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The contradictions of health service through reflection of the doctor-patient relationship

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In spite of the fact that the concepts of marketing and competition are considered to be an unrelated trend in health provision, the medical community has been forced into the competition. This competition has even widened to the Hungarian Health Service to preserve basic working conditions such as devices, instruments, and the battle to overcome the lower wages (Lantos–Simon 2005).

The fact that it is worth taking marketing aspects into consideration when analyzing the doctor-patient relationship can be considered a relatively new matter of consideration. The independent parameter of the research model used is the putative competence of first the provider, and then the consumer. The providers of the services are typically experts, who estimate risks according to professional aspects and methods (or how they define tasks). The dependent parameter is the perceived risk which is bilateral concerning the service (Veres 2003). One of the arbitrating factors is trust, which can be considered as an inclination to risk-taking behaviour and the other is patient's putative competence.

The following conclusions were proven in this research paper:

1. *In Hungary, the trust-level of the doctor-patient relationship is low; therefore the perceived risk is high.*
2. *The level of trust in the system is also low concerning health service.*
3. *Due to the above mentioned factors; both participants are dissatisfied with the level of communication, cooperation and of the partner's social competences.*

During this research, focus group interviews and semi-structured personal interviews were used to prepare quantitative analyses. The results of these qualitative investigations will also be presented.

The benefit of this research can be established, due to the fact that bilateral risk can be reduced by appropriate risk communication. Consequently, communication can be a risk–managing instrument if the participants of the transaction decide to take advantage of it.

Keywords: health service, doctor-patient relationship, risk perception, competence

1. Introduction

As members of a research team of the Institute of Business Studies at the University of Szeged, the chain of competence–risk–communication by a comparative research is examined. Three types of services are compared: health care, education and project engineering. In this study, the present results of the examination of medical services are summarized.

The goal of this paper is to discover and introduce characteristics of the perceived risk in the process of services, and also the opportunities of the reduction and treatment of this risk with the help of communication.

2. Different approaches concerning the research of risk

Defining risk is not easy because researchers use diverse definitions based on the research goals and scientific backgrounds. Commonly speaking, it can be derived that risk usually refers to an activity based on uncertainty. Uncertainty results from a state of insufficient knowledge. It can be stated that by enlarging the amount of obtainable information, the chance of success concerning certain activities can be increased.

According to often used definitions, risk is probability of the outcome of a potentially unfavourable event. Powell (1996) defines risk as the combination of an undesired and uncertain thing. This definition is sometimes expanded by saying that the probability of the event's outcome is multiplied by the rate of the caused damage. According to Emblemsvåg and Kjølstad (2002), risk is interpreted as a systematic method of how to fight with danger. Based on the above mentioned facts, the main point of the risk definition is the following:

a) Either the possibility of the occurrence of some unfavourable event,

b) Or the possible default of some favourable event.

Based on Renn's taxonomical approach, risk definitions can be ranked into four big groups.

- By risk, *technical approaching* researchers mean the failure of different devices and systems and they aim at treating their harmful physical, chemical and biological effects and these effects give the frame for their analysis and evaluation.
- While *economic approaches* use the dimension of negative consequences, satisfaction-dissatisfaction instead of the more objectively measured but more narrowly interpreted "damage" dimension.

- However *collective and social approaches* (sociological, social psychological, anthropological approaches) put emphasis on the role of the reference groups. When constructing the elements of reality, and therefore that of the risk, they widen the individual focus of the psychological approach (Renn 1992).
- *Cognitive psychological approaches* put emphasis on risk perception. Concerning the definition of risk, the significance of subjective judgement formation is huge. In the definition of risk, while taking subjective perceptions into consideration in addition to the predicted one-dimensional values, different quantitative and qualitative features are also taken into account and they interpret risk as a subjectively expected term (Slovic et al 1998).

Perceived risk in everyday life differs from specialists' opinion. People can overestimate certain dangers (flying), and underestimate others (driving).
The following factors play roles in perceived risk:

a) Availability bias: the judgement of an event depends on how easily one can bring it to mind.
b) Overconfidence: not realising the limits of one's own knowledge.
c) Demanding certainty: reduction of exaggerated fear caused by uncertainty (Radnóti–Faragó 2005).

The representatives of the psychometric approach put an emphasis on the necessity of measuring risks. First of all, they analyzed risk perception in connection with modern technological devices, methods and activities. One of their main methods is using questionnaires because within the frame of psychometric paradigm, people have to make quantitative value judgements on the riskiness of different risk-bearers' existing and desired rates in addition to the ideal level of regulation. At this point, these judgements are related to other judgements concerning other features.

