

A literature review gap theory, the nurse-patient relationship, and the hospitality ambassador

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A LITERATURE REVIEW: GAP THEORY,
THE NURSE – PATIENT RELATIONSHIP,
AND THE HOSPITALITY AMBASSADOR

by

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A thesis submitted in partial fulfillment of the requirements
for the Honors in the Major Program in Hospitality Management
in the Rosen College of Hospitality Management
and in The Burnett Honors College
at the University of Central Florida
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ABSTRACT

Historically, hospital institutions came out of the Middle Ages. The unfortunates who found themselves in these places included the poor, pilgrims, travelers, old and the orphaned. Started by Christians to take care of their own monks, hospitals were the epitome of charity and hospitality to its consumers.

The purpose of this paper is to use the Gap Theory to explore the nurse – patient relationship within a hospitality setting. This information will be used to clarify points within patients' hospital stays that could have an effect on the patients' intent to return or recommend the institution.

Four key attributes were discovered through the review of literature that can help nurses and patients enhance the therapeutic relationship. Trust, hospitableness, flexibility and activation are all attributes that must be present in this relationship for it to reach the full potential. Comprehensive trainings done often can help hospitals keep their nurses and other medical staff updated and educated on these attributes.

Literature supports the possibility that hospitals would benefit from an added position: the Hospitality Ambassador. This person would be able to take on non-clinical roles to help relieve the burden of the nursing staff while providing the personalized service that patients have come to expect.

DEDICATION

To my family: my husband Taylor and my parents Marcie and Allen, who have loved and supported me through the entire process. You have truly inspired me!

To Dr. Wilfred Iskat, Dr. Denver Severt and Dr. Po-Ju Chen who have pushed me to achieve far more than I thought possible and who have opened my heart to the world of research.

To students, employees, managers and researchers of the hospitality philosophy:
"Be the change you want to see in the world!"
- Mahatma Gandhi

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INTRODUCTION

From a historical point of view, medicine has set curing physical diseases as its mission and the importance of the patient's mental and emotional condition was not known. (Rotarescu & Ciurea, 2009). Today, hospitals and patients increasingly are realizing the patient's perception of their condition and their overall experience in the hospital play a large role in the patient's comfort and recovery time. Rotarescu and Ciurea (2009) confirmed "there is already a scientific basis according to which a limit to the medical efficiency appears not only during the prophylactic process but also during treatment. This efficiency can be enhanced by curing the emotional state of the patient at the same time with his/her medical state" (p. 378). Thus, emotional state and perception play a large role in the tendency of a patient to return to a given hospital or recommend it to others.

Using Clark and Isen's (1982) notion that people strive to experience positive emotions and avoid negative ones, Bloemer and de Ruyter (1999) argued that customers who experience positive emotions will strive to repeat the service experience and become loyal customers. These authors also found positive emotions had a similar impact on customer loyalty over and above that of customer satisfaction. (Karl, Harland, Paluchette, & Rodie, 2010, p. 157)

Thus, the study of patient's perceptions of hospitality in a hospital setting should be of great interest to hospital executives and medical practitioners wishing to increase patient intent to return or recommendation rates.

According to Severt and Aiello (2008),

Specific studies have been done pertaining to service mission alignment with strategy, systems and staffing, employee perceptions of customer service by hospital workers and the increased efficiency of hospitality based support systems when managed together. These examples illustrate that for the most part, hospitality industry studies have remained focused on the food service and amenity portion of the patient experience leaving much room for the further study of a philosophy of hospitality in a hospital setting. (p. 666)

The lodging sector, specifically hotels, would therefore be the first choice for comparison to the hospital setting. After all, what is a hospital but a hotel for those in need of medical care and their family and friends? A closer look at hospitals reveals many similarities to hotels. Severt and Aiello (2008) stated,

Parallels can be drawn between the host/ guest exchange in hotels and hospitals and for some time the two industries have been compared in some regards to amenities offered. Parallels can include round the clock residential services including bedding, maintenance, security and food service. Both environments also deal with large planned or unplanned variances in demand. Integrating, communicating and managing different types of patrons bring many other similarities. (p. 665 - 6)

In the hospital environment and the hotel environment the guest/ patient and visitors “evaluate their perceived experience and build future intentions (to return or not return, to recommend to others or not to recommend to others) surrounding their unfolding service experience” (Severt & Aiello, 2008, (p. 666). The unfolding

experience is based on the guest's/ patient's perception of their reality and anyone can alter that perception.

It is the hospital staff, medical professionals, and employees that patients come in contact with during their hospital experience, that influence the patient's perception of "hospitality" received during the experience. Therefore, it is the people involved in the patient's hospitality experience, not the facilities where this experience takes place, that are the basis of the study of the concept of "hospitality" in a hospital setting in this paper. It can be given or received anywhere, in any situation. Whenever there is a provider of service, an action required or sought and a recipient there is an opportunity for the practice of an activity described as "hospitality".

Patten (1994) found, "the concept of hospitality is traced back to medieval times when, during journeys, strangers were offered comfort in terms of lodging and food" (p. 80A). Although medical care is the reason for hospital visits, food and lodging comforts are factors that impact patients' perceptions of care received. But, according to Patten, that is not the end of "hospitality" and its positive effects on the patient.

Once basic medical and comfort needs of the patient have been met, "hospitality" factors can have an even greater impact on patient perception and intent to return or recommend. These small actions, such as a friendly smile, a listening ear or a simple reassuring statement can have such a positive effect on patient comfort and recovery time that there is a lasting effect on their perception of the hospital. This may last long after the patient has left the hospital. Pizam (2007) stated,

I strongly believe, as does the entire medical community, that a person's state of mind can affect his or her physical well-being. This is especially true for persons that are ill or recovering from major medical procedures. By providing this "ity" factor [hospital to hospital/ity], which is synonymous with excellent customer service, a hospital can improve the chance of recovery for their customers.

(p. 500)

So, what is the "ity" factor? It is the essence that will enhance the patient perception of comfort and service. Pizam (2007) stated that the "ity" factor is the "philosophy of ultimate service to one's customers and total dedication to their needs and wants" (p. 500).

