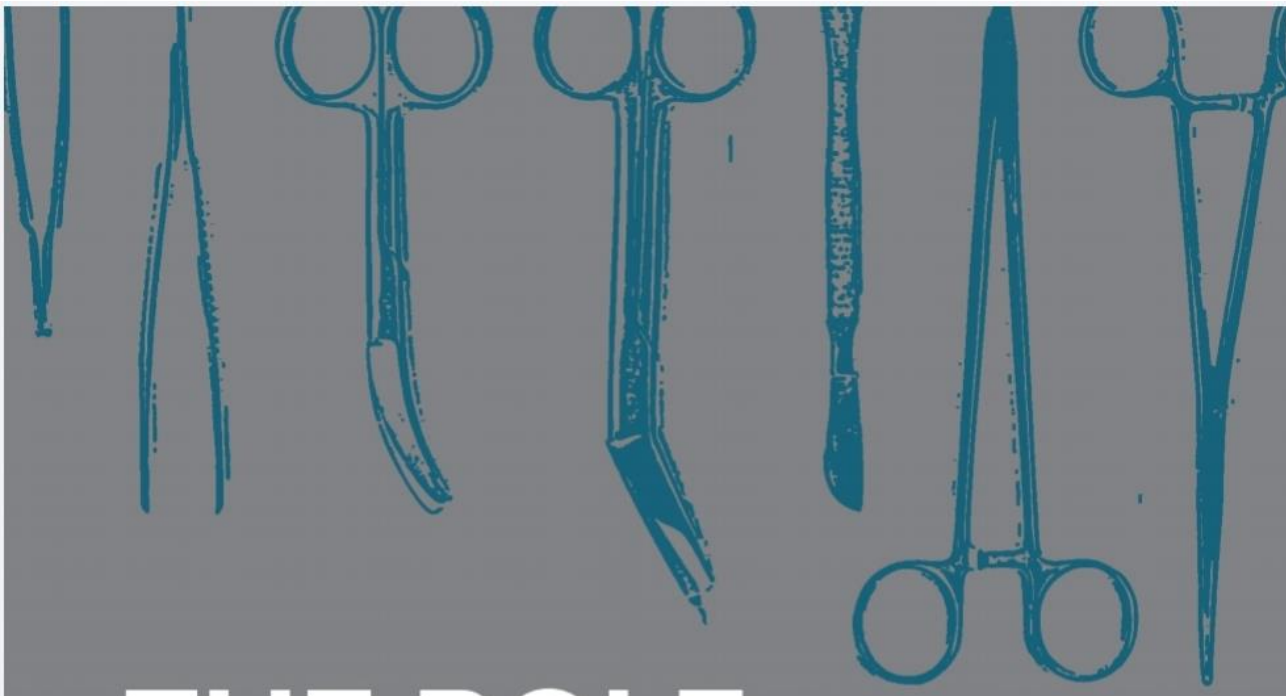
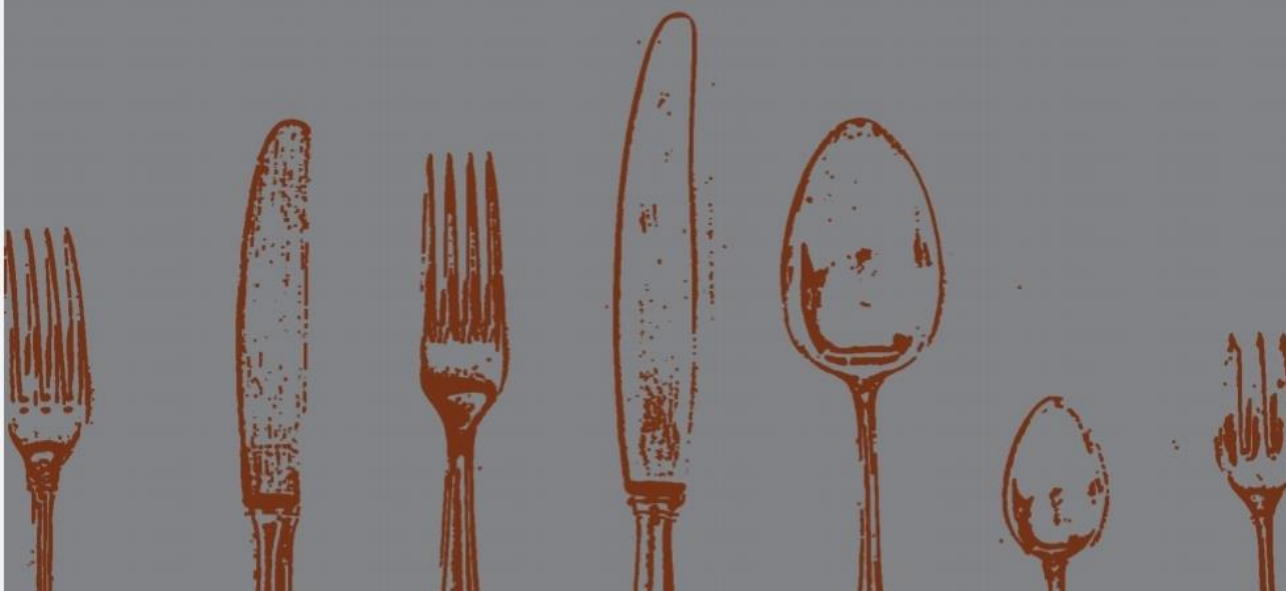


