CUSTOMER EXPERIENCE QUALITY DIMENSIONS IN HEALTH CARE: PERSPECTIVES OF INDUSTRY EXPERTS

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ABSTRACT

Purpose – In an era which patients are acting as consumers, this paper aims to emphasize the importance of patient experience and reveal the key concepts for patient experience according to industry experts' perspectives. Seven key concepts are presented as the critical dimensions of patient experience.
Methodology - A qualitative study is designed and conducted following the phenomenological approach. 15 experts are interviewed about the patient experience and content analysis is conducted to the answers in texts. Results are grouped under certain concepts which address to key concepts of patient experience.
Findings- The results show that experts agree on certain critical dimensions for patient experience which are: provider type, function, patient type, preference, touchpoint diversity, psychology, interaction, and environment.
Conclusion-This study is about the expert approach of patient experience which intersects marketing and health care. The results contribute to the literature with its novel approach considering industry expert opinions, and also act as a guide for health care managers to improve patient experience.

Keywords: Patient experience, customer experience, healthcare marketing, hospital experience, experience marketing
JEL Codes: M31, I12, L80

1. INTRODUCTION

For the last 30 years, marketing has been continuously evolving into new perspectives in order to attract the transforming consumers. The focus of exchanging the goods has been turned to exchanging relationships (Bowden et al., 2015; Hunt, 1983) and creating, improving and sustaining the relationships have been accepted as the core marketing activities (Morgan and Hunt, 1994). The transactional perspective of traditional marketing, so called goods-dominant logic, is converted into a relationship-based marketing, so called service dominant (S-D) logic (Vargo and Lusch, 2004; 2008). The S-D logic opened a perspective, which suggests that consumers interactively co-create value within organizations (Brodie et al., 2011). Customers develop relationships with the sellers and this relationship creates the value bilaterally (Harmeling et al., 2017) instead of buying goods and exiting the system unilaterally. Recently, this perspective leads to a new era in the marketing literature with its impact on transforming passive consumers into empowered ones. Empowered consumers are actively connected and informed, and aware of their ability to co-create value for the firms (Prahalad and Ramaswamy, 2004).

Along these lines, patients have been also transformed and have started to behave like traditional customers, who are rationally evaluating the alternatives before making a purchase decision, since they have the chance to choose between different health service alternatives, especially by searching online and by being informed with the data gathered online (Mazurenko et al., 2016). They evaluate their alternatives of hospitals although switching costs may not be inexpensive for them (Otani et al., 2009). Hence, satisfying and retaining the patients, so treating them as consumers by providing better medical service have been a critical issue for health care organizations (Amin and Nasharuddin, 2013; Alhashem et al., 2011; Arasli et al., 2008), since better experience scores have some positive value co-creative results such as decreased churn rates (Colgate and Hedge, 2001), increased loyalty (Kessler and Mylod, 2011), recommendation (Long, 2012; Otani et al. 2010), and revisit intention (Otani et al., 2010; Swan et al., 1985). The challenge for healthcare organizations in such a competitive environment is to be able to win the hearts of patients by seeing the service from patients' eyes and focusing on providing high quality service experience and excellent patient satisfaction ratings (Deshwal and Bhuyan, 2018; Otani et al., 2009).

Apart from medical solutions, today's patient is searching for a memorable experience instead of a competent one (Gilmore and Pine, 2002; Lemke, Clark, and Wilson, 2011). This creates a competitive challenge for organizations in order to keep the patient satisfied and engaged in value co-creation process. Hence, engaging the patient into the co-creation process is possible with providing a satisfying service resulting with a high experience quality. The experience is considered as a holistic process in the co-creation perspective, including a series of all interactions (Klaus and Maklan, 2013) including communication, service, and usage quality (Lemke et al., 2011) which should be taken as a whole instead of distinct elements. This study aims to understand what the critical touch points are to serve higher patient experience quality in a health care organization. Expert interview findings are used to reveal critical points to build a positive and memorable patient experience.

2. LITERATURE REVIEW

Creating high quality experience value is one of the main objectives of service organizations (Maklan and Klaus, 2011; Verhoef et al., 2009). Customer experience quality is conceptualized as the "perceived judgement about the excellence or superiority of the customer experience" (Lemke et al., 2011). There is a significantly positive relationship between customers' experiences and evaluations of a particular service (Otto and Ritchie, 1995). The experience and the service are two complementary assets of an organization because good customer experience can be achieved by a good customer service (Berry, Shankar, and Parish, 2006). Besides, the customers do not only consider the product and service quality; they evaluate the whole experience quality proposed by the organization, in parallel with the attribution theory (Lemke et al., 2011).

