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INVESTIGATING THE RELATIONSHIP BETWEEN VALUE CONGRUENCE AND PATIENT SERVICE QUALITY

By
Morris D. Davis

A DISSERTATION

Submitted to
School of Business and Entrepreneurship
Nova Southeastern University

in partial fulfillment of the requirements
for the degree of

DOCTOR OF BUSINESS ADMINISTRATION

1997

A Dissertation
entitled

INVESTIGATING THE RELATIONSHIP BETWEEN VALUE CONGRUENCE AND PATIENT SERVICE QUALITY

By

Morris D. Davis

We hereby certify that this Dissertation submitted by Morris D. Davis conforms to acceptable standards, and as such is fully adequate in scope and quality. It is therefore approved as the fulfillment of the Dissertation requirements for the degree of Doctor of Business Administration.

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1997

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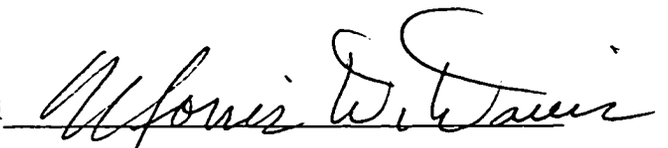
Signed 

Morris D. Davis

ABSTRACT

INVESTIGATING THE RELATIONSHIP BETWEEN VALUE CONGRUENCE AND PATIENT SERVICE QUALITY

by

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Traditional prescriptions for enhancing service quality, which have placed a heavy emphasis on measurement and control, are gradually being supplanted by a focus on the behavioral dimensions of service quality. Some new approaches toward understanding service quality focus on the extent to which service quality values are shared among the organization's human resources. Shared values (value congruence) appear to foster improvements in an organization's service orientation. A relationship between value congruence and organizational performance has been observed among industrial production employees (Adkins et al., 1996; Meglino et al., 1992; Meglino et al., 1989) and among hotel service employees (Braunlich, 1990).

Dodson (1996) unsuccessfully attempted to establish an empirical link between the degree of "employee/manager" value congruence and perceived patient service quality levels. Dodson's research was conducted at a large southeastern university teaching and research hospital. Dodson suggested that this link might be successfully established at a small, private hospital in another geographical region.

This study was conducted to determine if, in fact, an empirical linkage could be established between value congruence and perceived patient service quality in a sample of managers and patient service employees from a small private hospital in the Pacific Northwest. Service quality values were measured operationally by manager and employee responses to an instrument developed by Braunlich (1990) and adapted by Dodson (1996) for research in hospitals. Patient service quality was measured by responses to a 54-item questionnaire sent to the patient's home after discharge from one of the hospital's seven nursing units. The response rate for the patient service quality questionnaire was

approximately 30%, while that for the service quality values questionnaire was approximately 60%.

Regressing perceived patient service quality scores on value congruence scores produced a statistically insignificant result. Therefore, the null hypothesis (i.e., no relationship between manager/employee value congruence and perceived patient service quality) could not be rejected. It was suggested that future researchers should seek to test the hypothesis by comparing value congruence data and patient service quality data from several hospitals, rather than from simply the patient service units of a single hospital.

ACKNOWLEDGMENTS

I would like to dedicate this dissertation to those whose kindness, selflessness, and generosity of spirit helped make it possible. No person is an island, especially when seeking to write a creditable doctoral dissertation.

Those who encouraged me to continue my efforts despite adverse circumstances are deserving of special recognition. Chiefly, I would like to thank my dissertation advisor, Dr. Richard T. Rees. Throughout the process of writing my dissertation, Dr. Rees demonstrated a singular and remarkable talent for locating silver linings in the dark clouds that sometimes rained discouraging and frustrating torrents upon the project. I would also like to highly praise members of my dissertation committee, Dr. David Morton and Dr. Robert Preziosi, whose skills and precious time were so generously tendered on my behalf.

Obtaining permission to gather the data required for this research was, at the outset, frustratingly difficult, thereby placing the project's successful completion in serious jeopardy. Fortunately, through the selfless and generous efforts of Mr. Alvin Klinner (Born: 1/28/30 - Died: 6/28/97), the required permission was finally obtained. Thanks Al, your friends at C.U.P. miss you very much!

