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THE IMPACT OF TRUST AND STEREOTYPES ON THE TYPE OF DOCTOR – PATIENT RELATIONSHIP
A STUDY ON POLISH HEALTH CARE MARKET

Dr Katarzyna Krot, Bialystok University of Technology, Management Department, 16-001 Kleosin,Poland
katarzynakrot@gmail.com

ABSTRACT

Purpose: *The doctor-patient relationship is a crucial element of healthcare. Literature distinguishes between four models of the doctor-patient relationship: paternalistic, shared decision making, interpretative and informed choice. Socio-economic transformations also alter the nature of this relationship. Therefore, the aim of this paper was to investigate the model of doctor-patient relationship and to identify the determinants of this relation.*
Methodology: *The study was carried out in the form on a sample of 208 students in the Podlasie Region.*
Findings: *The model of a doctor-patient relationship preferred by respondents was determined by stereotypes associated with the size of the city where medical services were provided and the gender of the physician, as well as the level of trust for the competence and integrity of the doctor.*
Originality: *Many authors emphasize that the paternalistic relationship is being replaced by the more balanced contacts between the physician and the patient. The study results show, however, that this is not so definite. Many patients still prefer to submit to the authority of the doctor (paternalistic relationship)*

Key words: model of doctor-patient relationship, trust, stereotypes

INTRODUCTION

Medical services are characterized by a high level of uncertainty and risk. Patients lack professional knowledge which would allow them to assess the quality of services obtained (Berry and Bendapudi, 2007). For this reason, they require advice which facilitates making decisions connected with the market (concerning the choice of a doctor), as well as those connected with health. Properly constructed doctor-patient relationship helps to resolve these dilemmas, but also possesses therapeutic value. Changing socio-economic conditions also alter the character of this relationship. It is worthwhile, therefore, to take a look at the model of doctor-patient relationship currently preferred. Hence, the aim of the research conducted for the needs of this article was to stipulate the preferences concerning the doctor-patient relationship and the identification of the factors affecting the character of this relationship. The research, formulated as a random survey, was conducted with 208 students of two higher learning institutions in the city of Bialystok: the Bialystok Technical University and the University of Bialystok. The article was realized as part of a research grant (no. DEC-2011/01/D/HS4/05664) financed by the National Science Center.

THE PHYSICIAN - PATIENT RELATIONSHIP

Medical services are services which the patients require but not necessarily desire and which are connected with a high level of stress and emotional commitment (Berry, Bendapudi, 2007). The doctor-patient relationships can assume many forms depending on the personal and social predispositions of the doctor and the patient (socio-demographic characteristics, professional authority of doctors, the consumerist attitude of patients, professional socialization of future doctors, the currently accepted model of medicine and health), as well as economic factors (changes in the health care system leading to the development of market mechanisms, competition).

Four models of doctor-patient relationships are mentioned by literature: paternalistic, shared decision making, interpretative and informed choice. Every one of these models is connected to a different attitude of the doctor toward the patient (Cullen, 2005). The paternalistic relationship signifies full submission of the patient to the authority of the doctor, who assumes full responsibility for treatment and its results (Szasz, Hollender, 1956). On the opposite side of the spectrum is the informed choice relationship model, in which the physician comprehensively cooperates with the patient and his family in the domains of health education, prevention, diagnosis and medical problem solving. In this relationship the doctor informs the patient about potential treatment possibilities and their effects (including side-effects), but the final decision is made by the patient. This model assumes that the patient is an equal partner in the relationship (Lagerlov et al., 1998). The third type of relationship – the shared decision making, relies on an authoritative position of the doctor, but it is the patient himself who chooses the level of engagement in the decision-making process connected to treatment, and who has the ability to influence the final course of treatment (Elwyn et al., 2000). In turn, the interpretative model assumes that the basis for meeting at the physician's office is the patient's medical history and the doctor only fulfills the role of an advisor (Eriksson et al., 2007). The essence of the physician-patient relationship is subject to dynamic changes. Researchers claim that the paternalistic relationship type, with the dominant role of the doctor, was characteristic of the past (Gruber, Frugone, 2011). Currently, this model is undergoing a transformation in favor of a more equal distribution of the treatment process control and responsibility on both partners. The relationship is, therefore, becoming more like a partnership and more focused on the patient (Hausman, 2004). In a partner relationship the patient is treated more like a customer who receives essential information from the doctor and then evaluates it and makes decisions based on his own needs (Cullen, 2005). Consumerization of health care, growing access to knowledge and education, formation of internet communities concentrated around health problems, cause the relationship between doctor and patient to undergo further changes (Laing et al., 2005). However, results of some studies show that at times the patients prefer the paternalistic model of the physician-patient relationship (Tapp et al., 2009).

