A dramaturgical view of the health care service encounter

Cultural value-based impression management guidelines for medical professional behaviour

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The consumption process in a service, in most cases, involves a series of interactions between the customer and the organization that provides the service. These interactions or service encounters (otherwise called "moments of truth") provide the customer with opportunities to evaluate the quality of the service received. Conversely, these interactions present the service provider with opportunities to manage customer perceptions of service quality. Thus, a prerequisite to improving service quality is a thorough understanding of the service encounter in the context of the entire consumption experience.

Our knowledge of quality in services has advanced beyond primary development levels; we are able to recognize and distinguish between "good" and "bad" service quality (Chase and Kellog, 1990) by discerning attributes and relationships among attributes of (un)acceptable service quality. Initial work by Parasuraman *et al.* (1985) on the structure of service quality (comprised of the attributes of reliability, assurance, tangibles, empathy and responsiveness) has prompted continued discussion of the issue of measurement of service quality (see Carman, 1990; Cronin and Taylor, 1992, 1994; Parsuraman *et al.*, 1991, and 1994); and that of Bolton and Drew (1991), Anderson *et al.* (1994), and Rust and Oliver (1993) have addressed the impact of efforts on firm performance. Although there has been considerable progress in measuring these attributes of service quality, our knowledge of service quality will not progress beyond what Jaikumar and Bohn (1986) call the second development level unless we are able to obtain knowledge on the control of these attributes. Once we have the knowledge to control the attributes at the customer contact level, we should be able to anticipate and manage contingencies in delivering quality service effectively.

The dramaturgical view of the service encounter is an approach that has been used to understand the service consumption experience (Grove and Fisk, 1983). Impression management principles discussed by sociologists using the drama metaphor in social behaviour present guidelines to control the service encounter. The basis of the dramaturgical view in services marketing is the metaphor of (customer and provider) behaviour as drama and the service

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experience as theatre. Early work in the area of drama and theatre by sociologists Burke (1945, 1950, 1968), Goffman (1959, 1967, 1974) and later by Perinbanayagam (1974, 1982, 1985) used this symbolic interactionist paradigm to understand social behaviour. This resulted in the emergence of the sociological school of thought in understanding human behaviour by viewing people as deriving meanings from symbols in any setting. Brissett and Edgley (1990) suggest that this metaphorical depiction offers insights most forcefully when examining face-to-face interactions such as in high-contact services.

Indeed, as a subset of human behaviour, the service encounter is a personal (and social) interaction between service provider and service customer. A service encounter is a social encounter, especially in high contact service experiences. While it is true that all service encounters are alike in that they share certain common characteristics, there are differences in client expectations and perceptions, provider characteristics and service delivery realities (Czepiel *et al.*, 1985). A significant constituent of individuals' expectations and perceptions in social behaviour is accounted for by their cultural values (Barnouw, 1963). As social interactions, all service encounters are performed within the context of the cultural background of the participants: that is, both the client and the service provider representing the organization. Thus, culture plays an important, if sometimes unrecognized, part in the service encounter. Cultures have been studied along value orientations of societies in terms of an individual's relationship to nature, time, activity, and other individuals. Service encounter guidelines can be established by relating impression management along these cultural values. The drama metaphor is particularly useful in a high-contact service such as in health care, because the health care consumer (compared to users of other services) is relatively less knowledgeable to evaluate the technical aspects of the service and, therefore, utilizes other perceptual cues such as provider behaviour and tangibles in the setting to evaluate quality (Hulka and Zyzanski, 1982; Ware and Snyder, 1975; Ware *et al.*, 1983).

In viewing the health care experience as theatre, this paper demonstrates how the drama metaphor is applicable and useful in understanding perceived quality in health care services. Once the relevance of the metaphor in health care services is established, a strategic model of the medical encounter is presented. Finally, impression management guidelines based on individual variations of cultural influences for improving the perceived quality of the health care experience in patient-provider encounters are suggested. To suggest that it is possible to capture the intricate variations in every medical encounter is unrealistic. From a practical standpoint, this paper serves to stimulate the imagination of physicians and health care administrators on managing patient evaluations by paying attention to certain characteristics of the medical encounter. However, the impression management guidelines presented here could also be applied to interactions between patients and other medical/paramedical providers, e.g. physiotherapists, where a similar basis for relationship may exist.

The dramaturgical view of health care service encounters

The drama perspective in services has been discussed and elaborated in the marketing literature (see, for example, Grove *et al.*, 1992). Essentially, the marketing mix as extended for services by inclusion of the "three new Ps" of participants, physical evidence, and process (Booms and Bitner, 1981; Magrath, 1986; Prus and Frisby, 1984) parallel the drama concepts of actors/audience, setting, and performance (Grove *et al.*, 1992). Thus, there are three critical elements that need to be examined in establishing the relevance of the drama metaphor to health care services:

(1) *actors/audience* – the roles of the patients and the medical personnel as participants;

(2) *setting* – the physical evidence of the facility where the service is delivered and consumed as determined by the patient's medical condition; and

(3) *performance* – the process and outcome of health care delivery and consumption.