HOSPITALITY

Brotherton (1999) reached a working definition of hospitality, which is the basis of our research, as “a contemporaneous human exchange, which is voluntarily entered into, and designed to enhance the mutual well-being of the parties concerned” (p. 168). This could mean then, that any interaction between two people that is mutually enhancing of their well-being and entered into voluntarily could be described as hospitality. The Random House Dictionary as found on Dictionary.com defines hospitality as “the warm reception of guests or strangers” (Hospitality, 2011). Neither one of these definitions describes an ending point where hospitality stops so, for this review, it will be assumed that hospitality continues until one party exits the exchange. For example, when the patient leaves the hospital, that particular exchange experience has ended.

PURPOSE

The purpose of this paper is to use the Gap Theory to explore the nurse – patient relationship within a hospitality setting. This information will be used to clarify points within patients' hospital stays that could have an effect on the patients' intent to return or recommend the institution.

Four key attributes were discovered through the review of literature that can help nurses and patients enhance the therapeutic relationship. Trust, hospitableness, flexibility and activation are all attributes that must be present in this relationship for it to reach the full potential. Comprehensive trainings done often can help hospitals keep their nurses and other medical staff updated and educated on these attributes.

Literature supports the possibility that hospitals would benefit from an added position: the Hospitality Ambassador. This person would be able to take on non-clinical roles to help relieve the burden of the nursing staff while providing the personalized service that patients have come to expect.

HOSPITALITY RESEARCH

O’Conner (2005) highlighted, only once an understanding of hospitality's origins and its place in human nature is achieved can one expect to discover what hospitality means today, and more importantly what it will mean to those entering the industry in the future. The common thread where the commercial context of hospitality is described as a “formal and rational system of (usually monetary) exchange whereby hospitality is provided in particular institutional forms (hotels, restaurants) that are essentially impersonal [... For] the most part, hospitality is no longer about the personal giving of the host's own food and accommodation but a matter of impersonal financial exchange. (O’Gorman, 2009, p. 777)

According to Airey & Tribe (2000) and Botterill (2000), hospitality research is in danger of becoming all about work. Tribe (1997) stated that hospitality research is trapped in the vocation and action orientation. This concept is understandable to Airey & Tribe (2000) because the modern history of hospitality is based on vocational, on the job training (Morrison, 2002, p. 163).

More recently, O’Gorman (2009) said that hospitality research is in danger of falling into the teleological fallacy: meaning that research and historical literature are comparing two items that have nothing to do with one another in time, culture or context (p. 778). Several historical documents give rules and regulations for lodging, food and drink establishments that have to do with that time period and culture. To compare these to documents outside of that culture and context and to deem one better, or more acceptable than the other, is not conducive to understanding hospitality. He states

“although the statements made may be given some credibility because they sound convincing and echo characteristics within other hospitality literature [for example] that humanity’s organic and spiritual qualities have disappeared and everything is being replaced with commerce. Fortunately, this is at worst, simply not true, or at best a myopic and one-sided view of society” (O’Gorman, 2009, (p. 777).

“It is proposed that the intrinsic qualities and complexity of social interaction in hospitality phenomena render a single disciplinary perspective inadequate. The field has the potential to draw on and synthesize virtually the whole range of social science disciplines, transcending disciplinary boundaries as appropriate,” (Morrison, 2002, p. 164). “If the hospitality research community’s mission is knowledge, pursuit and creation, then there is limited value in constructing artificial barriers as embodied in status obsessions and disciplinary boundaries” (Morrison, 2002, p. 164).

Research shows that situations of interest to hospitality researchers are so complex and changing that many meanings can be derived. A variety of research paths can and should be taken to reach discovery. “Awareness, and appreciation, of alternatives, philosophies, modes and methods of inquiry is desirable, if not required” (Morrison, 2002, p.165). Taylor & Edgar (1996) suggest that “much hospitality research tends to be characterized by a shallow and partial grasp of the relevant base disciplines at best and a complete ignorance of them at worst” (Morrison, 2002, pg. 165). Because of this phenomenon, research in the hospitality field has become an activity by academics, for academics and is contained in a closed system where studies are similar to one another and revolve around the same vocational tendency. To open this system

and allow for expanded knowledge gain researchers must step away from industry labels and vocational definitions. Allow the abstract philosophy to guide research and there will be a much wider gain for hospitality research. The same flexibility required in hospitality situations should also be required in hospitality research.

Morrison (2002) states the following considerations for “hospitality” research:

Evaluate research outputs in terms of scientific value, guard against research emulation and knowledge perpetuation, be liberated from a focus on functionalism and a preoccupation with the world of work, establish a clear yet unconstrained definition and delineation of the scope of the field, enhance the level of internal coherence, locate hospitality as a specialist field within an open system of inquiry and inform future research agendas. (p. 167)

THE 'EXPERIENCE'

The World English Dictionary as found on Dictionary.com defines the word experience as 1.) The totality of characteristics, both past and present, which make up the particular quality of a person, place or people. 2.) The faculty by which a person acquires knowledge of contingent facts about the world, as contrasted with reason. 3.) The totality of a person's perceptions, feelings, and memories. 4.) Verb: to participate in, undergo. 5.) Verb: to be emotionally or aesthetically moved by, feelings (Experience, 2011). In other words, experiences are how we as people gain understanding, make decisions, learn and file away all of the knowledge we have about life and its parts. This review is addressing definition number three: perceptions, feeling and memories; specifically, patient expectations and perceptions based on hospital experiences.

"Carbone & Heckel (1994) argued that customers always get more than they bargained for, because a product or service always comes with an experience. That experience may be good or bad, lasting or fleeting, a random phenomenon or an engineered perception," (Walls, Okumus, Wang, & Kwun, 2011, p. 10). Today, this concept is more important than ever. When two products are essentially the same it is the individual experience had by the consumer that will ultimately determine which one was more successful than the other. Researchers now want to understand the overall experience, not just the product. They ask themselves, why did that consumer like that experience? What about the health transaction will make the patient remember that hospital?

Employing an economic and marketing perspective, Schmitt (1999) declared that experiences are private, personal events that occur in response to stimulation and involve the entire being as a result of observing or participating in an event. He postulated that in order to stimulate desired consumer experiences, marketers must provide the right setting and environment (Walls, Okumus, Wang, & Kwun, 2011, (p. 11).

Walls, et al go on to quote Knutson and Beck (2003) who “proposed a model that relates experience to expectations, perceptions, service quality, value and satisfaction” (p. 12).

