**CASE 1**

**TEACHING NOTES**

**THE TWINS’ FIRST SERVICE ENCOUNTER**

**QUESTIONS:**

**1. Based on the scale of market entities, is health care tangible dominant or intangible dominant? Please explain.**

In general, the core benefit the hospital offers is health care. Health care is on the intangible dominant side of the continuum, but has many tangible components.

**2. Using the servuction model as a point of reference, categorize the factors that influenced this service encounter.**

Typical responses should be similar to those provided in Exhibit I.

Emmy’s and Maddy’s first service experience highlights some of the basic differences between the production and delivery of goods versus that of services. In contrast to goods, services deliver a bundle of benefits to the consumer through the experience that is created for the consumer. Most consumers of goods never see the inside of the factory where their goods are produced. In contrast, consumers of health care services are physically present within the production factory. As a result, patients do interact with personnel who perform the service and are influenced by the physical aspects of the surrounding environment.

One simple but powerful model that illustrates the factors that influence the service experience is the servuction model. The servuction model is comprised of two parts: that which is visible to the patient and that which is not. The visible part of the servuction model consists of three parts: the inanimate environment, the contact personnel/ service provider, and other patients. The invisible component of the model consists of the invisible organization and systems.

# The Inanimate Environment

The inanimate environment consists of all the nonliving features that are present during the service encounter. Since health care services are intangible, they cannot be objectively evaluated like goods. Hence, in the absence of a tangible product, patients look for tangible clues that surround the service to base service performance evaluations. The physical appearance of the hospital, its grounds, hallways, elevators, stairwells, patient rooms, public restrooms, and food facilities enter into the patient’s perception of the hospital’s overall performance.

# Contact Personnel/Service Providers

Unlike the consumption of goods, the consumption of services often takes place within the “service factory.” The interactions between patients and staff can be termed “critical incidents” or “moments of truth” and represent the greatest opportunities for gains or losses in terms of influencing patient service quality perceptions. Due to the lack of separation between patients and providers, providers must possess interpersonal skills in addition to technical skills. Unfortunately, due to the demands of the job, most employees receive the technical training, while training in patient relations is treated as secondary or as “fluff.”

# Other Patients

The visible portion of the servuction model is completed with the introduction of “Patient A” and “Patient B.” Patient A is the recipient of the bundle of benefits that is created through the service experience. Patient B refers to other patients who are part of Patient A’s experience and who can dramatically impact Patient A’s experience. Emergency room waiting areas and semi-private rooms provide ample evidence of just how large an impact, both positive and negative, patients can have on one another.

# Invisible Organization and Systems

The visible components of the servuction model are supported by the invisible organization and systems. The invisible organization and systems reflect the rules, regulations, and processes upon which the organization is based; therefore, the impact upon patients can be very profound. The invisible organization and systems determine factors such as: information forms needed to be completed by patients, the number of staff scheduled for each shift, and the policies of the organization regarding everything from the number of visitors to discharge procedures.

**2b (optional). Another very useful exercise is to interpret the signals sent to the family by the factors that comprise the servuction model. Ask students the following:**

**Place yourself in the shoes of the parents of Emmy and Maddy. How would you interpret each of the factors that were classified in Question #2?**

Answers will vary. Examples are provided in Exhibit II.

**3. Develop a molecular model for this hospital.**

Although answers will vary, in general, the core benefit the hospital offers is health care. The tangible and intangible components of the experience that spin off from the center may include the various departments, various personnel, equipment and supplies, etc.

**4. Discuss corrective actions that need to be taken to ensure that a patient’s subsequent service experience will run more smoothly.**

Discussion will most likely be centered on training issues and the importance of each individual in the patient’s overall service evaluation. It is hoped that this case assists personnel in looking at the “big picture” instead of just their own areas. Ultimately, everyone is responsible for patient perceptions of service quality.

# Suggested Solutions:

*The Power of Personal Touches*

One of the primary objectives of every hospital should be to determine strategies that reduce the anxiety and increase the individuality associated with the hospital experience. The pink ribbons that were placed in Emmy and Maddy’s hair, the stickers and signs of encouragement that were attached to the incubators, and the homemade patch quilts that were given to the girls by the local sewing club humanized the tubes and the machinery and sent the message that the girls were special and loved. As parents, the personal touches also reduced our anxiety during the times when we were not at the hospital...surely, if the staff cared enough about the twins to exhibit so many personal touches, the quality of care would be consistent with these actions.

*Selection and Training of Contact Personnel*

Since health care is a people business, it needs to employ personnel who really enjoy being around others. Hiring personnel with competent technical skills is only a beginning. Personnel with technical and interpersonal skills puts the hospital over the top and differentiates it from its competitors.