The physician-patient relationship and trust

The relationship between the physician and the patient is conditional on many factors lying on both the patient's and the doctor's side, and is the result of interactions occurring between both parties at the doctor's office (Leventhal, 2008; Spake, Bishop, 2009). These factors include: the assessment of a physician's competence (Brown, Swartz, 1989), psychological comfort of the patient (Spake et al., 2003), empathy, understanding, attention and kindness

displayed by the doctor (Winsted, 2000; Ruyter et al., 1999; Gruber, Frugone, 2011), privacy and confidentiality, as well as integrity. These are behaviors which build trust. Trust could be defined as confidence and the expectation that a partner in a relationship will work toward common interests (Gilson, 2003), and that neither of the sides will ever act to harm a partner by using his vulnerable points against the other (Morgan, Hunt, 1994). This also signifies that there is a will to vest personal assets in the relationship with someone else. Trust is the result of positive images which are the outcome of previously shared interactions (Brockner et al. 1997), and the assessment of the level of credibility of a partner in the relationship.

Patients need trust at every phase of building a relationship with a physician and in every model of such a relationship. Trust is the result of the ability to build a relationship. Trust helps patients to openly speak about their problems and to take part in the co-creation of a medical service and effective treatment (Gruber, Frugone, 2011). Trust also allows the patient to believe the information related by the doctors concerning the arrived at diagnosis or treatment method. Only in cases where it is possible to ensure that the information being passed on by a credible doctor is accepted, patients will view the potential relationship as less risky. Trust also determines the atmosphere of the meeting at the doctor's office, ensuring the patient's satisfaction and loyalty, complying with advice, treatments continuation, and, what follows, faster patient recovery (Hall, 2001). Patients, therefore, look for characteristics and benefits of their interaction with a physician in order to regain trust and continue the relationship (Gruber, Frugone, 2011). Trust in a doctor is, therefore, the result of rational as well as emotional reasons. Previous positive patient experiences connected with a skillful solution of a health problem may become a source of trust. However, positive emotions, bond formation and commitment are no less important in gaining patient trust (Dobiegała-Korona, 2009). The changes which are occurring to the current physician-patient relationship do not signify the depreciation of the meaning of trust. Rather, trust is becoming a negotiable element of the relationship and depends on technical abilities, style of communication, knowledge related to the patient and the ability to prove the accuracy of medical decisions (Rowe, Calnan, 2006).

Physician-patient relationship and stereotypes

Research shows that age, gender or the nationality of a physician may influence the relationship and, in effect, the results of treatment (Shaha, Ogdenb, 2006). The study conducted by Cooper-Patrick et al. (1999) indicates that patients who visited a woman doctor assessed the consultation as more mutually active than in the case of a man. In other studies women were viewed as more focused on interpersonal relations, as showing more support and responding to the emotions of relationship partners, while men were more goal-oriented (Nicolai, Demmel, 2007).

On the other hand, McKinstry and Yang (1994) ascertained that the doctor's age has an influence on the assessment of a relationship. It turns out that while older physicians were viewed as more inclined to listen, of being more thorough and of providing a greater feeling of security, younger doctors were seen as having more up to date knowledge, being more willing to explain and clarify medical questions and preferring more informal ties. Similar results were obtained by Shaha and Ogdenb (2006). In their research they confirmed that young doctors, in the opinions of patients, have better technical skills and are more willing to investigate the emotional aspects of patients' state of health. Patients, in contacts with those

physicians, more readily accept and adhere to the recommendations of the doctor, continue treatment more willingly and show loyalty to the doctor, as well as possess greater confidence in his diagnoses.

