouth, too.

Over time, the loyalty construct has been treated by scholars in different ways. Loyalty is the feeling of attachment to or affection for a company's people, products, or services (Jones and Sasser,Jr., 1995). Loyalty is conceptualized as the relationship between the relative attitude toward an entity (brand / service / store / vendor) and repeat patronage (Dick and Basu, 1994). Loyalty to the service provider is conceptualized in terms of repeat patronage, switching behavior, word-of-mouth recommendations and complaints. i.e., a loyal customer is one who will continue to purchase a commercial service, will recommend its provider to others, will not switch to another provider, and will not complain (Shamdasani and Balakrishnan, 2000). Oliver (1999) argued that consumers could become loyal at each attitudinal phase relating to different elements of the attitude development structure and theorized that they become loyal in four phases: in the cognitive sense first (cognitive loyalty); then in the affective sense (affective loyalty); still later in the conative sense (conative loyalty); and finally in the behavioral sense (action loyalty). In the first phase of loyalty development, *the cognitive loyalty,* the brand attribute information available to the consumer indicates that one brand is preferable to its alternatives. This stage is also referred to as loyalty based on brand belief only. *Affective loyalty* is the second phase of loyalty development at which a liking or attitude toward the brand has developed on the basis of cumulatively satisfying usage occasions. The next phase of loyalty development is the *conative loyalty* (behavioral intention) stage, as influenced by repeated episodes of positive affect toward the brand. Conation, by definition, implies a brand-specific commitment to repurchase. Conative loyalty, then, is a loyalty state that contains what, at first, appears to be the deeply held commitment to buy. *Action loyalty* is the last phase whereby the intentions are converted to actions. There are many studies in the loyalty literature that specifically address one or more of these phases.

One of the best weapons that marketers have ever invented to resist commoditization is to boost brand loyalty. Brand Loyalty is defined as a positively biased emotive, evaluative, and/or behavioral response tendency toward a branded, labeled or graded alternative or choice by an individual in his capacity as the user, the choice maker, and/or the purchasing agent (Sheth & Park, 1974). According to this definition,

loyalty could be operationalized as the repeat purchasing frequency or relative volume of same brand purchasing (Tellis, 1988) and loyal customers as those who re-bought a brand, considered only that brand, and sought only brand-related information (Newman and Werbel, 1973). In summary, loyalty is like a deeply held commitment: to patronize a preferred product/service consistently in the future despite situational influences and marketing efforts exerted by the competitors to cause switching behavior (Oliver, 1999).

The role of relationship marketing in loyalty formation is apparent: theories of relational exchange that emphasize the benefits of close, long-term relationships are receiving increasing attention among marketing researchers and practitioners (Berry, 2002). Exchanges vary along a continuum from discrete to relational (Keith *et al.,* 2004): discrete exchanges are characterized by a short term orientation, limited communications, and interactions limited to buying and selling issues, with the associated competitive behavior among the individual parties engaged; relational exchanges are characterized by extensive communications, commitment, and a long term orientation. The emphasis on relationship marketing is based on the premise that relationship marketing practices result in close relationships between a seller and a buyer and lead to higher and prolonged loyalty (Anderson, 1995). In services marketing, the relationship between the service provider and the customer is central to the perceived value of the service that is delivered and hence loyalty. The present paper aims to answer whether the changing relationship between the service provider (doctor) and the customer (patient) from an impersonal level to a personal level enhance the customers' perception of value and re consultation behavior.

RECOMMENDATIONS AND LOYALTY IN HEALTHCARE

Recommendations are influential sources of information. Recommendation was the method adopted for selecting a new service supplier in about 50% of the cases studied by Keaveney (1995). Source of patient recommendation is a topical area often mentioned in the healthcare marketing literature (Barnes and Mowatt, 1986; Hoerger and Howard, 1995; Lupton, Donaldson, and Lloyd, 1997). Reports by Cody (2000) say that 46% of dental patients attributed their selection of the dentist to recommendation. Patients identify their doctors based on the three important factors of ability, availability, and affordability.

