Applying justice and commitment constructs to patient–health care provider relationships

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Abstract

Objective To examine patients' experiences of fairness and commitment in the health care context with an emphasis on primary care providers.

Design Qualitative, semistructured, individual interviews were used to gather evidence for the justice and commitment frameworks across a variety of settings with an emphasis on primary care relationships.

Setting Rural, urban, and semiurban communities in Nova Scotia.

Participants Patients (ages ranged from 19 to 80 years) with varying health care needs and views on their health care providers.

Methods Participants were recruited through a variety of means, including posters in practice settings and communication with administrative staff in clinics. Individual interviews were conducted and were audiotaped and transcribed verbatim. A modified grounded theory approach was used to interpret the data.

Main findings Current conceptualizations of justice (distributive, procedural, interpersonal, informational) and commitment (affective, normative, continuance) capture important elements of patient–health care provider interactions and relationships.

Conclusion Justice and commitment frameworks developed in other contexts encompass important dimensions of the patient–health care provider relationship with some exceptions. For example, commonly understood subcomponents of justice (eg, procedural consistency) might require modification to apply fully to patient–health care provider relationships. Moreover, the results suggest that factors outside the patient–health care provider dyad (eg, familial connections) might also influence the patient's commitment to his or her health care provider.

EDITOR'S KEY POINTS

- Having someone whom patients can refer to as *my doctor* (as opposed to, for example, having encounters with different providers each time a medical need arises) leads to greater satisfaction with services, greater trust in the provider, and increased frequency of service interactions.
- Findings suggest that current conceptualizations of justice and commitment capture important elements of health care interactions and relationships.
- With respect to discourse surrounding bases of commitment, data suggest that patients might remain with providers because they are attached to and genuinely like their providers (affective commitment); they think they have no other choice in health care providers or their care would be disrupted if they left (continuance commitment); or they believe they ought to be loyal to their health care providers and they would feel guilty if they left (normative commitment). A patient might also remain because of a sense of obligation toward family members who seek care from the same provider and whose care might be disrupted should the patient switch providers.

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Appliquer les modèles théoriques de justice et d'engagement aux relations entre patients et soignants

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Résumé

Objectif Déterminer ce que les patients pensent des aspects d'équité et d'engagement dans le contexte des soins primaires, avec une insistance particulière sur les relations avec les soignants.

Type d'étude On a utilisé des entrevues qualitatives individuelles semi-structurées pour recueillir des données sur les aspects de justice et d'engagement dans une variété de situations, en insistant sur les relations dans les soins primaires.

Contexte Des communautés rurales, urbaines et semi-urbaines de la Nouvelle-Écosse.

Participants Des patients âgés de 19 à 80 ans requérant un niveau variable de soins et ayant des opinions variables sur leurs soignants.

Méthodes Différents moyens ont été utilisés pour recruter les participants, y compris des affiches dans les établissements de pratique et la communication avec le personnel administratif des cliniques. Les entrevues individuelles ont été enregistrées sur ruban magnétique et transcrites mot à mot. On a utilisé une approche de théorie ancrée modifiée pour interpréter les données.

Principales observations La façon actuelle de concevoir la justice (distributive, procédurale, interpersonnelle, informationnelle) et l'engagement (affectif, normatif, de continuité) s'applique considérablement aux interactions et interrelations entre patients et soignants.

Conclusion Les concepts de justice et d'engagement développés dans d'autres contextes s'appliquent en grande partie à la relation patient-soignant, malgré certaines exceptions. Ainsi, certaines sous-composantes de la justice (p. ex. la consistance procédurale) pourraient devoir être modifiées pour s'appliquer entièrement à la relation patient-soignant. De plus, nos résultats laissent croire que des facteurs extérieurs au couple patient-soignant (p. ex. les rapports avec la famille) pourraient aussi influencer l'engagement des patients envers leurs soignants.