By cognitive psychological methods, they tried to reveal the risk attitudes and perceptions present in a society or culture and the drawing of their cognitive maps was also attempted.

Slovic (1987) carried on research about the characteristics of laypeople's risk perception, as he found lay interpretations of risk important. Some of his most important questions are:

- What are the defining factors of the perceived risk (conceptual features, the influential strength of emotional factors, and the adequate notion of methods)?
- How accurate is the perception of an average person? (Do distortions come from the insufficiency of information or from the fact that skills are limited?)
- What steps must be taken in order to develop explanatory attitude towards risk?

– How can experts appreciate where the limits of their competence are?

His results show that despite less information and the possible mistakes, lay knowledge concerning risk reflects a steady consideration that is typically missing from the experts' risk evaluation (Slovic 1987). These thoughts, in connection with risk perception and communication, play a crucial role in scientific literature (Table 1).

Table 1. Different aspects of risk perception concerning experts and lays

Experts	Lays
Control and predictability of risk	Risk valuation is based on previous experience only in small amount
Objective risk identification, evaluation and minimisation	Risk cannot be perceived by senses
Scientific approach	There are no data, no statistics, the usage of these is not evident for them
Efforts made for providing general rules	The role of assumptions and individual concepts is more significant – individual value judgement
It would serve as the basis of rational decision concerning risk	They do not rely on unambiguously mechanical or economical aspects
Probability risk predictions	Emphasis on qualitative risk features, significance of the role of subjectivity, fear
Risk comparisons	Mixed usage of the above mentioned aspects-the inconsistence of judgement and action

Source: own construction based on Haller (2003)

3. Why "healthcare" specifically?

State health provision could not follow the "price boom" in health service which was caused by the improvement of medical science and pharmaceutical industry and the rising public needs worldwide. Related to the rising prices, besides the costs of the direct health provision, the expenses of the following factors have also appeared:

– insurances companies and
– management.

In addition to the rising quality of the hospitals' accommodations – mostly based on the insurance system – and other types of protection, the consequences of malpractice suits have been reduced. During the 1970s in Hungary, as a result of falling rates of the economy and the indebtedness of the state, variance could be perceived between the "medically possible and the economically affordable" terms.

Citizens have claimed to be informed of the introduction of the new, although expensive, medically possible methods of treatments but have had no or lessened chances to attain them. It is an interesting and understandable paradox, that as a result of the present effect of the slogan: "free and high quality", citizens do not connect the necessity of contribution payment with the expenses of health provision, or at the same time, payment of taxes with the spending on health care.

The developmental limits of the health provision system and the problems around its operation have appeared as political issues because if it is a state-run system. Therefore, it is not surprising that at the time of the change of the regime, the politically acceptable choice became the health service based on an individual insurance system. This change found its shape in an insurance system without consequence.

Health service is a huge system which defines the life of a society. It is the sum of those individual and social actions which aim to preserve and re-establish health and to provide its specifications. Its aim is to reach the best health state possible in the widest layer of the population.

The 3 main areas of health services:

- basic provision
- out-patient service
- in-patient service.

As a fourth factor, the pharmaceutical industry can also be listed here as an active participant. In our opinion, risk perception in health services has been outsized by the present "war psychosis" of health provision.

The interest towards the study of economics and management has risen dramatically among health services in comparison with the previous situation. Earlier, even economists dealt little with the economic problems of the health services, despite the fact that it is the founding member of the non-profit sector.

It is a global problem, even the most developed countries fight financial difficulties; the principle which says: "providing everything for everybody" has become unmaintainable (Égető 2002).

Doctors must possess a great deal of skills, abilities and professional knowledge in order to be good experts. Trust is more than necessary in health services; moreover, the rate of risk is also the biggest here in this sector (Hajdú–Bagi 2004).

Health care as a service sector seems an obvious area. The industrial era came to an end, and now lives the era of information. With reference to Garai (1997), in this new era, in the time of the second modernization "…we must take spiritual phenomena into consideration of economic factors." In the era of information, hastening is one of the most important features of people and society. Today, more qualification is possessed, but less intelligence; more knowledge, but less comprehension; there is more professionalism, but more problems arise; more medicine is available, but health conditions are lessened. People drink and smoke too much, they are too fat, they are stressed out, they watch television far too much and they do not exercise enough.

There are different active participants of health service who are the subjects of analyses. Their characteristics vary according to their concern in the health field.