Judgmental information about doctors' ability, availability, and affordability is gotten from the various sources of information available: both personal and impersonal. A patient may be recommended by others like family members, relatives, friends, or colleagues to take treatment from a particular doctor. Sometimes a doctor may recommend the patient to another doctor who is an expert in a specific field. Scholarly and popular medical journals do inform and influence patients' decision to consult particular doctors and or clinics. Though legally banned in many parts of the world, quasi advertisements and advertorials are important influences upon patient loyalty. Customer dependence on the source of recommendation is not unexpected in a high involvement and credence type service like that of healthcare. The patient has to necessarily rely heavily on extraneous cues and the process dimension of service delivery to evaluate and form opinions about the healthcare service. This is also a strategy adopted by patients to avoid the potential risk when they are uncertain about: what they want; which purchase will best match goals; and/or what adverse consequences might occur if the consultation is made. As Cox (1967) theorized long back, most consumers are risk adverse although the extent of risk perceived varies in degrees among them.

Crane and Lynch (1988) found from their research that the most frequently used cue by majority of patients in selecting doctors was personal referral. The primacy of personal sources of recommendation could be appreciated with the 'tie strength relationship model' proposed by Brown and Reingen (1987) which categorizes the recommendation sources according to the closeness of the relationship between the decision maker and the recommendation source. A strong tie occurs if the source is someone who knows the decision-maker personally but the tie gets weaker with the degree of impersonality involved in the relationship. The model also proposes that weak-tie sources which are more likely to have a greater expertise conducts information, whereas strong tie sources which are more likely to have a personal touch with the decision maker conducts both information and influence. Strong tie sources combine high degrees of credibility and personal touch simultaneously. Recommendations in addition to influencing the first consultation decision of the patient have the supplementary effect of preliminary loyalty formation in the patient, too. Lupton *et al.* (1997) found that consultations triggered by recommendations, may these be personal or impersonal, increased patronization behavior of the patients than in the case of self initiated consultations.

ROLE OF PERSONAL EXPERIENCE DEVELOPMENT IN FURTHERING LOYALTY

This much is established wisdom. The motivation to review the literature up to this point came from a few insights that managed to escape the eyes of one of the co-authors of this paper while he was undertaking his doctoral research (Salgaonkar, 2004). A re-reading of the workbooks prepared during the exploratory stage of his research gave us enough hints to think that source of recommendation's influence upon loyalty formation is, if anything, merely short lived. It might remain significant until a few, say 2 or 3, consultations are made, but thenceforth becomes far less a predictor of loyalty. The aforesaid study consisted of longitudinal interviews of patients wherein they were interviewed three times; the second one after a gap of one month from the first one; and, the third one after a gap of another two months. The first phase of interviews identified a judgmental sample of sixty respondents all of whom were first time visitors of the doctor. Many of them aired influences that resulted in their first visit, which encompassed almost in full the multitudes of information sources available. Personal and impersonal sources were cited nearly evenly, a chi-squire test revealed. Comments were such as: 'well, I think I ought to be patient for at least a reasonable amount of time before getting cure since it's my closest friend who suggested this doctor's name; you know, she won't cheat me'; 'I can't think my sister would have been saved of her asthma but for this doctor, I won't have been here but for her advice, and I do see good times ahead'; 'You know, my previous doctor gave me a recommendation letter to this doctor, otherwise I wouldn't have got a chance even to meet him, and I need to trust him'; 'This doctor is well-known, he appears in televisions and newspapers regularly, and he must definitely be good'; and so on. Many of these voices were found as moderated in the second phase of interviews conducted among the same respondent group, which could probably be explained by the intensifying influence of psycho-demographic factors upon the consultation decision criteria. But only a few of the patients had finally left the doctor. This reached the tumult when the third phase of interviews was conducted: many of the patients had already discontinued the treatment while a significant number of the remaining ones, among whom included even those who passionately cited recommendation sources as the cause of their first visit and the reason for their continued adherence, cited 'moments of

truth' or purely interpersonal experiences evolved in their interaction with doctor. It was inferred from the informal talks with some of those patients who switched the services of the doctor by the third phase of the interviews that the effect of recommendation in their cases could not offset the negative effect produced by the doctor's inability to strike a personal chord with them. In fact, when the doctor was unapproachable and did not have the required 'chemistry', patient switching was noted even while there were tangible improvements in the disease condition.