The actors/audience

In health care, physicians and patients have their respective roles to play. Anthropologists and sociologists have examined the rights and duties of the individuals who occupy these roles for the ill and the healers as defined in various societies (King, 1962). Parsons (1951, 1958) delineated these roles as follows: the physician has a professional role that demands technical competence, emotional neutrality and a commitment to serving people; and, the sick person occupies a social role in the relationship while being relieved of his or her normal social responsibilities in seeking medical help The meaning of illness is almost entirely determined by the medical profession (Freidson, 1970). Parsons (1975, p. 264) argues that the physician-patient encounter involves an "asymmetrical structure of role relationship" which is confined to a hierarchical component of authority, power and prestige.

Hippocrates wrote in fourth century BC (1923 translations) that the patient may recover his health simply through his contentment with the goodness of the physician! A further quote, with regard to how the physician might achieve this, suggests strong resemblance to theatrical metaphors:

> On entering (the sick person's room, the physician must) bear in mind (his) manner of sitting, reserve, arrangement of dress, decisive utterance, brevity of speech, composure, bedside manners, care, replies to objection, calm self-control... his manner must be serious and humane; without stooping to be jocular or failing to be just, he must avoid excessive austerity; he must always be in control of himself.

The simultaneity of consumption and production in services requires customer participation in the production of the service. In medical care, the physician's effective diagnosis depends on the accuracy of the patient's account of the complaints and symptoms. Physicians' advice carefully educates patients on

what their responsibilities are in the treatment process. Studies have shown that the socio-emotional satisfaction of the patient depends on the communicativeness of the physician and is a significant determinant of overall perceived quality (John, 1991). The socio-emotional satisfaction of the patient affects post-operative recovery and treatment regimen compliance (DiMatteo, 1979). Additionally, treatment regimen compliance affects the medical outcome. Thus, while the physician role in the physician-patient relationship is significant, the patient role in successful medical encounters is no small factor.

The setting

Since the patient must enter the premises of the health care provider in most health care experiences, the physical evidences at the hospital or nursing home or doctor's clinic play a significant role in the evaluation of quality. Service quality measurement instruments include measures of tangibles because customers of services have fewer intrinsic cues on which to evaluate service quality and, therefore, use extrinsic cues such as physical environment to infer quality (Zeithaml, 1981, 1988).

Drawing from research in environmental psychology, Bitner (1992) discussed the many ways in which the physical environment creates an image and influences the behaviours and satisfaction of employees and customers in service businesses. In her framework for understanding the relationships between the employees/customers with the physical environment, she discusses internal (cognitive, emotional and physiological) responses of the individuals and the resulting behaviours. A holistic perception of the "servicescape" evokes approach (positive) and avoidance (negative) behaviours from employees and customers. Bitner places the health care service encounter in the category of the most complex of "servicescapes". Although Bitner does not refer to any research in the health care area, studies have shown that certain colours and textures in the hospital room can affect the recovery process for the patient (King, 1962). From lily-white uniforms for all medical personnel to squeaky-clean floors and walls, the physical environment of the hospital communicates a sense of hygiene. The physical environment in a health facility elicits a certain social response from patients and visitors that is quite different from that in a setting such as at a cinema or a sports stadium.

The medical condition of the patient determines the type of facility where the patient will receive the health care service. Emergency and acute care requiring surgical procedures will very often require hospitalization. The medical condition would also determine the area/ward of the hospital where the patient will be treated. The physical environment in different wards can be very different. The emergency ward is designed for speedy medical attention and at times might look chaotic to the untrained eye. On the other hand, an in-patient is in a setting that is designed to enhance patient comfort and recovery from surgery and treatment. Ambulatory illnesses may not require a hospital visit and the patient might instead be consulting the physician in a clinic or doctor's office. Although much less complex an environment compared to that in a

hospital, patients in any health clinic are influenced by the setting in their behaviours and evaluations.

Perceptions of the physical environment have been shown to have influenced unrelated feelings about the object of consumption (Obermiller and Bitner, 1984). Health care settings are visually appealing and appear coherent in suggesting order and clarity. If the physical environment has a significant impact on the patient's evaluation of the health care experience, it behoves the health care provider to design the setting to evoke positive cognitive and emotional responses.

The performance

Comprising all the encounters with the contact personnel, patients evaluate the functioning of the hospital based on what they actually witness during these experiences. The performance in health care is primarily based on that of the physician. Other contributors (actors) to the performance include physicians' assistants, nurses and nurses' aides, surgeons, anaesthetists, laboratory technicians, pharmacists, admissions and discharge staff, housekeeping staff, etc. Each encounter contributes to the production of the service and the performance is the product of these encounters. In each case, the performance at the encounter is primarily based on the approach of the contact person as dictated by his/her role in the total service delivery. The patient uses both process and outcome cues of all of these encounters to evaluate the total health care consumption experience.

