Interactional behavior and relational impact of physicians in healthcare with emotional intelligence competencies

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Abstract: The focus of this research article is to examine how the Physician's interactional behavior namely, listening and explaining behavior is influenced by the patients' loyalty, and confidence, which are the components of emotional intelligence. This would appear to enhance its significance as of its kind conducted in the context of an advanced developing economy. The research enhanced suggests that development of effective communication skills in Physicians warrants due attention in medical education. Furthermore, the results of this study validate relevant measurement scales in India's context. Results confirm that the Physician-patient relationship is positively influenced by the interaction behavior of service providers, i.e. emotional labors, and further demonstrates that Physicians' interaction behavior is instrumental in developing an effective relationship with their patients and boosts patients' confidence in their Physicians. Additionally, effective interaction enhances patients' loyalty to their service providers.

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Introduction:

The quality of healthcare services is an issue that is generating increasing interest internationally from academics and practitioners. Healthcare services affect quality of life more than any other service sector. Healthcare services are high-credence services, characterized by a high degree of uncertainty and risk. Patients or their families usually lack the professional knowledge to judge the quality of the service being provided during the service delivery and even after receiving the service. Patients evaluate the quality of healthcare services based on their interactions or so-called "service encounters" with healthcare service providers, their Physicians. These interactions help build patients' confidence in their Physicians and the quality of the medical services being provided. Most patients are keen to form a relationship with their Physicians. The relationship between patients and their healthcare providers (especially Physicians) is very important because patients gain a certain sense of security regarding the outcome of the service provided to them. The quality of care improves through long-term relationships with Physicians who know their patients' medical history. On the other hand, due to intense competition, patients can exercise their right to a choice by switching if they are not satisfied with their healthcare providers. This can result in increased marketing costs and less profitability for the healthcare service provider. Therefore, the relationship is as critical to healthcare providers as it is to patients. As well as the core benefits of a service, the extant literature refers to a customer's motives for entering and maintaining a relationship with a service provider because there are perceived economic, functional, social, and psychological benefits.

Service Providers in Health Care:

Berry (1995) emphasizes the importance of customers' relational benefits for a successful business relationship and considered relational motives such as customers' desires for risk reduction and social benefits. Gwinner et al. (1998) propose three relational benefits from the customer's perspective: social benefits, confidence benefits and special treatment benefits. Owing to the nature of healthcare services, the relationship with Physicians is primarily driven by their patients' desire for risk reduction and confidence. Customer loyalty including repurchase behaviors and positive word-of-mouth communication has been seen as the ultimate relationship marketing outcome, and it has been viewed as the real strength of the relationship. Satisfaction is regarded as an equally important outcome of the buyer-seller relationship in the service context and it is a key variable of relationship continuity. Therefore, this study involving Physician-patient relationships proposes confidence, satisfaction and loyalty as relational outcomes and investigates the effect of Physicians' interaction behavior during the service encounters on these

relational outcomes. Understanding such relationships is necessary in order for better service practices to develop. Despite its obvious importance, there is little research exploring the impact of Physician behavior during the service encounters on relational outcomes. In particular, little is known about the influence of Physicians' communication behavior in building relationship satisfaction and confidence. This study attempts to broaden our understanding of the association between these relational outcomes and Physicians' interaction behaviors: listening, explaining and perceived competence. Listening refers to patients' perception that their Physicians are willing to take time to listen to them and pay attention to the issues that concern them. Explaining refers to patients' perception about their Physicians' ability to provide the information regarding their state of health, medication, home care and medical procedure required. Perceived competence is the extent to which patients trust their Physicians' skills and knowledge required to provide for their healthcare needs. Behavioral loyalty includes repurchase intentions and world-of-mouth recommendations as suggested by various scholars. This study is conducted in India, which is currently making great strides as an advanced emerging economy. Indians are considered to be relationship oriented and socially they engage in collectivist principles and practices, which historically have dominated India for much of its history. Little empirical research of service behaviors has been undertaken in emerging economies where healthcare systems work very differently in comparison to mature economies. This study attempts to bridge this important gap in the literature by integrating the findings in medical sociology literature and the work emanating from research in services marketing.