I would also like to acknowledge the cooperation and assistance of the fine professional staff at Our Lady Of Lourdes Health Center, especially, Sister Kathleen Mary McCarthy, Pamala Jones, Sally Ann Peters, Dennis Phister, and Keith Anderson. I will always remember their generous contributions of time and expertise during the data gathering phase of my research.

George Strickland and John Layman are also deserving of special thanks. These long suffering friends have devoted many hours of their valuable time to reviewing and cogently commenting on the style and substance of this doctoral dissertation. I would like also to thank Dr. David J. Lemak, of Washington State University, for his thoughtful comments on Chapter II.

Finally, I would like to thank my parents, Alvin and Aileen Davis, for teaching their son that dreams are important. They also taught me that some dreams are achievable only through extreme personal sacrifice and dogged persistence. With respect to the process of earning a doctoral degree, they could not have been more correct!

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CHAPTER I

INTRODUCTION

Background of the Problem

America's health care delivery system has all of the essential elements of a service sector business. There is reason to believe, moreover, that the quality of this nation's health care services may be greatly influenced by the attitudes, values, and beliefs of health care service employees. Evidence from hospital service quality literature suggests, for example, that the quality of face-to-face interactions between hospital patients and patient care providers is an important basis for patient perceptions of health care service quality (Williams and Calnan, 1991; Mallison, 1991; Fralic et al., 1991; Bowers et al., 1994; Molloy, 1994).

Even so, the relationship between patient service employee values and patient service quality has not been well established empirically. The research described in this dissertation focuses on the extent to which hospital managers and patient service employees have been imbued with

service quality values. An important objective of this research is to determine whether a measurable link exists between the extent of value congruence (i.e., shared values) between patient service employees and their management, and the level of perceived satisfaction with services provided by patient service employees.

While a great deal of literature has been created over the past decade on the general topic of quality, much of it has focused on elements and aspects of product quality. Nevertheless, most Americans purchase products (especially durable products) relatively infrequently, but purchase services almost daily (e.g., medical/dental care, Internet access, financial and investment advice, etc.). Seen in this light, it is easy to understand why Schneider and Chung (1996) have observed that service quality research is assuming increasing importance in this country.

As the United States continues its rapid evolution toward a service-based economy, more and more firms are gaining an understanding of how to create and manage high quality service delivery. The companies that are the most successful in this endeavor are likely to be among the most prosperous in the decades ahead. This is largely a

consequence of the fact that intense competition and deregulation are compelling businesses to differentiate themselves on the basis of high quality service delivery (Parasuraman et al., 1988).

Albrecht (1990) describes how the chief executive officer of Foodmaker Inc., which operates a chain of more than 1000 Jack-In-The-Box hamburger restaurants, has used customer research data to create a service quality model for the purposes of guiding and directing customer interactions. According to Albrecht, the Foodmaker Inc. chief executive officer does not discount the importance of good financial management and cost control, but sees quality customer service as a variable with the potential to immediately and permanently enhance the company's bottom line.

Peters (1987) observes that the Nordstrom company grew seven fold between 1978 and 1987, in a very competitive market, and without takeovers or acquisitions. Peters attributes Nordstrom's success in differentiating themselves from other upscale retailers of men's and women's clothing to the unparalleled levels of service provided to their customers. In other words, Nordstrom is one of an increasing number of companies coming to realize that exceptional

customer service, more often than not, actually enhances a firm's bottom line. Indeed, Peters contends that supplementary levels of service are becoming increasingly important competitive tools in many markets. Successful companies of the future, according to Peters, will focus heavily on providing high quality customer service.

The widely held belief that health care costs are excessive is an important rationale and driving force behind the quality movement taking place in this nation's health care industry. Hospitals tend to feel especially obliged to deliver better services at lower costs. As such, hospital administrators seem increasingly inclined to focus on quality initiatives as a solution to this dilemma (Albrecht, 1988).

Intense competition in the health care industry has also compelled health care providers to discover new and more profitable means of differentiating themselves from their competitors. One strategy for dealing with intense competition is for health care providers to differentiate themselves on the basis of high quality patient services. Indeed, a recent study found that the existence of a service quality orientation among hospital employees was a factor

that clearly differentiated high-performing from low-performing general service hospitals (Rapert and Babakus, 1996).

