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Hospital trust or doctor trust? A fuzzy analysis of trust in the health care setting

Sijing Zheng [a], Siu Fu Hui [b,1], Zhilin Yang [a,*]

[a] City University of Hong Kong, Hong Kong, China
[b] ALK Abello A/S in Great China, China

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ABSTRACT

Are interpersonal trust and organizational trust mutually complementary or substitutable in determining patient purchasing intention? To address this issue, we develop a theoretical model to distinguish and test the interrelationship between the two types of trust in the setting of the health care industry. Using multiple regression analysis and fuzzy-set qualitative comparative analysis, we reveal that organizational trust and interpersonal trust are complements rather than substitutes. We also examine how four primary boundary conditions (i.e., trust propensity, perceived behavioral control, price sensibility, and brand awareness) influence the relationships between the two types of trust and purchase intention. Our findings provide unique insights for health care practitioners to effectively manage trust in hospital-doctor-patient relationships.

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1. Introduction

Scholars have intensively investigated the production and formation of trust (McKnight, Cummings, & Chervany, 1998; Zucker, 1986). They regard that trust can develop in relation to either a human being or an organization (Doney & Cannon, 1997; Grayson, Johnson, & Chen, 2008). Organizational trust and interpersonal trust, though related, represent different concepts (Anderson & Narus, 1990).

Interpersonal trust comes from a relatively detailed and precise history of interaction with specific interactional partners (Kramer, Brewer, & Hanna, 1996). Through this extensive, long-term interaction, the trustworthiness of a given individual can be revealed. For example, Mayer, Davis, and Schoorman (1995) reveal that the evolution of interpersonal trust is dependent on mutual judgment on competence, benevolence, and integrity. Regarding organizational trust, however, customers draw inferences from historical corporate data (e.g., reputational information) and from their interaction with representatives, a subsample of the population on the basis of which customers are attempting to generalize organizational trust. In addition, scholars also recognize that interpersonal trust must be built from scratch each time someone encounters a new exchange partner, whereas organizational trust takes a long time to build and is relatively stable. Organizational trust can be considered a valuable strategic resource that contributes to a firm's competitive advantage (Grayson et al., 2008; Kramer et al., 1996).

The distinctions and interrelations between interpersonal and organizational trust, however, remain unclear. Some academics have suggested that organizational trust and interpersonal trust complement each other (e.g., Doney & Cannon, 1997; Milliman & Fugate, 1988; Strub & Priest, 1976). Indeed, they indicate that the presence of one enhances the effectiveness of the other. Others argue that organizational trust and interpersonal trust are substitutes (e.g., Luhmann, 1979; Merton, 1957). According to this relationship, the buyer would attribute successful collaboration to the competence and/or goodwill of a particular representative, but not to the whole organization, and vice versa.

The purpose of this study is to reconcile the two perspectives and provide new insight into trust development with the aim of elaborating theory on how the two types of trust work effectively together to influence purchase intention. The health care setting is a proper context in which to study trust because trust exists on both organizational and interpersonal levels. The development of our model provides a number of contributions to trust literature and to actual practice. First, we draw upon and integrate existing theories to specify the conditions under which organizational trust and interpersonal trust could be substitutes or complements. Second, we supplement the regression analysis with fuzzy-set qualitative comparative analysis (fsQCA). By doing so, we can draw out the “causal recipes” to explain the various possible combinations of trust and related mechanisms sufficient for obtaining high consumer purchase intention. Third, the present paper adds new insights to the supplier-buyer relationship by showing how suppliers (hospitals in our study) target the “right” consumers in the “right” situation.

* Corresponding author.
E-mail addresses: mksijing@cityu.edu.hk (S. Zheng), Andrew.hui@alk.net (S.F. Hui), mkzyang@cityu.edu.hk (Z. Yang).
[1] He is also a graduate of the Doctor of Business Administration (DBA) program at the City University of Hong Kong.

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The remainder of this paper is organized as follows. Section 2 contains theoretical background and research hypotheses. Section 3 describes the methodology. Section 4 looks at the test results and discusses their implications for theory and practice. In Section 5, we conclude by outlining the managerial implications, limitations, and an agenda for further research.

2. Theoretical background and research hypotheses

2.1. Defining trust

Trust, among other factors (e.g., commitment and shared values), has long been recognized as an essential relational attribute that can facilitate transactions and prevent opportunism (Gulati, 1995; Morgan & Hunt, 1994). A wide range of definitions of trust has been presented in the literature (Bradach & Eccles, 1989; Mayer et al., 1995; Sheppard & Sherman, 1998; Rousseau, Sitkin, Burt, & Camerer, 1998). For purposes of this discussion, we adopt Mayer et al.'s (1995) view by defining trust as the "willingness of a party to be vulnerable to the actions of another party". In other words, trust is an underlying psychological condition comprising the intention to accept vulnerability based upon positive expectations of the intentions or behavior of another.

