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The Satisfaction Snapshot features:
- relevant articles from healthcare industry experts
- case study success stories
- tips and tools for quality improvement
- patient satisfaction and other industry research findings
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The past fifteen years have seen an erosion of traditional hospital-doctor relationships. Financial pressures, decreased doctor autonomy, decreased doctor time spent in the hospital, and strained communications combine to drive doctor satisfaction with hospitals, their profession, and their own careers to the lowest levels ever experienced. The April 2012 Satisfaction Snapshot provides a white paper developed following extensive research into doctor satisfaction and doctor loyalty.

Predicting Doctor Loyalty
The New Science of Doctor Relationships
EXECUTIVE SUMMARY

Doctor Satisfaction and Loyalty—The New Science

- Many hospitals have not adopted modern methods of managing, measuring, and improving doctor relationships.

- Doctor loyalty is the ultimate goal; paramount to hospitals’ ability to survive and thrive in the near future.
  - Loyalty is an attitude derived from experience and evaluation leading to future behaviour.
  - As an attitude, loyalty has multiple indicators.
  - One indicator of loyalty is behavioural intention.
  - Written feedback from doctors predicts loyalty.

- Satisfaction is the strongest predictor of loyalty.

- The best practice approach to improving doctor loyalty behaviours is measuring both loyalty behavioural intention (“Likelihood to recommend”) and a valid, reliable measure of multidimensional doctor satisfaction.

- Predictors of doctor loyalty:
  - Satisfaction
  - Quality
  - Practice efficiency and convenience
  - Administrative adaptability

Introduction

The Old Way: Personal Relationships Erode

Historically, managing hospital-doctor relationships was more of an art than a science. The art of keeping doctors admitting patients consisted of two methods: personal relationship and mass communication. In the latter, the doctor group is treated as one collective body to which hospitals market themselves. Doctors become a “target audience” of hospitals’ marketing efforts. In the former, one or two senior leaders become the connection between doctors and the administration. Strong interpersonal relationships allow the hospital leader to understand the needs of the doctors. The changing health care environment neutralised the effectiveness of this art. Mass marketing is largely ineffective and not persuasive. Today, doctors and leaders simply work differently. The doctor numbers have grown in size and complexity; workloads have increased; doctors spend less time in the hospital and treating more patients in their office; and must cope with reduced status and eroding practice income. All this conspires to make the collegial, personal relationship approach ineffective.
The past fifteen years have seen an erosion of traditional hospital-doctor relationships. Financial pressures, decreased doctor autonomy, decreased doctor time spent in the hospital, and strained communications combine to drive doctor satisfaction with hospitals, their profession, and their own careers to the lowest levels ever experienced (Landon et. al. 2002, 2003; Keating et. al. 2004).

While doctors are visiting the hospital less and less, hospital administrators often find themselves searching for time to spend with their medical group. As the complexity of health care continues to grow, hospital administrators have an increasingly difficult job. In between putting out fires, trying to plan for an uncertain future, and gracefully representing the organisation, administrators who do find adequate time to meet with their medical group are truly remarkable individuals.

The consequences of dissatisfied doctors are significant:
- Dissatisfied patients
- Dissatisfied, demoralised, disengaged nurses who are at-risk for defection
- Lower levels of compliance with clinical protocols
- Riskier prescribing behaviour
- Greater malpractice risk
- Negative word of mouth
- Declining or inconsistent admissions

As technology and quality improvements migrate care away from the hospital, doctors have access to the new technology and capital financing that gives them the first opportunity to operate completely independent of any hospital. Ancillary providers bombard doctors with opportunities to invest or join day surgery centres customised to meet the needs of the doctor’s practice (Messinger & Walter 2003). When given the choice, most doctors remain independent of hospitals and reluctantly participate in any membership requirements of a medical group organisation—minimal involvement in hospital activities (Holm 2004). As hospitals’ financial viability increasingly depends on medical infrastructure, what are administrators doing to cope?

**The New Science: Doctor as Customer**

Hospitals are beginning to see doctors as customers. Positive things happen when doctors are viewed as customers rather than a supply, resource, or audience. A hospital is then able to apply the science and tools of quality improvement, customer service, and customer relationship management to managing hospital-doctor relationships.