Numerous studies by medical sociologists have demonstrated that the technical aspects of care are not sufficient in treating the patient and that socio-emotional aspects of care are more significant for the patient (Friedson, 1961; Ben-Sira, 1982). It is a paradox that patients are increasingly disenchanted with medical care when physicians today can do so much more for their patients with more sophisticated and powerful medical technology than previously. The explanation, argue many writers (Eisenberg, 1977; Engel, 1977; Shattuck, 1977) lies in the fact that as the body of technical medical knowledge grew, there developed a sharp division between the physical care of the patient as science and the emotional care of the patient as interpersonal art. DiMatteo (1979) conducted an elaborate social-psychological analysis of the physician-patient rapport, illustrating the need for "a science of the art of medicine". Attributes of patient perceptions of health care service quality have been measured by evaluations of professional competence, courtesy, communicativeness, access, and physical environment (Doyle and Ware, 1977). Brook and Williams (1975) divided these patient evaluations into two categories: caring and curing aspects. These categories parallel Gronroos' (1984) technical (content – what is delivered) and functional (mode – how it is delivered) conceptualization of perceived quality.

Thus, from a dramaturgical point of view, analysis of all health care encounters must include the actors, the setting and the performance. The patient as a customer evaluates the health care experience based on cues derived from these dimensions. The role of the provider and consumer affects

the outcome and evaluation of the encounter; the setting depends on the medical condition and affects the patient's evaluations; the performance directly impacts the medical outcome and most definitely influences patient evaluations. The nature of the medical encounter is determined primarily by the medical condition, the past relationship between the medical professional and the patient. It is possible to extend this analysis to all of the different types of health care encounters encompassing all the different actors/audiences, and their performances in different medical settings. Rather than attempting to discuss each of these encounters, the rest of the discussion is focused on the physician-patient encounter.

Modelling the physician-patient encounter

The relationship between physician and patient is asymmetrical, with the patient ascribing power to the physician by giving professional authority to him/her by seeking help in getting well. The physician's role assumes a degree of power, authority, and control that forces the patient's independence at risk. The degree of physician dominance and the patient's dependence varies by the patient's health condition. The patient's dependence is based on the physician's command of an esoteric body of knowledge acquired through training and experience legitimizing the profession and justifying the authority and the client's trust, confidence, and norm of obedience (Parsons, 1975). However, within this context of patient-physician relationship, physicians have been urged to adopt a more patient-centred approach and encourage patient-participation in clinical decision making (Slack, 1977).

"Disease", "treatment", and "cure" are central to medical care. The approach taken by the physician, depending on the medical situation, can be used as a typology of medical encounters. Szaz and Hollender (1956) use a psychoanalytical perspective to propose three basic types of medical encounters: emergencies, acute illnesses and chronic illnesses.

In *medical emergency encounters*, physicians adopt an active role in the medical encounter and the patient's role is relatively passive. In such an encounter, the physician's role is dominant and assumes total command of the situation. The patient adopts the inert recipient role under the circumstances. This can be likened to the parent-infant type of transaction.

In *acute illness encounters*, the physician adopts the role of a guide and helps the patient through medical consultation, advice and treatment. The patient suffers from pain, anxiety, or other distressing symptoms and is willing to co-operate. Thus, the patient adopts a co-operator role with minimal participation in the medical decisions. The patient simply accepts and follows the physician's advice. This can be likened to the parent/adult-child type of transaction.

In *chronic illness encounters*, the physician adopts the role of partner. The physician and the patient are partners in the medical decisions. The patient's own experiences provide reliable clues for therapy. The physician assists the patient to help himself/herself. The encounter assumes mutual participation

and the patients can and want to take care of themselves. This can be likened to an adult-adult relationship.

In these three types of encounters, the physician and patient (actor and audience) adopt roles and behave (performance) based on the medical situation in the operating theatre, or the clinic, or the doctor's office (setting). Whether this performance occurs in a hospital, a nursing home, or a clinic, the setting includes the physical layout of the facility, the decor and ambience of those parts of the facility that the patient has the opportunity to observe. The performance and the physical setting that is visible to the patient is the front region and that which is not visible to the patient is the back region of the service provider. Similarly, the health care provider does not see the back region of the patient, but is able to witness that patient's front region – when the patient is in the facility and in the presence of medical personnel. See Figure 1 for a visual depiction of the front and back regions of the patient and the physician.