1. *Doctors:* they must possess a great deal of skills, abilities, professional knowledge and competence. They have a "certificate" (medical degree) and they participate in continuous trainings (specialist examination, score collection), that is how they become qualified. Considering the present social (and within it, health care) conditions, it is established that they are overburdened, tired and exhausted.
2. *Patients:* They pay the Social Insurance without really knowing what is is, and still, health provision is not free. They feel defenceless, although they have guaranteed rights and health care representatives. They are constantly struggling with weight problems, they do not exercise enough and they eat in a very unhealthy way. They are afraid of treatments. They do not have complete trust in their doctors and make reports against the doctor if the 'broken part' cannot be replaced or fixed.
3. *Holistic health practitioners:* Most do not have degrees and their accreditation is not possible. This is an area overwhelmed by fraud, although, many of them have been proven skilful in their area of specialty. They do not cure the patient; only help the organism cure itself. Therefore, responsibility is not theirs either. They are often consulted when the client is desperate and hopeless and sometimes it has even become fashionable to visit a holistic health practitioner.

Taking into consideration the above mentioned facts, this is why the health system has been chosen as the focus of study. The health system is a high-risk sector, where everybody is affected and, therefore, deserves research.

4. Problem statement

The structure elements of the 19th, 20th and 21st century can be found in the present structure of the Hungarian Public Health. It is considered to be a relatively new aspect that it is worth taking marketing factors into consideration when analyzing the health care.

The notions of competition and marketing were not accepted in the public health of the USA until the 1980's. It was taken as a strange idea in the area of health care that business matters push their ways into the structure of public health and generate unworthy competition of healing.

According to Kotler, most institutions in the public health have no choice to avoid competition because there are institutions in the same field of supply and they have to compete with each other for demand. In his opinion, competition is forced not from outside, but it is formed inside of public health. Management methods and marketing tools can be used in this field, too.

Leisen and Hyman (2004) emphasize three elements in order to give a reason on the research based on marketing concerning the health services.

First of all, there has been a process lately, namely that the activity of doctors and other assisting organizations has been analysed along such statistics which were used only in business life before.

According to Peyser, the following statistics can be stressed:

- the behaviour of the consumers (patients)
- reputation or "good name"
- economic motivating factors (income, income over the wages)

The competition between services is getting progressively significant in the medical system; therefore, traditional marketing methods get increasingly more important roles in health services.

In addition, the doctor-patient relationship is a long-term relationship. Health services are essential from a personal aspect and they compel high rate commitment. Most consumers (patients) prefer continuous, long-term relationships with their doctors.

Moreover, trust is the crucial point of the doctor-patient relationship. The more expenses that accompany the damage caused by the incompetent service (for instance: malpractice suit), the bigger the role of trust is when evaluating the service. It becomes clear from research of Swan et al. (1999), that most patients are not experts in medical sciences; that is why they are obliged to believe that their doctors treat them well.

Based on the above-mentioned arguments, it can be stated that the doctor-patient relationship can be considered as an intense marketing relationship (Leisen–Hyman 2004).

Johnson and Grayson (2005) put an emphasis on the cognitive and affective dimension of trust in the relationship between services and consumers. By the consumer's cognitive aspect of trust, it is meant toward belief and deep conviction towards the competence of the service provider. The cognitive dimension of trust makes it possible to predict the probability rate of how the service provider will complete the promised engagements. On one hand, this knowledge originates from the observation of the supplier when acting in different situations. On the other hand, it is based on news coming from other services. Obviously, the consumer can never be absolutely sure concerning the result of the service, therefore trust in the competence of the provider always remains an important factor. This is particularly true concerning health systems.

The affective dimension of trust is based on those feelings which were arisen by the quality of the service and the interest experienced by the supplier. Certain pieces of information coming from others might influence the affective dimension of trust, but what counts considerably is personal experience towards the service. Besides information, it is based on emotions. As emotional raillery is getting deeper and deeper, the trust in the service provider may exceed the rate justified by the consumers' knowledge. Since emotions have such a considerable role, these relationships cannot be analysed well with the help on the economists' objective risk-evaluation models.