However, people bring different histories, beliefs and emotions to every event. Therefore, each experience is unique to the individual. While many hospitals are implementing standardized rooms, food, educational materials, trigger words, etc. in hopes of controlling patient perception, the same institutions are passing over the fact that two patients in the exact same hospital, in the exact same situation may ultimately respond differently due to personal history.

It is posited that consumer experiences do not operate in a vacuum, void of external or internal effects, but are unique for each individual. These influencing factors may include: perceived physical experience elements, perceived human interaction elements, individual characteristics and situational factors” (Walls, Okumus, Wang, & Kwun, 2011, p. 17).

Flexibility is a must for nurses in the hospital setting because of the ‘total experience’ phenomenon. Learning to read nuances and body language along with

trusting instincts when it comes to adjusting to each patient's expected experience are some of the ways that nurses can give the best support possible. Tailoring the experience to the patient, and being flexible when the situation changes, will create the strongest nurse – patient connection and yield the highest customer loyalty and 'intent to return' scores. "The purpose of this connection is to foster the consumers' awareness or interest in order to create a meaningful and fulfilling consumption/ transaction experience that will influence perceived consumption values, satisfaction and repeat patronage" (Walls, Okumus, Wang, & Kwun, 2011, p. 17).

The patient perspective of the experience is:

Based on the consumer's willingness and capacity to be affected and influenced by physical and/ or human interaction dimensions.... It is postulated, for example, that a business executive who checks into a resort hotel for business purposes may cognitively limit the experiences in order to achieve her stay goals.

However, the same executive traveling on her honeymoon may cognitively maximize (choose to engage) the experiences due to the purpose of the trip (Walls, Okumus, Wang, & Kwun, 2011, p. 18).

The same can be said for a patient coming in for a routine checkup versus a patient coming in for the first time with severe hip pain. Patients with a routine checkup may limit interactions with the healthcare providers to achieve the shortest possible stay. However, the patient with severe hip pain may maximize the experience to gain an understanding of the pain and the options for relief. Managers, especially in the highly emotional hospital setting, need to understand that some of these "intrinsically

emotional and personal experiences” are out of their control. Consumers can “default to the type of experience they want to have” (Walls, Okumus, Wang, & Kwun, 2011, pg. 18).

HISTORY OF HOSPITALS

Dating all the way back to the Ancient Greek culture, healing was linked to worship. According to Dominiczek (2011), the centers of healing were the temples of the god of health Asklepios, known as Asklepeions (p. 22). This theme continued into the Middle Ages of Christianity where prayer was a large part of the healing process.

“Although the Middle Ages are noted as a period of sterility or inertia in the Western world, one significant contribution emerged – the hospital,” (Bannister & Ireland, 1983, p. 31). The Roman Empire was falling and with it so was the health and wealth that so many had enjoyed. The ability of the Empire to take care of their people the way they had up to this point, was no longer possible. Shelters fell into disuse.

The few hospitals that existed were spinoffs of attempts by the Christian clergy to care for their own monks. The sick who found a place in these hospitals were helpless: paupers, pilgrims, travelers, the aged and orphans. For these people, Christian charity provided “hospitality”, especially food and shelter. However, they were places of terminal care rather than active treatment. (Bannister & Ireland, 1983, p. 31-2)

The crusades of the eleventh, twelfth and thirteenth centuries spurred the hospital movement in medieval Europe. It had become evident to the Crusaders that disease and pestilence were as deadly as the ferocity of the Saracens. Military hospitals sprang up to accommodate them along their routes to and from Jerusalem. The number of hospitals grew from this time on, with religion providing the dominant influence in their spread. But it remained for latter day

improvements in medical education and the discoveries of Pasteur, Lister, Harvey, Cushing and others to lend maturity to a concept born in the Dark Ages. (Bannister & Ireland, 1983, p. 32)

In the 16th century all across Europe, hospitals were becoming statements of the city they were in. Because of the reformation and the closing down of monasteries, churches and cities owned the hospitals together and each had pride in the establishment created. Hospitals were fast becoming a part of commerce and a reason to settle in a particular city.

The next change came in the 18th century. “It followed the Enlightenment emphasis on rationality, science, and nature,” (Dominiczak, 2011, p. 22). The development of the pavilion structure in hospitals revolutionized the structure of the hospital setting yet again. This structure allowed for better air flow, greater access to sunshine through windows and contributed to the ease of movement through hospital departments.

A true revolution in the concept of the hospital was caused by the accelerating progress of medical science in the late 18th and the 19th century. Hospital-based care maximized the medical experience by bringing together patients with similar conditions, facilitating statistical assessment, and—importantly—making clinical teaching possible. Thus, scholars entered hospitals, which became major sites of medical research on a trajectory rising until the late 20th century” (Dominiczak, 2011, p. 23).

Today, every major city has at least one hospital; most have several health systems with several different campuses. Hospitals and ease of access to them have a major role in city planning. What used to be driven by religious affiliation is now driven by marketing departments and their advertising executives. Today's hospital executive knows that cutting edge medicine, comfortable rooms and good food are just the beginning. They are looking for that one item that will take their hospital to the next level of patient satisfaction. What is it that patients will remember long after they leave the premise?

In a study by Fottler (2006), patients ranked the surgery team, their physician, surgical prep, friendliness and therapists as the top 5 key drivers of returning to a particular hospital while staff ranked concierge, therapists, [the attending] physician, surgical staff and friendliness as their top 5 key drivers. The fact that both patients and staff picked the people related to their experience rather than the physical attributes (room cleanliness, pain management, educational material) suggests that the future of the perception of hospitals is more dependent on the people rather than the facilities.

GAP THEORY

Across any and all industries, the success of an experience, specifically a service experience, is harder to describe than the success of a particular product. When a tangible item is present, consumers take their cues for describing the experience from the physical attributes of the item: size, color, taste, smell, feel and sound which are all categories in which to describe the physical item (Parasuraman, Zeithaml, & Berry, 1985). Take away the physical product and the consumer is left with an intangible experience. Absent of these concrete cues by which to judge an experience, consumers must come up with other ways to describe whether the experience was successful or not.

Parasuraman, Zeithaml and Berry (1985) researched just that phenomenon. They were aware that much research had been done on the tangible aspects of a transaction but little on the intangible experience. As people and communities have become more educated and complex, so have their demands for a service experience along with the product. Everything is marketable, not just the product but the whole transaction experience.