Literature Review:

Relational Benefits:

A strong relationship between people, communities or organizations is based on mutual benefits (Crosby et al., 1990; Gro¨nroos, 1994, 1996). In the relationship concerning service providers and customers, the latter expect to receive benefits beyond just the core service benefits from their service provider. Researchers have termed these relational benefits because they are essentially additional expected benefits (Bendapudi and Berry, 1997; Dwyer et al., 1997; Hennig-Thurau et al., 2000, 2002; Reynolds and Beatty, 1999). These relational benefits are said to provide the real reasons why "true relationships" exist (Barnes, 1994; Bendapudi and Berry, 1997). The relational benefits will be particularly valued by customers in situations where: first, little differentiation is possible between competitive products/services; and second, where the product/service is difficult to evaluate even after consumption (Fisk et al., 2007; Zeithaml, 1981; Zeithaml et al., 2009) – such as healthcare services. Relational benefits can be important in relationships between a single customer and a single employee such as in the case of exchanges between a patient and his/her Physician. These benefits are referred to as personal level benefits due to the particularly high levels of intimate contact between customer and employee (Hennig-Thurau et al., 2000). A typology of three relational benefits is developed by Gwinner et al. (1998) and empirically supported by some studies (Bendapudi and Berry, 1997; Berry, 1995; Gwinner et al., 1998):

- Confidence benefits, which refer to perceptions of reduced anxiety and enhanced comfort
- Social benefits, which refer to the emotional part of the relationship and are characterized by personal recognition of customers by employees, the customer's own familiarity with employees and the creation of friendships between customers and employees
- Special treatment benefits, which take the form of price breaks, faster service or individualized additional services

Of these three benefits, confidence benefits are highly valued and the most relevant for a high-credence service like healthcare service. This is because patients want to have as little anxiety as possible prior to undergoing medical treatment, and involve themselves positively in recovery following the treatment. Therefore, in the studies involving Physician-patient relationships, patient confidence in their Physician needs to be further explored.

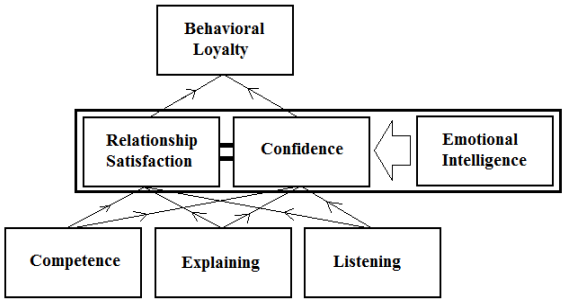

Figure 1: The Conceptual Model of the Study

Relationship Satisfaction:

The satisfaction in a relationship has been considered to be a measure of relationship quality. Relationship satisfaction has been defined as "customers' cognitive and affective evaluation based on their personal experience across all service episodes within the relationship". In other words, relationship satisfaction is accumulated across all the interactions in an ongoing relationship. In the Physician-patient relationship context, satisfaction is

generated by Physician behaviors during interactions with their patients.

Service Behaviors Responsible for the Customer Relationship:

Customer perception of service quality mostly focuses on technical concerns – what is provided and how the service functions or is provided. In service marketing literature, service quality perception includes interpersonal quality, technical quality, environment quality and administrative quality. Researchers in medical sociology have explored patients' perceptions of various aspects of medical services, and such studies have involved conducting patient satisfaction surveys comprising assessments of professional competence, interpersonal manner, access to and availability of resources. Reseachers identified four dimensions of service encounter: perceived competence, listening, dedication and effectiveness. They found that these four dimensions contribute more to the evaluation of the service encounter than the effectiveness of the service. In a study of patient satisfaction in a family practice centre, DiMatteo and Hays (1980) found conclusive evidence that if patients felt their Physicians were effective communicators, they also considered them to be technically competent and to be providing appropriate effective care. In the medical sociology literature, a physician's ability to establish rapport with patients is at least partially dependent on his/her communication skills. In another study, DiMatteo et al. (1979) found that Physicians' socio-emotional behavior such as caring and openness to communication tended to weigh heavily in patients' decision to continue the physician-patient relationship. According to these studies, the most important aspects of satisfaction with Physicians is patients' feelings of being genuinely cared for by their them, the degree to which their Physicians took time with them, explained and listened to them, and were accessible when needed. Johnson (1987) reviewed the literature in behavioral disciplines on communication styles and concluded that the marketing exchange between patient and practitioner is more satisfying for both parties when communication improves. A survey of surgical patients also highlights the need for Physicians to spend more time explaining what is wrong with the patient and possible treatments available to them. An extant review of previous studies both in service marketing and medical sociology literature indicates that two dimensions of service behaviors – perceived effectiveness of communication including listening and explaining, and perceived competence of Physicians – are the most important aspects of patients' satisfaction and contribute to relational benefits. Studies have also suggested that effective communication can foster trust in the development of the relationship. Effective communication between Physicians and their patients is helpful in reducing the uncertainties and suspicions that patients may have before and after the clinical service. Thus, effective communication between Physicians and their patients' enhances the latter's overall satisfaction with healthcare providers and reinforces confidence in the relationship. This two-way communication specifically includes listening from the patients and explaining by the Physicians.