POINTS DE REPÈRE DU RÉDACTEUR

- Le fait d'avoir quelqu'un auquel le patient peut s'adresser comme à son médecin (par opposition au fait, p. ex. d'avoir affaire avec des soignants différents chaque fois qu'il survient un problème médical) entraîne une plus grande satisfaction envers les services, une meilleure confiance envers le soignant et des interactions plus fréquentes entre les services.
- Nos observations donnent à croire que la façon actuelle de concevoir la justice et l'engagement s'applique en grande partie aux interactions et interrelations associées aux soins de santé.
- Quant aux opinions sur les bases de l'engagement, nos données laissent voir que les patients pourraient conserver le même soignant parce qu'ils lui sont attachés et qu'ils lui ressemblent vraiment (engagement affectif); parce qu'ils croient ne pas avoir d'autre choix de soignant ou que leurs soins manqueraient de continuité s'ils en changeaient (engagement de continuité); ou parce qu'ils se sentent obligés d'être loyaux envers leur soignant et qu'ils se sentiraient coupables de l'abandonner (engagement normatif). Un patient pourrait aussi conserver le même soignant à cause d'un sentiment d'obligation envers les membres de sa famille qui sont soignés par la même personne et dont les soins pourraient être perturbés advenant que le patient opte pour un autre soignant.

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A large body of research in the work organization domain supports the conclusion that perceptions of fairness are a primary determinant of relationship quality, including assessments of trust in decision makers.[1,2] Moreover, fairness perceptions are associated with the level and nature of people's attachments or commitments to entities.[1-4] Indeed, thinking that one is fairly treated tends to produce commitments based on identification and feelings of emotional attachment to the entity (eg, one's supervisor). In turn, fairness perceptions[1,2,5,6] and positive forms of commitment[3,4] relate to a multitude of positive outcomes, including greater employee well-being and adherence to organizational policies.

We extend these lines of research via qualitative interviews to consider patients' experiences of fairness and commitment in the health care context with an emphasis on patients' interactions with primary care providers. Indeed, a full understanding of outcomes, such as trust and treatment adherence, might require an understanding of the influence of these constructs. With a few exceptions (eg, work by Fondacaro et al,[7] and Hughes and Larson[8]), little research has examined these constructs in patient–health care provider encounters and relationships.

Fairness and commitment

Research by Gutek and colleagues, which examines interactions between customers and broadly defined service providers, suggests that having someone whom patients can refer to as *my doctor* (versus, for example, having encounters with different providers each time a medical need arises) leads to greater satisfaction with services, greater trust in the provider, and increased frequency of service interactions.[9-11] However, studies in the psychology and management literatures on organizational commitment suggest that simply remaining with or being committed to an entity does not necessarily translate into positive outcomes.[3,4] Indeed, people might remain with an entity (eg, their organization) because they have to, perhaps owing to a lack of available alternatives or high personal costs associated with leaving (termed *continuance commitment*); because they believe they have an obligation to, perhaps out of a sense of loyalty to the entity and feelings of guilt that arise at the thought of leaving (termed *normative commitment*); because they truly want to, perhaps because they truly like and identify with the entity (termed *affective commitment*); or because of some combination of these motives.[3,4] Affective commitment to entities is more strongly related to positive outcomes (eg, employee well-being, compliance with rules and procedures) than the other bases of commitment.[4]

With respect to building affective commitment within organizations, people's perceptions of fairness play a key role.[1-4] Assessments of fairness at work stem from people's evaluations of at least 4 primary elements.[1,5] Distributive justice reflects people's assessments of the fairness of the outcomes they receive.[5,12] Procedural justice reflects an assessment of the fairness of the procedures used to allocate outcomes or make decisions.[13,14] For example, to be fair, procedures should be based on accurate information, minimize the influence of personal biases, and uphold ethical and moral principles.[13] Interactional justice reflects the quality of interpersonal treatment individuals receive from decision makers and is subdivided further into interpersonal justice, reflecting judgments about the dignity and respect shown by decision makers, and informational justice, reflecting the adequacy of the information and explanations provided by decision-making agents.[5,15] Greater justice perceptions have been shown to positively predict numerous outcomes, including affective commitment to entities[1-4] and trust in decision makers.[1,2]

In the current study, we used qualitative interviews to gather evidence for these theoretical frameworks across a variety of settings with an emphasis on primary care relationships (eg, patients' relationships with their family doctors).

METHODS

Participants

Ethics approval for the study was obtained before commencing the research. Participants (8 men, 15 women) were recruited through a variety of means, including posters in practice settings and communication with administrative staff in clinics. We used criterion sampling[16] to recruit participants. Specifically, to ensure a diverse sample, we sought participants who had a range of opinions on their health care providers and who had a range of clinical needs. We included participants from across the age spectrum (19 to 80 years of age) who resided in rural, semiurban, or urban communities, and who used a variety of avenues (eg, walk-in clinics, family doctors, emergency departments) to access medical care. These selection criteria were used to capture potential diversity in patients' experiences of fairness and commitment as a function of demographic and setting variables. In total, 23 individual interviews were conducted between May 2006 and March 2007.