Hospitals are just beginning to apply a doctor satisfaction and loyalty approach to medical staff and VMO relations. Press Ganey research indicates that only 55% have a formalised process for measuring and improving doctors’ satisfaction. In contrast, more than 80% of hospitals measure and improve patient satisfaction.

More and more hospitals are integrating comprehensive doctor satisfaction data into operations. In a recent study conducted by Press Ganey, hospital administrators and chief medical officers were asked to identify the importance of doctor satisfaction and how they use it in their operations:
- Drive internal performance improvement
- Strategic planning purposes
- Make staff/personnel planning decisions

Twenty-three percent of hospitals use doctor satisfaction data in an executive incentive compensation program to drive internal performance improvement.

While doctor satisfaction is important on its own merits (Clark 2006), maintaining and promoting doctor loyalty is the paramount purpose behind surveying doctors and addressing their needs.

**Defining Loyalty**

The new science begins with understanding loyalty. Loyalty is the new dogma because it is closer in the causal chain to the ROI of repeat business and growth. But what predicts loyalty? Where does it come from? How do you improve loyalty?

Tremendous advancements have been made in neuroscience, consumer research, business, and social
Predicting Doctor Loyalty: The New Science of Doctor Relationships

Science—all furthering an understanding of perception, experience, emotion, evaluation, recall, and future behaviour. This provides the basis for loyalty research in all other fields. The findings were translated to healthcare and combined with the original research to model the relationship (Figure 1).

Loyalty is an attitude derived from experience and evaluation that leads to decisions about future behaviour.

An emotion. At its core, loyalty is an attitude—an affinity for or attitude towards someone or something that makes us want to return to that experience, service, product, person, or event (Dick & Basu 1994; Travis 2000; Appendix A).

From experience and evaluation. Attitude develops as a result of an experience or series of experiences over time, as well as reflection and evaluation of those experiences. We develop our strongest attitudes after we have the opportunity to reflect and judge past experiences (Dube & Schmitt 1991). These ongoing internal evaluations can be assessed through satisfaction measurement.

Leading to decisions about future behaviour. Attitudes lead to future decisions about what we will do in response to our experience—behavioural intentions. We may decide to return for the service, never return, or fall somewhere in between. Other factors (e.g., switching costs, situational circumstances, other people, or other influencers) may affect the decision. This facet of loyalty can be measured in conjunction with satisfaction.

Eventually, these feelings manifest in behaviour. When the opportunity arises, behavioural intentions and satisfaction judgments outwardly manifest in actual behaviour. Thus, loyalty is both behaviour and behavioural intention.

The behavioural consequences of loyalty include:
- Returning for the service
- Purchasing related services
- Exerting extra effort or paying more to return
- Not shopping for other options
- Recommending the service to others (aka, positive word of mouth).

Figure 1. Experience—Satisfaction—Loyalty Chain

Loyalty as behavioural intention, that is actions one will or could take if the opportunity presents itself, includes:
- Likelihood to return
- Proportion of products/services purchased or likelihood to purchase new products/services
- Willingness to exert extra effort or pay more to return (i.e., convenience or price tolerance)
- Refusal to consider other options
- Likelihood to recommend the service to others

How do these fundamentals of loyalty translate to the hospital-doctor relationship? Doctor loyalty as a behaviour includes:
- Remaining on the medical staff or VMO panel
- Maintaining or increasing admissions
- Referring patients to doctors in the system
- Participating on committees and in quality improvement initiatives
- Not shopping for other options
- Refusing overtures from investment groups or entrepreneurial colleagues.
- Recommending the service to other doctors (aka, positive word of mouth).

Doctors loyalty as behavioural intention includes:
- Intent to remain on the medical staff or VMO panel
- Admissions intentions (e.g., reducing splitting)
- Willingness to exert extra effort or pay more to return (i.e., convenience and price tolerance)
- Refusal to consider other options (e.g., bringing procedures in-office, competitors, or additional business ventures)
Predicting Doctor Loyalty: The New Science of Doctor Relationships

- Likelihood to recommend the hospital to friends, family, and other doctors.

**Measuring and Improving Doctor Loyalty: What is Best Practice?**

If loyalty is the “holy grail”, what predicts loyalty?


- Written feedback is also a predictor of loyalty; negative comments predict both the absence of loyalty behavioural intentions and actual behaviours (e.g., Mattsson, Lemmink, & McColl 2004).