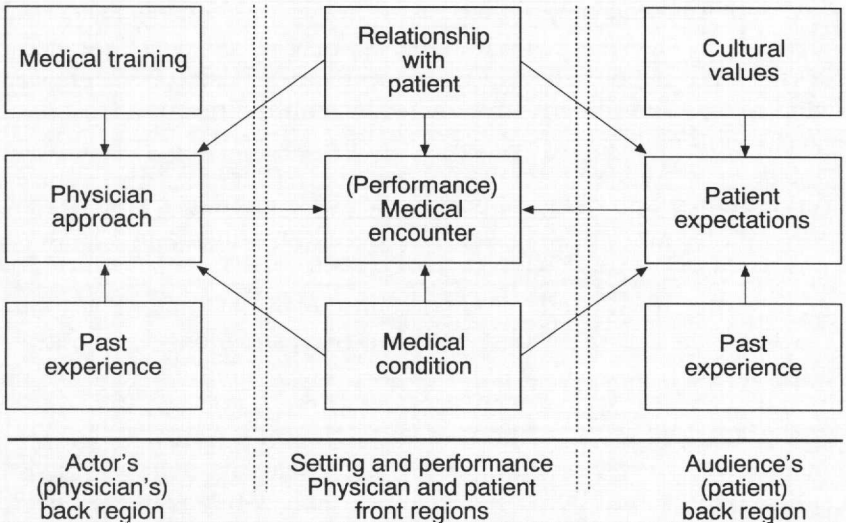

Figure 1.
A dramaturgical view of the physician-patient encounter

The performance takes place at the physician-patient encounter in the front regions of both the patient and the physician. The performance is dictated by the physician's approach, the patient's expectations, the medical condition and the relationship between the physician and the patient. The roles of the physician and the patient are determined by two groups of factors for each: those in their respective front regions and those in their respective back regions.

Front region factors are immediately apparent to both sides of the encounter. Information on the medical condition of the patient (emergency, acute, or chronic) and the physician-patient relationship based on previous encounters are generally shared by both parties. The performance, itself, is obviously visible to both the physician and the patient. Factors in their respective back regions are not readily apparent to both parties. The physician's back region

factors include his/her formal medical training and experience. The physician draws from these factors in determining the approach to the patient encounter. The patient's back region factors include his/her past medical experience and cultural background and are not necessarily easily evident to the physician. The patient draws from these factors in determining expectations at the encounter. The physician's approach and the patient's expectations are further mediated by the medical condition and their relationship through past encounters, if any.

One of the objectives of the physician should be in improving patient evaluations of the performance. To accomplish this, the physician would need to understand each patient's expectations. The front region factors (medical condition and relationship with patient) that influence patient expectations are readily available to the physician. However, since the back region factors that affect patient expectations are not easily evident, the physician needs to understand the influence of the back region factors on patient's expectations. In order to manage the encounter in such a way that the patient evaluates the physician's performance favourably, the dramaturgical view would suggest that the physician adopt some impression management guidelines.

Assessment of cultural influences on the service encounter

It is generally accepted that the cultural orientation of an individual is expressed through values which affect attitudes and, thus, in the form of behaviour considered appropriate and effective in a given situation. Values are generally held beliefs that specify general preferences and play a determining role in cultural influences on any service encounter. These basic values are culture specific but permit individual variations. In other words, individuals behave in a fashion that results from biological tendencies that are hereditary and guided by value orientations dictated by the culture. Based on the research of cultural anthropologists (particularly that of Hofstede, 1984; and Kluckhohn and Strodtbeck, 1960), Riddle (1986) suggested that these basic values of an individual's perspective of nature, time, activity, and relationships with other people can be used to understand customer expectations at the service encounter.

The influence of cultural values on the service encounter through the expectations of the customer can be examined via: individuals' relationship with nature, their orientation to time, their modality of behaviour, and their relationship with other individuals. Answers to the following questions provide the cultural value orientation of an individual or a society.

- What is the relationship of people with their environment? Do they seek to control it or do they consider it impossible or inappropriate to control?
- What is the temporal focus of human life? Are people oriented to the past or the future? Is time relative and the amount of time expended on a task dependent on the fulfilment of other more important things such as the respect that needs to be paid to the interpersonal relationship (a function of their past) involved in the activity? Or, is time absolute with high

standards of temporal precision and is not sacrificed to accommodate other needs but is allocated based on future benefits only.

- What is the modality of human activity? Are individuals relatively more focused on the activity itself or the results of the activity? Do individuals place greater emphasis on the experience of "being" or on "doing"?
- What is the modality of one's relationship with others? Is the "self" determined by an individual or group focus? Is individual welfare relatively more or less important than group welfare?