A hospital's human assets play an integral part in efforts to improve the quality of its patient services (Fralic, 1991). Patient service employees are the key to service quality improvements in hospitals, because they engage in the vast majority of face-to-face interactions with hospital customers. The interactions between health care customers and health care providers during the service delivery process are usually quite intense and often not directly supervised. In a very real sense, it is the perceived quality of these often intense interactions which determines the degree of patient satisfaction with the health care services received. A problem for hospital management is how to delimit and structure these interactions in a way that produces patient services of consistently high quality.

One approach to managing the quality of the interaction between the health care provider and the health care customer revolves around concerted efforts by hospitals to inculcate service quality values into managers and patient

service employees. This approach to managing service quality in hospitals is, to some extent, predicated on the assumption that the greater the degree of congruence between management and the employees who provide patient services, the higher the resultant service quality. Corporate culture literature shows that service quality value congruence between employees and their organization really does make a difference. This body of literature strongly suggests that organizations stressing such shared values generally perform better than organizations which do not foster value congruence (Deal and Kennedy, 1982).

Organizational behavior literature also supports the idea that certain aspects of corporate culture, particularly shared values, have significant effects on levels of service quality. This seems to be especially true for those types businesses in which employees have frequent face-to-face customer contact (Meglino et al., 1989).

Statement of the Problem

Although it is quite likely that both management employee and nonmanagement employee values are significant factors in the provision of high quality services, most

organizations historically have separated their research on employee values and attitudes from their research on customer perceptions of product or service quality (Schneider, 1980).

Even though patient service quality is, and will continue to be, a matter of utmost importance to the health care community (Taccetta-Chapnick and Rafferty, 1997), very little research has been directed toward establishing a link between shared service quality values and customer service quality in a hospital environment.

This dissertation, however, simultaneously investigates employee values and customer perceptions of service quality. As such, it focuses on assessing employee values, and on ascertaining the nature of the linkage between value congruence and the perceived quality of services provided by patient service employees.

The importance of this research rests with the possible implications of a linkage between service quality value congruence and patient service quality. Therefore, if high levels of value congruence are shown to be related to high levels of patient service quality, this suggests that it may be possible to develop low cost (or perhaps even no cost)

methods for enhancing patient service quality. For example, service quality improvements might be implemented at hospitals through the use of seminars, workshops, and special training classes designed to communicate and imbue the organization's values into both management and nonmanagement employees.

In addition, the service quality values questionnaire used in this research (see Appendix B), or an instrument very much like it, might be used to help hospital human resource departments identify prospective employees who seem to possess service quality values congruent with those of the organization, its managers, and its current staff of patient service employees. Similarly, the quality of services provided by hospital work teams might be enhanced if team members were chosen, at least in part, based on whether their service quality values were congruent with other team members and with team leaders/supervisors.

The research presented in this dissertation will also contribute useful information to the body of knowledge on service quality. As the literature review presented in Chapter II clearly demonstrates, relatively little is known about service quality value congruence between managers and

employees, or about the nature the relationship between such value congruence and patient service quality.

Purpose of the Study

The purpose of this study is to conduct empirical research focused on understanding the relationship between service quality values held in common by patient service employees and their managers/supervisors, and the perceived quality of the services provided by these patient service employees.

As such, this research project is designed to measure the quality-related values of hospital managers/supervisors, as well as the quality-related values of patient service employees. The research is also focused on measuring patient perceptions of hospital service quality, and the degree of measurable association between service quality value congruence and perceived patient service quality.

Research Question

A research question has been formulated to guide and focus the research on which this dissertation is based. The research question to be addressed by this dissertation is as

follows: Is there a relationship between the degree of service quality value congruence between hospital managers/supervisors and patient service employees, and the level of service quality provided by these patient service employees?

Hypothesis

The hypothesis tested by this researcher can be stated as follows:

HO: The null form of the hypothesis is: There is no significant relationship, with respect to service quality value congruence between hospital managers/supervisors and patient service employees, and the perceived quality of services provided by these employees.

H1: The research form of the hypothesis is: There is a significant relationship, with respect to service quality value congruence between hospital managers/supervisors and patient service employees, and the perceived quality of services provided by these employees.