Furthermore, studies have also shown the relationship between satisfaction and loyalty to be non-linear and slightly moderated by personal attributes that contribute to higher or lower satisfaction (e.g., trust, affect, expectations) (Oliva et. al. 1992; Bloemer & Kasper 1995). This has important implications:

- The loyalty effect remains weak until doctors rate a hospital’s services the full “5” on a 1 to 5 balanced scale (“Very Poor” to “Very Good”). Simply put, good is not good enough to keep your doctors loyal. As Bloemer (1992) confirms, when “satisfaction increases above a certain level, customer loyalty will increase rapidly.”

- Doctors may systematically differ on the values they place on different components of service based upon their expectations, trust, affection, and other personal factors.

In fact, many of the personal variables that factor into the loyalty decision are beyond the hospital’s control (e.g., lifestyle desires, family relationships, geographical preferences, convenience, personality, self-image, trust, affection). Therefore, loyalty on its own cannot be achieved or pursued as a reasonable goal by many providers…satisfaction is the only feasible goal for which they should strive. (Oliver 1999).

For this reason and others, measuring loyalty alone is inadequate. All of the aforementioned loyalty behaviours (e.g., maintaining admissions, referrals, recommending) may convey a false impression of doctor loyalty. Doctors may simply lack better options or be burdened with high switching costs (e.g., temporarily decreased performance, uncertainty, pre-switching evaluations, setup, and sunk costs) (Jones, Mothersbaugh, and Beatty 2002). Once opportunities arise and the perceived switching-costs decrease, the façade drops and a doctors’ true feelings and behavioural intentions surface.

Similarly, surveying doctors for overall satisfaction alone or using only a small number of measures has proven inadequate. Equal overall satisfaction scores can still show differences in loyalty behavioural intention (Stauss 1996). Especially in the service settings, loyalty and satisfaction constructs are multidimensional with aspects such as interpersonal relationships, involvement, and communication typically playing prominent roles (Czepiel 1990; Mano & Oliver 1993; Berry 1993). In hospital-doctor service relationships these are especially complex constructs that require multiple measures to accurately assess each facet.

In sum, both science and Press Ganey’s experience partnering with clients who achieved the great success in improving admissions and referrals (loyalty behaviour, see Clark 2006) shows that measuring and improving both behavioural intention measures of loyalty and loyalty’s antecedents—doctor satisfaction is critical to hospital success. Specifically, we recommend measuring doctor satisfaction using a unique multidimensional approach (described below) and doctor loyalty by asking behavioural intention questions that research shows are the most predictive of actual behaviour as well as profitable growth—“Likelihood to recommend” measures of loyalty behavioural intention (Reichheld 2003; 2001). Written feedback also predicts loyalty and must be integrated into the survey process. The satisfaction measures that correlate strongest with the loyalty behavioural intentions measured and the qualitative doctors comments garnered will guide an organization’s strategic approach to optimal doctor relationships.

**IN A NUTSHELL:**

- **Doctor loyalty is the ultimate goal.**
- **Loyalty is an emotion derived from experience and evaluation leading to future behaviour.**
- **Loyalty is categorised as both behaviour and behavioural intention with multiple indicators.**
- **Behavioural intention measures effectively predict doctor loyalty behaviour.**
- **Satisfaction is the strongest predictor of both loyalty behaviour and behavioural intention.**
- **Written feedback also predicts loyalty.**
- **The best practice approach to improving doctor loyalty behaviours of a medical staff is measuring loyalty behavioural intention (“Likelihood to recommend”) and using a scientific, multidimensional approach to doctor surveying.”

1Several studies cited include the health care services setting or utilise Press Ganey measures.
Predicting Doctor Loyalty: The New Science of Doctor Relationships

Study Description

**Purpose**
If the ultimate antecedent of doctor loyalty is a set of multidimensional doctor satisfaction measures, the crucial question becomes “What are the dimensions of doctor satisfaction most predictive of loyalty?”

To answer this question, this paper draws on existing research studies and original data analysis from Press Ganey’s national database on doctor satisfaction. This analysis will:
- Ascertain the predictors of doctor loyalty
- Decipher how doctor loyalty can be influenced

**Method**
This study combined a comprehensive literature review with original data analysis. The systematic literature review evaluated more than 3,000 original research articles retrieved from the National Library of Medicine’s PubMed/Medline database. The literature review provided the basis for the model discussed earlier and ensures that the research remains grounded in current science.