THE ROLE OF HOSPITALITY IN A HOSPITAL ENVIRONMENT



1. Introduction

1.1 Research topic

The last decade we have seen an increased interest of hospitals in hospitality (Wu, Robson, & Hollis, 2013). Hospitals have looked at hotels for the surroundings and physical environment to give a better impression of hospitality. The focus is primarily on the design of the hospitals and physical environment for patient, family, friends, and other visitors.

Already in the 1950's Malott & Deane (1959-1961) stated: 'the hospital in certain respects is a very specialized hotel'. The concept was that hospital managers learn from management approaches which are used in the hospitality industry. Innovations and practical experience from hotels have been implemented into healthcare organizations in different means. This development is not surprising as the two industries share the goal to achieve a high customer satisfaction. In the last decennia not only hospitals but also major corporations do show interest in hospitality.

Although innovations and practical experiences of hospitality are implemented into hospitals the role of hospital staff is largely overlooked. Hollis & Verma (2015) have argued that success in both healthcare and hospitality depends on a culture of respectful treatment and valuing all stakeholders in the organization. Therefore, an effective culture makes employees feel both important and appreciated. Another challenge according to Hollis et al. (2015) for hospitals is the inflexible buildings, aged facilities but staff can overcome this negative factor. Staff in hospitals can overcome negative experiences of patients, guests, and other visitors of the hospital.

To influence the experiences of visitors in hospitals Lashley & Morisson (2003) have put forward the hypothesis that meeting the needs of guests is a primary focus and commitment in commercial operations through the relationship between a host and a guest. Brotherton (1999), Oh (2009) remind us that hospitableness includes both an attitude and environment of welcoming. Pizam (2007) argues that 'ity' is the difference between hospitals and hospitality, whereas the 'ity' can make a significant difference in the recovery and experience patients have. Hospitableness is of great influence in an organization and therefore effects the experience of nurses, visitors, guest, patients, and employees.

Brotherton (1999) argues that a host and guest experience is described by many exchanges between staff and customers. Often experiences in hospitals revolve about involuntary stayover and also patient and family have to deal with uncomfortable situations. You can understand that a patient rather prefers to be at home. The stayover for the patient is involuntary and the patient is forced to be in a strange environment with uncomfortable situations in order to get better.

Guibert (1993) describes uncomfortable situations during treatment in 'The compassion protocol' (1993) and writes about the personal experience of the examination with a fiberscope and hints to the feeling that the medical gaze is intrusive, silencing to the body and even talks about orally being raped. Fiberscopes are very flexible and are used by medical specialists as an instrument to help to examine problems in a patient's body without having to make large incisions. Uncomfortable treatment situation is also congruent with the work of Hepple, Kipps & Thomson (1990) who found that patients talk about being ignored of their individuality which leads to feelings of depersonalisation. Nouwen (1976) argued that many patients get well but

leave the hospital with hurt feelings because of the impersonal treatment they received during their stay.

The hurt feelings are due to the sometimes silent and impersonal care from professionals who do not always recognize that for most people the stay in a hospital it is an emotional, stressful and fearful event as described by Peloquin (1993). Care professionals must understand that they become significant others to the patient because of the special connection that illness brings. The experience patients have depends on the attitude of each individual care professional. Brotherton (1999) argues that the relationship between host and guest is critical during the stay in a hotel and characterised by many exchanges. In hospitals often, patients feelings are furthermore subject to enhancement due to fear, illness, and loss of privacy.