These imply that patients might be generally willing to linger for a subjectively determined minimum period of time before finally switching over to another doctor for the resumption of treatment: that is, for a particular disease condition and given the patient psychology, there could be an expected minimum trial period until which the patient waits even if no cure is forthcoming. While it is not that those patients who approach a doctor without any sort of recommendation will de patronize soon after the very first consultation itself unless the expected cure is readily gotten, the aforesaid minimum period of waiting time could be less for them than their counterparts prejudiced by recommendations. Given the compelling instances of evidence harnessed from our previously mentioned exploratory study (Salgaonkar, 2004), it is quite straightforward to propose that the presence of recommendations heavily influences the nature of patient patronization during the few initial consultations, although it ceases to remain as a significant factor in the longer course. That is, in course of time, with an enriching consultation history, patients begin to give more weightage to the satisfactory or dissatisfactory outcomes borne out of their own personal interactions with the doctor causing to minimize the promotional role of external sources of recommendation in continued consultations.

Actually, the power of personal experiential judgments of patients in determining their satisfaction has already been noted in the literature. According to Morath (2003), consumers, through their purchasers of healthcare services, are demanding new methods, new metrics, and higher standards of accountability and are turning up the heat on providers to act with the consumer perspective in mind. Present-day patients advocate continuous and consumer-driven healthcare delivery and have the least tolerance for the doctor's failure to engage them. A study by Roter *et al.* (1998) concludes those doctors who were trained in non-verbal communication skills, those who used significantly more target skills, those who used more facilitation in their visits, those who asked more

open-ended questions, and those who used more emotional talk had more patients who shared more personal and disease related information. Such patients tended to use more positive talk and spread more positive word of mouth compared to other patients. They judged their doctors as sounding more interested, friendly, and responsive and were noted to be more satisfied in general. Relational exchanges between a patient and the doctor favorably influences the patient's perception of the benefits received, may be because it permits information to be exchanged at a more tacit plane not possible otherwise. Equipped with this added information base, the doctor may understand the patient and the disease condition in a richer context enabling him to tailor the service to more precisely meet the patient's expectations. Similarly, the patient also becomes more realistic in his expectations so that the chance of a disconfirmation is comparatively lower. The net result is that both parties work together to resolve the problem in harmony (Morgan and Hunt, 1994).

Thus, we have this situation: irrespective of whether personally satisfied or not, patients continue to exhibit loyalty (evidenced through the intensity of consultations in the past) due to the influence of external sources of recommendations during the early few consultations; i.e., when the number of past consultations is low. However, when the number of past consultations reaches a critical maximum, loyalty begins to become almost exclusively a matter of the patient's own satisfaction and gets only insignificantly swayed by the influence of recommendations from external sources whatsoever.

The more familiar a product or service becomes by frequent patronization, the more positive becomes its image, thus forming an additive feedback loop. In a similar study on tourists, it has been established by one of the co authors of the present paper that there is a positive association between the number of past visitations to a destination and destination attachment, which is a construct in environmental psychology literature that stands equivalent to patient satisfaction in health care (George, 2004). If attachment is not formed within the timeframe of a few visitations, the tourist stops to visit that destination. Also, belief-updating perspectives in predicting the effect of prior experience on the relationship variables is supported in the marketing literature in general (Aaker, 1991).

Continuing from the discussion so far, we have the following hypotheses:

H1: *There is a positive association between the recommendation received by a patient about a doctor and the*

patient's preliminary loyalty to the doctor.

H2: *There is a positive association between the extent of past consultations and the development of patient's own satisfaction with the doctor.*

H3: *The effect of recommendation upon loyalty formation as given by H1 becomes insignificant with the development of patient's own satisfaction with the doctor.*

The model emerging from the hypotheses is given below in Figure 1.

As per the model given, the recommendations from external sources could lead to a series of consultations, which is nothing but the preliminary stage loyalty (see the dashed line C' to loyalty). This is though unsustainable. The patient's own satisfaction is given in the model as a mediator, the ripening which is vital for sustainable loyalty.