In 2005, Press Ganey surveyed more than 22,000 doctors using a measurement system that surpasses psychometric standards for reliability and validity.

Survey questions are designed to enable admitting doctors to evaluate their experiences practicing in a hospital. Questions range across the entire spectrum of clinical experiences—including, but not limited to, quality assessments of medical equipment and technology, nursing staff, patient care, execution of written orders, path turnaround time, and their own fellow medical staff members.

The research discovered four distinct dimensions of the doctor practice experience of paramount importance to their satisfaction and loyalty:
- Quality of patient care
- Ease of practice at the hospital
- Relationship with leadership
- Overall assessment

Results

**Loyalty: What Works**
Table 1 and Table 2 reveal the strongest predictors of doctor loyalty for the two most robust measures of loyalty behaviour intention. “Likelihood to recommend to colleagues” predicts referrals and word-of-mouth effects among medical staff and the “Likelihood to recommend to friends and family” predicts doctors’ own loyalty behaviour in maintaining or increasing admissions.

### Table 1. Highest Correlations to Loyalty Behavioral Intention Measure—Likelihood to Recommend to Colleagues

<table>
<thead>
<tr>
<th>Survey Item</th>
<th>Recommend facility to other doctors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. O5. Satisfaction with facility</td>
<td>0.878</td>
</tr>
<tr>
<td>2. O6. Quality of care at facility</td>
<td>0.817</td>
</tr>
<tr>
<td>3. O4. Facility enhanced your practice</td>
<td>0.748</td>
</tr>
<tr>
<td>4. O2. Patient care made easier</td>
<td>0.741</td>
</tr>
<tr>
<td>5. O3. Administration deals with changes</td>
<td>0.688</td>
</tr>
<tr>
<td>6. A1. Quality of patient care</td>
<td>0.677</td>
</tr>
<tr>
<td>7. I5. Confidence in Hospital Admin</td>
<td>0.660</td>
</tr>
<tr>
<td>8. O1. Timely clinical info re: patients</td>
<td>0.659</td>
</tr>
<tr>
<td>9. J5. Response of Hospital Admin</td>
<td>0.641</td>
</tr>
<tr>
<td>10. A3. Response to doctors’ concern</td>
<td>0.617</td>
</tr>
</tbody>
</table>

*p < 0.001*

### Table 2. Highest Correlations to Loyalty Behavioural Intention Measure—Likelihood to Recommend to Family & Friends

<table>
<thead>
<tr>
<th>Survey Item</th>
<th>Likely to recommend facility to friends &amp; family</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. O5. Satisfaction with facility</td>
<td>0.800</td>
</tr>
<tr>
<td>2. O6. Quality of care at facility</td>
<td>0.790</td>
</tr>
<tr>
<td>3. O4. Facility enhanced your practice</td>
<td>0.709</td>
</tr>
<tr>
<td>4. A1. Quality of patient care</td>
<td>0.685</td>
</tr>
<tr>
<td>5. O2. Patient care made easier</td>
<td>0.668</td>
</tr>
<tr>
<td>6. O3. Administration deals with changes</td>
<td>0.622</td>
</tr>
<tr>
<td>7. O1. Timely clinical info re: patients</td>
<td>0.622</td>
</tr>
<tr>
<td>8. J2. Response of Nursing Staff Lead</td>
<td>0.590</td>
</tr>
<tr>
<td>9. I5. Confidence in Hospital Admin</td>
<td>0.589</td>
</tr>
<tr>
<td>10. J1. Response of Medical Staff Lead</td>
<td>0.579</td>
</tr>
</tbody>
</table>

*p < 0.001*
These results are noteworthy for several reasons:

- **Satisfaction is the chief predictor of doctor loyalty.** Supported by the literature review, satisfaction with the facility was the strongest predictor of loyalty for both measures. This means that satisfaction and all the factors that coalesce to determine satisfaction represent the surest path to enhancing doctors' loyalty.