Data collection

The individual (semistructured) interviews were conducted by the first 2 authors (C.H. and P.T.) and were audiotaped and transcribed verbatim. Private, individual interviews were chosen because they allowed participants to express their opinions about their relationships with their health care providers frankly and

confidentially. A basic interview guide was followed; questions pertaining to the nature and quality of patients' relationships with their health care providers were posed. Interviews were approximately 45 minutes long, though they ranged between about 30 and 60 minutes.

Coding and analysis

The analysis was guided by modified grounded theory methods, which sought to develop and understand connections between and among analytical categories.[17-19] Transcripts were read independently by 2 members of the research team (C.H. and P.T.), who searched for examples of justice and commitment, and who identified additional passages for further consideration. Emerging ideas were compared and contrasted and then linked to the justice and commitment categories that were known through the literature. Disagreements were resolved through team discussion, and an open-coding strategy was also used to accommodate other findings. Through this strategy, data were coded using QSR N6, a software program designed for textual analysis. Reports were generated for each code, permitting the research team to confirm or qualify the coding structure, as well as to ensure it continued to accommodate the data. Such an approach is well suited for examining multiple perspectives on a complex issue, such as the nature of relationships between health care providers and patients. Our main focus in this paper is to present thematic categories that illuminate constructs of justice and commitment from our interviews.

RESULTS

Overall, findings suggest that current conceptualizations of justice and commitment capture important elements of health care interactions and relationships. **Tables 1**[5,12-15] and **2**[3,4] present definitions adapted (by the authors) to the health care context and representative interview quotes of the key justice and commitment constructs.

Based on past research,[7] we conceptualized distributive justice in terms of need-based principles (wherein outcomes or resources are allocated based on individual need). This distributive justice principle is in contrast to equality-based allocations (wherein all individuals receive the same outcomes or resources regardless of need or inputs) or equity-based allocations (wherein outcomes are allocated according to individual contributions or inputs).[12] Findings relating to the fairness of need-based outcome allocations tapped many domains, including wait times for appointments, referrals to specialists, and resolutions to medical issues.

Evidence for most of the procedural justice components was also noted. For example, procedural accuracy was reflected in statements regarding the thoroughness of the doctors' procedures to diagnose issues, including referrals to specialists when necessary. Concerns related to bias suppression were evident, for example, in statements regarding providers' attitudes concerning participants' ethnocultural backgrounds or sexual orientations. Correctability was evident in statements reflecting the participants' abilities to change treatment pathways because of ineffectiveness or lack of suitability. Voice or representativeness concerns were evident in statements regarding the providers' willingness to listen to patients' concerns regarding their care or conditions. The notion of procedural consistency over time and across patients was less evident; rather, consistency emerged as a concern through the concepts of continuity of care and coordination among health care providers. Finally, the procedural justice construct of ethicality appeared less applicable to the one-on-one patient–health care provider interactions that were the focus of the current research; no interview quotes were coded with this label.

The concept of interpersonal justice was also evident in patients' discourse about their health care interactions and relationships. For example, statements regarding the level of sensitivity, dignity, and respect afforded the patient were made. Informational justice was also evident not only in terms of the provision of explanations for courses of action and treatments, but also in terms of information about one's condition and educational information (eg, how to read food labels for diabetes care).

With respect to patient commitment to providers, all 3 types of commitment were evident within the patient interviews.[3,4] That is, patients articulated the decision to remain with their health care providers using all of the known commitment constructs: having a true identification with and liking of their providers (ie, affective commitment); acknowledging a lack of alternatives or a loss of investments that would accrue if they left their providers (ie, continuance commitment); or believing they had an obligation to remain with their health care providers (ie, normative commitment). Interestingly, a potential additional subcomponent of normative commitment was identified. Some patients expressed remaining with health care providers not necessarily because of a sense of obligation to their providers, but rather because of a sense of obligation toward family members who seek care from the same provider and whose care might be disrupted if the patient switched providers.

DISCUSSION

Analyzing health care relationships and interactions in terms of justice perceptions appears to be a viable approach. However, some justice constructs might need refinement to provide a better fit to this health care context.