Ancient wisdom in near and far eastern cultures such as in India, China and Japan as might be evident in religion and philosophy would suggest that individuals can and must not attempt to control nature, ascribing events to God and destiny; the past and tradition assume significant importance; the experience itself is the accomplishment; and group consensus and welfare are paramount. While it might not be possible to assess an individual's cultural orientation to these values with direct questions, the physician could attempt to be sensitive to the patient's orientation to these values. Although a patient's back region, or cultural values may not be readily obvious, the physician should be looking for indications from patients (via general verbal and non-verbal behaviour) regarding their preferences on these encounter attributes. As the relationship between physician and patient progresses over time during a single encounter or over a series of encounters, both doctor and patient will find it easier to behave and allow the other to behave according to their respective value preferences within the boundaries of the formal roles of physician-patient. The longer the relationship of the physician with a patient and his/her family members, the deeper the understanding of these cultural values.

Some specific questions during the initial approach prior to the clinical examination phase of the patient would serve well to learn a patient's orientation to these cultural values. Physicians ask questions and make comments that "break the ice" and sets the patient at ease in the first few minutes of the encounter. Some carefully chosen questions that capture these cultural orientations might be included in that initial conversation to assess a patient's desire to participate in the decision, or relative emphasis on process versus outcome, or attention to time and personal status. It would also be helpful to sensitize all customer contact personnel in the health care facility to these concerns; for example, the front desk personnel that are involved in patient scheduling might maintain some information on a patient's orientation to time so that scheduling can be more accommodative of individual differences. Thus, although it is difficult to assess cultural orientations before the first encounter or even during a single encounter, attention paid to these issues and mapped over time, will provide insights into a patient's expectations at the service encounter.

Impression management guidelines

An understanding of these cultural values when juxtaposed on the medical condition-based models of patient-physician relationship just discussed, provides us with guidelines for impression management. These guidelines are

presented as five encounter attributes: participation; control; relationship; flexibility; and process (see Table I for impression management guidelines at the physician-patient encounter).

It must be noted that in implementing the following guidelines, one must allow for situational factors. For example, the individuals might exhibit variations along their value orientations on different occasions depending on the time available. Age might also be a mediating factor in an individual's value orientation. Certainly, the medical condition would dictate how the guidelines can be implemented, as discussed earlier.

Encounter attributes	Impression management guidelines based on cultural influences
Participation and control	Individuals differ in the extent of desired control and participation in the service encounter. When patients desire a high degree of control of the encounter, the medical professional must allow greater patient participation in the diagnosis and treatment decisions. In general, these patients will expect more communicativeness from the physician or nurse
Flexibility of time	Individuals may consider time to be relative or absolute. Some patients expect duration of time spent with them to be flexible to their status in their personal relationship with the physician, while others would be particular about meeting scheduled times regardless of their personal relationship with the physician
Attention to process	Individuals differ in the relative emphasis placed on the experience of an activity v. the accomplishment of the activity. Assess patient orientation to process and outcome. There are patients who place more emphasis on physician behaviour during the encounter, while others place a greater emphasis on their medical outcomes
Interpersonal relationship	Individuals can be group-oriented or individualistic. Patients who are individualistic will expect greater respect as an individual, while others are more likely to base interpersonal relationships on relative power and status – and behave commensurate to personal status relative to the physician's status in society

Table I.
Impression management guidelines for medical professional behaviour

Participation and control

Individuals vary in the extent to which they expect uncertainties to be controlled at the service encounter and in the attribution of lack of control to the service provider or to nature. This cultural orientation is best explained by such constructs as locus of control, tolerance of ambiguity, and fatalism. Based on their orientation, patients will differ in the extent to which they expect to participate in the service encounter to obtain greater control. To accommodate these individual variations, physicians should first assess the patient's orientation to control and participation so as to approach the patient encounter keeping this in mind.

A physician who understands the significance of the cultural background of the patient, for example, might allow for more participation in the diagnosis of

medical needs and present the patient with the various options for treatment in coming to a mutual decision on how to handle the situation. This approach would be appropriate for the individual who is less comfortable with uncertain situations and desires more control; it might serve to reduce the attribution of any adverse consequences solely to the doctor. Conversely, with other individuals the physician might be able to proceed with less participation by the patient and the patient is more likely to attribute any adverse medical outcomes to forces beyond the physician's control. Although it is not always possible to include the patient in the clinical decision-making process (such as in dire medical emergencies), the physician would give the patient some sense of control, for those desiring it, by sharing with the patient as much information as possible. Thus, for some individuals the physician might adopt a partner/guide role allowing more information exchange and participation on the part of the patient.

Flexibility of time

Some individuals consider time as absolute, while others consider time as relative. Individuals vary in the extent to which they expect flexibility in the duration and the immediacy of the service encounter. If time is considered absolute, individuals are less likely to be flexible with time. On the other hand, if time is considered relative, other events and priorities such as previous relationships with the physician take precedence over commitment to other planned appointments. Some patients are less apt to discount long waiting times or may expect the physician to be flexible with the amount of time spent in the encounter so as to accommodate their specific needs. Other patients might be willing to wait their turn but are not willing to be flexible, once they have waited for their turn and expect to be accommodated as scheduled.