Listening:

Listening is one of the six major components of the interactivity dimension, along with responsiveness, didactics, understanding, personalization and psychological proximity. Willingness to listen demonstrates that a person has a certain degree of attentiveness. It is essential for the customer oriented approach of a salesperson and is positively related to customer satisfaction. The consumer's perception of a salesperson's listening behavior has an impact on the promotion of long-term relationships, building of trust and satisfaction, and anticipation of future interactions. In the healthcare service context, patients themselves are the primary sources of information used by Physicians to understand their medical needs. Taking the time to listen to their patients is the first step for Physicians to provide proper care, treatment and quality service.

Explaining:

The explaining behavior involves explanation of the condition, which includes:

- Providing patients with information regarding their condition
- Changes in condition and prognosis; explanation of the process of care which includes the process of explaining tests
- How and why they are being conducted; treatments, therapies, etc.
- Explanations of self care including patients being provided with information about
- How to take care of themselves at home to promote recovery or optimal health; and
- Explanation of medicines incorporating information on how to take medication, their possible side effects, etc.

Perceived Competence:

Competence is defined as the possession of the required skills and knowledge to perform services. Similarly, expertise is also defined as the customer's perception of a salesperson's competencies associated with the product, information and service delivery. Professional competence is defined as a dimension of service quality measuring the salesperson's knowledge and expertise.

Loyalty:

In this study, loyalty is conceptualized to include the behavioral aspect of repurchase intention, the attitudinal aspect of willingness to recommend or positive word-of-mouth and the cognitive side of being the first choice to come to mind. Service marketers aim to ensure that out of their marketing efforts, they can generate favorable behavioral outcomes. Customer loyalty in the business world has long been considered a key behavioral outcome. Loyalty is generally expressed in terms of two behavioral outcomes:

- Repurchase intention
- Willingness to recommend.

Repurchase intention indicates whether or not a customer will maintain the relationship with his or her service provider. Word-of-mouth recommendation is the extent to which customers will inform their friends, relatives, and colleagues about the consumer experience. Customers who recommend a service firm to others are also likely to continue using the service provider for their own needs. Word-of-mouth has been found to play a particularly important role in the advertising of services. It is a powerful force in influencing future buying decisions, particularly when the service is perceived as high risk for the customer; and it also helps in attracting new customers as relational partners for a company's offerings. The link between satisfaction and loyalty has been well established in the literature. Satisfaction leads to the creation of a strong relationship between the service provider and customer, leading to relationship longevity, or customer retention. Service loyalty depends more on interpersonal (face-to-face) interactions. Therefore, the customer's perception of the face-to-face interaction with the service provider is one of the strongest determinants of loyalty. It has been discovered that confidence in the relationship has a positive impact on satisfaction ratings in channeling relationships between manufacturers and buyers and in service interactions. Greater levels of confidence in the interaction will result in less anxiety leading to greater satisfaction. Confidence/trust in a relationship reduces uncertainty and vulnerability, especially for services that are difficult to evaluate due to their intangible, complex and technical nature. Patients should be expected to be loyal to their healthcare provider when they gain confidence in their Physicians.