Definitions

Hospital: An organization whose mission is to deliver medical, surgical, and other restorative care to ill and injured individuals.

Nursing Unit: A hospital subunit characterized by specific patient interactions associated with the process of delivering health care services. A nursing unit may encompass more than one hospital department. The seven nursing units in which this dissertation research was conducted are: the Intensive Care Unit (ICU), the Obstetrics and Gynecology Unit (OB/GYN), the Medical and Surgical Unit (MEDSURG), the Pediatrics Unit (PEDS), the Rehabilitative Care Unit (REHAB), the Restorative Care Unit (RCC), and the Alcohol and Drug Treatment Unit (ADTU).

Patient: A patient is defined as a person, over the age of 18, treated by one of the hospital's nursing units. This definition, in effect, also refers to the adult parent of a child treated by one of the hospital's nursing units, who is asked to complete a patient service quality questionnaire on behalf of their child.

Patient Service Employees: These are nonmanagerial/nonsupervisory employees who work in

association with one of the hospital's seven nursing units and spend at least 25% of their time on the job interacting with patients.

Managers: These are members of the hospital staff who have been formally designated as managers or supervisors, and whose job is to manage or supervise the day-to-day work of hospital patient service employees.

Service Quality Values: Service quality values are personal attitudes or dispositions toward concepts related to service quality. Patient service employees and their managers/supervisors typically have somewhat similar service quality values. Service quality values may serve as standards for delivering the types of patient services that are likely to be perceived by customers as being of high quality.

Patient Service Quality: This is defined as a hospital patient's evaluation of the actual care received. A patient's evaluation of health care services is thought to be based on their perceptions of the actual service provided, discounted by their personal standards and expectations of what this care should have been.

Value Congruence: A measure of the degree of sameness in attitude between management/supervisory employees and patient service employees regarding aspects of service quality.

It should be noted that definitions of the terms listed above are generally consistent with definitions provided by Dodson (1996). There are, however, two exceptions to this statement. First, a "nursing unit" differs from the definition of a hospital department provided by Dodson (1996), in that a nursing unit is a distinctive treatment unit, which may encompass more than one hospital department. Second, the patients in Dodson's (1996) study were apparently all adults over 18 years of age. For the present study, however, the definition of a patient may also encompass the adult parent of a minor patient, who completes a patient service quality questionnaire on behalf of their child.

Summary

Chapter One provides background information relevant to the research problem on which the succeeding four chapters of this dissertation are focused. Chapter One also

identifies the research problem being addressed in this dissertation. Chapter One defines the purpose and significance of the research and specifies the research question around which the dissertation is focused. The null and research forms of the hypothesis are also presented in Chapter One.

Chapter Two presents a review of appropriately representative literature on values, service quality, and value congruence.

Chapter Three provides a detailed description of the methodology employed to gather and analyze "service quality values" and "patient service quality" data.

Chapter Four presents results derived from tabulating and analyzing data generated by means of the research methodology described in Chapter Three.

Chapter Five summarizes the dissertation's key points and discusses potential implications of the research results presented in Chapter Four. Chapter Five also proffers prospective strategies for carrying out future research on value congruence and patient service quality.

CHAPTER II

REVIEW OF THE LITERATURE

Why Values are Important

Chester Barnard observed that an employee's personal values have an important influence on their behavior in an organization. According to Barnard, personal values even influence the employee's decision to remain or not to remain in the employ of an organization (Wren, 1987). Fritz Roethlisberger believed that many workplace interactions and relationships could be attributed to the personal values of employees (Roethlisberger & Dickson, 1939).

Kluckhohn (1951) theorized that, in organizations where employees share similar work related values, the employees generally will have a more accurate picture of role expectations in the organization, than will employees in organizations where such value congruence is weak or absent. Kluckhohn (1951) pointed out that, because values are linked to modes of behavior, employees who share a more accurate picture of role expectations are able to, within the

context of the organization, more accurately predict one another's behavior. It has been theorized that such work related values define the general modes of behavior that "should" or "ought" to be exhibited in the workplace (Kluckhohn, 1951; Rokeach, 1973; Schein, 1985). England (1967) characterizes thoughts of what should or ought to be, as "work values applied to work place settings." Organizations, just like individuals, can be characterized on the basis of their value orientation. In fact, the culture of an organization is typically reflected in the collective values of its employees (Drucker, 1988).