METHODOLOGY

Studies connected with the preferred model of physician-patient relationship were mainly conducted in the 80's. For some time this area of research has been somewhat neglected, even though socio-economic conditions have changed, which means that the model of the doctor-patient relationship could have also changed. It is therefore worthwhile to return to studying this issue. Hence, the main goal of the research conducted for the needs of this article was to define the preferences concerning the doctor-patient relationship and to identify factors which influence the character of this relationship. As a result the specific objectives of this study are:

- the impact on the individual dimensions of trust (competence, integrity and benevolence) on the preferred type of doctor-patient relationship;
- the impact of stereotypes on the preferred type of doctor-patient relationship;
- determinants of the model of the doctor-patient relationship (regression model)

The main presumption of the study was to assume the patient's perspective, or to verify the relevance of factors connected to doctor trust and the way they were perceived by the patients.

Doctor trust was therefore studied as trust relating to three dimensions most often quoted by literature: competence, integrity and benevolence. Stereotypes, however, were related to the age and gender of the physician and the location of the medical practice (big city vs. small town). Realization of these goals demanded conducting primary research formulated as a random survey. This being a pilot program only 208 second and third year students of two higher learning institutions: the Bialystok University of Technology and the University of Bialystok, participated in the study. This constitutes significant limitation of the research, because of the defined socio-demographic characteristics of the study sample. Table 1 contains the characteristics of the study sample.

Table 1. Structure of the study sample

Place of residence			**Gender**		
	Number	percentage		Number	percentage
city of Bialystok	104	50,0	woman	124	59,6
village	35	16,8	man	84	40,4
up to 50 thousand	48	23,1	**age**		
50-100	15	7,2	under 25	180	86,5
100-200 thousand	2	0,9	25-35	27	12,98
200-300 thousand	4	1,9	36-45	1	0,5

Net earnings calculated per person in a household			Education level		
do 500	22	11,1	secondary	127	61,0
501-1000	62	31,3	licentiate	58	27,9
1001-1500	57	28,8	higher	23	11,1
1501-2000	28	14,1	**University**		
2001-2500	14	7,1	Technical University of Bialystok	74	35,6
above 2500	15	7,6	University of Bialystok	134	64,4

Source: self study based on research

MODEL OF THE PHYSICIAN – PATIENT RELATIONSHIP –STUDY RESULTS

The aim of the research was to define the type of doctor-patient relationship preferred by the respondents. The participants were given a choice of four short descriptions of these relationships corresponding to the four types of relationships: paternalistic, shared decision making, interpretative and informed choice. It is worth notice that the preferences of respondents are very diverse. Most people, 29% of those studied, expect a paternalistic relationship from their doctor, meaning that they declare a full willingness to submit to the doctor, in line with the conviction that "the doctor knows what he's doing" (table 2).

Table 2. Models of the physician-patient relationships

	Number	Percentage
paternalistic	60	29,0
shared decision making	55	26,6
interpretative	36	17,4
informed choice	56	27,0

Source: self study based on research results

However, slightly fewer participants (27%) expected the opposite type of a relationship, the informed choice, in which the doctor cooperates with the patient and his family informing them about various possibilities of treatment and its consequences. Over 26% of respondents decided that they prefer the shared decision making model. Slightly more than 17% chose the interpretive relationship as the preferred type of contact with their physician.

The identification of factors influencing the choice of the model of the physician-patient relationship became the next research objective. A study of literature proves that the course of this relationship is dependent upon the level of confidence placed in a doctor. The respondents, therefore, had the task of defining the level of their trust in doctors in the following spheres: competence, integrity and their trust in the benevolence and good intentions of the doctor. It turned out that most respondents declared a limited level of trust (the majority of answers state that they mainly trust or do not have a defined position, table 3).

Table 3. Level of trust in the physician-patient relationship

	Trust in competence		Trust in benevolence		Trust in integrity	
	Number	Percentage	Number	Percentage	Number	Percentage
definitely yes	6	2,9	5	2,4	10	4,8
mainly yes	148	71,1	104	50,0	105	50,5
neither yes nor no	35	16,8	68	32,7	65	31,3
mainly no	17	8,2	30	14,4	25	12,0
definitely no	2	1,0	1	0,5	3	1,4

Source: self study based on research

Previous research (Shaha, Ogdenb, 2006; Nicolai, Demmel, 2007) indicates that the model of the doctor-patient relationship is also conditioned by the attitudes and stereotypes guiding the patient concerning the gender, age and the location of the doctor's medical practice. Therefore, the respondents, given a choice: woman-man, younger-older, a big city doctor or small town doctor, were asked to indicate a person whom they most trust as a doctor. Almost 24.5% of them stated that they trust a woman doctor more than a man (table 4). For 62% the question of gender of their doctor was irrelevant.