Concept of Emotional Intelligence:

Emotional Intelligence (EI) was formally conceptualized by Salovey & Meyer (1990). Salvovey & Meyer (1990) and Pfeiffer (2001) stated that EI is a subset of social intelligence which involves the ability to monitor one's own and other's feelings; emotions to discriminate among them and to use this information to guide one's thinking and ability. Salovey and Meyer (1990) later examined a variety of skills including management skills that relate to EI. This model consisted of four components of abilities mainly, a) to perceive accurately, appraise and express emotion; b) to access and or generate feeling when they facilitate thought; c) to understand emotion and apply emotional knowledge; and d) to regulate emotions, to promote emotions and intellectual growth. Contrary to Salovey & Meyer's (1990) model, Goleman (1995) proposes EI's model which consists of two components mainly personal competence and social competence. Personal competence includes self-awareness (the keystone of EI), self- regulation and motivation while social competence consists of empathy and social skills. Self-awareness is the ability to recognize and understand one's own moods, emotions, drives and their effects on others. Self-confidence, realistic self-assessment and often a self-deprecating sense of humor are among characteristics of self-awareness. In self-awareness leaders are supposed to be able to recognize a feeling as it happens, to accurately perform self-assessment and have self-confidence. Goleman's study (1995) found that effective leaders are those who demonstrate self-awareness, have high self-confidence as well as able to assess their strengths and weaknesses. It can be concluded that a high level of self-awareness that is associated with EI tend to encourage leaders to demonstrate self-confidence, earn respect and trust from followers. Meisel (2004) found that self-awareness is the greatest predictor of success in everything people do.

Self-regulation or self-mastery is the ability to control emotions, to remain calm, encounter problem and resistance, manage stress skillfully, finding ways to handle fears, anxieties, anger and sadness and to stay focused on the tasks performed. Individuals with self-regulation are able to handle change and being comfortable with ambiguity. Through self-regulation, leaders can objectively consider the needs of others despite their own immediate feelings. Goleman (1998) highlighted that qualities of self-regulations are like trustworthiness, integrity, conscientiousness, self-control, adaptability, innovativeness and taking responsibility for one's own actions. A leader with EI is expected to be able to keep disruptive emotions and impulses (self-control); maintain standards of honesty and integrity (trustworthiness); take responsibility for one's performance (conscientiousness); handle change (adaptability) and be comfortable with novel ideas and approaches (innovation). A leader with EI would be optimistic and show happiness despite obstacles, setbacks and failure. Motivation relates to expanding energy in a specific direction for a specific purpose. It refers to the emotional tendency guiding or facilitating

the attainment of goals. It encompasses achievement drive (meeting a standard excellence); commitment (alignment of goals with the group and organization); initiative (acting on opportunities) and optimism (persistence reaching goals despite setbacks). Good emotion will encourage leaders to be more motivated in the tasks performed. Motivation also involves passion, confidence, enthusiasm and normally zeal to work not because of money or status but to pursue goals with energy and persistence. Maxwell (1999) contended that passion is the first step towards achievement that increases willpower; passion changes individual and allow individual to become a more dedicated and productive person. Further, Maxwell (1999) suggested that a leader with great passion and few skills always outperforms a leader with great skills and no passion. Meanwhile, motivated leaders will have a high desire to achieve and are constantly optimistic in any situations while unmotivated leaders tend to be pessimistic and may give up earlier. Highly self-motivated individuals and leaders are result oriented who have a high drive to meet their objectives and standards (Goleman et al., 2002). Leaders who have the ability to maintain balance will always keep themselves motivated, optimistic and hopeful to be a role model and inspire others. Social skills or interpersonal skills refer to a person's proficiency in managing relationship with others and building networks. It involves the ability of meeting each other's needs; relating to each other over time and exchanging information about one's feelings, thoughts and ideas. Other qualities of social skills are effectiveness in leading change, persuading others, building and leading teams (Goleman 1995). As a fundamental to EI, social skills relate to leaders who have the ability to influence (induce desirable responses in others through effective diplomacy to persuade); to communicate (listen openly and send convincing messages); to lead (inspire and guide groups and individuals); to build bonds (nurture instrumental relationships, to collaborate work with others towards a shared goal) and to cooperate (create group synergy in achieving goals). The ability of leaders to manage interpersonal skills tends to motivate and inspire the followers or subordinates. Effective leaders can deal with a diversity of people including personalities that are not emotionally stable, able to develop networks and play organizational politics (Zaslow, 2004).Empathy is a person's ability in sensing the emotional makeup of other's feeling and perspective and taking active interest in their concerns and problem (Goleman, 1998). Accordingly, empathic people will treat others according to their emotional needs. Empathic leaders are those who are expert in building and retaining talent; sensitive with diversities; appreciative of various perspectives and avoid unnecessary conflicts. Leaders who are highly empathic are also skilled in managing other's problem. They are able to understand others by being aware of their needs, perspectives, feelings, concern and sensing the developmental needs of others. EI helps leaders to recognize and respect subordinates with feelings, opinion, ideas, unique needs and abilities. Accordingly, empathic leaders help followers to grow and develop; to enhance their self-images and sense of self worth; and to achieve their needs and goals through social skills.