Peters and Waterman (1982) observe, moreover, that the research they have conducted in the American business community suggests that the best American firms take their value systems very seriously. The best firms possess high levels of value clarity, with respect to company standards and principles. Peters and Waterman contend that, for these companies, values are the very essence and foundation of their corporate culture.

Posner and Schmidt (1984) carefully researched the relationship between individual and organizational values, utilizing a sample of 1500 American managers, ranging from

immediate supervisors to high level executives. Their results strongly suggest that management's efforts to clarify and merge corporate and personal values has a significant managerial and organizational payoff. Indeed, strong corporate cultures have been shown to be an important element in business success (Deal and Kennedy, 1982).

Kluckhohn (1951) suggests that, when work related values are widely shared by members of an organization, employee performance may ultimately be enhanced within the organization. According to Meglino et al. (1991), values can affect important organizational outcomes in two ways: internal integration and external adaptation.

Internal integration stems from shared values which, according to Meglino et al. (1991), allow a person to more accurately predict the behavior of others. According to the authors, sound behavioral predictions often translate to a more positive interpersonal "affect." Internal integration is the likely result of situations in which an individual's values are congruent with those of their supervisors and/or with the larger organization for which they work. Internal integration is associated with such positive outcomes as job satisfaction and organizational commitment.

External adaptation, the second mechanism suggested by Meglino et al. (1991), is predicated on the notion that those individuals having shared values tend also to manifest similar cognitive processes. This, in turn, typically eventuates in similar interpretive and classification processes regarding environmental events. It is postulated by Meglino et al. (1991), that when individuals perceive value similarities in one another, they have a tendency to develop a positive affect for one other. The state of positive affect can help them cooperate in efforts to more effectively accomplish the organization's goals and purposes.

Meglino, Ravlin and Adkins (1989) sought to determine whether positive organizational outcomes, such as satisfaction and commitment to an organization, were related to a high degree of organizational value congruence between managers and employees. In their study, questionnaires measuring organizational commitment, job satisfaction and work values, were administered to 191 production workers, 17 supervisors, and 13 managers of a large industrial products plant. Research results showed that production workers demonstrated greater satisfaction with their organization,

and had a greater commitment to it, when their work values were highly congruent with those of their supervisors. The relationship between organizational commitment and value congruence was especially apparent for longer tenured production employees. The most conclusive research finding, however, was the presence of significant levels of value congruence between workers and management, even among the lowest ranking production employees.

Adkins, Ravlin and Meglino (1996) have also attempted to determine whether the degree of congruence in work values is linked to how well the employee "fits" into the work environment. Their study was carried out in an industrial setting, and attempted to assess the relationship between the degree of co-worker value congruence and work-related outcomes (e.g., satisfaction with the work environment, job performance, and attendance). The researchers found a significant positive relationship between co-worker value congruence and satisfaction with the social aspects of the work environment. However, this relationship existed only for low-tenured employees (tenure measured by the number of years on the job). For individuals whose jobs were highly interdependent, value congruence seemed to be positively related to supervisor ratings of their job performance. The

researchers found a positive relationship between value congruence and job attendance only for high-tenured workers. Researchers suggested their most significant findings were that, when job interdependence is high, value congruence between co-workers is related positively to attendance and harmony in the workplace.

Meglino, Ravlin, and Atkins (1991) found that a follower's level of anticipated satisfaction with a leader is related to the degree to which the follower perceives value congruence between the leader and themselves. The researchers assembled a sample of 63 banking executives, 61 MBA students, and 102 undergraduates. These subjects completed a work values survey and were shown a video on leadership behavior. As noted above, the degree of congruence between the values of the leader, as portrayed in the video, and those of the subject, was significantly related to the follower's anticipated level of satisfaction with the leader.