Experience is being formed personally and subjectively in a holistic set of interactions with any contact across certain touchpoints of the organization (Gentile et al., 2007; Lemke et al., 2011; Meyer and Schwager, 2007). Verhoef (2009) states that it can be considered a total set of experiences including the steps of search, purchase, consumption, and after-sale service. However, search is not the very first step of the set. Being exposed to marketing communication activities should be considered as a step-in customer experience. For instance, if it is a hotel service, the trip between the visitor's house and the hotel is an effective step in the experience (Tribe and Snaith, 1998). Hence, the perceived value is created in any single touchpoint and in their combination. Bitner's (1990) model of servicescape includes four dimensions: (1) atmospherics, (2) social factors, (3) physical design, and (4) layout and orientation. Although these dimensions seem to be applicable to all consumer behavior contexts (Suess and Mody, 2018), healthcare should have a specific approach because of its complex system which includes thousands of processes (al-Assaf, 1999). Thus, as a system-oriented business, identifying the key components of processes and analyzing them in flowcharts is necessary (Deming, 1986). Early identification of opportunities for improvements in these processes is critical for initiating early interventions.

In this sense, designing and evaluating the patient experience need a process perspective. To illustrate, the experience of a patient may start with an online search of a good physician. After searching for the physician online or offline, the patient finds the hospital and gets an appointment. In the appointment day, he/she reaches the hospital by car or public transportation. Some personal perception is created in the patient's mind after entering the hospital triggered by the smell, the physical evidence, the crowdedness, the atmosphere in general. The interactions with the employee in the desk, with the employee in the waiting area, and with the physician in the consulting room continue shaping the experience. The service quality delivered in this whole process, the competence of the physician, and the responsiveness of the employees are additional factors to form the experience. Treatment result and the following attitude of the physician can be counted as further steps for the patient experience. In this example, several touchpoints can be determined: webpage, physical atmosphere, employee interaction (staff and physician), patient follow-up. Each touchpoint, whether it is under the control of the company or not, gives some clues about the journey of the customer and helps exploring the experience (Verhoef et al., 2009; Swinyard, 1993). In parallel with this illustration, patient experience is defined as "the sum of all interactions, shaped by an organization's culture that influence

patient perceptions across the continuum of care" (The Beryl Institute, 2018). It is critical to determine the relevant touchpoints in that continuum in order to offer a memorable experience to the patient.

John's (1996) study shows how healthcare setting might include different dimensions leading to a complex structure to manage. He analyzes the physician-patient encounter dramaturgically and finds three different regions: (1) Actor's (physician's) region: medical training, physician approach, past experience, (2) Setting and performance – physician and patient front regions: relationship with patient, medical encounter (performance), medical condition, (3) Audience's (patient's) back region: cultural values, patient expectations, past experience. It is evident that there is a need to focus on the service experience which has a complicated set of interactions. Since patients are not just patients anymore, and they are the consumers of health services (Levine, 2015), healthcare service experience become more critical to gain the acceptance and engagement of the patient. Hence, a strong healthcare system is a must in order to deliver quality and value to patients (Camgoz-Akdag and Zineldin, 2010) by treating them as consumers. As a first step to build a strong healthcare system, this study gathered the expert opinions about the main patient experience points with an aim of understanding the perspective of the healthcare playmakers about patients. The qualitative study is expected to shed light on the current situation and provide a clear focus about critical touchpoints upon which further quantitative studies may be conducted on improving experience quality levels.

3. METHODOLOGY

Following Mazurenko et al. (2015), who used phenomenological approach suggested by Starks and Trinidad (2007), a qualitative study was designed and conducted to find out the critical dimensions of patient experience. This method deals with analyzing the content about experience collected by observing and interviewing, and clusters the identifications to describe the meaning of a related phenomenon (Starks and Trinidad, 2007).

In order to specify the critical experience points, expert opinions were collected face-to-face. For the interviews, top and mid-level managers or physicians at private hospitals, and academic researchers having expertise on the field were selected for the in-depth interviews. In total, fifteen interviews were conducted. The demographic characteristics of the interviewees are shown in Table 1.

Table 1: Characteristics of the Interviews

| Number	Position	Hospital Scale	Hospital Type
1	Assistant Prof.	-	-
2	Researcher	-	-
3	Physician	Large	Private / SSI[*]
4	Prof. Dr.	-	-
5	Assistant Strategy Director	Large	Private
6	Dr / Hospital manager	Large	Private / SSI
7	Prof Dr	-	-
8	Dr / Hospital manager	Small	Private / SSI
9	Patient relations	Small	Private / SSI
10	Guest relations*	Large	Private
11	Hospital manager***	Large	Private
12	Head physician	Large	Private
13	Patient relations	Large	SSI
14	Head physician	Large	SSI
15	Assoc. Prof.	Large	SSI

Note:

*SSI: Social security institution (SGK)
**Guest relations is the same position as patient relations. However, using the term "guest" instead of "patient" is an indicator of the experience approach of the hospital.
***She is the only hospital top manager without a medical background.