A mediator, also known as an intervening or process variable, is a variable that fully or partially accounts for the relationship between an independent variable and a dependent variable. In the present model, own satisfaction represents a path through which a major effect of the independent variable (IV) reaches the dependent variable (DV). If the postulation that the mediating variable is causally related to the outcome is correct, something that substantially changes the mediating variable will, in turn, change the outcome (Baron& Kenny, 1986). Complete mediation is the case in which the intensity of past consultations no longer affects patient loyalty after the mediator has been controlled and so path C' in the model becomes zero. Partial mediation is the case in which the path from IV to DV is reduced in absolute size but is still different from zero when the mediator is controlled. The practical significance of a mediating relationship like this is that the independent variable becomes a less relevant predictor of

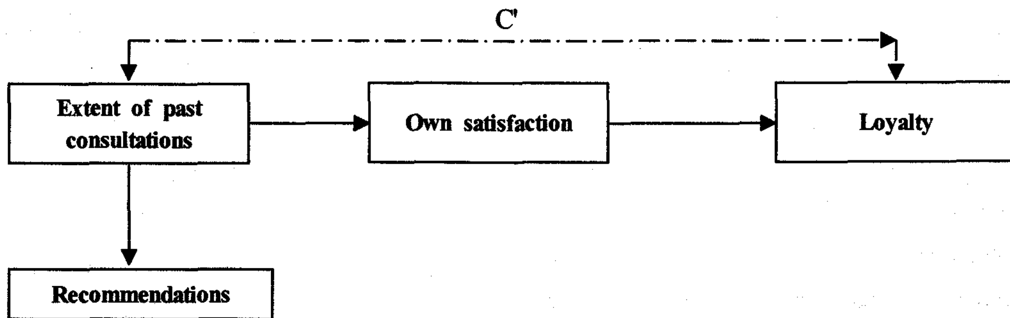

Figure 1 Model depicting the hypothesized relationships

dependent variable as the mediating variable becomes significant (Asher, 1976; James & Brett, 1984).

THE RESEARCH METHOD

The study was taken up in two phases. The first phase of the research was an exploratory qualitative study involving data collection from the patients via personal interviews. In all, personal interviews with 55 patients were conducted with the objective of finding out how patients choose a doctor. The list of patients for personal interviews was prepared by randomly taking names and addresses of patients from the doctors' appointment book, which almost all the doctors maintain. The personal interviews were conducted with the patient respondents at their residence or at their place of work as per their convenience. Meeting the patients at the doctor's clinic was deliberately avoided. This was necessary to avoid any bias in responses that could have been cropped up in the mind of the respondents, were the interviews taken at the clinics. The findings derived from the personal interviews served as valuable inputs for designing a pilot questionnaire, which was later improved and administered to test the hypotheses generated.

Questions were asked to unearth the nature of patients' consultative relationships with the doctor in the past, both in terms of the number/frequency and the intensity/duration, as well as satisfactory or otherwise outcomes of such relationships. It was the consensus among the researchers that both frequency and duration were to be considered in any measure of the richness of past consultations even though the extant research in general compromised for number/frequency alone. Towards this, to each respondent, questions were asked about the total number of times consultations were made so far, the year and month of the first consultation, and the average duration of a consultation. Dividing the total number of consultations with the number of months across which these consultations were made and multiplying this figure with the average duration of a typical consultation yielded a faithful measure for the intensity of past consultations variable. The data collected was normalized before further analysis. In addition, respondents were asked if their first visit to the doctor was self initiated or was prompted by any type of recommendations. Own satisfaction of the respondents with the doctor was measured across a 5 point likert scale in response to the statement 'I am personally satisfied with the doctor'. The measure for loyalty construct and its operationalization has been borrowed from

Shamdasani and Balakrishnan (2000). This scale has been operationalized from the definitions of service loyalty found in the research by Bitner (1990) and Dick and Basu (1994) and has demonstrated reasonable levels of validity and reliability. The four items from this scale included in the present questionnaire are: 'I will continue to consult my present doctor in future'; 'I will not switch to another doctor in future'; 'I will recommend my doctor to my friends and family members'; and, 'I will not complain about my doctor to others'. Following Churchill (1979) second and fourth item statements were reverse coded.