Table 1. Justice constructs and illustrative quotes

ELEMENT OF JUSTICE	DEFINITION ADAPTED (BY RESEARCHERS) TO THE HEALTH CARE CONTEXT	ILLUSTRATIVE QUOTES
Distributive justice[12]	Perceptions of the fairness of the outcomes patients receive (ie, that they believe they need) (eg, timely appointments, medications, and access to care including referrals)	"I can get in to see him pretty much anytime I want." "I find it great, you can always rely on her and if she doesn't know what your problem is, she'll find out." "I've never been helped any time I've ever went there. Ever. Not once."
Procedural justice[13,14]	Perceptions of the fairness of the decision-making procedures used by the health care provider to diagnose problems and make decisions or recommendations	
• Accuracy	Is accurate information collected and used to make decisions? Does the provider use good information and informed opinion?	"He had a routine that [made sure] he didn't miss anything." "He doesn't just speculate ... he'll send you for tests." "She tends to ... brush things off and not really investigate enough to make sure there is nothing else going on."
• Bias suppression	Does the provider suppress personal biases against the patient (eg, based on race, age, sexual orientation)?	"I told him I was homosexual ... it just wasn't an issue." "They're judging you and you know they are. I could just read that from her."
• Consistency	Is there consistency in decision making (over time and across patients)? (Continuity and coordination of care were included in this category)	"It's just important that all my records are in one place." "She wants to encourage regular monitoring."
• Correctability	Does the patient have the ability to correct flawed or inaccurate decisions (eg, treatments that the patient does not feel comfortable with or that are not working)?	"I'm not comfortable questioning the doctor." "The nice thing about [her] is that if something wasn't working for me I can just go in and say, 'We need to look at something else.'" "I used it once and I didn't like the effect ... so, I said I'm not going to take this [medicine] ... I'm taking it back to [the doctor] and telling him I want something more current."
• Voice or representativeness	Does the provider ensure that the opinions of those affected by the decision have been taken into account? Does the provider ask the patient for input regarding his or her care and consider the patient's viewpoint? Does the provider give the patient ample opportunity to present his or her case or symptoms?	"I just honestly felt that she cared about what I was talking about." "The doctor needs to hear my voice." "I think probably he doesn't take me seriously."
• Ethicality	Does the provider adhere to prevailing ethical and moral standards?	No quotes were coded with this label
Interpersonal justice[5,15]	Does the provider treat the patient with dignity, respect, consideration, and sensitivity, and show a general sense of caring about the patient?	"She is not the sort of doctor that will ever say, you know, 'This is a ridiculous waste of my time. Why are you bothering me with this little thing?'" "There's always that kind of warm welcome, and 'How've you been?'" "It's kind of very sterile, like 'What's wrong with you? Next!'"
Informational justice[5,15]	Does the doctor adequately explain courses of treatment and diagnoses? Does the doctor explain how he or she arrived at a course of treatment? Is he or she honest in his or her communications with patients? Does he or she give patients information (eg, about side effects)?	"She is explaining why I need this, why I need that, and what the procedure is like." "She just signs the paper and goes ... 'This is what work you need done' ... I'd like to know what it's for ... I want to know what each one means and what ... they're testing for. She never tells me." "I don't feel like taking a pill just because they say ... 'You have this. Take an antibiotic.' Like, I need to know why."

Table 2. Commitment constructs and illustrative quotes

BASIS OF COMMITMENT	DEFINITION ADAPTED (BY RESEARCHERS) TO THE HEALTH CARE CONTEXT	ILLUSTRATIVE QUOTE
Affective[3,4]	Commitment characterized by an emotional attachment to, and identification with, the health care provider. Health care provider has a great deal of personal meaning for the patient. Patient stays with the provider because he or she truly wants to	"[I would] break out into sweats if she told me she was going to retire or if she was moving .... It would be a terrible, a terrible day for me." "She just seems like a family member." "I am at home now ... and I don't plan to, like, move ... and I'm not going to go back into that dark, cold, negative space."
Continuance[3,4]	Commitment characterized by an acknowledgment of the perceived cost associated with discontinuing the health care relationship (eg, care would be interrupted if the patient left the health care provider; there are few other options available in terms of health care providers). Patient stays because he or she has to	"There's not a lot of available doctors ... I just ... stick with her." "If I had to find another doctor, I couldn't do it again ... it would just be so exhausting." "I don't really want to change right now ... there's so much history there ... whether it's good or bad, it's there."
Normative		
• To doctor[3,4]	Commitment characterized by a belief that it is one's moral obligation to remain with the health care provider. Patient would feel guilty if he or she left the health care provider; patient thinks that he or she owes the health care provider his or her loyalty. Patient stays because he or she ought to	"I have thought about, uh, how, you know, what's she going to think if I all of a sudden just leave ... I would feel bad even though we don't really have ... that good of a relationship."
• To family members who see the same provider	Commitment based on concerns about disruption in family members' care if the patient left. Patients believe they have an obligation to their family members, so they remain with the providers	"She's my daughter's doctor as well and I don't want ... I just hate to think about breaking that." "I come with a family package ... with my mum ... [she] is in her 80s now ... there are doctors that won't take anyone over a certain age ... I don't want to have more than one family doctor involved ... "