The semi-structured interviews with hospital employee started with the question of: "Can you name a unit where patients meet your hospital and after the experience in that unit, they select the same hospital for other needs?". Then, a discussion was conducted about the patient experience or satisfaction measurement methods used in that hospital. The participants were requested to name a unit of the hospital where a research may provide an overall insight in terms of patient experience, in order to discuss the importance of touch point diversity in patient experience. Each interview approximately took one hour. The answers to interview questions were written in text format and a content analysis was conducted through the text. The three-step analysis process was adopted as it is shown in Figure 1. First, themes cited in highest frequency (e.g. state insurance contract, customer type, location etc.) were listed. Second, the themes were classified in terms of some pre-defined concepts (e.g. function, interaction, environment, etc.). Finally, the concepts were grouped under more specified categories based on the extent to which they comprise the subconcepts. This three-step categorization allowed to figure out the most critical points for better patient experience from the management perspective.

Figure 1: Process of Analyzing the Expert Interview Results
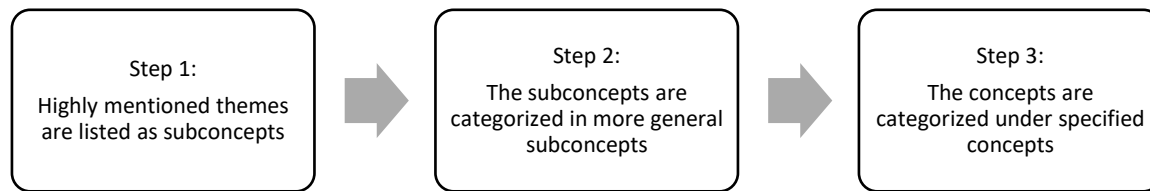
4. FINDINGS

After analyzing the interviews with health care experts, the critical concepts for patient experience were acquired. Mainly; the type and function of the private hospital, type of the patient based on the reason why he/she is in the hospital, preference of the patient, touchpoint diversity in the organization, patient psychology, interaction with physicians and staff, and hospital environment are found as the key concepts to evaluate the experience in a hospital. Designing a better patient experience hinges upon those key concepts in a private health care organization.

4.1. Key Concepts of Patient Experience

The key concepts are the themes which become prominent in the interviews. The interviewees mainly talk about the effective factors for better patient experience, and their words are organized as a list of themes with a list of themes. After the list of the themes are written down, they are considered as subconcepts and grouped under broader concepts. Subconcepts, concepts, and their definitions are listed in Table 2.

Table 2: Key Concepts of Patient Experience

Subconcepts	Concepts	Concept definitions
1. State insurance contract	Provider type	Defines the type of the private hospital
2. Treatment 3. Area of specialization 4. The ability of providing rapid and accurate solution	Function	Defines the main objective of establishment of the healthcare provider
5. Treatment type 6. Customer type	Patient type	Defines the one who evaluates the experience
7. Preference of a physician 8. Variety of the process	Preference	Defines the behavior whether the patient chooses a specific unit/doctor or randomly enters the hospital
9. Process management	Touchpoint diversity	Defines how many different points that a patient touches through the journey
10. Supporting the patient psychologically 11. Personnel directions	Psychology	Defines a patient's feeling of safety
12. Physician communication 13. Staff communication	Interaction	Defines the main information gathering and information giving activities between the patient and the personnel

Hospital type

Hospital type is the class of the health care provider in terms of territorial legal practice. In Turkey, Ministry of Health, Social Insurance Institution (SSI-SGK), and Private Sector provide healthcare services (Camgoz-Akdag and Zineldin, 2010), and the hospitals are grouped under two classes: state or private hospitals. This system creates a segment difference between patients as customers. Since the scope of this research is limited to only private hospitals, these hospitals were included in the sample of the interviews. However, private hospitals are separated into two groups: the hospitals that do or do not accept the state insurance. The customers of these two groups seem to have different characteristics. For instance, a hospital manager indicates that they have lost a group of patients after they signed a contract with Social Insurance Organization to accept state insurance in their hospital:

"Some people, especially the premium segment customers, do not want to enter an organization by walking under a signboard indicating the state insurance contract. They do not feel like they belong there.".

Although the state insurance allows lower-income patients to be treated in private hospitals, which offers a social opportunity, some premium patients feel like the hospital is not special enough to be treated in.

Function

Function defines the main objectives of the healthcare provider. This concept has different dimensions:

(1) Treatment: Some healthcare organizations provide only check-up, blood tests, or dialysis. Some others provide a general package of treatment in various areas. Hence, the experience differentiates in different types of hospitals. An academician among the interviewees indicates that talking to check-up patients may not provide an idea about the hospital experience, because the main objective of a hospital is not a check-up test:

"The function of a hospital is not diagnosis, it is treatment. Check-up patients do not see any treatment process, so they cannot have a whole experience quality perception".

(2) Area of specialization: There are some hospitals which are specialized in Oncology, or Cardiology, etc. The area of specialization could be critical in choosing the hospital. For instance, a manager of an Oncology-focused hospital says that their patients first visit the hospital about oncological reasons, while a Cardiology-focused hospital manager answers about cardiological reasons. Thus, the results indicate that some hospitals have an area of specialization and the experience of the patients are formed mainly under this perception of specialization.