Parasuraman et al (1985) discussed a set of open ended service experience related questions with 12 different focus groups. Some groups were executives from four major companies in the US and other groups were consumers. Six groups were all male and six were all female. Through analysis of the answers received during the sessions of these focus groups, Parasuraman et al found 5 common service quality gaps (Table 2) and 10 determinants of service quality (Table 3) that could be

generalized in any service setting and were being used by consumers to judge successful or unsuccessful experiences. Table 1 explains how each Gap is connected and where the line is drawn between gaps that the company has control over and gaps that are up to the consumer only.

Table 1: GAP Model of Service Quality
GAP model of service quality

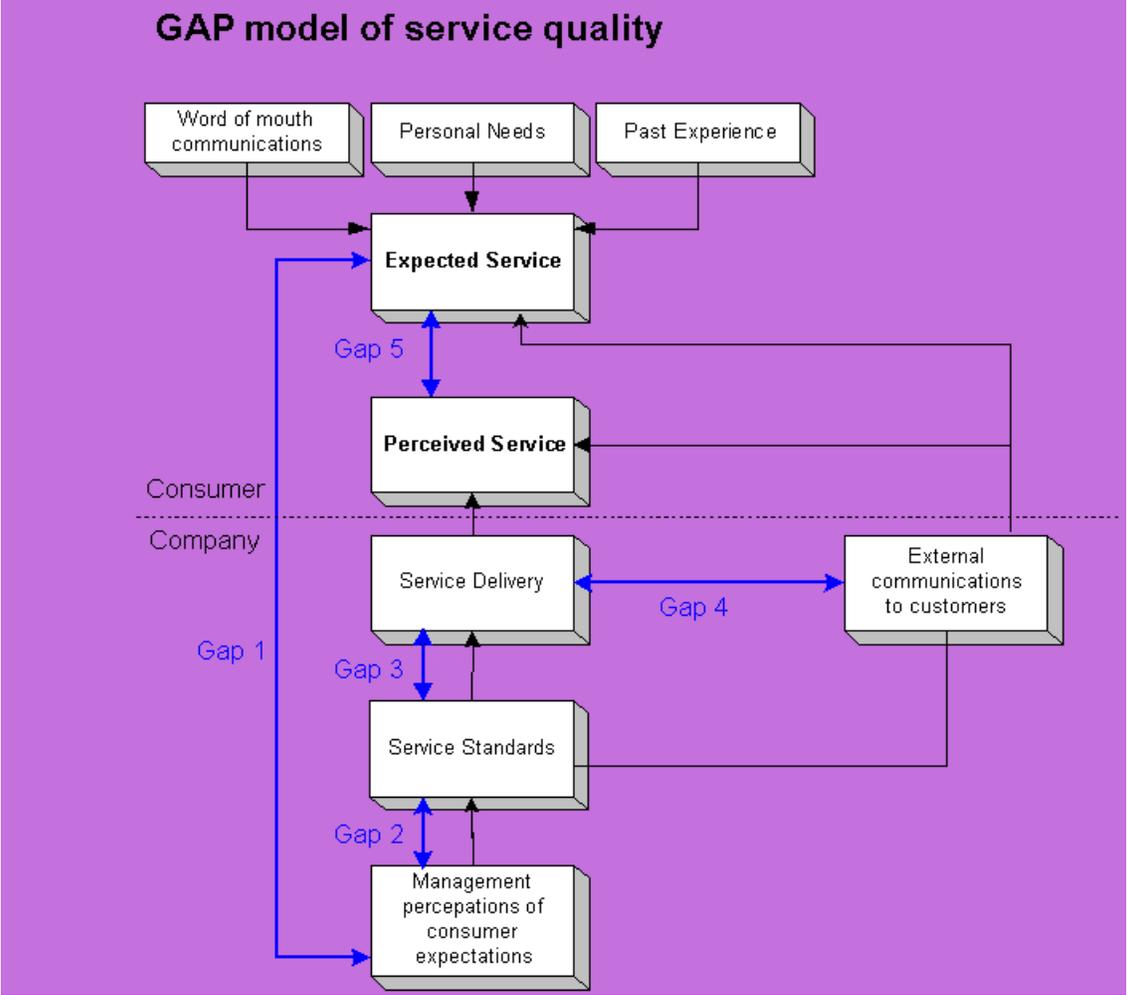


Table 2: 5 Service Gaps

Gap 1	Consumer Expectation vs. Management Perception Gap
Gap 2	Management Perception vs. Service Quality Specification Gap
Gap 3	Service Quality Specification vs. Service Delivery Gap
Gap 4	Service Delivery vs. External Communications Gap
Gap 5	Expected Service vs. Perceived Service Gap

(Parasuraman, Zeithaml, & Berry, 1985)

Table 3: Service Determinants

Reliability	Consistency of performance, dependability
Responsiveness	Willingness or readiness of employees to provide service
Competence	Possession of the required skills and knowledge to perform the service
Access	Approachability and ease of contact
Courtesy	Politeness, respect, consideration and friendliness of contact personnel
Communication	Keeping customers informed in language they understand/ listening
Credibility	Trustworthiness
Security	Freedom from danger, risk or doubt
Understanding the Customer	making the effort to understand the customers' needs
Tangibles	Physical evidence of the service

(Parasuraman, Zeithaml, & Berry, 1985)

The five common service gaps will be discussed further, as they pertain to the hospital setting, within nine of the determinants of service quality. Tangibles will be excluded from this discussion as this review is focused on people and their involvement in the hospitality experience. All other determinants of service have to do with the perception of people and their actions.

Gap 1: Consumer Expectation – Management Perception Gap

Executives may not always understand what patient expectations for high quality service are. They may be focused on cutting edge technology while patients are focused on bedside manner. This gap does not mean that one or the other is right or wrong; it means that if executives want patients to perceive their hospital as meeting expectations then they need to know what those patients' expectations are. Communicating these needs through research and education can help to close this gap. Access, Credibility, Communication and Understanding the Customer could be key determinants in this gap.

Gap 2: Management Perception – Service Quality Specification Gap

Market availability and time availability can make it difficult for a hospital manager to specify exactly what it is he or she wants. He or she may want to say that specialists are available twenty four hours a day, seven days a week; however, the labor supply for those times may not be available or consumer demand for those services may not be high enough at certain times of the day to allow for the extra labor. Researching the expectations of the patient and making the service quality specifications according to those expectations, all the while keeping the specifications reasonable and doable can

help to close this gap. Reliability, Responsiveness and Communication could be key determinants in this gap.