Hypothesizes Generated:

- *In the Component of Listening*
  - ***(H1) - Physicians' listening behavior is positively related to patients' relationship satisfaction.***
  - ***(H2) - Physicians' listening behavior is positively related to patients' confidence in the Physician.***
- *In the context of Relationship under the phenomenon of Explaining*
  - ***(H3) - Physicians' explaining behavior is positively related to patients' relationship satisfaction.***
  - ***(H4) - Physicians' explaining behavior is positively related to patients' confidence in the Physician.***
- *In the context of Relationship under the phenomenon of Perceived Competence*
  - ***(H5) - Perceived competence of the Physician is positively related to patients' relationship satisfaction.***
  - ***(H6) - Perceived competence of the Physician is positively related to patients' confidence in the Physician.***
- *In the context of Relationship under the phenomenon of Loyalty*
  - ***(H7) - Relationship satisfaction is positively related to patients' loyalty towards their health care provider.***
  - ***(H8) - A patient's confidence in his/her Physician is positively related to relationship satisfaction.***
  - ***(H9) - A patient's confidence in his/her Physician is positively related to patients' loyalty towards their healthcare provider.***

Methodology:

Research setting:

This study is set in India, which has several features that make this study particularly relevant. Over the last two decades India's economic character has much changed and the pressures of globalization have resulted in increased competition. Medical patients are now much aware of their rights and expectations as customers, and the common wisdom

suggests that Physicians will have to adapt behaviors if they want their healthcare businesses to succeed. This has implications for the resulting relationships with patients. In India one can observe two extremes in its social system, specifically what is now known as consumer segments. On one hand, India has the world's largest English-speaking population and a huge middle class, yet on the other hand about one third of its population lives in abject poverty. The latter group is mostly ignorant about their rights and choices as consumers and are thus not discerning. These two customer segments are qualitatively distinct. The segments do not indicate clearly whether patients' interpretation of Physicians' competence and behavior is important for Physician-patient relationships. No systematic empirical investigation has been undertaken on the impact of Physicians' listening and explaining behaviors and perceived competence on their relationship with patients in an emerging economy such as India. It is this gap in the knowledge that makes the study very important.

Sample and Data Collection:

Since the study is set in the context of a Physician-patient relationship, the population consisted of all patients who have visited the same Physician more than three times a year in selected clinics in the city of Mumbai in India. Specialist Physicians who require more than one visit from a patient over a period of time were considered ideal for the study. As such, dentists, gynecologists, physiotherapists, obstetricians and family Physicians met the contextual requirement. The clinics were approached for permission to conduct the survey at their premises. The Physicians and clinics were further assured that the survey would not in any way disrupt the business of the establishment and only those patients willing and able to respond to the survey would be requested to fill out the questionnaire. Finally, 11 clinics were selected as sites for conducting the survey. After the clinics were identified, patients who waited to see the Physician in these clinics were approached in the reception area in order to familiarize them with the procedure. The patients were informed that the survey was a part of research and that their responses would be kept completely confidential. They were also told that the Physician's permission to conduct the survey had been obtained and as such, they were under no pressure to fill out the questionnaire. The survey was carried out under the personal supervision of the one of the co-authors. A total of 340 completed questionnaires were obtained. These 340 responses were from 188 female and 152 male participants, most of who were aged between 20 and 45 years. More than 55 percent of respondents worked in the service sector. Almost all the respondents possessed a graduate or postgraduate level qualification. In total, 20 responses were omitted due to incomplete information being supplied for many questions, and consequently a total of 320 completed questionnaires could be used for analysis.

Survey Instrument and Scale Validation:

All the constructs were measured using multiple items, where respondents were asked to indicate their agreement on a Likert scale from 1 (strongly agree) to 7 (strongly disagree). First, Stewart's scale (Stewart et al., 1999) was used to measure each Physician's listening behavior and explaining behavior. Second, Brown's scale (Brown and Swartz, 1989) was used for Physician's perceived competence. Third, for measuring a patient's confidence in the Physician-patient relationship, the scale developed by Hennig-Thurau et al. (2000) was used and for the relationship satisfaction the items were drawn from the scale developed by De Wulf et al. (2000).