Trust exists at multiple levels in our society (McKnight et al., 1998; Sheppard & Sherman, 1998; Zaheer, McEvily, & Perrone, 1998). In the early treatment, trust was viewed as an underlying psychological condition: trust in human nature (Deutsch, 1958). This personality-based form of trust has been referred to by other scholars later as "a disposition to trust" (Kramer, 1999; McKnight et al., 1998). It was not until the 1980s that trust was defined, in a specific relationship, as the reliance by one entity (person, group, or firm) upon a voluntarily accepted duty on the part of another entity to protect the interests engaged in an economic exchange (Hosmer, 1995; Larzelere & Huston, 1980; Rotter, 1967). At this stage, scholars observed the importance of trustworthiness. Interestingly, parallel studies in the field of sociology took a collective view to argue that trust is a set of social expectations and is essentially social and normative rather than individual and calculative (Lewis & Weigert, 1985; Shapiro, 1987; Zucker, 1986). Thus, different types of trust were uncovered and set the stage for later examination.

2.2. Interpersonal trust and organizational trust: Substitutes or complements?

Interpersonal trust comprises the foundation of interactions in a dyadic fashion, and includes individual cognition and emotions related to specific incidents, processes or individual characteristics. Zand (1972) defines interpersonal trust as the willingness of one person to increase his or her vulnerability to the actions of another person whose behavior is not under his or her control. Interpersonal trust differs from the traditional idea of trust propensity in that it focuses on a specific partner with whom a person has an exchange relationship (Couch & Jones, 1997). Such interactions take specific contextual factors into consideration. Presumably, one's trust reflects the status or quality of one's current relationship with the trustee (Butler & Cantrell, 1984; Jennings, 1971; Michalos, 1990). For example, in the medical setting, patients have autonomy to accept or reject their doctors' prescription. It is believed that during the doctor-patient encounter, trust in a doctor may increase the likelihood that a consumer would follow the doctor's recommendations. For example, a patient might build a strong and intimate relationship with a doctor over the years, and when the doctor transfers to another hospital, the patient will follow the doctor and change to that hospital as well. Moreover, when interpersonal trust is high, a patient is more likely to give the doctor the benefit of the doubt rather than jump to conclusions about the doctor's motives and intentions. Even if suspicions arise from unexpected actions by one party, the predictability inherent in high interpersonal trust is likely to be associated with lower levels of doubt. That is to say, if a patient trusts the doctor, s/he will be more likely to resolve disagreements and buy the prescribed medication.

Organizational trust refers to a customer's views regarding the functioning and capability of a particular organization or public institution (Lewis & Weigert, 1985; Morgan & Hunt, 1994). Organizations strive to increase organizational trust because such bonding helps them maintain long-term relationships with customers (Bradach & Eccles, 1989). When no trust encompasses the relationship between consumers and an organization, both parties face high uncertainty and risk in conducting a transaction. In addition, belief in a firm's system can reduce the risk of jeopardy arising from interpersonal distrust. Organizational trust in a health care setting can be specified as structural assurances, which are measured by hospital reputation (or mass communication influence), and certification endorsement (McKnight et al., 1998; Meyerson, Weick, & Kramer, 1996). Organizational reputation affects customer's judgments about the organization in that customers believe an organization with a good reputation signals a high-level of trustworthiness (Barney & Hansen, 1994; Rindova, Williamson, Petkova, & Sever, 2005). It reflects the professional competence of an organization on which one can rely in the absence of sufficient information (Fombrun, 1996). Certification endorsement officially recognizes or acknowledges the competence and professionalism of an organization. Taken together, organizational trust enhances customers' trust beliefs, encourages customers' purchase intention and helps organizations maintain a long-term relationship with their customers.

In line with previous studies (e.g., Doney & Cannon, 1997; Grayson et al., 2008), we view "trust" as a function of attributes in the interpersonal relationship and in the individual-organizational relationship. The effects of two trust factors, thereby produce an interaction on a consumer's decision making. Grayson et al. (2008) refer these two types of trust as "narrow-scope trust" because it "reflects only the relationship in which it has developed and thus has a relatively limited scope of influence." Scholars have variously interpreted the tension between organizational trust and interpersonal trust. Some scholars argue that trust can develop through a transference process (Doney & Cannon, 1997; Milliman & Fugate, 1988; Strub & Priest, 1976). For example, Strub and Priest (1976, p.399) describe the "extension pattern" of gaining trust as using a "trusted third party's definition of another as trustworthy as a basis for defining that other as trustworthy." In other words, trust can be transferred from one trusted "proof source" to another person or another group with which the trustor has little or no direct experience. The public reporting of an organization's policies enables customers to make an informed choice about their employees while customer trust in an organization may, in turn, derive from accumulated employee experience. In health care organizations, trust in a hospital influences the degree of trust in a doctor, who is part of that organization (Goold, 2001; Mechanic & Schlesinger, 1996; Ubel et al., 1995). This can be explained by the "halo effect", which proposes that people tend to associate qualities of its internal subsidiaries with the qualities of one party. Conversely, key personnel represent an important personal source of trust for the firm. As a primary point of contact, patients' trust of a doctor can spill over to the hospital. As one of our interviewees conveyed, "Doctors matter. I will come to a district hospital with top-quality doctors, rather than national hospitals with inadequate doctors." Therefore, each factor can invoke a different trust-building process. When transference occurs, organizational trust and interpersonal trust complement each other and interactively determine the decision outcomes. Scholars have argued that distrust in one sphere of a relationship can also transfer to other spheres if a person lacks other information (Kramer, 1999). For instance, a person's past experience with insurance salespeople often results in an initial state of distrust (Adkins & Swan, 1980).

The functionalist view paints a different picture of how decisions are made. According to this view, social systems depend on the effective and efficient enactment of certain critical functions (Durkheim, 1933). Functionalist theories predict that over time, a particular function can

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