(3) The ability of providing rapid and accurate solution: This theme is the other main objective of a hospital. It is in parallel with one of dimensions in healthcare developed by Zineldin (2006) as quality of processes. This dimension includes the functional quality about the healthcare provider's core services. One of the managers reports:

"Addition to treatment, the ability of providing the accurate treatment solution rapidly is critical for a hospital to serve a good experience. The solution must exactly finish the problem and must have to be found as soon as possible. The patient does not want to wait or lose time with weak treatment types."

Patient type

Patient type can be grouped under two different classifications: (1) treatment type, and (2) customer type. Treatment type is related with the field in which the patient is treated. This means that departments are organized based on the medical needs of patients. However, apart from medical needs, some psychological needs may be differentiated for different departments. Thus, the patients consider various points while evaluating the experience. To illustrate, Pediatrics and Rheumatology include different dynamics. In Pediatrics, the patient is the child. But, the anxiety level of the mother, who is the actual consumer, may be high. On the other hand, Rheumatology is generally the second visiting point after a general inspection. Here, the anxiety level may increase because of some disease that cannot be found in the first round. Different from all, emergency service has its own anxiety level because of the need for rapidity. Hence, the needs of patients in different departments has its own frame, which makes patients diversified.

On the other hand, patients are grouped as their customer types: inpatients and outpatients. Since outpatients do not stay at the hospital, their experience is different than inpatients. Health organizations consider these two types separately in terms of experience. Another grouping may be made as patients and their relatives. However, it is seen that patients' relatives are never

considered as separate actors in the healthcare system based on the interview findings. The relatives and the patients are making the decisions together, so they may constitute a single decision-making unit.

Preference

Patients sometimes prefer some specific physicians and choose the hospitals just for that physician. For instance, gynecology is a sensitive area for women, and they do not randomly select their gynecologist.

"A woman can visit other hospital units instantly when she visits her gynecologist, but she does not visit gynecology instantly when she is in hospital for some other unit"

says a physician. Additionally, patients visit the well-known physicians no matter in which hospital they work. If the physician changes the hospital where he/she works, the patient also changes the hospital. Thus, experience perception of a patient may differ with his/her preference. Furthermore, patients may have a negative perception about the hospital, but they may still go to that hospital only for the physician. One of the interviewees who is also an oncology patient tells her story:

"I never choose that hospital because I know that they are not good at their work. However, I went there for my chemotherapy, only for the physician. He was the assistant of my surgeon, so his suggestion is important."

Hence, physician preference becomes critical for the experience. If there is a special preference, they mention the physician especially when talking about the hospital experience.

Touchpoint diversity

Health organizations have various touchpoints and this makes the health care system complex. Since the experience inside the organization is considered in this paper, the touchpoints start from the reception and end with payment desk. Between these two touchpoints, there are many different points such as departmental reception, inspection, waiting areas, other patients, etc. An example shows that, in some cases, the patients are even affected by the parking areas of the hospitals:

"A woman and her husband came into the hospital. It was obvious that a problem in the parking lot came out. The husband said: 'Is this the hospital you praised a lot?'"

It is obvious that the parking problem is attributed to the hospital. On the other hand, as it is mentioned above, the patient's relative affects the decisions made by the patient. Additionally, process management is a critical dimension for patient experience. A head physician says:

"Hospitals design the process from the entrance to the exit. However, the process should not be broken if the patient enters from the side door. Employees should have the practical intelligence to create solutions for such instant situations."

Mood/Feelings/Psychology

Patient mood dimensions are highly mentioned in interviews. The staff is the most effective factor on patient's mood. One of the managers reports,

"The patient expects to be supported emotionally when he/she enters the hospital. He/she is full of questions. The critical thing is metaphorically keeping holding the hand of the patient from the beginning till the end."

In order to improve patient experience, the patients should be welcomed positively and sent with a helping hand. This helping hand can only be provided by the personnel. Since the patient expects special attention to him/herself, the medical and administrative personnel play a vital role in patient's feelings. When a patient enters the hospital, the personnel directs him/her to the relevant unit. These directions are critical for the patient's journey in the organization. As a physician indicates,

"The satisfaction may come from the administrative staff. Patients have a general idea about the organizations by evaluating even only the staff".

Thus, the interaction with the patient becomes critical for experience quality.

Interaction

Service consumption includes a set of interactions between the customer and the provider. Expert interviews show that the communication between the patient and the employee is the most critical interaction in the healthcare consumption process. The employees, so-called the medical staff, have a great impact on healthcare. The medical staff can be physician, nurse, or

administrative personnel as caregivers, and they have distinct interaction points. All those interactions are mentioned as the effective experience points in the interviews. Although the physician interaction may be thought as the most critical one, nurse is as important as the physician is.

"All of the operational support such as diaper changing is made by the nurse and administrative personnel. Since a physician does not and actually cannot do that, managers should concentrate on hiring talented staff."

says one of the physicians in the interviews. Remembering a patient during his/her second visit and asking him/her how he/she is, creates positive outcomes as several interviewees say.