Table 4. Physician stereotypes

	Frequency	Percentage
Gender		
I trust a woman more	51	24,5
it does not matter	129	62,0
I trust a man more	28	13,5
Age		
I trust a younger person more	29	13,9
it does not matter	96	46,2
I trust an older person more	83	39,9
Place of providing medical services		
I trust a small town doctor more	9	4,3
it does not matter	101	48,6
I trust a big city doctor more	98	47,1

Source: self study based on research results

The age of the physician does not influence the level of trust in him with almost half of the respondents (table 3). Among the others, about 40% trust older doctors more and nearly 14% younger doctors more. Slightly more than 47% of those asked declared that they have a higher degree of trust in physicians practicing in a big city than in a small town (table 4). Here as well, for almost half of the respondents the place of practice does not affect the way of perceiving the doctor.

In order to ascertain which factor explains the patients' decisions concerning the preferred type of a relationship with a physician, a multiple regression model was created. In this model „relationship type" became the dependant variable while the three determinants of trust (competence, benevolence and integrity), stereotypes based on age, gender and the place

of practicing medicine, as well as the economic and demographic variables (such as gender, place of residence and net earnings per person per household) were used as independent variables. The first phase showed that some of the factors were statistically irrelevant, therefore, an attempt to correct the model was made. In the final version the model only contains two determinants of trust: trust in the competence and trust in the integrity of a doctor, as well as the place of residence, net earnings per person per household and those variables illustrating stereotypes based on the size of the town where the practice is located and doctor's gender. The coefficient of determination was R2=0.25 while p=0.00000. A detailed model of the parameters is contained in table 5.

Table 5. The regression model

	b	**Std. error - from b**	**p**
Independent variable	3,377100	0,583063	0,000000
Stereotype based on size of city where practice is located	0,636064	0,150681	0,000039
Competence trust	-0,332449	0,133434	0,013631
Net earnings per person per household	-0,199391	0,055805	0,000454
Place of residence	-0,154898	0,064264	0,016950
Stereotype based on the physician's gender	0,189626	0,092537	0,041902
Integrity trust	-0,200877	0,114065	0,079933

Source: self study based on research results

It has been proven that the respondent preferred relationship type is determined to a greatest degree by the stereotypes connected to the size of the city where the medical practice is located (p=0.000039). The relationship type also depends on the doctor's competence (p=0.014) as well as trust in his integrity (p=0.079). Curiously, trust in the benevolence of medical personnel did not fit into the model. Demographic and economic variables, such as earnings per person per household (p=0.000454) and place of residence of respondents (p=0.016950), determined relationship type but to a slightly lesser degree.

CONCLUSION

The physician-patient relationship is a key part of providing medical services (Spake, Bishop, 2009; Gruber, Frugone, 2011). This relationship is dynamic in character and may additionally assume a different form, depending on social predispositions of the doctor and the patient as well as on economic factors. Many authors emphasize that the paternalistic relationship is being replaced by the more balanced contacts between the physician and the patient. The study results show, however, that this is not so definite. Many patients still prefer to submit to the authority of the doctor (paternalistic relationship) than to take responsibility for their medical decisions. The all-present informational chaos (available but unconfirmed knowledge provided by the media) urges patients to look for support in persons possessing professional medical knowledge, may be the source of these types of preferences. The changing role of the physician and the patient should inspire research into the factors which substantially influence the preferred model of this relationship. The results of this study

indicate that stereotypes connected to how a doctor is perceived, especially stereotypes concerning gender and location of the medical practice, are strong and statistically vital factors affecting the course of this relationship. It seems that the more favorable perception of women doctors and those from smaller towns is connected to the preference of the paternalistic relationship. The conducted analysis also permits to conclude that the level of trust in the competence and integrity of the doctor also determines the model of the relationship. Curiously, trust in benevolence of doctors turned out to be completely irrelevant in the choice of the relationship. It is worth mentioning that greater trust both in the competence and in the integrity of doctors is connected rather to the paternalistic relationship than to the informed choice relationship. The expectation of a paternalistic approach of a doctor therefore concerns people who demonstrate a high level of trust.

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