Gap 3: Service Quality Specification – Service Delivery Gap

This gap provides most of the challenges on the marketers' side of the industry. Even with all of the specifications in place, trained personnel do not always act or react the same way in the same situation. Performance cannot be standardized so managers may need extra help training and maintaining personnel performance. Service quality perception can change instantly and a consumer's view of an entire organization can be affected by one person. Training, often and comprehensive, as well as performance based incentives can help to close this gap. Reliability, Responsiveness, Competence, Courtesy and Understanding the Customer could be key determinants in this gap.

Gap 4: Service Delivery – External Communications Gap

The media has a lot of influence on the expectations of patients in a hospital setting. If the commercial or billboard says "60 minute wait time or less in the emergency room" then the patient expects to wait sixty minutes or less to be seen by a doctor. If they wait longer expectations have not been met and their perception of the hospital may end up being negative. However, if the advertisement for "60 minute wait time or less in the emergency room" really meant that the patient would be seen by a triage nurse within sixty minutes, and not a doctor, and that is explained in the advertisement or in a sign posted within the emergency room, then the patient's expectations have been met and their perception could change for the positive. Not promising more than can be accomplished and explaining any changes in plan quickly

and completely can help to close this gap. Reliability, Access, Courtesy and Communication could be key determinants in this gap.

Gap 5: Expected Service – Perceived Service Gap

This is the culmination of all four previous gaps and the one that involves the patient. If all four previous gaps were filled then this gap should be very small. If any one of the previous four gaps were not filled then this gap grows. The size of this gap is based on the size of the combined gaps in the previous four sections. This is where the patient makes a decision to return to a particular hospital if the need arises or to recommend it to another possible patient. The larger the difference between expectation and perception, whether in a negative or positive direction, the more unlikely or likely, respectively, a patient is to return or recommend. Research into patient expectations for their nurses, doctors and staff can help to close this gap. All 9 determinants are keys to this gap.

GAP THEORY ANALYSIS

When all literature for this review was analyzed two facts stood out. The first is that marketers can only do so much to influence patient perception. Where they have the most influence is in educating the patient on what to expect. Ultimately, however, it will be up to patients to decide what their expectations are and if they were met. Those on the marketer's side (the first four gaps) need to focus more on researching patient wants and needs. The second fact is that hospital executives need to be reminded that not every dissatisfied patient is the nurses' or doctors' fault. Patients present with their own history and intentions and must decide how they will handle the situation. Keeping this in mind, the following studies will be used to illustrate how the gap theory was used to arrive at these two facts.

Nurse – Patient Relationship: Gaps 1 and 4

Hospital administrators and nurse managers are expecting nurses to stay current with all of the emerging technology that is available to assist in their jobs. This means that extra time must be allotted for training and specializations. Managers also expect that nurses will keep up with clinical advances in their field and participate in trials to advance their field. This means extra time for research and analysis. Lastly, managers expect that nurses are able to take on fifteen to twenty five patients in a single work day and be able to assist in any situation whether it is medical or emotional, concerning staff or friends and family. This means extra time for listening, explaining and lending a hand. Where does all this time come from? What happens to the balance of personal

time and work time? How does this shorten the period between entrance into the workforce and burnout?

Increased patient acuity levels coupled with technological advances in clinical care will continue to shift the nursing role to a highly specialized clinical focus that compromises their contribution to customer-oriented nonclinical activities. Consequently nurses will have increased difficulty in balancing patient clinical needs with expectations for hospitality services. (O'Malley & Serpico-Thompson, 1992, p. 30)

Something will have to give – and that is usually the therapeutic, or hospitality-related, relationship between nurse and patient. Due to the constraints on nurses' time the quality of this relationship and the quality of the rest of the non-clinical duties is in danger of becoming much less than what the patients are expecting.

“Traditionally, such a relationship is considered to be the essence of... nursing and one which, through its support brings about insight and behavior change in the patient” (Moyle, 2003, p. 103). The essence of nursing is to take the time to get to know the patient, build “a trusting relationship where values are respected as the nurse listens to the patients concerns, provides information and advice, relieves distress by encouraging the expression of emotion, improves morale through review of established outcomes and encourages the patient to practice self-help” (Moyle, 2003, p. 103).

According to Rathert and May (2007), “a climate for customer service is facilitated by identification and understanding of what the market expects... for quality. The IOM [Institute of Medicine] and others have asserted that patient centered care

should be central to all other actions in the health care industry,” (p. 3-4). But what is patient centered care and how does it relate to the concept of hospitality?

Rathert and May continued, “Patient-centered care means tailoring care to “. . . specific needs and circumstances of each individual. . .” and that care should be orchestrated so that it responds to the person, “. . .not the person to the care” (p. 4). So, being dedicated to a patient’s needs means putting their care first and being of ultimate service to the patient means tailoring the experience to the patient.

There is a problem when the medical personnel ignore the way patients react from an emotional point of view.... This lack of interest in the emotional reality of an illness neglects something obvious which shows that the emotional state of people can play a significant role... during the recovery process. (Rotarescu & Ciurea, 2009, p. 378)

There are two reasons that the therapeutic relationship is losing ground. One is that the operational workload of the nurse is too large to allow for the face time needed with each patient to build the relationship and the other is the possibility that the therapeutic relationship does not come naturally to everyone. According to a study by Moyle (2003), while “the nursing professions... acknowledge the therapeutic relationship; doubt is raised about whether the ideals of such a relationship do actually occur consistently and effortlessly in practice” (p. 104).

Nurse – Patient Relationship: Gaps 2 and 3

Going to the hospital signifies that something related to health status is out of the ordinary for a patient so they may already be in a heightened emotional state. When they arrive at their destination, the surroundings are cold and unfamiliar. These potential patients may feel that someone else knows more about the patient and their body than the patient does and that can lead to feelings of being out of control of oneself or helplessness. In Moyle's (2003) study "participants' views appeared to be given little value and nurses were seen to hold the power in the development and maintenance of treatment" (p. 106). Patients perceived that when nurses were not bedside and did not seem to be coming back in the near future that they were using "textbook knowledge in their reports to professional colleagues and avoided an approach that both involved and empowered the patient" (Moyle, 2003, p. 106).