Environment

Environment includes the location, proximity, physical design, and other patients. Location and transportation are two of the elements about the hospital facility. One of the managers tells that they lost some of their patients after they moved to a location that is close to a more prestigious area and far from major transportation lines. Similarly, another manager says that since their hospital is in a high prestige area, their patients are more sensitive to experience quality issues. In addition, the inclusion of insurance contract can lead to different perceptions among the patient groups. If a healthcare organization has a state insurance contract, that organization directly holds a different patient segment. The remarkable note by a manager about the insurance, mentioned in provider type, can be also considered as an environmental theme. The effect of "other patients" comes out when the state insurance contract is applied. Since the presence of state insurance indicates the hospital type, the patients coming to the facility can be important for other patients in terms of the created atmosphere.

5. CONCLUSION

Considering patients as empowered consumers in today's marketing world, this study reveals eight points critical for patient experience by interviewing fifteen different industry experts including physicians, managers, and academicians. The results do not include any clue about the medical outcomes but reveal that healthcare experts accept patients as decision-makers who have a voice in the market. Provider type, function, patient type, preference, touchpoint diversity, psychology, interaction, and environment are extracted as the key critical points of patient experience. A patient or patient relative in various psychological states considers the type and function of the provider, the interaction between the employee and the environment of that provider and the previous information heard before the visit while evaluating the experience. Among these dimensions extracted, provider type, function and touchpoint diversity are the ones, which are not flexible in terms of organizational structure. These are the institutional characteristics of the healthcare organization. However, interaction, preference, psychology, and environment can be adjusted considering the patient type. In particular, it is found that by constituting a proper interaction schema, organizations can have a preferred profile with the help of a well-designed environment, which makes patients feel better. Yet, the most critical point is found as the interpersonal interaction between the patient and the employee and the discussion therefore should focus on the interaction dimension.

Previous literature revealed various dimensions for patient experience. Cleanliness, quality, and accessibility are found as effective layers for designing a better service environment for patients (Suess and Mody, 2018). Additionally, patient experience is examined under five factors: environmental, emotional, behavioral, comfort, and social experience (Deshwall and Bhuyan, 2018). In other studies, six major experience episodes are stated shaping the overall patient experience, namely admission process, nursing care, physician care, staff care, food, and room (Otani, 2009; 2010; 2012). Trust, general communication, first-contact accessibility, whole-person care, and respectfulness are also identified as patient experience dimensions in primary care service (Brauer et al., 2018). Majority of the previous research have focused on selected specific departments of a hospital and revealed human-related factors for a better patient experience. This study offers a novel framework comprising a general approach to hospital instead of being branch-specific, through the analysis of experts' opinions. Experience quality in healthcare services includes functional and technical sides of the services (Brady et al., 2006; Gronroos, 1984). Technical sides include the medical treatment points (Mazurenko et al., 2015) such as, existence of post-operative complications (Danforth et al., 2014), achievement of the surgery or treatment goals (Biggs, et al., 2015), patient-nurse ratios (Jha et al., 2008), or the type of medical intervention (Marks et al., 2015). Functional sides include the operations excluding medical services, such as process management, operational excellence, managerial decisions. In previous studies, clinicians' perspective suggests that functional skills are critical for patient experience while patients' perspective focuses on interpersonal skills (Kim et al., 2004; Safran et al., 2003). However, this study presents that experts including physicians are now aware of the importance of interpersonal skills. The most critical point of patient experience is found as the interaction. Since the interaction with physicians and also nurses have an impact on overall satisfaction of a hospital (Vinagre and Neves, 2008), the experience focus of the health care organization should be the communicational skills of the employees in all levels.

In healthcare services, patients have some anxiety or stress because of the lack of knowledge or control about medical treatment (Klaus 2018; Berry et al., 2015). Since hospital experience is held under stress (Hultman et al., 2012; Tanja-Dijkstra, 2011), an environment which reduces the stress level should be provided (Andrade and Devlin, 2015). Ulrich's theory of supportive design (Ulrich, 1991) suggests that a physical environment supports the patients' well-being with its positive nature. According to the theory, environment with positive conditions and resources such as social interactions, sense of control over the environment, and positive distraction may be used to reduce the stress level (Andrade and Devlin, 2015; Ulrich, 1991). According to distraction theory (Shirey and Reynolds, 1988), positive distractions such as photographs, newspapers, etc. or smiling and talking people around the waiting room can help patients forget about their anxiety (Andrade and Delvin, 2015; Berman et al., 2008) However, physical environment is just one layer of the service design (Andrade and Devlin, 2015). Social elements of the service environment should also have a supportive characteristic in order to foster the patient's well-being (Andrade and Devlin, 2015; Ulrich, 1991). in addition to the physical service environment, the interaction with physicians, nurses and administrative staff has a critical effect on experience quality perception (Gill and White, 2009). Patients even prefer only one provider for all health issues if they are familiar with the provider, thus avoid the need for building an effective communication (Needham, 2012; Lathrop, 1993). Positive interaction increases the patients' confidence on medical advices (Sandoval et al., 2006). However, the satisfying interaction requires engaged employees who are aware of their contribution to the experience perception of patients and continuously work for delivering excellent service. Perpetual controls and disciplinary checks should be used as effective tools for internal marketing in order to have engaged employees (Fortenberry and McGoldrick, 2016). Although it is rather difficult to create such a culture, not only managerial staff but also the frontline employees have to care about patient experience feedback in order to foster creating the patient experience centered environment (Graham et al., 2015). Patients are consciously or unconsciously affected by the process they experience in the hospital. Although Shostack (1982) warns that leaving services to individual talent will lead an ineffective flow, in this study, individual talent is expected to be able to rule the whole system. The leaders should leverage their teams in terms of better interaction with the patients by taking the actions which provides the continuum of care at all touch points (Wolf, 2016).

