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When the customer is the patient: Lessons from healthcare research on patient satisfaction and service quality ratings☆

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ABSTRACT

As customer satisfaction and service quality have become increasingly important, management scholars have developed an impressive body of research regarding their antecedents. However, important gaps remain regarding satisfaction in diverse populations, better specifying practices and mechanisms, and the forms and effects of co-production practices. Oft-overlooked health services research on patient satisfaction and experience provides evidence of how the sector manages the extreme complexity, co-production, and intangibility of health care delivery where the financial and human consequences of low quality are high. Consequently, health care organizations, out of necessity, have developed specific practices to manage complexity and diversity (cultural competence and relational work systems), intangibility (compassion practices), and co-production (patient-centered care) to customize care and improve patient satisfaction and service quality. We also discuss the interpersonal processes (e.g., empathic communication) by which they do so. Then, we briefly explore unique temporal dynamics of care delivery and its measurement over time, and conclude with implications for future research on customer satisfaction and service quality (e.g., novel practices in health care as natural experiments) and patient satisfaction and service quality (e.g., building on management research to examine the effects of leadership, service climate, and emotional labor).

Customer experience is an increasingly important topic due to macro-changes in industry composition in the developed world (i.e., more service work, less manufacturing work) and technological advances that allow consumers to make their assessments immediately and widely known (e.g., social media like Yelp!, Facebook, and Twitter). More generally, services possess three interrelated characteristics that make them especially worthy of inquiry by organizational scholars including — 1) the complexity arising from and the diversity and unpredictability of customer needs and timing of those needs (Argote, 1982), 2) the difficulty of evaluating service quality due to its inherent intangibility, and 3) the need to co-produce services with customers (Bowen & Schneider, 1988).

Fortunately, research on customer experience provides insights into how to manage the unique challenges of service delivery (Bowen & Schneider, 2014). In addition to the broad and multi-faceted work on services in marketing research, there are two active and vibrant literatures in the management literature on customer service and its effects on customer experience — a micro-literature on emotional labor or how individuals manage emotional regulation, including expressions (surface acting) and perceptions and feelings (deep acting) (Grandey, 2000; Hülsheger & Schewe, 2011). There is also a macro-literature on service climate — the shared sense of service quality and the practices which foster it (Hong, Liao, Hu, & Jiang, 2013). The literature on service climate typically examines

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leader characteristics (e.g., service-focused leadership, Schneider, Ehrhart, Mayer, Saltz, & Niles-Jolly, 2005), leader behaviors (e.g., empowering others, Martin, Liao, & Campbell-Bush, 2013), and bundles of high-performance work practices (e.g., empowerment, extensive training, rigorous selection) occasionally with a service-specific focus (Chuang & Liao, 2010; Subramony & Pugh, 2015). These antecedents influence customer perceptions through service climate (Hong et al., 2013 for a review and meta-analysis), with the "strength" of the service climate (Schneider, Salvaggio, & Subirats, 2002) enhancing the effects. Service climate itself shapes other behaviors that are associated with customer experience outcomes including employee capabilities (i.e., human capital, Haber & Reichel, 2007; Van Iddekinge et al., 2009), responsiveness (Grandey, Goldberg, & Pugh, 2011), and customer-focused discretionary effort (Martin et al., 2013). Despite this substantial progress, important gaps remain in the literature. First, emerging evidence suggests that community demographics affect the employee–customer relationship (Brief, Butz, & Deitch, 2005), but there has been limited empirical examination of how organizations manage a diverse customer base and the resulting customer experience (Subramony & Pugh, 2015). Recent research also finds that customer satisfaction measures may be systematically biased (Hekman et al., 2010). Second, research on customer experience consistently finds that "concern for customers" and high performance work practices are associated with higher ratings of customer experience, but the practices and underlying mechanisms by which they do so are imprecise. Third, although there is an active literature on co-production in marketing and services research, there is comparatively little management research. Specifically, there are interesting anecdotes and examples of how organizations use specific management practices to engage in co-production with their customers (Bowen & Pugh, 2009), however, there is a relative paucity of management research regarding the use of specific practices and their consequences.

We turn to a parallel literature on patient satisfaction and service quality experience from health services research to help fill some of the identified gaps in the organizational behavior and human resource management literatures. Health services research may be especially useful because healthcare organizations experience acute challenges of complexity, co-production, and service intangibility. The heightened conditions in healthcare organizations can be useful for theoretical development as well as providing a potential leading indicator of how to cope with challenging conditions (Eisenhardt & Graebner, 2007; Farjoun & Starbuck, 2007).