Impersonal treatment and the feeling of depersonalisation was noted by Foucault (1973) and he was the first to coin the term ‘medical gaze’ and this occurred early in his study ‘The Birth of the Clinic’ (1973). This change was fundamental and showed the objectification of the patient where physicians did not see the patient but only concentrated on the illness or broken part of the patient. Foucault (1973) mentioned the change of how physicians looked at the patient. According to Foucault the perspective changed from asking the patient “How are you?” to “Where does it hurt?”. Under the valuation of the medical gaze, Foucault argues, that ‘under the observation by doctors who know and decide, who govern and dissect, isolate and classify, the patient is becoming a passive and silent object of knowledge (1973, p. 89)’. The opposite of ‘Gazing’ is mentioned by Davenport (2000) as ‘witnessing’ and is to acknowledge the whole life of the patient which, according to Davenport (2000), seems to be a struggle to keep in balance.

Is the wish for hospitality by management made clear enough for all staff members and stakeholders? Management has to focus on several logics, take care for the patient and staff, and also wants to focus on hospitality. Is the meaning of hospitality clear to nurses and do nurses experience support in providing hospitableness to patients (Lakhoua, 2019). What is the role of hospitableness in hospitals?

1.2 Background of this research

The trigger of this research and book is personal experience with the treatment of colon cancer for which I still have check-ups this present day. From first-hand I have experienced hospital visits whereby my experiences and feelings were noted right after the time of treatment and visit of the hospital. Diagnosed with cancer I decided to note my experiences during hospital visits. I decided to write down experiences right after the visit, mostly on my phone. I wrote down experiences as objective as possible. I wrote down how I felt and how the experience was in contact with the nurses or specialist. Feelings, practical problems and how I was treated were noted.

Experiences were written down through my own eyes , as a patient with experience in hospitality. While being treated I observed the behaviour of and between staff and, how employees approached me. At the same time, I logged any personal feelings of myself right after the visit. After the visit I sat down and asked myself: 'What just happened?' writing down my experiences. "What just happened?" was noted as objective as possible. To the best of my knowledge not with a negative or positive state of mind but clearly to explain how feelings occurred while being treated by nurses. The documentation of these personal occurrences initiated as a consequence of plans to write a book about hospitality in hospitals, seen through the eyes of a patient who has experience as a hospitality professional. Although reflective, these recording of experiences can give a realistic view on how patients are treated and

indicate how other patients feel. Nobody who treated me in the hospital were aware of my intention to note occurrences. Therefore, I would like to presume that behaviour of nurses and staff was genuine. Recordings of my own experiences, ethnography, is the genuine impression of stories of people explained in own words according to Roper & Shapira (2000). Ethnography is valuable because the researcher submerges himself in the real world of the participant and provides a realistic experience. I was a participant of real-world treatment in hospitals.

1.3 Context

The basis of this book deals with the context of a hospital setting in two major hospitals in the North of the Netherlands. Research was before the outbreak of Covid-19 in 2020. Although healthcare is overwhelmed by the number of patients who suffer from consequences of Covid-19 it does not make hospitality less important. Former patients stress the lack of human contact and the horrors of not being able to see the face of the healthcare specialist who had treated them.

In both hospitals hospitality managers and board of directors are very willing and in support of this research and were fully corporative. The two hospitals differ in size, one with 578 beds, and one which has a capacity of 1.116 beds. Martini hospital has a patient valuation report number of 8.2 (2019), the amount of daily treatments is 32.727 per year, total of hospitalization is 29.215 per year and first polyclinic visits in the hospital are 143.963 patients per year. Isala has a report number of 8.1 (2019), daily treatment amount of 43.644 per year, hospitalizations a year of 64.324 and first polyclinic patients of 223.157 (Ziekenhuizen, 2019). Interviews, observations, and recordings were done at the hospitals. In table 1 on the next page quantitative information of the hospitals is presented.