A patient-centered approach, which suggests the increased interaction quality with patients and their families, will lead higher positive outcomes (Anderson et al., 2018), and can be effective for patient satisfaction in a nervous and stressful environment (Hutton and Richardson, 1995) by overcoming patient's negative feelings (Suess and Mody, 2018). Thus, interaction can be considered as an umbrella dimension for patient experience for affecting on having a better environment, accordingly on moods of the patients in all types positively. Further studies may additionally analyze patients' opinions and may compare and contrast the results from two perspectives. Besides, some quantitative studies may clarify the effects of experience quality on behavioral and attitudinal outcomes of patients.

REFERENCES

Al-Assaf, A. F. (1999). Introducing Quality in Healthcare: An International Perspective. *Journal for Healthcare Quality, 21*(1), 4-15.

Alhashem, A.M., Alquraini, H. and Chowdhury, R.I. (2011). Factors influencing patient satisfaction in primary healthcare clinics in Kuwait. *International Journal of Health Care Quality Assurance*, *24*(3), 249-262.

Amin, M. and Nasharuddin, S. Z. (2013) Hospital service quality and its effects on patient satisfaction and behavioural intention*. Clinical Governance: An International Journal*, *18*(3), 238-254

Anderson, S., Nasr, L. and Rayburn, S. W. (2018). Transformative service research and service design: synergistic effects in healthcare. *The Service Industries Journal*, *38*(1-2), 99-113.

Andrade, C. C. and Devlin, A. S. (2015). Stress reduction in the hospital room: Applying Ulrich's theory of supportive design. *Journal of Environmental Psychology, 41*, 125-134.

Arasli, H., Ekiz, E.H. and Katircioglu, S.T. (2008). Gearing service quality into public and private hospitals in small islands. *International Journal of Health Care Quality Assurance*, *21*(1), 8-23.

Berry, L. L., Davis, S. W., and Wilmet, J. (2015). When the customer is stressed. *Harvard Business Review, 93,* 86–94.

Berman, M. G., Jonides, J. and Kaplan, S. (2008). The cognitive benefits of interacting with nature. *Psychological Science, 19,*1207-1212. http://dx.doi.org/10.1111/ j.1467-9280.2008.02225.x

Biggs, T., Fraser, L., Ward, M., Sunkaraneni, V., Harries, R, and Salib, R. (2015). Patient reported outcome measures in septorhinoplasty surgery. *Annals of The Royal College of Surgeons of England, 57*(1), 63-65.

Bitner, M. J. (1990). Evaluating Service Encounters: The Effects of Physical Surroundings and Employee Responses. *Journalof Marketing, 54*(2), 69-82.

Bowden, J. L. H., Gabbott, M., and Naumann, K. (2015). Service relationships and the customer disengagement-engagement conundrum*. Journal of Marketing Management, 31*(7–8), 774–806.

Brady, M. K., Voorhees, C., Cronin, J. J. and Bourdeau, B. L. (2006). The good guys don't always win: The effect of valence on service perceptions and consequences. *Journal of Services Marketing, 20(*2), 83-91.

Brauer, P. Royall, D., Kaethler, A., Mayhew, A. and Israeloff-Smith, M. (2018). Development of a patient experience

questionnaire to improve lifestyle services in primary care. *Primary Health Care Research and Development, 19*(6),

542-552.

Brodie, R. J., Hollebeek, L. D., Juric, B., and Ilic, A. (2011). Customer engagement: Conceptual domain, fundamental propositions, and implications for research. *Journal of Service Research, 14*(3), 252–271.doi:10.1177/1094670511411703

Camgoz-Akdag, H. and Zineldin, M. (2010). Quality of Health Care and Patient Satisfaction: An exploratory investigation of the 5Qs model at Turkey, *Clinical Governance: An International Journal, Emerald Publications, 15*(2), 2010.

Colgate, M. and Hedge, R. (2001). An investigation into the switching process in retail banking services. *InternationalJournal of Bank Marketing, 19*(5), 201-212

Danforth, R. M., Pitt, H. A., Flanagan, M. E., Brewster, B. D„ Brand, E. W., and Frankel, R. M. (2014). Surgical inpatient satisfaction: What are the real drivers? *Surgery, 156*(2), 328-335.