Table I: Model fit indices for CFA models

Model	x^2	(d.f.)	RMR	RMSEA	GFI	AGFI	NFI	TLI	CFI
Measurement model for listening, explaining and perceived competence	104.6	51	0.059	0.057	0.950	0.923	0.917	0.942	0.955
Measurement model for outcome variables	96.4	32	0.055	0.079	0.943	0.902	0.923	0.925	0.947

Table II: Construct validity and Reliability

Constructs	Composite reliability	Cronbach *a*	Average variance extracted
Listening	0.762	0.794	0.446
Explaining	0.693	0.724	0.362
Perceived competence	0.719	0.737	0.408
Perceived confidence	0.613	0.683	0.354
Relationship satisfaction	0.713	0.743	0.454
Behavioral loyalty	0.822	0.859	0.542

Table III: Means, Standard Deviations and Correlations

Variables	Mean	SD	Lis	Exp	Com	Conf	Sat
Listening (Lis)	4.712	0.867	–				
Explaining (Exp)	4.677	0.812	0.51*	–			
Perceived competence (Com)	4.562	0.825	0.46*	0.50*	–		
Confidence (Conf)	4.589	0.872	0.39*	0.49*	0.65*	–	
Relationship satisfaction (Sat)	4.660	0.883	0.65*	0.60*	0.58*	0.53*	–
Loyalty (Loy)	4.620	0.819	0.43*	0.56*	0.72*	0.63*	0.55*

Note: n = 320; *Correlations are significant at $p < 0.01$

Table IV: Regression Results

Variables DV	Regression 1		Regression 2		Regression 3	
	Perceived confidence Unstandardised regression coefficients	SE	Relationship satisfaction Unstandardised regression coefficients	SE	Loyalty Unstandardised regression coefficients	SE
Listening (Lis)	0.227 **	0.041	0.421 **	0.034		
Explaining (Exp)	0.316 **	0.041	0.313 **	0.035		
Perceived Competence (Com)	0.553 **	0.041	0.29 **	0.040		
Perceived confidence (Conf)			0.115 *	0.044	0.389 **	0.040
Relationship satisfaction (Sat)					0.273 **	0.045

Note: Values are unstandardised regression coefficients, with standard errors in parentheses;
* $p < 0:01$; ** $p < 0.001$

Fourth, and finally, behavioral loyalty was measured using the scale developed by Zeithaml et al. (1996). The Appendix provides a list of all the items used in the survey instrument. The reliability and validity of constructs was assessed by confirmatory factor analysis (CFA) using AMOS 7. As CFA is very sensitive to sample size, two separate models were constructed to perform so as to have several cases per free parameter (Bollen, 1989). One model comprised the three constructs of an individual Physician's behavior: listening, explaining and perceived competence. The second model comprised the three constructs of outcome variable: perceived confidence, relationship satisfaction and behavioral loyalty. Table I presents the fit indices for both models.We can see that the fit indices are in the acceptable range as suggested by Bentler (1992) for both models, and this provides support for the scales' reliability and validity. We also found that all the individual factor loadings are highly significant, which supports the contention of convergent validity (Anderson and Gerbing, 1988). We calculated the Cronbach alpha coefficient, composite factor reliability, and average variance extracted for each of the scales. These values are indicated in Table II. The reliability values (Cronbach alpha coefficient) were higher than 0.70 for all the constructs except for one. The construct of confidence was 0.68, which is very close to the norm. Composite reliability values were also higher than 0.6. However, the value of average variance extracted was lower than 0.40 for some of the scales. The discriminant validity was further investigated using constrained analysis (Sharma, 2000), which entailed constraining the covariance between all pairs of constructs to unity. All of the constrained models were significantly worse than all the unconstrained models. Furthermore, following Gefen et al. (2000), different combinations of two latent variables were combined into one in an alternate model and the resulting chi-square was compared to that of the original model. Here again the original model proved to be a better fit than any of the alternate models, providing conclusive proof of discriminate and convergent validities.