The composite questionnaire thus developed was pre tested with a few patients mainly to ascertain whether the wordings and phrases used in the questionnaire conveyed the same meaning as the researcher wanted to convey and also to check whether there was a smooth flow of questions. There were no major difficulties encountered by the respondents and as such only minor changes were to be incorporated. The questionnaire administration was restricted to patient respondents taking treatment for chronic ailments such as cardiac problems, asthma, and diabetes from doctors having private practice only. These ailments are such that they cannot be treated completely but can only be managed through the rest of the patient's life. That is, the patient would be required to repeatedly consult a doctor for regular check up and proper management of the ailment. It was felt appropriate to choose the chronic ailment segment (cardiac, asthma, and diabetes) for the study to control the variation that could be accounted in terms of the protraction of the ailment.

The patient respondents were identified by taking their names and addresses from the appointment book maintained by doctors. Only those doctors having private practice and having a professional ranking of 'A+' or 'A' were contacted to get the details of the patients. Selection of 25 doctors was done based on a Must See List (MSL)[1] of two reputed pharmaceutical companies. It was initially decided to take an average of 10 patients per doctor from these 25 doctors, which would make about 250 patient respondents. This was proposed in order to get a fair representation of the population. However some doctors refused

1) Must See List (MSL) is a list containing the names, addresses, specialization, and category (A+, A, B etc.) of the doctors. This list is given to the Medical/sales representatives of the companies to aid them in their day to day work. The categorization of A+ and A class is generally given by the companies based on the number of patients seen by a doctor.

to give the appointment book and disclose the name and address of their patients and as such the researcher had to depend on the names and addresses obtained from 19 doctors making the total of 250 patients. The questionnaire was administered to patients by meeting them personally at their residence or place of work as per their convenience and the questionnaires got filled. In all 246 patient respondents were approached with the questionnaire (the others could not be met despite repeated visits). Some patients refused to answer, yet some others returned the questionnaire mostly incomplete, which left the researcher with 194 completed and usable questionnaires.

DATA ANALYSIS AND INTERPRETATION

The data collected through the 194 filled in questionnaires was tabulated and analyzed making use of the functionalities of the SPSS-13 data analysis package.

First, an independent sample t-test was

Table 1

Group Statistics

	recommend	N	Mean	Std. Deviation	Std. Error Mean
past_consultations	1.00	51	2.1613	.56913	.07969
	2.00	53	2.9411	.54814	.07529

Table 2

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means						
									95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
past_consultations	Equal variances assumed	.207	.650	-7.117	102	.000	-.77974	.10956	-.99704	-.56243
	Equal variances not assumed			-7.112	101.409	.000	-.77974	.10964	-.99722	-.56226

performed with past consultations as the test variable and the recommendation status (No=1; Yes=2) as the grouping variable. The relevant outcome tables of the t test are shown below (See tables 1 & 2).

Since the significance value for the Levene's test is high, the results that assume equal variances for both groups are used. The results indicate that the group means of past consultations for those visiting the doctor with recommendation (2.9411) and those visiting without recommendations (2.1613) are significantly different (p<0.01). Thus, the first hypothesis is supported.

The procedure for testing the mediating role of own satisfaction is as follows (Baron& Kenny, 1986): The first step is to show that the predictor variable X is related to the outcome variable Y. If this first

Table 3

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.613[a]	.376	.370	.82274

a. Predictors: (Constant), past_consultations

Table 4

ANOVA[b]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	41.550	1	41.550	61.383	.000[a]
	Residual	69.044	102	.677		
	Total	110.594	103			

a. Predictors: (Constant), past_consultations

b. Dependent Variable: loyalty

Table 5

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	-.376	.337		-1.116	.267
	past_consultations	.787	.101	.613	7.835	.000

a. Dependent Variable: loyalty

analysis is not significant, one must stop looking for a mediated relationship. The second step is to show is that the predictor (X) predicts the mediator (M). At this stage, for M to mediate, there should at least be a correlation between X and M. If X exerts its effect through M then if one control for M, the X variable should no longer be related to Y. In other words, in the combined regression equation Y = a + b1M + b2X, b2 should emerge as statistically insignificant and b1 significant. Also, the variance explained by the model implied by the above equation should be significant, overall. The regression output tables are presented below:

(a) To prove that X predicts Y:

The above given tables (tables 3, 4, & 5) imply that the intensity of past consultations

Table 6

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.710[a]	.504	.499	.64542

a. Predictors: (Constant), past_consultations

Table 7

ANOVA[b]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	43.200	1	43.200	103.705	.000[a]
	Residual	42.490	102	.417		
	Total	85.690	103			

a. Predictors: (Constant), past_consultations

b. Dependent Variable: own_satisfaction

Table 8

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	*(Constant)*	.507	.264		1.919	.058
	past_consultations	.803	.079	.710	10.184	.000

a. Dependent Variable: own_satisfaction

predicts 37% of the variance in patient loyalty (significant at $p<0.01$).