Leader perceptions, just like the perceptions of followers, are affected by value congruence. Posner, Kouzes, and Schmidt (1985), for example, found that the degree of value congruence between managers and their organization impacted managers in several salutary ways. In a survey of

6,000 managers, they found that the degree of value congruence was positively related to such attributes as: the manager's sense of personal success, managerial commitment, ethical behavior in the organization, perceived importance of organizational goals, and perceived importance of employees and other internal stakeholders.

While the research of Posner, Kouzes, and Schmidt (1985) showed that value congruence can impact those at the top levels of an organization (i.e., managers), the research conducted by Judge and Bretz (1992) has demonstrated the importance of value congruence, even prior to an individual's association with an organization. Judge and Bretz (1992) sampled college students to determine the extent to which an organization's values, relative to other attributes of a job (such as pay and benefits), impacted individual job choice. Their results indicated that congruence between the individual's personal values and perceived organizational values significantly influenced job choice. The college students in the sample tended to choose jobs with a value content similar to that of their own personal value systems.

Even so, the ability of value congruence to shape such organizational outcomes as job satisfaction or organizational commitment can vary situationally. For example, Meglino, Ravlin, and Atkins (1992) conducted research using a sample of production workers. The work value scores of production employees were compared to the work value scores of their supervisors. Researchers measured the degree of value congruence by a variety of indexes, all of which were based on the same work values instrument. The degree of value congruence between employees and their supervisors was then correlated to outcomes such as job satisfaction and organizational commitment. The results of this process were somewhat mixed. Researchers speculated that, because of the impersonal nature of the production work environment, the absence of intense day-to-day interpersonal interaction between workers and their supervisors explained the weaker than expected effect of value congruence on organizational outcomes. The researchers suggested that a relatively intense level of interaction between supervisors and their employees enhanced the influence of value congruence, on such outcomes as job satisfaction and organizational commitment. In other words, when the work place situation was characterized by close

interpersonal contact between individuals, the influence of value congruence on such outcomes as job satisfaction and organizational commitment was stronger and more apparent.

Such observations as those delineated in the preceding paragraph allude to the importance of supervisor/employee interaction, and are given additional credence and support by the research of Grant and Bush (1996), who carried out an empirical investigation of salespersons. Their research focused on the socialization of salespersons in several sales organizations. The researchers found that certain types of socialization processes were more effective than others in enhancing the degree of value congruence between employees and their managers. Such value congruence, in the opinion of researchers, served to enhance the strength of the sales force culture.

Fisher et al.(1996) state that, among management professionals, values, attitudes, and beliefs are highly correlated with the manager's performance in the firm. Moreover, the authors contend that, a high level of shared values and beliefs among members of work teams, is related

to high levels of work team performance. Fisher et al. (1996) studied 10 work teams, consisting of three to five undergraduate engineering students. The authors found strong evidence that team performance is positively related to the extent to which values are shared by a team's members.

The above results are consistent with results obtained in a study of person-organization "fit," in which Posner (1992) attempted to determine whether demographic factors, such as age, gender, ethnic background, organizational level, management position, length of service, and functional area, were related to work attitudes. Posner sampled more than 1600 professional and management personnel from a large manufacturing firm. He found that person-organization value congruency was related significantly to favorable work attitudes, and that this relationship was not moderated by any of the above demographic factors.

Deal and Kennedy (1982) have defined strong organizational culture as a system of rules, which delineate behavioral standards within the organization. By virtue of such established expectations, employees are more likely to

react appropriately in a given situation. Conversely, in weak corporate cultures, employees may squander a great deal of time simply deciding what to do and when to do it.

These authors characterize values as the very core of a firm's culture. Values, as such, provide employees with easy to understand models of success. According to Deal and Kennedy (1982), such tangible models of success tend to establish standards and goals for achievement within the context of the organization. Values can also provide a common pathway for all employees, and provide behavioral guidance in the context of everyday job duties. Moreover, the financial success of a given company, according to Deal and Kennedy (1982), may hinge on the extent to which employees understand, accept, and act upon the values of the firm.

Some authors have focused on shared values, in particular, as an important ingredient in the creation of high quality customer service (Schneider, 1980). Schneider concluded from his research on service employees and their management that, in instances where service quality value

congruence was found, a service culture was often observed, in which the employees and their customers derived benefits from the high quality services that were provided.