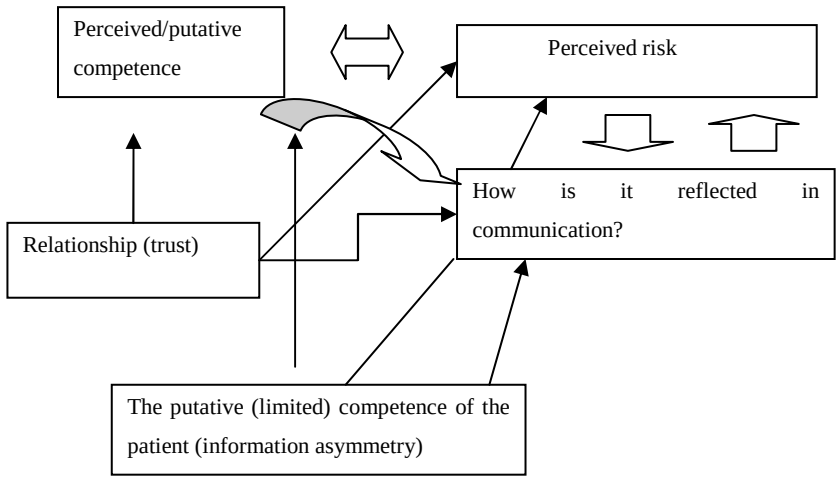
The public health system in Hungary has several special characteristics. The indexes of statistics concerning the Hungarian Public Health mainly meet the requirements of the development of the Hungarian economy. The expenses of Public Health in GDP in Hungary are almost equal to OECD average. However, expected life spans of people are lessened, risks of getting ill are increased, and chances of recovery are worse than most other developed countries.

It can be stated that there is competition for resources in the Hungarian Public Health. The main reason of this competition is the great lack of resources, and the main purpose of it is to ensure better circumstances for medical treatments. "This usually goes together with self exploitation, which reduces personal and organisational effectiveness. This kind of competition is basically not useful on a social level; but, at present, this ensures the working ability of the Public Health in Hungary" (Lantos–Simon 2005, p. 45.).

5. Research model

The independent parameter of this research is putative competence, which is the judgement about the savvy of, first, the provider, and then the client. The suppliers of the services are usually experts, who estimate risks according to professional aspects and methods (namely, how they define tasks).

Figure 1. Research model



Source: own construction

6. The results of focus group interviews

In this particular research, focus group interviews (three of them were prepared: one with doctors, one with holistic health practitioners and one with pharmacists – being "qualified patients") and semi-structured personal interviews (with subjects who – as many members of our society – already had experiences in the Hungarian public health system: had been patients) were used to prepare the quantitative analysis. The main topics of the interviews are the following: perceived competences, perceived risk, and communication in the process of the health care service.

While defining the competence of a physician, important differences were found. Patients said that the main elements of the doctor's competences are their social competences:

- the quality of the information
- the manifestation of the empathy of the doctors
- the personality of the doctors

However, in the doctor groups, the overall experience is that doctors consider the criteria of the profession when judging their own competence. The knowledge and the observance of the rules of the profession, the adequate expertise, the ability of making decisions, qualification, and firmness are all important aspects. The interviewed doctors are aware of the fact that "being nice and friendly means a lot to the patients; although, according to them, it has nothing to do with being professional".

The doctors are much more aware of their informational superiority and often look down on the patients' information resources (usually obtained through the media). This information is accepted only by certain parts of the patients' history and experience.

The patients judged the medical interventions risky, because "a life is at stake"… they identified the following risks:

- improvement does not occur in the state of the patient
- the state of the patient deteriorates after the treatment
- malpractice
- Death.

Among competence factors reducing the perceived risk, other organizational aspects also appear concerning the patient groups, such as the reputation of the hospital and its equipment. Patients are highly influenced by good experiences and stories of other patients. Furthermore, the perceived competence of the healthcare staff also plays a significant role by means of primarily the communication and the judgement of their professional activity as determined by:

- the reputation of the doctor
- his medical costume or uniform
- the doctors ability to make contact with the patient and therefore helping the patient venture to make contact
- the expertise of the nurses and how much time they deal with the patients
- the superiority of the preparations before an operation

In the perception of the competence elements increasing risk, there was also difference between the two groups:

- The patient groups emphasized the lack of information concerning the doctors as one of the most important risk factors.
- As for the doctors, the lack of time, the uncertainty and the limits of risk communication ("all risks must be told beforehand otherwise we might be sued, but it is impossible to tell about all the risks") were emphasized.

One question was presented on how to communicate the elements of the medical competence in different healthcare situations. According to certain research (Maryn 1998), most complaints concerning medical services are not in connection with clinical competences, but with communication problems. The most frequent complaint is that the doctor does not pay enough attention to the patient.

The two groups gave diverse answers concerning this question. Doctor groups put an emphasis on:

- education,
- direct interactions,
- the role of agreement declarations,
- And on an overall information.

