Antiservice Within the Medical Service Encounter: Lessons for Radiologists Beyond Service Recovery

SA-CME

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Abstract

Recent modifications in the metrics for reimbursement have reinforced the importance of radiology service-delivery experiences of patients. Evaluating current radiology practices calls for reflection on the various touch points with patients, as well as their overall satisfaction. If problems occur during encounters, service failure, or lack of satisfactory medical experiences can be transformed through service recovery, whereby patients-as-customers are given chances to voice their concerns, and health care providers across the spectrum can work together to resolve problematic issues. This paper takes a systemic view of the patient experience as embedded in the care continuum, recognizing that different beliefs, attitudes, and behaviors of members of the health care team can negatively affect or sabotage patient satisfaction. Although radiologists are only one of many roles in the care continuum, recommendations are discussed for how they can integrate service satisfaction as a pervasive communal goal among all health care team members.

Key Words: Service recovery, antiservice, service failure, continuum of care

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INTRODUCTION

Following the repeal of the Medicare Sustainable Growth Rate and the enactment of the Merit-Based Incentive Payment System, physicians are recognizing the dynamic shift in reimbursement [1]. In particular, radiologists will be expected to participate in Medicare's Physician Quality Reporting System (PQRS) as a demonstration of added value to avoid practice penalties [2]. New metrics of reporting within this system will include patient care experiences, which will depend heavily on satisfactory service delivery.

As a result, leaders in radiology practices have a new mandate to restructure and improve their patient-customer experiences [3]. In preparation for adapting practices to meet these measures, radiologists must recognize the shortcomings and failures of their current practices of service delivery. Inherent to discovering these failures is having checkpoints in place that swiftly identify and repair negative experiences; this process is known as service recovery. Review of one's current practice must additionally detect antiservice elements, which are people or policies that purposefully reduce patient satisfaction. A paucity of research within our field is dedicated to understanding these vital components, so we must rely on the abundant service marketing literature for guidance. We turn our attention in the next section to this literature and describe its basic tenets, with an eye to processes in a radiologic context. Scenarios are presented that show how and why we must change, articulating the connection from theory to cases. The paper closes with best practices distilled from the previous two sections, providing a template for successful service delivery and provision.

Service Literature Review

The service marketing literature clearly acknowledges that customer satisfaction is highly correlated with how service performance is perceived by patients [4]. An underlying reason may be that most patients do not recognize the clinical side of the quality dimension in the way in which it is ordinarily recognized by physicians. Their consideration of subjective performance is best viewed from one

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of three customer metrics: equitable, ideal, or expected performance [5]. The first is what a patient feels should occur during service delivery, given their current health status; the second is what services and treatment should happen under the best possible circumstances; and the third involves what service delivery is likely to transpire given their experience with current or similar health care providers.

Consider, for example, wait time to begin a radiologic study: equitable service might be being served according to when one arrived at the facility; ideal service would be walking up to sign in and receiving immediate service; expected service could be a wait of no longer than usual for similar appointments. Of course, other aspects of interpersonal and mechanical treatment are important to patient satisfaction as well.

The particular metrics that are used notwithstanding, customers automatically do some form of "gap" analysis that compares their expectations to delivered service [5]. Once again to our simple example; if a patient arrives on time for radiologic services, waits longer than usual, and sees that other patients who came in afterward are being served first, the gap analysis leads to low levels of perceived satisfaction. Another way of looking at processes of customer evaluation is in terms of the concept of "zone of tolerance" [6]. This zone is composed of levels of perceived satisfaction that capture the range within which a patient must evaluate health care experiences for them to be viewed as acceptable. Curiously, levels of service delivery above this zone are predicted to result in delight; levels below the zone lead to dissatisfaction [7,8]. Service marketing suggests that health care service delivery below the lower rung will eliminate the possibility of loyalty to the health care provider and cause relationship damage that may influence compliance.

Of course, it need not end there, even if a lack of patient feedback on such matters is the likely scenario. The service literature describes something referred to as the "recovery process," which allows customers an outlet to articulate complaints soon after dissatisfaction arises and simultaneously allows health care providers to find ways of making amends [3,9]. This practice encourages patients to use recovery "voices" and articulate concerns about health care delivery under conditions of previous delivery failure [10]. Surprisingly, if the patient is adequately ameliorated and feels that concerns articulated are handled properly, the medical encounter results in a "service recovery paradox" that improves overall satisfaction beyond what may have occurred if the service originally delivered was judged to not be within the zone of tolerance [11]. Therefore, recouping lost patient satisfaction may be possible if customers are able to reveal their dissatisfaction and believe that change is forthcoming.

Naturally, sometimes the problem has less to do with what radiologists and their staff members fail to do, and more to do with the mental states of patients who are fearful of treatments, tired from waiting elsewhere in the continuum of care, or just plain unhappy [12]. Many "touch points" occur, during which the various staff members can adjust the patient's affect by simply providing a genuine human interaction [3]. Assuming that most patients are looking for care and normally are appreciative of good service, experiences that fail to meet expectations and disallow possible service recovery lead to a cognitive process called "counterfactual thinking" [13]. When this cognitive task manifests itself, customers try to make sense of poor service delivery by attributing it to an organizational actor who could and should have performed differently. The consequences of service failures beyond dissatisfaction include anger, bitterness, and intentions not to return or decisions not to comply with recommended treatments [14]. Expressed disapproval can negatively affect staff as well, through a process of emotional contagion [15].

REVIEW OF ANTISERVICE LITERATURE

The move from poor service delivery to an antiservice experience may seem like too far a stretch. This construct suggests that people or policies are purposefully seeking to reduce overall customer satisfaction. Consider the patient who misses a scheduled appointment in an overbooked office but is still charged a nonreimbursable fee for failure to cancel in a timely manner. The extent to which such actions are deemed "antiservice" depends on how severe they are to the patient, how flexible the health care provider is perceived to be, and how adequately penalties are explained in advance and at the time of imposition [16]. Yet this one situation may be only the tip of the proverbial iceberg in terms of extremely detrimental perceptions of all service providers.

A more pervasive expression of antiservice is what Harris and Ogbonna [17] refer to as "service sabotage." In these circumstances, someone or several people in the continuum of care may actively seek to reduce levels of patient satisfaction, often under the assumption that they deserve this treatment because of some perceived defect that is the patient's fault [18]. For instance, consider patients from rural communities who enter complex, university-affiliated hospitals in more-urban locations, as the scenarios describe. It is entirely possible that some support staff, as well as medical personnel, will look at their self-presentation in dress, deportment, and use of language, and judge them negatively, both personally