Table 1: Details Hospitals

Hospital	Report	Amount of beds	%	Daily treatments	%	Total of hospitalization	%	Polyclinic visits	%
Martini	8.2	578	34,12	32.727	42,85	29.215	31,23	143.963	39,21
Isala	8.1	1116	65,88	43.644	57,15	64.324	68,77	223.157	60,79
Total		1694	100	76.371	100	93.539	100	367.120	100

Interviews were held in two major hospitals in the North of the Netherlands, Martini in Groningen, and Isala in Zwolle. Although I have family who work in hospitals the idea was to first get to know the culture of nurses and hospitals. Therefore inquisitive questions were asked to nursing staff to get into the culture of hospitals. Three layers in the organisation of hospitals were interviewed; service assistants, nurses, and head of departments. The Interviews within three layers of the organization provides a comprehensive view of nurses on hospitality in hospitals.

Interviews were held in closed environment like small offices or remote corners of the organisation. In all cases the interviews were recorded in a private setting. Consent was given orally where after interviews were transcribed verbatim. Interviewees did speak freely due to the knowledge that names will be held and will stay anonymous. Findings of interviews where used in follow up interviews to obtain more specific information and knowledge about the perspective on hospitality by nurses. From the first interview information was gathered and used for sequel interviews and so on.

After processing the interviews, two days of participant observation took place in the hospitals where also spontaneous interviews occurred on location. Remarks and observations were spoken into a voice recorder on location and transcribed soon after. All information of interviews, practical observation and observation was collected and combined to process. All this information

provides a clear and comprehensive picture of hospitality in hospital organisations.

1.4 Purpose of this book

Hospitals as organizations are focussed on measurable procedures and processes and the wish for more hospitality shifts the organization to an unknown area of expertise. Hospitality has influence on the hospital organization as it is in both a hotel and hospital that guests and visitors evaluate their experience and also decide to visit again or not, to recommend or not. Decisions what hospital to visit are made by patients due to change of both policies and rise of insurance costs in the Netherlands. More patients in the Netherlands have rising healthcare costs. Rising cost of health insurance makes the patient aware of the cost of healthcare but also gives the patient the reasoning that quality can be expected in technical and personal treatment as one is paying (more) for it.

Behaviours of customers are supported by the theory of planned behaviour and reasoned action by Ajzen (1985). Planned behaviour and reasoned action become important for hospitals due to the choices that are made by patients. The patients choose if a revisit is an option. Due to the own costs' patients have to pay, the patient wants to have influence on the choice of hospital. Patients will therefore choose the hospital where treatment was of high quality. The patient will not make this decision on the quality of the technical care but on the treatment by hospital staff. The patient has no knowledge on technical care and therefore will base his opinion on how he was treated by staff.

For this reason, nurses are important and have great impact on patients. Nurses see patients often, several times during the day and get to learn the patient, the life, the family and how the patients deal with pain.

Several moments a day contact is made with the patient. These moments of contact between the nurses and patients are important for the wellbeing of patients. Normann (1991) describes moments of contact between employee and customer as the '*moment of truth*'.

The '*moment of truth*' is the precise important moment of service quality delivered by the employee at the precise moment to the customer. The literature about '*moment of truth*' refers to services in a hotel. That '*moment of* truth' I like to transfer to a hospital setting. For patients who are in a strange environment, insecure, feel sick and are vulnerable that moment for the nurse to attend at the bed is significant. At the bedside and throughout the whole organisation, between the nurse and patient '*moments of truth'* will occur regularly. The '*moment of truth*' is important for nurses to comfort and care at the precise accurate moment for the patient. This book gazes into the view hospitality professionals have on hospitableness during contact with patients.

1.5 Overview book

This book consists of a total of ten chapters. In this chapter introduction of the theme occurs, research topic, background context and purpose of the study was explained.

The next chapter, chapter two, consists of the literature review. All theories that are relevant are explained, discussed in length for this book. In chapter three the *service logic model* is explained. This chapter is divided into the different logics of the model. Several other models are discussed in this chapter and it is clarified why the *service logic model* is chosen.

Chapter four contains the service blueprint. The connection between logics and a practical blueprint is explained. Chapter five highlights the care path. The care path is a technical path the patient experiences and is developed by management of the Martini hospital. This path provides a clear route for

management so it can see in theory a patient journey through the hospital. Chapter six explains the general research design and problem statement.

Research questions of this book are shown in chapter seven. Chapter eight explains the method of the research. Details about research, who is interviewed, how data was collected, how data was analysed, and how coding took place. In this chapter some ethical issues and limitations are discussed. Results are explained in chapter nine. In chapter nine interviews, observations, personal experiences and interviews of management are explained. Chapter ten consist of discussion. Research questions of chapter ten are answered in this chapter. Final chapter eleven finalizes this book with conclusion and recommendations.