A physician who understands a patient's orientation to time might accommodate a patient who views time as relative and expects the physician to be flexible with time. Other patients, who view time as absolute, would be more understanding of the situation and would be willing to wait for their turn. But, having waited for their appointment, these individuals are not likely to tolerate any unplanned or unreasonable delays. For these individuals, the physician would have to ensure that scheduled meetings are conducted on time or that there is no undue length of waiting time. If there are multiple steps in the patient path before the encounter with the physician, these patients may not tolerate unbalanced capacity causing unreasonable waiting times at the various steps in the process. Prioritizing appointments based on the degree of medical emergency is standard approach in medical practice. Without violating this requirement, physicians might consider a patient's orientation to flexibility with time within the context of the urgency of the medical condition.

Attention to process

Individuals vary in the extent of emphasis placed on the task or goal of an activity, as opposed to the experience of the activity itself. Some individuals are

more concerned with the interaction and the service encounter itself than whether the service was done right, while others might be inclined to the opposite. Individual variations in the relative importance of the process and the outcome of the patient encounter require that the physician first assess the patient's preferential emphasis and then accommodate the differences.

For those patients who are more likely to evaluate a medical service based on the process itself the physician would pay more attention to his/her bedside-manner. In their cases, the physician would have to place relatively more emphasis in the performance of the art of care, i.e. the "caring" aspects of medical care. On other hand, patients who pay relatively more attention to the medical outcome would necessitate that the physician exhibit more attention to the competence of diagnosis and medical treatment so as to ensure a higher probability of successful medical outcome. These patients pay more attention to the "curing" aspect of medical care. Even in medical emergencies where the physician's natural tendency is to concentrate on the successful medical outcome, patients who place preferential emphasis on the process might actually be helped more effectively in successful rehabilitation if the physician is able to demonstrate a more than expected attitude of "caring".

Interpersonal relationships

Individuals in societies that are more group-oriented pay more emphasis on personal relationships based on group needs by paying attention to status and power or proximity of family/friend relationship. These individuals would accept and expect hierarchical structure in society and business to dictate the tone and manner of the encounter. Individuals in individualistic-oriented societies are less likely to base relationships on group needs. Such patients would expect that the encounter be just the same for them as for any other patient regardless of the status of the individual in society.

A physician might have to pay special attention to the status of an individual who pays particular respect to the hierarchical structure in business and society. An individual who is group-oriented would expect the physician to treat him/her with more respect if he/she has a high status in society. Other patients who are individualistic and do not readily accept hierarchical structures would not tolerate what appears to be inequitable treatment of patients based on societal status. The medical condition of the patient might not be adequate in determining the approach that the physician might take with the patient. The attitude and approach of the physician might have to address the societal status of some patients.

Conclusion

The health care service consumption experience involves a series of encounters. These encounters need to be managed for patient satisfaction and improved perceived quality. This cannot be achieved unless the expectations of the patient at the encounter with the medical professional are better understood. The dramaturgical view of the service encounter helps us understand the

medical encounter. The performance of the actors and audience in theater is determined by the playwright who dictates the script. In health care encounters, the performance of the physicians and the patient is dictated by the medical condition directing the approach of the medical professional and the patient's role.

In health care services, medical personnel need to have certification in order to qualify for the profession. The medical profession has rigorous educational programmes for its doctors and nurses. However, these programmes are focused on technical skills and knowledge and do not formally cover the functional aspects. Such skills are picked up informally during the required residency or internship programmes, and improved over time.

Just as in theatre where the actors and audience bring their respective personalities to "twist" the script, the physician and the patient bring their respective cultural backgrounds to the medical encounter. No two actors produce identical performances with the same script for the same play. Similarly, no two audiences react/review the same performance in the same manner. In health care service, these differences are a function of their past experience with medical care and their individual personalities, which are determined to a great extent by their cultural values. Physicians can improve the performance and, thus, perceived quality by approaching each patient encounter using a better understanding of the cultural background of patients and how this might be relevant in the patient's medical condition.

References

Anderson, E.W., Fornell, C. and Lehmann, D.R. (1994), "Customer satisfaction, market share, and profitability: findings from Sweden", *Journal of Marketing*, Vol. 58, July, pp. 53-66.

Barnouw, V. (1963), *Culture and Personality*, Dorsey Press, Homewood, IL.

Ben-Sira, Z. (1982), "Lay evaluation of medical treatment and competence development of a model of the function of the physician's affective behavior", *Social Science and Medicine*, Vol. 16, pp. 1013-19.

Bitner, M.J. (1992), "Servicescapes: the impact of physical surroundings on customers and employees", *Journal of Marketing*, Vol. 56, pp. 57-71.

Bolton, R.N. and Drew, J.H. (1991), "A multistage model of customers' assessments of service quality and value", *Journal of Consumer Research*, Vol. 17, March, pp. 375-84.