"In the healthcare industry, consumerism means having a voice, information, and participating in decision making. These factors are critical factors for patients.... These factors were defined and judged mainly by providers, usually physicians and nurses, rather than by patients" (Lee & Yom, 2007, p. 546). This means that even though hospitals may advertise that patient input is extremely important to them, many employees are still taking over that role. Lee & Yom (2007) "found that consumers, by and large, have a different baseline and standard than healthcare specialists, who are the providers" (p. 546). The challenge is that patients and healthcare providers have different expectations as to how decisions should be made and what factors are

important to each decision. Ultimately it is the patients' perceptions of those standards that count on satisfaction and intent to return surveys.

Nurse – Patient Relationship: Gap 5

This is the gap where the marketers' influence stops. Whatever the managers have perceived that patients want, whatever specifications they have made for the delivery of service, whatever service has been delivered and whatever the media has to say about it have now been handed to the patient for the patient to judge. Just one gap, of any size, could be the difference between a successful service transaction and an unsuccessful one.

For example, Moyle (2003) explained that patients in this study perceived the admission process to set the standards of a relationship higher than what was actually doable once the patient was admitted. The patients commented on how nurses initially took the time to listen to their concerns and fears and this helped them to overcome the fear of being admitted. They also commented on the fact that nurses were always present at the bedside before or after unfamiliar procedures and this offered them comfort and reassurance.

They described this presence as something that they yearned for throughout their hospitalization, but recognized that nurses never again provided presence at the same level as in the first moments of admission. Bedside presence was recalled as offering the opportunity for intimate communication and for privacy... where the patient could talk through their concerns.... Such presence also

demonstrates an eagerness to help overcome the illness together (Moyle, 2003, (p. 105).

Another study done by Lim and Tang (2000) “indicated that patients had low expectations related to hospital services. They also found that assurance was the most important dimension,” (Lee & Yom, 2007, p. 547). Since most of this research is focused on patient perception and perception is compared to expectation in the final decision, more research needs to be conducted to find out what patient expectations are for hospital services, what hospital services they are concerned with and why their perceptions are low. Patient perception needs to be compared to patient expectation but those expectations must be known so that perceptions of those expectations can be altered to exceeding, or at least meeting, expectations. When these are aligned it is expected that intent to recommend and intent to return scores will go up.

Usually consumers purchase products and evaluate them through their experience of using them. If they decide to purchase the products again, because of their positive experience, they then tell others of the qualities of the products. So the image of the products may be established during the consumers’ usage, evaluation and word of mouth advertising. On this reason, it is meaningless for providers to evaluate the products [experiences] and improve the products [experiences] based only on their own standards and criteria without considering the consumers’ standards and criteria. (Lee & Yom, 2007, p. 546)

It is crucial that hospital marketers understand what patients expect of hospitality and the therapeutic relationship in a hospital setting. This information can then be

passed on to the managers so that they can make service specifications that meet and exceed known patient expectations. Knowing that these expectations came from patients can help nurses and doctors to provide the best personalized service experience for each patient. Having this personalized service from a nurse or doctor who understands the emotional side of the patient can help keep the patient calm, educated and willing to play an active role in their recovery.

ENHANCING THE THERAPEUTIC RELATIONSHIP

In order to enhance the therapeutic relationship as stated previously in the section on Nurse – Patient Relationship: Gaps 1 and 4, an understanding of that relationship must be reached. Until that relationship, and all of its intricate parts, is understood, training and application will be difficult and erratic. Through analysis of the literature reviewed four common themes were found. These four themes are the basis of the nurse – patient relationship and each is intertwined with the others so that without one the relationship cannot be realized to its full extent. The four themes are trust, hospitableness, flexibility and activation. This section will give a brief definition of each term and explain its function in the therapeutic relationship.

Trust

According to the World English Dictionary as found on Dictionary.com, trust is the reliance on and confidence in the truth, worth, reliability, etc., of a person or thing (Trust).

Arendt (1958) stated trust can be considered as an action. It may be considered as interpersonal and impersonal. Interpersonal trust is relational, personal and exists between people. It involves values and emotions and results from us working with other people so when a front line employee transacts with a guest, they act in trust, based on the harmonizing effects of trust. Impersonal trust is a detached variation of the same concept and is exercised when dealing with strangers. Impersonal trust allows frontline employees to use information sourced from outside their own first hand experiences with confidence. Trust

creates harmony and cooperation in organizations (Skinner and Spira, 2003) and because it has multiple phases, it is a dynamic construct. (Lovell, 2009, p.146)

How and to what degree a nurse is able to utilize the impersonal trust qualities is personal. However, the culture of the hospital and its training program can have a large effect on impersonal trust. The more empowerment that a nurse has, the more they may be willing to go that extra mile for the patient. Upper management sets the stage for interpersonal trust in the workplace by how they show trust in middle management. Middle management will then takes the emotional information gained on trust and use it to set their own stage for trust in frontline nurses. At the end of this chain, front line nurses take the emotional information gained on interpersonal trust from management and from coworkers and use it to set the stage for impersonal trust with each patient.

“Shapin (1994) stated trust is a quality that must be present in harmonious and successful relationships” (Lovell, 2009, p. 147). If this quality is missing from any relationship then the relationship will not reach its full potential. Patients will reap the benefits, negative or positive, of the quality of trust within the organization. Trust builds upon trust, mistrust builds upon mistrust. If trust is present in every level of a hospital before the patient arrives and all links are intact, nurses will have the training and experience to extend it to the patient upon arrival, adding another link to the chain. This link will be the basis of every other experience (diagnostic or clinical) a patient has within the hospital setting.

Hospitableness

The Random House Dictionary as found on Dictionary.com defines hospitable in three ways. 1.) Receiving or treating guests or strangers warmly and generously. 2.) Characterized by or betokening warmth and generosity towards guests or strangers. 3.) Favorably receptive or open (Hospitable, 2011).

It is not a bonus, anymore, to go above and beyond a patient's request. It is a requirement. It is these voluntary moments of hospitality that set each nurse, doctor, or hospital apart from the other, but the very nature of a voluntary act means that it is performed, undertaken, or brought about by free choice, willingly or *without being asked* (Voluntary, 2011). New ways of acting hospitably towards patients must be utilized to increase favorable patient perception and exceed expectations. This is where the hospitality philosophy comes in. This concept and the following quote are based in the travel and tourism industry, but easily apply to the hospital setting.