The need for continually educating personnel is also evident. The orderly who remarked that the babies would not live and the nurse who asked if we were going to take the babies to another hospital are examples of personnel who were unfamiliar with the capabilities of their own hospital. These remarks not only needlessly increased our anxiety, but also decreased our faith in the hospital’s abilities.

Continual training is needed not only to educate personnel but also to remind personnel that although coming to work may be a daily routine for them, a trip to the hospital for many patients is far from ordinary. The security guard who was more concerned with the position of the car and talking to his buddy than with why the people in the car had drove up to the emergency entrance in the first place was mind boggling. With the exception of our initial phone call to the hospital, the security guard experience was our first impression as we entered the hospital. The actions of the security guard, the orderly’s remarks, and the inexperienced resident set the tone for that first day’s experience.

*Family and Friends as Partial Employees*

Due to the unpredictability of consumer demand in most services, the only time supply matches demand is by accident. Hence, realistically, patient needs are not always going to be satisfied at the exact time when the patient need occurs. Moreover, patient’s family and friends are often at a loss regarding how they can make a contribution to the patient’s recovery efforts. Idle friends and family combined with the constraints placed on staff often result in confrontation and patient dissatisfaction.

One solution to this problem is to view the patient’s friends and family as partial employees. By empowering family and friends to conduct basic tasks, such as getting ice, bedding, towels, and light refreshments for the patient, the family and friends become partial employees of the hospital and can provide basic services for patients when needed. Ultimately, partial employees increase the supply of service available to all patients, since the staff has additional time that was once dedicated to providing basic services. Furthermore, family and friends as partial employees are given a sense of control that is otherwise frequently missing for them throughout the patient’s hospital experience. As Emmy and Maddy’s parents, our involvement in the NICU and the Grower Room gave us some sense of making a meaningful contribution, while it provided the staff additional time to attend to other duties.

*The Recognition of “On Stage” and “Backstage” Areas*

Due to the patient’s presence in the service delivery process, employee job satisfaction/dissatisfaction is visible to patients and directly related to patient perceptions of the quality of service provided. The hospital setting should be viewed as “on stage” and “backstage.” “On stage” occurs when providers and patients are sharing the same experience. In contrast, “backstage” occurs in areas where providers are isolated from the patient and their family and friends.

Recently, I was watching a video tape of the twins that was taken shortly after they were born. The video portion of the tape shows just how small the babies really were and the concern of their parents. The audio portion of the tape reveals how concerned the staff was with their own work schedules for the next several weeks and included a long diatribe on how a new scheduling procedure should be implemented. I remember thinking at the time that the scheduling issue competed with the care of the babies, and I really did not give a “flip” about their scheduling problems. The tape provides a good example of how patients, their families and friends, and service providers are present in the “service factory” at the same time. Consequently, administrative and other nonpatient-related issues should be addressed and/or discussed backstage in break rooms or other areas where patients and their guests are not present.

*Reducing Anxiety during Personnel Changes*

One of the biggest lessons that I personally learned throughout this experience was that the quality of care often fell through the cracks during shift and other personnel changes. New faces would appear, and we would often have to establish relationships all over again, which added to the anxiety and frustration of the hospital experience. When the patients were not able to effectively communicate for themselves, I often had to make sure that the new personnel were clear about changes in care and/or the particular care that was needed. I was surprised by how involved we had to become to ensure that all the pieces of the health care puzzle fit together.

One possible solution to this problem is to have the existing staff at least introduce the new shift worker to the patient. Particular areas of patient concern could be addressed to all parties involved while introductions are being made. This would enhance the continuity of the service provided and reduce patient anxiety.

*Actively Seeking Patient Feedback throughout the Experience*

Studies show that most companies do not hear from 96% of their unhappy customers. Within the hospital setting, customer complaints often result in a face-to-face confrontation between the patient and the provider of the service. Consequently, patients may be reluctant to openly complain for fear of retaliation in the form of declining health care service.

Patient representatives need to actively seek patient feedback to provide a buffer between the patient and the health care provider. Waiting until the hospital experience is over before asking for patient feedback is too late. Due to the patient’s active involvement in the production of health care services, service quality and customer satisfaction perceptions are made both during and after the service experience. This evaluation process allows the health care provider to alter the patient’s experience while the patient is still within the health care facility.

Interestingly, recovering from service failures often results in a type of service recovery paradox—where patients may rate the quality of care more favorably when a failure occurred and was corrected than had the service been delivered correctly in the first place. It appears that making corrections midstream often act as another form of “personal touch” and indicates to the patient that the health care delivery system does care about the welfare of its patients. Consequently, patient complaints should be viewed as opportunities for the hospital to improve its patient satisfaction ratings.