- **Quality valued above all other factors.** Doctors treasure quality at the facilities to which they choose to admit patients. Figure 1 highlights the effect "Quality of care at facility" has on doctor loyalty. The correlation coefficient of $r = 0.80$ tells us that doctors will act with a predictably powerful disposition in favour of facilities with greater quality of care. When doctors evaluate quality of care at a facility, they not only judge the clinical quality evident among colleagues and staff but the quality of their surgical and specialist counterparts. Further reinforcing the salience of quality is doctors' ranking of “Quality of patient care” as the fourth and sixth items most important to their loyalty. This assessment of quality takes into account the human capital providing direct patient care—nurses, aides, therapists, and all the support processes. Efficiency and effectiveness are also components of quality especially important to doctors.

- **Doctors’ need for efficiency and effectiveness in hospital operations is expressed in the third and fourth loyalty factors—"Facility enhanced your practice" and "Patient care made easier".** The health care environment continues to exert tremendous pressure on doctors. They need and expect hospitals to be both accommodating and to contribute directly to doctors' bottom line by ensuring flawless operational efficiency—from the doctor's perspective. This includes convenient access to facilities such as OR, diagnostic imaging, or cath lab. The results confirm those found in other studies that identify consumer-like behaviour among doctors admitting patterns (Burns & Wholey 1992), and demonstrate that improving service to medical practices and providing this sort of extrinsic motivation results in greater doctor satisfaction—more admissions and referrals (Burns et. al. 2001, Rezac 1991). With more options than ever, doctors are making it clear that their loyalty will only be given to those hospitals that approach them as valued customers whose unique needs are assessed and met. Hospitals should not expect doctors to prove their loyalty. Rather, doctors expect hospitals to demonstrate loyalty by helping their patients and their practice. The strength of this relationship—"Patient care made easier"—is demonstrated in Figure 2.

- **Administrative adaptability—the key characteristic doctors most value in hospital executives.** On local, regional, and national levels, the health care marketplace is rapidly changing and doctors are on the frontlines. When the medical indemnity crisis hit, doctors suffered the most. As pay-for-performance continues to emerge, doctors must change their clinical practices. As the risk/reward scenarios are continuously redefined and the demands of clinical practice change, doctors look to hospitals to adapt and
Predicting Doctor Loyalty: The New Science of Doctor Relationships

support their needs. Figure 3 demonstrates the correlation analysis. Doctors are telling hospital administrators that if they do not do at least a “very good” job of adapting the hospital’s services, policies, procedures, and the tenets of their customer-provider partnership, doctors will find another partner willing to customise processes and procedures to meet their needs. The doctor-owned specialty hospital trend is also indicative of this strong loyalty factor. More and more doctors are abandoning the idea that they need a hospital partner to practice—they can do it on their own.

What doesn’t work?

With an understanding of the factors driving doctor loyalty, it is important to note the factors that have little impact on doctor loyalty. If your goal for a particular project is to improve doctor satisfaction and loyalty, it is important not to waste time and resources on initiatives with little or no payoffs.

Table 3 outlines the doctors’ responses that are least predictive of their loyalty intentions. It should not be a surprise that services that are not mission-critical to most doctors, such as pharmacy and physiotherapy, were least correlated to doctors’ loyalty. What may be a surprise is that technological aspects, such as radiology turnaround and online information systems, received low priority from doctors. These data confirm a growing body of research (Likourezos et al. 2004) that demonstrates that advancements in information systems technologies do not translate into increased doctor satisfaction. While the need for health care information technology (IT) innovation is great and there is the potential for doctor dissatisfaction with IT systems, a hospital cannot rely on electronic medical records or other IT innovations to increase doctor satisfaction. In the final analysis, doctors (save the most advanced academician) rarely need the latest and greatest technology. Rather, the evidence demonstrates that doctors need the fundamentals of medical technology and the operational efficiency to enable the seamless integration of technology.

Table 3. Lowest Correlations to Loyalty Behavioural Intention Measures

<table>
<thead>
<tr>
<th>Survey Item</th>
<th>Recommend facility to other doctors</th>
<th>Likely to recommend facility to f/f</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacy</td>
<td>0.394</td>
<td>0.391</td>
</tr>
<tr>
<td>Turnaround for radiology results</td>
<td>0.410</td>
<td>0.390</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>0.387</td>
<td>0.377</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>0.392</td>
<td>0.374</td>
</tr>
<tr>
<td>Specialists around for consults</td>
<td>0.353</td>
<td>0.370</td>
</tr>
<tr>
<td>On-line access to path/rad info</td>
<td>0.348</td>
<td>0.351</td>
</tr>
</tbody>
</table>

Conclusions

New Science—New Practices

New science means applying quality management expertise to measuring and improving the inherent quality of the health care facility as experienced by the doctor. The result? In every industry, the result of any great customer experience is customer loyalty.