Deming, W.E. (1986). Out of the crisis, Cambridge, MA: MIT Press.

Deshwal, P. and Bhuyan, P. (2018). Cancer patient service experience and satisfaction. *International Journal of Healthcare Management, 11*(2), 88-95.

Fortenberry, J. L. and McGoldrick, P. J. (2015). Internal marketing: A pathway for healthcare facilities to improve the patient experience. *International Journal of Healthcare Management, 9*(1), 28-33.

Gentile, C., Spiller, N., and Noci, G. (2007). How to sustain the customer experience: an overview of experience components that co-create value with the customer. *European Management Journal, 25,* 395–410.

Gill, L. and White, L. (2009). A critical review of patient satisfaction. *Leadership in Health Services, 22* (1), 8-19

Gilmore, J. H. and Pine, B. J. (2002). Differentiating Hospitality Operations via Experiences: Why Selling Services is Not Enough. *Cornell Hotel and Restaurant Administration Quarterly, 43*(3), 87-96.

Graham, C., Flott, K., King, J., Gibbons, E., Jenkinson, C., Fitzpatrick, R. (2015). Strategies and challenges for monitoring patient experience at the local level. *International Journal of Healthcare Management, 8*(1), 1-3

Grönroos, C. (2004). The relationship marketing process: Communication, interaction, dialog, value. *Journal of Business andIndustrial Marketing, 19*(2), 99–113.

Harmeling, C. M., Moffett, J. W., Arnold, M. J., and Carlson, B. D. (2017). Toward a theory of customer engagement marketing. *Journal of the Academy of Marketing Science, 45*(3), 312–335.

Hultman, T., Coakley, A. B., Annese, C. D. and Bouvier, S. (2012). Exploring the Sleep Experience of Hospitalized Adult Patients. *Creative Nursing, 18*(3), 135-139

Hunt, M. H. (1983). The making of a special relationship: The United States and China to 1914. New York, NY: Columbia University Press.

Hutton, J. D. and Richardson, L. D. (1995). Healthscapes: The role of the facility and physical environment on consumer attitudes, satisfaction, quality assessments, and behaviors. *Health Care Management Review, 20*(2), 48-61.

Jha, A., Orav, E., Zheng, J., and Epstein, A. (2008). Patients' perception of hospital care in the United States. *The New England Journal of Medicine, 359*(18), 1921-1931.

John, J. (1996). A dramaturgical view of the health care service encounter: Cultural value-based impression management guidelines for medical professional behavior. *European Journal of Marketing, 30*(9), 60-74.

Kessler, D. P. and Mylod, D. (2011). Does patient satisfaction affect patient loyalty? *International Journal of Health Care Quality Assurance, 24*(4), pp.266-273

Kim, S. S., Kaplowitz, S., and Johnston, M. V. (2004). The effects of physician empathy on patient satisfaction and compliance. *Evaluation and the Health Professions, 27*(3), 237-251.

Klaus, P. (2018) Luxury patient experience (LPX): review, conceptualization, and future research directions. *The Service Industries Journal, 38*(1-2), 87-98.

Klaus, P. and Maklan, S. (2013). Towards A Better Measure of Customer Experience. *International. Journal of Market Research, 55*(2), 227-246.

Lathrop, P. J. 1993. Restructuring Health Gare: The Patient Focused Paradigm. San Francisco: Jossey-Bass.

Lemke, F., Clark, M. and Wilson, H. (2011). Customer experience quality: an exploration in business and consumer contexts using repertory grid technique. *Journal of the Academy of Marketing Science, 39*, 846-869.

Levine, S. (2015). We Are All Patients, We Are All Consumers. NEJM Catalyst. Retrieved from: https://catalyst.nejm.org/we-are-all-patients-we-are-all-consumers/

Long, L. (2012). Impressing patients with improving HCAHPS. *Nursing Management, 43*(12), 32-37

Maklan, S. and Klaus. P. (2011). Customer Experience Are We Measuring the Right Things? *International Journal of Market Research, 53*(6), 771-792.

Marks, M., Audige, L„ Reissner, L„ Herren, D. B., Schindele, S„ and Vlieland, T. P. V. (2015). Determinants of patient satisfaction after surgery or corticosteroid injection for trapeziometacarpal osteoarthritis: Results of a prospective cohort study. *Archives of Orthopaedic and Trauma Surgery, 135*(1), 141-147.

Mazurenko, O., Zemke, D. M., Lefforge, N., Shoemaker, S. and Menachemi N. (2015). What Determines the Surgical Patient Experience? Exploring the Patient, Clinical Staff, and Administration Perspectives. *Journal of Healthcare Management, 60*(5), 332-346.

Mazurenko, O., Zemke, D. M., and Lefforge, N. (2016). Who Is a Hospital's "Customer"? *Journal of Healthcare Management,61*(5), 319-333.