Booms, B.H. and Bitner, M.J. (1981), "Marketing strategies and organizational structures for service firms", in Donnelly, J.H. and George, W.R. (Eds), *Marketing of Services*, American Marketing Association, Chicago, IL, pp. 47-51.

Brissett, D. and Edgley, C. (1990), *Life as Theater: A Dramaturgical Sourcebook* (2nd ed.), Aldine Publishing, New York, NY.

Brook, R.H. and Williams K.N. (1975), "Quality of health care for the disadvantaged", *Journal of Community Health*, Vol. 1, pp. 32-156.

Burke, K. (1945), *A Grammar of Motives,* Prentice-Hall, New York, NY.

Burke, K. (1950), *A Rhetoric of Motives*, Prentice-Hall, New York, NY.

Burke, K. (1968), "Dramatism", in *International Encyclopedia of the Social Sciences*, VII, Macmillan, New York, NY, pp. 445-52.

Carman, J.M. (1990), "Consumer perceptions of service quality: an assessment of the SERVQUAL dimensions", *Journal of Retailing*, Vol. 66 No. 1, pp. 33-55.

Chase, R.B. and Kellogg, D.L. (1990), "Conclusion: the state of service management knowledge", in Bowen, D.E., Chase, R.B. and Cummings, T.G. (Eds), *Service Management Effectiveness*, Jossey-Bass, San Francisco, CA, pp. 384-94.

Cronin, J.J. Jr and Taylor, S.A. (1992), "Measuring service quality; a reexamination and extension", *Journal of Marketing*, Vol. 56, July, pp. 55-68.

Cronin, J.J. Jr and Taylor, S.A. (1994), "SERVPERF versus SERVQUAL: reconciling performance-based and perceptions-minus-expectations measurement of service quality", *Journal of Marketing*, Vol. 58, January, pp. 125-31.

Czepiel, J.A., Solomon, M.R., Surprenant, C.F. and Gutman, E.G. (1985), "Service encounters: an overview", in Czepiel, J.A., Solomon, M.R. and Surprenant, C.F. (Eds), *The Service Encounter*, Lexington Books, Lexington, MA.

DiMatteo, R.M. (1979), "A social-psychological analysis of physician-patient rapport: toward a science of the art of medicine", *Journal of Social Issues*, Vol. 35 No. 1, pp. 12-33.

Doyle, B.J. and Ware, J.E. (1977), "*Physician Conduct and Other Factors that Affect Consumer Satisfaction with Medical Care*", Rand Corp., Santa Monica, CA.

Eisenberg, L. (1977), "The search for care", *Daedalus*, Vol. 106, pp. 235-46.

Engel, G.L. (1977), "The care of the patient: art or science?", *The Johns Hopkins Medical Journal*, Vol. 140, pp. 222-32.

Friedson, E. (1961), *Patient's Views of Medical Practice*, Russell Sage Foundation, New York, NY.

Friedson, E. (1970), *Professional Dominance: The Social Structure of Medical Care*, Aldine, Chicago, IL.

Goffman, E. (1959), *The Presentation of Self in Everyday Life*, Doubleday and Co., New York, NY.

Goffman, E. (1967), *Interactional Ritual*, Doubleday and Co., Garden City, NJ.

Goffman, E. (1974), *Frame Analysis: An Essay on the Organization of Experience*, Harper & Row, New York, NY.

Gronroos, C. (1984), "A service quality model and its marketing implications", *European Journal of Marketing*, Vol. 4.

Grove, S.J. and Fisk, R.P. (1983), "The dramaturgy of services exchange: an analytical framework for services marketing", in Berry, L.L., Shostack, G.L. and Upah, G.D. (Eds), *Emerging Perspectives on Services Marketing*, American Marketing Association, Chicago, IL, pp. 45-9.

Grove, S.J. and Fisk, R.P. (1991), "Observationl data collection methods for service marketing: an overview", working paper, Clemson University, SC.

Grove, S.J., Fisk, R.P. and Bitner, M.J. (1992), "The service experience as theater", *Advances in Consumer Research*, Association for Consumer Research, Provo, UT.

Hippocrates (1923), *Works Volume II: On Decorum and the Physician*, with English translation by Jones, W.H.S., Heinemann, London.

Hofstede, G. (1984), *Culture's Consequences: International Difference in Work-Related Values*, Sage. Beverly Hills, CA.

Hulka, B.S. and Zyzanski, S.J. (1982), "Validation of a patient satisfaction scale; theory, methods and practice", *Medical Care*, Vol. 20 No. 6, pp. 649-53.

Jaikumar, R. and Bohn, R.E. (1986), "The development of intelligent systems for industrial use: a conceptual framework", *Research on Technological Innovation Management and Policy*, Vol. 3. JAI Press, Greenwich, CT.