According to Lovell (2009), It might be argued that the perception of the... frontline employee as dull and low skilled (Lucas, 1993; Carr et al., 2005) has impacted on their employment performance. Perceived in this way, employees are subject to an atmosphere where direct control (Martin, 2004) and a cost focused approach (Kelliher and Johnson, 1997) are common. This affects the way the employee is treated by management and by guests, and perhaps, the employee feels about themselves in their employment. (p.145)

When related to hospitals, the frontline employee function is usually covered by nurses. Their skills, at this point in time, are generalized in each area of the hospital

which means that they take on many different tasks throughout the day that require their ability to quickly and smoothly change focus and manage their time efficiently. If a nurse feels that other staff or patients view them as low skilled and dull there is the possibility that this could affect their attitude, motivation and patient care level.

Many authors have pondered the question of why these lowly paid, overworked (Bitner, 1992, Bitner et al., 1997) poorly treated (Martin, 2004) employees will act as if they are paid a fortune to smile, be pleasant, remain calm under pressure and act beyond the operational requirements of their job to please/satisfy/delight.... It may be proposed that these employees are acting in 'sheer human togetherness': hospitableness. (Lovell, 2009, (p. 150)

The benefit in a hospital is that, by the sheer operational function of feeding, sheltering and caring for the sick, hospitals are already set up for the application of the hospitality philosophy, of humanity and sheer human togetherness. Caring for, sheltering and feeding the sick demands an understanding of trust and the therapeutic relationship. "Levinas (2006), suggests humanity is represented by a moral imperative; of 'us' being more concerned 'for the other', and that we 'live' when we show our care for others. He proposes it is only when we consider the other person that we know our own humanity" (Lovell, 2009, (p. 150).

Considering the other person is a simple concept, yet it is one so often times forgotten in a world of standardization and generalization. Considering the patient is what drives personalized treatments and emotional understanding of the patient which can then, in turn, drive positive feelings for the patient towards the nurse and hospital.

Lovell goes on to explain that trust is the catalyst for sheer human togetherness. Nurses come to work trusting that he or she has been trained correctly, the equipment is working properly and there will be organizational help to carry out the reasonable requests of each patient. The patient trusts that his or her nurse has all the capabilities mentioned above and cares enough about him or her to be hospitable. If just one of these links in the chain is broken and the patient notices, the patient's trust is broken. The blame will land on the nurse because the nurse is the tangible aspect of the service transaction.

Flexibility

The Random House Dictionary as found on Dictionary.com defines flexible as susceptible of modification or adaptation (Flexibility, 2011).

Lee and Yom (2007) researched the difference between nurse and patient expectations in a hospital setting. Using a 5 point Likert scale and the 5 new ServQual dimensions they discovered that "the mean scores for the nurses' expectations were consistently higher for all five dimensions than the means scores of the patients. The highest ratings were given to reliability, followed by assurance, responsiveness, empathy, and tangibility by both nurses and patients" (). The top 4 ratings were given to categories that include human interaction and the ability of the nurses and patients to create a positive, trusting, flexible relationship.

"The least important expectation of the patient was for nurses to provide a comfortable enough environment to rest in, while the least important expectation of nurses was to provide courage and hope" (Lee & Yom, 2007, p. 549). This is where

the largest gap was seen between expectations. If nurses view themselves only as clinical facilitators of medicine (especially due to the increased technological aspect of their career) but patients see them only as a companion through the frightening journey of sickness and disease then some flexibility in understanding the roles of both nurse and patient needs to be realized.

Courage and hope are both items that will increase the well-being of patients while helping to give them a reason to play an active role in their own healing. However, patients cannot expect that a nurse has time to sit with them for three or four hours a day holding their hand through the entire process. Situations change in a hospital setting and they change quickly. Patients must realize that nurses have many jobs to do in a day and, therefore, move between each one quickly.

Activation

The World English Dictionary as found on Dictionary.com defines the word activate as to make active or capable of action (Activation, 2011).

Consumers are more educated now than ever before on what their experience should entail and they are more aware than ever that they are no longer “mere purchasers but rather co-producers who actively build their own consumption experiences through interactions with the environment, sellers and other consumers” (Hibbard & Mahoney, 2010, P. 377). Awareness of being a co-producer, however, does not produce action. The amount of action, or activation, a consumer might display is ultimately up to each individual.

“Consumer and patient activation refers to the degree to which the individual understands that they must play an active role..., and the extent to which they feel able to fulfill that role,” (Hibbard & Mahoney, 2010, P. 377). This means that each person has or can find the skill, knowledge and means to participate in their hospital experience. In a study by Hibbard and Mahoney (2009), they discovered that “activation is also predictive of health outcomes and healthcare utilization” (p. 377).

The more active role that a person plays in their own healthcare the less helpless they feel and the more able they are to positively affect their health. In a study by Hibbard, Mahoney and Stock (2007) they followed chronically ill patients over a 6 month period and “showed that those that did become more activated significantly improved multiple health related behaviors. That is, as they apparently began to feel more ‘in control’ of their health, they changed many things about how they took care of themselves” (Hibbard & Mahoney, 2010, p. 377). This indicates that if it is understood what activates people and how to make that activation happen can be figured out, it could possibly reduce the need for acute or long term care. “Given that activation is linked with behaviors and many health outcomes, investigating how people become more or less activated becomes important” (Hibbard & Mahoney, 2010, p. 377).

Activation relies heavily on the “norms” of a person’s life. What thoughts and beliefs were they raised with? What do their coworkers and friends believe? Do they have a healthcare provider that regularly talks about ways to take care of themselves? “The greater degree to which [proactively protecting and promoting their health] is articulated and modeled in the social environments and institutions where people live,

work and get their healthcare, the more likely it is that individuals will adopt it into their belief system” (Hibbard & Mahoney, 2010, p. 378). Hospitals that promote trust, hospitableness, flexibility, education and support will be able to more effectively activate their patients to play a positive role in their own healthcare. The more activated and positive a patient is about their health outcome, the more positive the emotion will be that is tied to that particular institution.

When a patient experiences the positive impacts of this activation they tend to gain confidence. Gaining confidence and experiencing success can actually lead to more successes. Results from human flourishing studies indicate that when people experience more positive emotions in their daily lives, they tend to widen the array of behavioral responses, to be more open to new information and to adapting to new behavioral strategies.... Short term benefits of positive emotions include increased creativity, problem solving ability and openness to new experiences and information. (Hibbard & Mahoney, 2010, p. 378)

However, note that the reverse is true as well. Hibbard & Mahoney go on to explain, “Experiencing multiple failures in attempting to manage an... illness or adopt a healthy behavior is likely to result in feelings of being overwhelmed, disempowered, discouraged and ultimately in taking a passive approach to healthcare” (p. 378). This reduces the ability of patients to want to play a part in their healthcare or care about becoming educated on options.