Meyer, C. and Schwager, A. (2007). Understanding Customer Experience. *Harvard Business Review, 85*(2), 116-126.

Morgan, R. M., and Hunt, S. D. (1994). The commitment-trust theory of relationship marketing. *Journal of Marketing, 58*(3),20–38. doi:10.2307/1252308.

Needham, B. R. (2012). The Truth About Patient Experience: What We Can Learn from Other Industries, and How Three Ps Can Improve Health Outcomes, Strengthen Brands, and Delight Customers. *Journal of Healthcare Management,57*(4), 255-263.

Otani, K., Waterman, B., Faulkner, K. M., Boslaugh, S. and Dunagan, W. C. (2009). Patient Satisfaction: Focusing on "Excellent". *Journal of Healthcare Management, 54*(2), 93-103.

Otani, K., Waterman, B., Faulkner, K. M., Boslaugh, S. and Dunagan, W. C. (2010). How Patient Reactions to Hospital Care Attributes Affect the Evaluation of Overall Quality of Care, Willingness to Recommend, and Willingness to Return. *Journal of Healthcare Management, 55*(1), 25-37.

Otani, K. Waterman, B. Claiborne, W. (2012). Patient Satisfaction: How Patient Health Conditions Influence Their Satisfaction. *Journal of Healthcare Management, 57*(4), 276-292.

Otto, E.J. and Ritchie, B. J. (1996). The service experience in tourism. *Tourism Management, 17*(3), 165–74.

Prahalad, C., and Ramaswamy, V. (2004). Co-Creating Unique Value with Customers. *Strategy and Leadership, 32*(3), 4-9.

Safran, D. G., Montgomery, J. E., Chang, H., Murphy,J., and Rogers, W. H. (2003). Switching doctors: Predictors of voluntary disenrollment in Medicare managed care. *Health Care Finance Review, 25*(2), 55-66.

Sandoval, G. A., Brown, A. D., Sullivan, T. and Green, E. (2006). Factors that influence cancer patients' overall perceptions of the quality of care. *International Journal for Quality in Health Care, 18*(4), 266-274.

Shirey, L. L. and Reynolds, R. E. (1988). Effect of Interest on Attention and Learning. *Journal of Educational Psychology,80*(2), 159-166.

Shostack, L. (1982). How to Design a Service. *European Journal of Marketing, 16*(1), 49-63.

Suess, C. and Mody, M. (2018). Hospitality healthscapes: A conjoint analysis approach to understanding patient responses to hotel-like hospital rooms. *International Journal of Hospitality Management, 61*, 59-72.

Starks, H., and Trinidad, S. B. (2007). Choose your method: A comparison of phenomenology, discourse analysis, and grounded theory. *Qualitative Health Research, 17*(10), 1372-1380.

Swan, J. E., Sawyer, J. C., van Matre, J. G. and Gee, G. W. (1985). Deepening the understanding of hospital patient satisfaction: Fulfillment and equity effects. *Journal of Health Care Marketing, 5*(3), 7-18

Swinyard, W. R. (1993). The effects of mood, involvement, and quality of store experience on shopping intentions. *Journal of Consumer Research, 20*, 271–280.

Tanja-Dijkstra, K. (2011). The impact of bedside technology on patients' well-being. *Health Environments Research andDesign Journal, 5*(1), 43-51.

The Beryl Institute. (n.d). Defining patient experience. Retrieved from www.theberylinstitute.org/?page=DefiningPatientExp

Tribe, J. and Snaith, T. (1998). From SERVQUAL to HOLSAT: Holiday Satisfaction in Varadero, Cuba. *Tourism Management,19*(1), 25-34.

Ulrich, R. S. (1991). Effects of interior design on wellness: Theory and recent scientific research. *Journal of Health Care Interior Design, 3*, 97-109.

Vargo, S. L., and Lusch, R. F. (2004). Evolving to a new dominant logic for marketing. *Journal of Marketing, 68*, 1–17.doi:10.1509/jmkg.68.1.1.24036

Vargo, S. L., and Lusch, R. F. (2008). Service-dominant logic: Continuing the evolution. *Journal of the Academy of MarketingScience, 36*(1), 1–10. doi:10.1007/s11747-007- 0069-6

Verhoef, P., Lemon, K. N., Parasuraman, A., Roggeveen, A., Tsiros, M., and Schlesinger, L. A. (2009). Customer experience creation: determinants, dynamics and management strategies. *Journal of Retailing, 85*, 31–41.

Vinagre, M. H. and Neves, J. (2008). The influence of service quality and patients' emotions on satisfaction. *International Journal of Health Care Quality Assurance, 21*(1), 87-103,

Wolf, J. A. (2016). Critical Considerations for the Future of Patient Experience. *Journal of Healthcare Management, 62*(1), 9-12.

Zineldin, M. (2006). The quality of health care and patient satisfaction: An exploratory investigation of the 5Qs model at some Egyptian and Jordanian medical clinics. *International Journal of Health Care Quality Assurance, 19*(1), 60-92.