Healthcare delivery is irreducibly complex because human disease is inherently complex and may manifest itself differently across patients. Even when the diagnosis is apparent, the best course of treatment may not be (Nembhard, Alexander, Hoff, & Ramanujam, 2009). The demographic heterogeneity of patients amplifies the complexity (Sofaer & Firminger, 2005). Healthcare professionals can provide the same service, but the patient may experience it differently as a function of their current condition. Thus, high quality care is highly customized care; it is based in an intimate and particular understanding of the patient (Benner, Tanner, & Chesla, 1996). There is also extreme knowledge asymmetry between provider and patient due to the highly educated, professionalized, and specialized healthcare workforce. The knowledge gap is often exacerbated by the emotionality and vulnerability felt by patients and their families as they cope with health problems and managing complex disease processes (Dempsey, McConville, Wojciechowski, & Drain, 2014). Yet providers are also highly reliant on information from the individual patient. These conditions necessitate making care delivery more tangible, often by engaging patients and their families in the co-production of the care. Co-producing care is particularly difficult though due to the history of medicine that has privileged the interests of the provider (Abbott, 1991, 1993; Nembhard et al., 2009) over the interests and preferences of the patient.

Healthcare presents two additional and unique challenges to achieving high customer satisfaction and service quality. First, the potential consequences for the patient (i.e., customer) and, recently, the organization (i.e. hospitals and other healthcare delivery settings,) are qualitatively different in healthcare. Care delivery carries with it a high risk for harm from services performed relative to other industries. The cost of failure is much greater in terms of patient injury and in some cases death, especially for vulnerable populations (i.e., young, old, chronically ill, minorities, and lower socio-economic status patients, Sofaer & Firminger, 2005). Healthcare is also delivered under high regulatory scrutiny that, recently, began linking payment to delivering what patients perceive to be a high-quality experience (Federal Register, 2011). Second, care delivery may unfold over a longer time horizon than other service encounters, and satisfaction with the care experience influences patients' willingness to participate in their care and comply with the treatment plans (e.g., go to follow-up appointments, take medication). Both participation and compliance influence subsequent health outcomes (Golin, DiMatteo, & Gelberg, 1996; Sofaer & Firminger, 2005).

The difficult conditions in healthcare delivery have led these organizations to adopt and implement specific practices to ensure a high quality patient experience by carefully customizing and tailoring care to patients' unique needs. To address the heightened complexity and diversity of patients and their conditions, healthcare organizations implemented practices like relational work systems to ensure cross-boundary coordination (Gittell, Seidner, & Wimbush, 2010), and cultural competency (Weech-Maldonado et al., 2012) to provide customized care to diverse populations. Relatedly, there has been an industry-wide effort to develop a better, more actionable, and unbiased set of measures of patient experience known as the Consumer Assessment of Healthcare Providers and Systems (CAHPS, (Elliott, Edwards, Angeles, Hambarsoomians, & Hays, 2005; Elliott, Kanouse, Edwards, & Hilborne, 2009a, Elliott et al., 2009b; Giordano, Elliott, Goldstein, Lehrman et al., 2010; Goldstein, Farquhar, Crofton, Darby, & Garfinkel, 2005). Given the multiple forms of suffering that characterize care delivery for patients and those who treat them (Dempsey et al., 2014), healthcare organizations have also moved beyond "concern for customer" (Burke, Borucki, & Hurley, 1992) to implement specific compassion practices to make the care process more tangible and increase the amount, clarity, empathy, and quality of communication with patients (Lown, Rosen, & Marttila, 2011). Lastly, some healthcare organizations have implemented macro-practices that radically restructure care through co-production known as patient-centered care (Rathert, Wyrwich, & Boren, 2013), as well as micro-practices like bedside reports (i.e., care transitions between providers occur with the patient as participants, Gregory, Tan, Tilrico, Edwardson, & Gamm, 2014).

The purpose of this paper is to highlight how findings from research in the challenging healthcare context may help fill important gaps in research on customer satisfaction and service quality ratings in other industries. To do so, we explore sets of practices and processes implemented in healthcare to address the service challenges of complexity (cultural competence, relational work systems,