Data Analysis and Results:

We tested our theoretical model using regression analysis, developing a composite measure for the dependent and independent variables by taking an average of different items in a scale. Averaging of items involves the assumption that all the items contribute equally to the construct. However, such an

assumption is reasonable, as the scales are well established and we test the psychometric properties of the scale in our sample. There was no problem regarding multicollinearity between independent variables because the VIF values were less than 2.5. Three regression models were developed. In the first regression, listening, explaining, and perceived competence were entered as independent variables; and perceived confidence was entered as a dependent variable. In the second regression, listening, explaining, perceived competence, and perceived confidence were entered as independent variables; and relationship satisfaction was entered as a dependent variable. In the third regression, relationship satisfaction and confidence were entered as independent variables; and loyalty was entered as a dependent variable. Table III presents the mean, standard deviation and correlation of the variables. Table IV presents all the regression results. In regression 1, listening (b = 0.227, p </= 0.001), explaining (b = 0:316; p </= 0.001) and perceived competence (b = 0:553; p </= 0:001) have a significant positive relationship with confidence. In regression 2, confidence (b = 0:115, p </= 0.010), listening (b = 0:421; p </= 0.001), explaining (b = 0:313; p </= 0.001) and perceived competence (b = 0:290; p </= 0.001) have a significant positive relationship with relationship satisfaction. In regression 3, confidence (b = 0:389; p </= 0.001) and relationship satisfaction (b = 0:273; p </= 0.001) have a significant positive relationship with loyalty. Thus, all our hypotheses are supported.

Discussion of Results:

The results show that giving patients time to say what they would like to say and listening to them carefully improves their relationship satisfaction with their Physicians. When patients sense/perceive that the Physician is listening to what they are saying, it enhances their confidence in the Physician. This finding is in line with the literature (Ramsey and Sohi, 1997) that customers' perception of a salesperson's listening behavior plays a pivotal role in enhancing relational outcomes. Moreover, this study shows that listening behavior does have a significant direct effect on relationship satisfaction whereas Ramsey and Sohi's study found only an indirect effect on satisfaction. This study also contributes to the literature by testing the direct effect of Physicians' explaining behavior on patients' relationship satisfaction and confidence. Explaining is found to have a positive effect on these two relational outcomes. Interestingly, listening appears to be a relatively more important antecedent of satisfaction than explaining in our case. This study confirms that the perception of Physicians' competence has a positive impact on both relationship satisfaction and confidence, and this appears to be consistent with findings in other studies (Chandon et al., 1997; John, 1991; Parasuraman et al., 1985, 1988). When compared to communication behavior like listening and explaining, patients' perception of their Physician's competence contributes more to confidence building, while listening contributes more to relationship satisfaction. Between listening and explaining, explaining is found to contribute relatively more than listening in confidence building with the Physician. This indicates that the Physician's explanation provides the patients with clues to judge his/her competence and helps to build confidence in their Physician. Meanwhile, listening carefully to patients demonstrates the Physician's respect and concern for their patients' health problems and complaints; therefore creating satisfaction with the relationship. This study further confirms that relationship satisfaction does positively correlate with loyalty (Gro¨nroos, 1994; Zeithaml et al., 1996), particularly for the Physician-patient relationship. Meanwhile, both relationship satisfaction and confidence have a positive impact on loyalty, and confidence has more of an impact on patients' loyalty than relationship satisfaction. These findings suggest that enhancing a patient's confidence is likely to improve their relationship satisfaction with their Physicians, and eventually increase patients' loyalty with their service providers. Generally, the findings generated in this study are consistent with the literature (Bendapudi and Berry, 2006; DiMatteo, 1979; DiMatteo and Hays, 1980). Specifically, a Physician's good communication behaviors drive patient satisfaction, and are critical for trustworthy Physician-patient relationships. Apparently, one would expect patients to value the technical skills of Physicians the most. However, the technical quality of medical care is difficult for patients to evaluate even after receiving treatment due to their limited ability to judge the Physician's technical skills. Hence, they evaluate their relationship with the Physician based on what they are able to judge (Bendapudi and Berry, 2006). Therefore, it is logical to accept the key argument of this paper that patients are likely to assess the relationship satisfaction with their Physicians by evaluating their communication behaviors.

Implications of the study and Recommendations to Practitioners:

The findings of this study emphasize importance that Physicians must have good communication behaviors. It is also clearly evident that this study adds new knowledge to this field of endeavor, and further research in this area should be pursued. Furthermore, the findings of this study have important implications for medical practitioners,

healthcare managers, healthcare education curriculum developers and medical service organizations.