The challenge that healthcare providers face is to make sure that this does not become part of the patient’s self-concept. That is to say,

Once people internalize the knowledge that they can, or cannot be, in control of their health and functioning through their own actions, this knowledge appears to be relatively stable.... This belief about their ability to manage their health becomes a part of the individual's self-concept.

(Hibbard & Mahoney, 2010, p. 378)

A chain of small, easily achievable steps, as explained below, can assist patients in the climb towards high activation. This is how patients will learn to be 'in control' of their illness and feel positive about the outcome options.

Based on the literature review, this study summarized that levels of activation can have a major effect on the daily lives of patients outside of the hospital setting. Those that are at low levels of activation probably have a fairly negative outlook on life, fear change and are in a negative cycle. They do not want new information or new options because they already believe that nothing can be done. "This means encouraging behaviors and steps where the individual is likely to experience a success.... By encouraging small steps that are realistic, given the individuals lack of activation it is possible to start that positive cycle," (Hibbard & Mahoney, 2010, p. 380). These steps need to be tailored to the individual to yield more positive results. As each patient feels that they are being supported in a positive change they will become more likely to increase personal activities that support the positive change. As these positive changes continue to happen, the positive image of the nurse or hospital that encouraged these changes continues to grow.

CONCLUSION

The increase in workload for nurses is a deep concern to many people. There are only so many tasks that can be completed each day and only so many nurses to complete them. Concern is centered in the quality of work that will be produced, the quality of time spent with patients, the quality of research being produced and the quality of life nurses have.

This is a major concern for hospitals because nurses tend to be the face of a hospital due to the fact that they have the majority of face time with patients. If a patient does not get quality face time with nurses, or even time at all, no matter the quality – then their perception of the hospital will not be as positive as it could be. If the patient expectation is not to have this face time and they don't get it then their expectation has been met, but not in an outstanding way. This could lead to no recommendations at all – good or bad. However, if the patient expects to have this face time with the nurses and does not get it then their expectations have not been met, in an outstandingly negative way. This could lead to recommendations to not go to the hospital in question and in not returning themselves.

There are three suggestions to enhance the relationship between nurses and patients and create positive perceptions that go above and beyond patient expectations in an outstanding way. The first suggestion would mean having highly trained human resources personnel to test prospective nurse candidates for personality traits conducive to the therapeutic relationship. The second suggestion would be to add classes into nursing programs that increase awareness of the specific personality traits

that are conducive to the therapeutic relationship. This would also require hospitals to have awareness seminars including information on the four traits (trust, hospitableness, flexibility and activation) mentioned in the literature review. These training sessions would have to be repeated often for those members of the team that are not predisposed to the attributes.

While these are both viable solutions that would get the job done, they are very time consuming and could cost more than many institutions are willing to spend. The third solution, and the most cost effective and patient related, is to add a new position to the hospital staff: the Hospitality Ambassador. This position has been tried in a few hospitals with great success.

Due to the amount of clinical technology that will be coming out in the near future, a great amount of time will be spent on education and improving the clinical services of nurses. Hospitality may have to be provided by another position altogether—one that focuses on providing the human connection.

To balance another position such as a Hospitality Ambassador could be a major challenge for hospitals.

The nursing shortage, coupled with declining financial reimbursement, is requiring hospitals to 1) maximize the appropriate utilization of scarce professional nursing resources; and 2) design systems that augment nursing clinical functions with a new level of patient centered non-clinical support services. (O'Malley & Serpico-Thompson, 1992, p. 30)

Adding a Hospitality Ambassador would help to relieve the nursing staff's workload and would also increase patient contact time and therefore, increase loyalty.

“The goal of this newly created role is to balance customer expectations and perceptions and close the gap between the two along the five service quality dimensions: empathy, assurance, responsiveness, reliability and tangibles” (O'Malley & Serpico-Thompson, 1992, p. 31). O'Malley and Serpico-Thompson (1992) conducted an observation while this staff member was being integrated into the hospital. They discovered that this Hospitality Ambassador could spend more face time with the patient and family and friends, thus allowing clinical personnel to focus on the medical care of the patient. The Ambassador was also able to help in a minor clinical capacity or as a runner between departments thus allowing the clinical personnel the ability to stay in their designated area. Response to this program has been extremely positive. “The costs associated with this program are almost entirely labor related. It should be noted that when this program is instituted hospital wide, significant cost efficiencies will be realized through economies of scale and shifting positions from centralized services” (O'Malley & Serpico-Thompson, 1992, p. 33).

The institution of a Hospitality Ambassador can have several positive effects on a hospital. First, cost efficiencies are noted because this person can act in several different capacities (minor clinical, runner for clinical personnel, runner for food services, minor housekeeping duties, minor spiritual care duties, and patient liaison). Second, patients will have the option of having the same person guide and help them through the entire process. A familiar face in an unfamiliar place can help them to relieve stress,

increase happiness and encourage activation. This person will be familiar with the patient, their emotional state and daily physical needs and therefore can help motivate the patient to play an active role in their own recovery. Third, because nurses and doctors need to maintain a certain amount of objectivity with each patient due to their constant tie with sickness and death, the hospitality ambassador can take on the emotional attributes of the patient's situation. Fourth, through the personalized service the hospitality ambassador is able to provide, the patients' expectations of service and hospitality have been met. This raises the positive perception of the hospital and therefore can increase satisfaction scores as well as intent to return and/ or recommend scores.

Future Research

Future research should include empirical studies on the amount of output a nurse is required for one shift and the amount of output actually achieved in one shift. This will allow hospital executives to know exactly what is being done each day, the quality of the work and where specializing could be useful. This will also highlight the duties that could be taken over by a Hospitality Ambassador to relieve stress from the clinical staff.

Studies should also be done on the effectiveness of hospitality ambassadors in different departments, various hospital sizes and multiple countries.

Lastly, empirical studies should be done to decide the title for this position – what message should be portrayed by the title – and what type of position this should be. Should this position be an executive, hourly employee or volunteer?

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