(b) To prove that X predicts M:

The above given tables (tables 6, 7, & 8) imply that the intensity of past consultations predicts around 50% of the variance in patients' own satisfaction (significant at $p<0.01$). In addition to providing a partial proof to the mediation model, this proves the second hypothesis, H2, as well.

(c) To prove that, while controlling for M, X does not predict Y.

The above given tables (tables 9, 10, & 11) imply that patients' own satisfaction

Table 9

Model Summary

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.745[a]	.555	.547	.69767

a. Predictors: (Constant), own_satisfaction, past_consultations

Table 10

ANOVA[b]

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	61.433	2	30.716	63.106	.000[a]
	Residual	49.161	101	.487		
	Total	110.594	103			

a. Predictors: (Constant), own_satisfaction, past_consultations

b. Dependent Variable: loyalty

Table 11

Coefficients[a]

Model		Unstandardized Coefficients		Standardized Coefficients		
		B	Std. Error	Beta	t	Sig.
1	(Constant)	-.723	.291		-2.486	.015
	past_consultations	.238	.121	.185	1.968	.052
	own_satisfaction	.684	.107	.602	6.391	.000

a. Dependent Variable: loyalty

significantly mediates the relationship between past consultations and loyalty. It may be noted from the coefficients table that past consultations have become insignificant ($p>0.05$) with the introduction of own satisfaction variable. In addition, the standardized coefficient for past consultations has decreased to 0.185 from 0.613 (See table 5). Another important support to the claim of significant mediation is that the overall adjusted R^2 has increased from 0.370 (model with past consultations alone) to 0.547 (model with past consultations mediated by own satisfaction).

CONCLUSION

In healthcare, history of patient loyalty to the doctor could be traced back to ages when the family doctor was considered as the healer of the family and the whole family depended on him for its health needs and at times as regards other family matters as well. The doctor patient relationship has gradually evolved over time and has taken a business sort of outlook in a tightened market economy where loyalty of the patient (customer) to the doctor (service provider) became the deciding factor for the success of the doctor's commercial survival (Halliday and Hogarth Scott, 2000). Patients are becoming increasingly concerned about making the right healthcare choices as their burden of healthcare costs continues to escalate. For these reasons, the marketing of healthcare services has become essential for the financial survival of physicians and healthcare organizations.

A patient is a vulnerable customer due the highly credence nature of healthcare services. The patient, even after experiencing the service, is not able to judge the objective merits of the service. He does not have the technical means at his disposal to assess the quality of the service and hence relies more on other cues like recommendations. Similarly the perceived high risk level involved in the process as well as the high personal nature of the service makes many patients to rely more on the recommendation of trusted and close acquaintances such as friends, relatives, or colleagues who have directly or otherwise have impressions of the services of that doctor. Our research reveals that even in the absence of any visible symptoms of cure, patients exhibit the propensity to stick on to services of the same doctor for a relatively longer period of time than patients who choose the doctor for the first time without anyone's recommendation.

It is a crucial finding that with the development of first person experiences with

the doctor the patient begins to rely less and less upon the cues from recommendation sources and probably forms own notions of satisfactory and otherwise encounters, as well as of benefits and losses. In other words, affective bonds or emotional attachment, though not the only one, could hold a decisive key to true and prolonged loyalty. True loyalty is guaranteed if a unique chemistry of affective bond between the doctor and the patient is developed and truly loyal patents will have a far higher propensity to recommend their doctor to others, thus putting the basis of sustainable competitive advantage in the formation of such bonds. Relationship marketers should not miss this key aspect while developing their strategic marketing plans.