Implications for practicing Physicians:

First, practicing Physicians should note that the traditional approach to treating patients only with medicines will no longer suffice their patients' needs. Patients expect more than that from their Physicians. For example, patients want their Physicians to be more humane and exhibit more kindly behavior in their interactions with them. Therefore, Physicians should broaden their approach in treating patients by incorporating the needs of patients in their service delivery. Second, since effective communication can greatly contribute to the creation, development and retention of long-term relationships with their patients, Physicians need to seriously consider making their communication efficient and effective. Specifically, this involves building and retaining relationships with clients through better-than-average interaction and explaining behavior. Third, since retention of customer loyalty is vital and harder to achieve than simply attracting clients in the first place, Physicians, medical specialists, etc. should endeavor to enhance the level of patient loyalty by delivering professional and attentive customer-driven interaction behavior. Such loyalty can be maintained by providing high quality services to patients in terms of informative and beneficial communication. Fourth, Physicians need to respond to clients' confidence in them by providing quality services based on their needs and satisfaction. For example, many patients consider their Physicians as advisors and open their hearts to them in sharing personal issues with them in the hope of obtaining guidance in overcoming issues that are indirectly associated with their illness. Practicing Physicians should consider this important issue while interacting with patients. Fifth, Physicians need to improve their listening behavior by letting patients communicate what they actually want from their Physicians. Physicians should then assure their patients that the issues they raised have been heard and they will do what is necessary. Finally, Physicians should be fully aware of the service needs of patients. Their interaction strategy should be tailored to understand the unique communication needs of the individual patient for facilitating the development of mutual bonding.

Implications for Management:

First, in order to improve patients' satisfaction and increase their loyalty to the medical service providers, management should evaluate their Physicians' performance not only in terms of their technical proficiency but also their ability and willingness to effectively communicate with their patients during interactions. Second, management can formally introduce in-service training programs aimed at equipping every individual Physician with the knowledge and interaction skills needed for professional communication with patients.

Implications for Clinics/Hospitals:

First, a medical practice that invests in training Physicians with the aim of equipping them with a high level of interactive and professional communication skills is likely to gain a competitive advantage in their target markets. It does this by offering differentiated medical services to its clients and this strategy will result in expanding the client base for the relevant medical practice. Furthermore, these medical practices are likely to retain patients in the long-term. Second, such clinics will have to develop a code of practice to suggest that its Physicians actively engage in appropriate and formally recognized interaction behavior when they are with their patients. As Physicians' listening and explaining behaviors are instrumental in building good Physician-patient relationships and strengthening patients' confidence in their Physicians, strict implementation of these codes would be instrumental in creating happy and satisfied patients. Furthermore, occasional surveys of client satisfaction of services with special references to the interaction and listening behavior of Physicians would enable a healthcare service management group to be alert to any actions required to ensure that patients' needs are being met.

Implications for Medical Education:

Medical schools should integrate a specific course on professional communication into their medical degree curriculum so that medical graduates and specialists have the required communication and interaction skills when they go out into "the real world" to practice. Furthermore, during their internship programs Physicians should be encouraged to practice showing their respect and compassion for patients by active listening and explaining.

Conclusion:

Communication is a two-way process and therefore effective Physician-patient interactions and reciprocal communication can never be accomplished without an active involvement of patients in the process. The complex and personal nature of healthcare services encourages patients to build a strong relationship with their Physicians and this relationship is facilitated by appropriate interactions between them. To sum up, Physicians need to re-think their service delivery focus and consider a possible shift from mere treatment orientation to more behavioral orientation because patients want Physicians to be more caring and interactive in dealing with them; they do not want healthcare professionals to simply prescribe medicines. This change in Physicians' behavior would benefit both Physicians and patients and very likely result in better

relationship building and enhanced clients' confidence in Physicians. The obvious outcomes of this customer-driven shift in service orientation would be more loyal and satisfied patients, resulting in individual Physicians enjoying a better image and their organization enjoying the financial benefits of providing more personalized care services. While these outcomes have implications for all Physicians generally, this is more applicable to Physicians and the medical practices in an emerging economy with a large population such as India, where the Physician-population ratio is very low and as such Physicians usually have to see a large number of patients compared to medical specialists or GPs in developed countries. The reality is that in countries such as India Physicians have less time to spend on each patient and consequently patients have less healthcare-related information and education in emerging economies. It is essential that Indian medical practices develop a culture of fostering effective communication and explaining behavior and this will require communication skills training.

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