John, J. (1991), "Improving quality through patient-provider communication", *Journal of Health Care Marketing*, Vol. 11, December, pp. 51-60.

King, S.H. (1962), *Perceptions of Illness and Medical Practice*, Russell Sage, New York, NY.

Kluckhohn, F. and Strodtbeck, F. (1960), *Variations in Value Orientations*, Row, Peterson and Company, Evanston, IL.

Kotler, P. (1973), "Atmospherics as a marketing tool", *Journal of Retailing*, Vol. 49, Winter, pp. 48-64.

Magrath, A.J. (1986), "When marketing services, 4 Ps are not enough", *Business Horizons*, Vol. 29, May-June, pp. 44-50.

Obermiller, C. and Bitner, M.J. (1984), "Store atmosphere: a peripheral cue for product evaluation", in Stewart, D.C. (Ed.), *American Psychological Association Annual Conference Proceedings, Consumer Psychology Division*, American Psychological Association, Washington, DC, pp. 52-3.

Parasuraman, A., Zeithaml, V.A. and Berry, L.L. (1985), "A conceptual model of service quality and its implication for future research", *Journal of Marketing*, Vol. 49, Fall, pp. 41-50.

Parasuraman, A., Zeithaml, V.A. and Berry, L.L. (1991), "Refinement and reassessment of the SERVQUAL scale", *Journal of Retailing*, Vol. 67, Winter, pp. 420-50.

Parasuraman, A., Zeithaml, V.A. and Berry, L.L. (1994), "Reassessment of expectations as a comparison standard in measuring service quality; implications for future research", *Journal of Marketing*, Vol. 58, January, pp. 111-24.

Parsons, T. (1951), *The Social System*, Free Press, Glencoe, IL, pp. 428-79.

Parsons, T. (1958), "Definitions of health and illness in the light of American values and social structure", in Jaco, E.G. (Ed.), *Patients, Physicians, and Illness*, Free Press, New York, NY, pp. 165-87.

Parsons, T. (1975), "The sick role and the role of the physician reconsidered", *Milbank Memorial Fund Quarterly/Health and Society*, Vol. 53, pp. 257-78.

Perinbanayagam, R.S. (1974), "The definition of the situation: an analysis of the ethnomethodological and dramaturgical view", *The Sociological Quarterly*, Vol. 15, Autumn 1974, pp. 521-41.

Perinbanayagam, R.S. (1982), "Dramas, metaphors, and structures", *Symbolic Interactions*, Vol. 5 No. 2, pp. 259-76.

Perinbanayagam, R.S. (1985), *Signifying Acts*, Southern Illinois University Press, Carbondale, IL.

Pranter, C.A. and Martin, C.L. (1991), "Compatibility management: roles in service performers", *Journal of Services Marketing*, Vol. 5 No. 2, pp. 43-54.

Prus, R.C. and Frisby, W. (1987), "Marketplace dynamics: the Ps of 'people' and 'process'", in Wallendorf, M. and Anderson, P.F. (Eds), *Advances in Consumer Research*, Association for Consumer Research, Provo, UT, pp. 61-5.

Riddle, D. (1986), *Service-led Growth: The Role of the Service Sector in World Development*, Praeger New York, NY.

Rotter, J.B. (1966), "Generalized expectancies for internal versus external control of reinforcement", *Psychological Monographs*, Vol. 80 No. 1, Whole No. 609, pp. 1-28.

Rust, R.T. and Oliver, R.L. (1993), "Frontiers in service quality", in Roland, T.R. and Oliver, R.L. (Eds), *Frontiers in Service Quality*, Sage, Beverly Hills, CA.

Shattuck, F.C. (1907), "The science and art of medicine in some of their aspects", *Boston Medical and Surgical Journal*, Vol. 157, pp. 63-7.

Slack, W.V. (1977), "Patient power", *Lancet*, Vol. 30, p. 240.

Szaz, T.S. and Hollender, M.H. (1956), "A contribution to the philosophy of medicine", *Archives of Internal Medicine*, Vol. 97, pp. 585-92.

Ware, J.E. and Snyder, M.K. (1975), "Dimensions of patient attitudes regarding doctors and medical care services", *Medical Care*, Vol. 13, August, pp. 669-82.

Ware, J.E., Snyder, M.K., Wright, W.R. and Davies, A.R. (1983), "Defining and measuring patient satisfaction with medical care", *Evaluation and Program Planning*, Vol. 6, pp. 247-63.

Zeithaml, V. (1981), "How consumer evaluation processes differ between goods and services", in Donnelly, J.H. and George, W.R. (Eds), *Marketing of Services*, American Marketing Association, Chicago, IL, pp. 186-90.

Zeithaml, V. (1988), "Consumer perception of price, quality, and value: a means-end model and synthesis of evidence", *Journal of Marketing*, Vol. 52, July, pp. 2-22.