**Source:**

K. Douglas Hoffman, “Rude Awakening,” *Journal of Health Care Marketing*, 16, 2 (Summer 1996), pp. 14–20.

*EXHIBIT I*

*FACTORS THAT INFLUENCED THE SERVICE ENCOUNTER*

***Contact Personnel/Service Providers:***

*The nurse who suggested to take a shower Fourth floor nurses Representative Hospital patient*

*The security guard NICU staff*

*The triage nurse Grower room staff*

*The orderly Nesting personnel*

*Maternity ward nurses*

*First nurse in maternity room* ***Other Patients:***

*Junior resident on duty Woman in labor*

*Senior resident on duty*

*Dr. Baker* ***Inanimate Environment:***

*Dr. Johnson Small, dingy, dirty room*

*New shift of nurses Nesting room*

*Dr. Arthur*

*Operating room team* ***Invisible Organization:***

*Neonatal staff in operating room Shift changes*

*Recovery room nurse Insurance forms*

*Volunteer worker Staff scheduling*

*Fourth floor nurse who asked if babies were  
going to be sent to another hospital*

*EXHIBIT II*

*EMOTIONAL RESPONSE TO SERVUCTION FACTORS*

*SERVUCTION FACTORS: INTERPRETATION:*

***Contact Personnel/Service Providers:***

*The nurse who suggested to take a shower “We were not in an immediate*

*emergency situation.”*

*The security guard “More concerned about the*

*parking lot than why people were*

*coming to the emergency room.”*

*The triage nurse “Fast and efficient”*

*The orderly “Inexcusable thing to say”*

*Maternity ward nurses “Pleasant demeanor resulted in a total culture shift.”*

*First nurse in maternity room “Took control, related-well*

*immediately”*

*Junior resident on duty “The cavalry had arrived, but they*

*were riding donkeys and armed with*

*sling shots.”*

*Senior resident on duty “Took control when it was apparent*

*that the patient was upset...maybe should have taken control sooner”*

*Dr. Baker “Wish he had arrived sooner, but we also understand that it does not necessarily work that way.”*

*Dr. Johnson “Worked in conjunction with Dr.*

*Baker...two heads are better than*

*one. We are still curious about how*

*everyone took their time talking about everything, and then all of a sudden*

*it was an immediate emergency.”*

*New shift of nurses “Bad timing on our part...we had to*

*establish relationships all over again.*

*Dr. Arthur “Very straightforward, professional,*

*yet caring. Very credible.”*

*Operating room team “Everyone had a role to play, which*

*was executed very well. Involved us*

*in the delivery process.”*

*Neonatal staff in operating room “The competitiveness between the*

*two teams with regards to the babies’*

*vitals indicated that the babies must*

*be typical preemies.”*

*Recovery room nurse “Helpful”*

*Volunteer worker “Pleasant surprise for me. Joyful and*

*emotionally devastating for my wife*

*because of all the tubes.”*

*Fourth floor nurse who asked if babies were “Sent the signal that the hospital was*

*going to be sent to another hospital not adequately prepared to serve our*

*babies’ needs.”*

*Fourth floor nurses “In general (not all), tended to be more*

*interested in the technical aspects of*

*their jobs and making the rounds than*

*the patient’s individual needs. Blaming*

*other shifts for mistakes was inappropriate.”*

*Hospital patient representative “Made a difference almost immediately.*

*Diffused potential face-to-face*

*conflict between patient and providers.”*

*NICU staff “Very good on both the technical and the emotional sides of their jobs.” The only negative was that at times some staff seemed more concerned with their schedules than with patient care.”*

*Grower room staff “In comparison to the NICU experience, the grower room experience was a big*

*let down. Why are our babies in ‘the hole?’”*

*Nesting personnel The concept itself is a good idea; however, sleeping on furniture and being overwhelmed*

*by personnel all night long before you take twins home the next morning does not necessarily lead to a smooth transition once you get home. We were physically and emotionally exhausted.”*

***Other Patients:***

*Woman in labor “It was a surreal experience. My wife had just been rushed out of the room, and I was thrown a*

*set of scrubs. I was told to put them on, and someone would come and get me if they were able. I sat in an empty room on a stool watching The Weather Channel track Hurricane Felix while the woman next door screamed through her labor.”*

***Inanimate Environment:***

*Small, dingy, dirty room “Direct association between the cleanliness of the room and the quality of care.”*

*Nesting room “Congestion added to the stress of the situation.”*

***Invisible Organization:***

*Shift changes “Necessary evil...consistency and quality of care frequently fell between the cracks during*

*shift changes.”*

*Insurance forms “Good idea to fill them out ahead of time...better idea to actually have them available.”*

*Staff scheduling “Major source of concern for most of the providers.”*