As for the verbal and formal elements of the doctor-patient communication, the importance of the doctor-patient communication was in part appreciated by the physicians. Some of them recognised the significance of communication in the improvement of the doctor-patient relationship ("patients prefer being treated as partners"). What is more, informational asymmetry also appeared ("if the doctor informs the patient well, then the patient's expectations are down-to-earth" "the doctor knows what to do in certain situations while the patient does not").

Although, problems also occurred like lack of education (we have not been taught this) and doubts concerning the importance of communication.

Based on the interviews, the doctor-patient communication seems rather authoritarian. When doctors talk about patient compliance, they mean that patients should follow the doctors' orders ("…He must go to see a doctor and he must take the doctors' words").

Compliance or adherence to health service provider recommendations is widely considered to be a remarkable factor in health outcomes, and several aspects of it are found to be affected by factors that evolve in the consulting room (Vajda 2009). However, according to the doctors interviewed, only patients are responsible for patient compliance. This statement was emphasised by all of them, and they all considered the level of the patient compliance low. This typical phenomenon could be sensed, and as for the doctors' interpretation it seemed "…as if many devoted experts wanted to do good to the patients despite their willingness" (Lantos–Simon 2005, p. 47.). It is a pity that patients interpret it completely differently. How is it in reality according to the statistics? According to different surveys concerning different diseases, in every case, the long term treatment patient takes even less than half of the prescribed medicines. The worst results occurred in the treatment of asthma, where patients take only one in four pills (Lantos–Simon 2005, p. 48.).

A separate chapter is devoted in connection with the loss of trust. In the patient groups, the effects of the media and direct experience could be shown. The

media has a significant role in spreading bad examples and malpractices. Patients consider doctors incompetent based on their behaviour ("the doctor gives the same medicine for everything, my state is getting worse and worse… the doctor is not available when he is needed… and I have to wait far too much…")

In the doctor groups, the following statements were made:

- the loss of trust is rooted in the circumstances of the treatment
- physical condition of the institute itself
- lack of attention towards the patient
- lack of the nurses' activity

The doctors being exhausted and tired were mentioned in each and every interview ("to be on over-duty") and as a result, they make mistakes. The question about who is responsible for this was raised, but was never answered.

According to the patients' opinion, delineating the risks is the occupational duty of the doctor; whereas, they add that detailed information depends on the seriousness of the problem. Dentistry, family doctor's services, dermatology, ophthalmology, and orthopaedics were appointed as a "less risky field". They considered surgery and obstetrics risky and fields where prompt decisions have to be made and aggressive intervention is needed. They presume that the longer the medical intervention is, the higher risk there is. On the part of the patient, risk can by reduced by prevention, gathering information, trust, keeping to the instructions of the doctor, a positive approach and belief in the recovery, a solicitous choice of the doctor and collaborating with her/him. On the part of the doctor, risk can be reduced by: less acute patients, identifying diseases in time, empathy and due experience.

The service is considered successful by the patients, principally, if the recovery is univocal, although they see that it can be different depending on the seriousness of the problem. Secondary, but essential to the aspect of success is if: the treatment is rapid and effective, it is accompanied by less inconvenience, pain is minimal, there is scarce risk and the duration of their recovery fits to what they anticipated. According to some opinions, even the right diagnosis is an essential peculiarity of success – although it can't be tested by the patient. If the patient meets with failure – lack of recovery – his/her attitude becomes distrustful with the doctor and his/her fear rises. Patients are content when: the treatment meets their expectations or it is even better, the doctor uses modern technology, the patient is recovered, they get fast, accurate and effective medical attendance, they see that the doctor does her/his best in order to promote the anticipated results. A participant noted that contentment depends on the seriousness of the disease. They consider more important to raise the quality of the service by improving the provision rather than the doctor. The staff should "handle patients as humans" and the equipment of

hospitals should be improved. Patients responded that feedback is still necessary when a patient is content because the experience of success reinforces the doctor.

7. Conclusions

To highlight the conclusion of this research, there are significant differences between doctors and patients in the expectations related to perceived competences, risk-perception and communication. The differences in these approaches contribute significantly to the fact that the level of confidence is low and the perceived risk is relatively high in the doctor-patient relationship; these reduce the patient compliance and the efficiency of the service. It is also clear to us that the evaluation of the quality of health care services is deeply influenced by the above mentioned variables. The communication between doctors and patients should contain the characteristics of the risk communication to raise the level of the trust and the satisfaction in the health service. Henceforth, results should be obtained by using quantitative methods. It is also illustrated in this research that the methods of service-marketing might contribute to enhancing quality of health care services effectively.

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