However, since there is a positive association between the richness of past consultations and the formation of own satisfaction (which is the quintessence of affective bonds and emotional attachment) and since the former is a great deal influenced by the recommendations, maintaining a pool of patients who would become good news ambassadors would always reward a doctor. Significant emphasis should thus be laid in holding the presently patronizing patients and making them still more loyal to attract new patients through them. It may not be easy for doctors to judge whether patients are personally satisfied with their services except by empathizing with them (Merkel, 1984). This means doctors shall have to grow beyond their traditional status as ultra-rational and cold-blooded machines. In other words, soft skill requirements of doctors should not be underemphasized when hospitals consider enhanced technological approaches to patient services management.

After this much said, the present study is not without faults. For instance, the sample selected for the study consisted of only one segment made up of cases suffering from chronic ailments like cardiac problems, asthma cases and diabetes. All these are irreversible ailments having no permanent cure but only management of the case, thereby compelling the patients to consult doctors on a regular basis. This sample was chosen for the practical reason that this would ensure a critical proportion of ‘regular’ patients in the sample, except for whom many items in the questionnaire would have become irrelevant and the stated purpose of the research would continue to remain unmet. Yet, the special nature of these diseases itself might have given risen to a relatively higher patient loyalty, say, in view of the switching costs involved. For example, during the exploratory phase of the study, many respondents apprehended that effectively communicating the treatment

history, especially those aspects of it which have not been codified and written down, to a new doctor is an uphill task. In the research design, proper manipulation checks ought to have been applied for variables such as recommendation and prior experiences to ensure that patients choose their doctors based on these variables; this however was not done due to oversight and hence remains a constraint upon the results, especially when it comes to deriving its managerial implications.

Another limitation of the study is that it tries to study the dynamics of something, viz, the development of own feelings of satisfaction in the patient, which is a cross-temporal process, with a single point measurement scheme. What would have better suited for a research of this sort is a longitudinal research design. Such a design could also have incorporated a time tested satisfaction scale like the SERVQUAL (Parasuraman *et al.*, 1988), with the measurement of patient expectations and patient perceptions of doctor's performance at two points in time. But, this is not a serious concern as the present study itself is conceived based on an attitudinal-behavioral principle and not on disconfirmation. At the same time, a longitudinal study could probably have helped us to see more clearly the difference between loyalty as mere intention and the actual behavior. Note that patient loyalty was measured for the present study as an intentional measure. The present researchers have this hunch that the gap between stated intention and actual behavior diminishes with the increase in own feelings of satisfaction.

Thus, the findings of the present study need not necessarily be applicable in toto across the varied specialties and situations where many other factors might be affecting patient loyalty. It would be naïve to assume that in all situations patient loyalty to a doctor will solely depend upon the doctor since patients are often in the middle of a consumption process, the inputs for which are gathered from different independent suppliers over which the doctor does not have direct control. Even though, the doctor merely assembles these, patients normally attribute (Folkes, 1984) the causes of all service failures to the doctor alone even if some of them occurred due to the law quality at the input stage. Also, certainly, the present findings need an almost full overhaul for them to be suitable in the emerging means of healthcare like the tele-medicine.

Having understood that recommendations play an important role in getting new patients and also that recommendations influence initial patient loyalty it becomes

necessary to know in more detail the reasons why patients recommend and how often. These reasons could be attributed to many aspects such as the personality of the patient who recommends, interpersonal factors associated with the doctor, relationship with the person to whom he is recommending, among others. Getting a grip over these motivational factors will help the doctors to frame strategies, which may be directed towards inspiring patients to recommend more patients and more often. The doctors can probably integrate these motivational factors into their healthcare Customer Relationships Management programs too.

As noted throughout, the dynamics of own satisfaction formation is the kernel of true patient loyalty, which is a dark area in the sphere of marketing knowledge. It could be partly biology and psychology that shape this; and partly those powerful discourses that are the outcomes of wider historical, political, and ideological processes themselves. While marketing can definitely create narratives, images, and brands that mediate healthcare services to the potential patient markets, how much can healthcare marketers wheedle their resources to the development of a strong sense of personal satisfaction and attachment consciousness in the present patients is still open to debates. Certainly, attachment manipulation cannot be achieved in a quick go, since it essentially reflects the slow developmental progression of individuals.

(논문접수일: 2006년 4월 29일)
(게재확정일: 2006년 8월 24일)

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