For example, the notion of procedural consistency might need to be broadened to include issues of continuity of care and coordination among health care professionals; these concerns were evident in patient discourse surrounding their health care interactions. Consistency in decision making across patients, however, did not emerge; it might be somewhat difficult for patients to assess consistency across their providers' patients, making this concern less salient. However, this concern might be seen in broader statements with respect to preferential access to medical treatment (eg, magnetic resonance imaging) for certain groups (eg, athletes). Ethicality also did not emerge as a concern in patient discourse. Similarly, it might be that broader judgments about the health care system are more susceptible to concerns about ethical treatment (eg, long wait times to see specialists and to be seen in emergency departments).

In the context of clinical care, aspects of voice and interpersonal justice might also become somewhat indistinguishable. In the primary care context, procedural justice and interpersonal justice are often (although perhaps not always) tied to the same person—the primary care provider. In this sense, justice type and justice source are nested in the same relationship, possibly muddying the distinction between the elements of justice.[20] This finding might be highly contextual and there are likely other aspects of clinical care in which these 2 justice domains are more sharply differentiated.

With respect to discourse surrounding bases of commitment, our data suggest that patients might remain with providers because they are attached to and genuinely like them (affective commitment); they think they have no other choice in health care providers or their care would be disrupted if they left (continuance commitment); or they believe they ought to be loyal to their health care providers and would feel guilty if they left (normative commitment).[3,4] Interestingly, some patients also reported staying with their health care providers owing to, in part, a felt obligation to their family members who see the same provider and whose care might be interrupted if the patient left. Thus, while commitment in clinical care is typically thought to be based on the provider-patient dyad, there are times when other networks shape the relationship. In our data, this was most clearly expressed when the same provider rendered care to parent and child. Familial connections, then, might foster normative commitment to providers. Future research could investigate other relationships or networks outside of the family (eg, close friends, coworkers, others who share an illness

or disease experience) that might influence patients' commitment to their health care providers.

Limitations

Our data do not speak to the causal relationships among judgments of fairness, bases of commitment, and other important outcomes (eg, patient satisfaction, trust, treatment adherence). Thus, in future quantitative research, we encourage researchers to validate self-report measures of the justice and commitment constructs tailored to health care interactions and relationships. Subsequently, researchers could use a longitudinal design to examine consequences of perceptions of justice and bases of commitment in terms of patient outcomes such as satisfaction and health behaviour (eg, following recommendations, reporting ineffective treatments). Although not the specific focus of the current research, future research might also seek to understand patients' judgments of fairness with respect to the broader health care system outside of their relationships with their primary care providers. For example, research might seek to uncover patients' views concerning the fairness of the distribution of health care resources and spending in Canada. Moreover, judgments of the fairness of the procedures used to allocate health care spending and set health care priorities could be assessed. In addition, research might assess patients' views pertaining to the adequacy and timeliness of information sharing with respect to broader health care decisions, priorities, and initiatives.

Conclusion

Further research on perceptions of fairness and bases of commitment might help clarify aspects of patient–health care provider relationships and interactions that are not captured in current health care literature (eg, studies on communication). These constructs might be important for understanding the quality and outcomes of patient-doctor relationships, including assessments of trust and satisfaction, and behaviour such as treatment adherence. Indeed, understanding what factors facilitate such positive outcomes is of paramount importance to the effective functioning of the health care system. We suggest that investigations applying research and theory in social and organizational psychology—including further studies applying the constructs of justice and commitment—might shed new light on important outcomes of patient–health care provider relationships.

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Contributors

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Competing interests

None declared

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