Managerial Implications & Practical Tactics

- Doctors demand partnership in exchange for loyalty. They demand that their needs are understood and met. There is no better, more scientific, or systematic way to assess and address doctors’ needs than to survey the dimensions that predict doctor loyalty and address the unique needs presented by the medical staff or the VMOs.
- Measure doctor loyalty by using the behavioural intention measures of “Likelihood to recommend to friends and family” and “Likelihood to recommend to colleagues”. These measures predict doctors’ propensity to continue or increase admissions and word of mouth and referrals, respectively.
Focus improvement efforts on the factors that predict doctor loyalty behavioural intention. Specifically, measure and improve doctor satisfaction with:

- Quality of care
- Ease of practice
- Administrative adaptability (i.e., relationship with leaders)

Utilise multiple methods to understand the perspective of your doctors. For example, a core strategy for high performing organisations has been measuring and improving the satisfaction of all customers, including doctors, through:

- Annual doctor satisfaction survey
- Quarterly hospital/doctor accountability report
- Monthly doctor call program
- Monthly doctor loyalty team
- Doctor “action line” (daily)
- Personal contact (daily)
- Shared expectation sessions (periodic)

Slice and dice your doctor data to determine the types of doctors most dissatisfied and at-risk for leaving.

Progressive hospitals are also using this doctor satisfaction data to drive performance improvement, guide strategic planning, direct personnel planning, and incentivise executives. Integrate doctor satisfaction data into your strategic planning and management decision making process. For all decisions, consider the impact on doctors.

- Do not make doctors prove their loyalty to the hospital. Rather, a hospital should prove its loyalty to doctors by proactively and scientifically assessing and addressing their needs.
- Do not simply consider the value of a doctor or doctor groups’ admissions. Calculate and consider the lifetime value of their loyalty to your institution. Understanding that a particular individual doctor may mean millions in future revenue tends to reframe perceptions.
- Hospital managers may already be working hard to respond to and address doctor needs. To achieve a full return on this investment in terms of doctor loyalty, it is absolutely necessary to effectively communicate these accomplishments. Doctors will not know what you have done for them unless you tell them. Likewise, you will not know whether doctors know and appreciate what you have done unless you measure.
Appendix A: Causal Factors Inside the Experience, Satisfaction, and Loyalty Chain (Literature Review)

Service experiences result in customers evaluating the experience and making judgments as to their level of satisfaction with that experience.

Satisfaction has many antecedents. Satisfaction is complex and multidimensional, the result of both cognitive and affective judgments (Mano & Oliver 1993).

Emotions—collections of chemical and neural responses generated by the brain—are feelings that motivate, organise, and guide perception, thought, and action (Damasio 1999; Oliver 1996). Emotions arise during the subjective experience and are brought about by a specific stimulus (e.g., a frustrating interaction with a staff member) resulting in a physiological and behavioural response in the patient. The emotions tend to intensify during reflection (Damasio 2000; Oliver 1993).

When anyone evaluates past experience, two appraisals—emotional (i.e., affect) and cognitive (i.e., logic)—factor into satisfaction judgments and behavioural intentions (Oliver 1993; 1994). The affective components of satisfaction represent the strongest predictor of loyalty (Yu & Dean 2001). Research from diverse fields have empirically confirmed this direct relationship between satisfaction and loyalty; specifically, satisfaction—especially the affective/emotional aspects of satisfaction—consistently predicts loyalty (e.g., Bloemer & de Ruyter 1999; Yu & Dean 2001). Likewise, Bloemer & de Ruyter (1999) found that satisfaction predicted loyalty with moderating effects from positive emotions. In fact, emotional intensity is such a strong predictor of future action that it necessitates measuring loyalty behavioural intention (“likelihood to recommend”) in conjunction with satisfaction as this comprises the total emotional impact of the events on an individual (Frijda et. al. 1992). Thus, to effectively predict real loyalty behaviours, both satisfaction and loyalty behavioural intention must be measured.
Predicting Doctor Loyalty: The New Science of Doctor Relationships

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