Service Quality

A Gallup Poll of senior corporate managers found that service quality was ranked as the most important factor in business success, even among managers from industries that were oriented toward products rather than services (Uttall, 1987). This suggests that one of the most compelling ways by which a firm influences public perception is through its overall quality image. A significant body of evidence indicates that customers recall negative service experiences much more readily than good experiences. For example, the results of a study carried out by the White House Office of Consumer Affairs concluded that, while only 1 percent of customers complain about inadequate or insulting service, more than 90% will never patronize the business again. This study also found that virtually every dissatisfied customer will relate their story of poor service to friends and

relatives. Some respondents in the study reported having related their stories of poor service quality to 20 or more persons. Conversely, study results indicate that, on average, satisfied customers will relate high quality service stories to approximately five persons. In the study report, the researchers suggest that a firm can best increase sales through satisfying its present customers, rather than actively attempting to recruit new ones. Finally, the study estimates that service companies lose approximately 10% of their business annually by failing to provide consistently high levels of customer service (Desatnick, 1987).

Sherden (1988) believes that service quality can be perceived as the context within which a product or service is found. While the concept of service may seem somewhat nebulous and ephemeral, according to Sherden, it is becoming the new competitive battlefield. Quality service is becoming known as the value added element that most constitutes a real basis for differentiation. As such, service quality can command a higher price, even though it may not be

proportionately more costly to deliver. High quality service has also been found to significantly influence the overall financial success of some industries. The more service-intensive the market, the more likely that improvements in service quality will constitute a competitive opportunity (Thompson et al., 1985).

Some service quality models are based on the notion that service customers compare the level of services received to the level of service expected, prior to the service actually having been delivered. For example, Lewis and Booms (1983) define service quality in terms of customer perceptions of the service level received, versus the level of service customers believe they should have received. Consequently, services delivered in excess of customer expectations tend to be rated by the customer as high quality, while services delivered below the level of customer expectations tend to be rated as low in quality. Service quality is, therefore, a function of the degree to which the level of service provided matches customer expectations. Lewis and Booms contend, not surprisingly, that quality service delivery is fundamentally a matter of conforming consistently to customer expectations. Gronroos

(1982) has developed a somewhat similar service quality model, in which the level of service quality is determined by a cognitive process, through which the customer compares the service quality expected to the service quality they actually receive. Smith and Houston (1982) contend, based on research with the "disconfirmation paradigm," that customer satisfaction with services is based on the extent to which customers' preliminary expectations of service quality are confirmed by the service actually delivered.

Berry et al. (1985) carried out several years of research, during which they conducted customer focus group interviews, as well as interviews with numerous business executives. Their object was to ascertain specific aspects and attributes of service quality. Berry et al., as an outcome of their work, proffered ten so called "service quality determinants." Berry et al. suggest, therefore, that service customers tend to evaluate the quality of a service in accordance with the following criteria:

1) Reliability: This is characterized by Berry et al. as the consistent and dependable performance of a given service. Reliability is, in other words, performing the service correctly and

accurately the first time, and performing it when it was promised.

2) Responsiveness: This is defined as the willingness of service employees to provide service at the required time, regardless of when that may be.

3) Competence: This can be thought of as the extent to which the service employee is equipped with the skills required to perform the service well.

4) Access: This refers to the relative ease with which a customer obtains a service (e.g., the waiting time for the service, or the number of hours of the day during which the service can be obtained).

5) Courtesy: This refers to the overall politeness of the service employee. In other words, it refers to the respect, consideration, and friendliness shown to customers by the service employee during the service transaction.

6) Communication: This refers to the requirement for service employees to listen to the needs of

their customers and to keep the customer well informed, in the most understandable language possible. As, for example, when the service employee is explaining the nature of the service, cost, and attention to delivery problems.

7) Credibility: This attribute focuses largely on the personal characteristics of the service provider. It can be thought of as the customer's perception of the service employee's honesty, believability, and trustworthiness. Moreover, it is the extent to which these personal characteristics are consistent with the image and reputation of the company with which the service provider is associated.

8) Security: This refers to the extent to which the customer is free from concerns involving danger, risk, or doubts about the service or the service provider, during the service transaction. It also refers to the potential for the service or the service delivery process to compromise the financial security and/or confidentiality of the service customer.

9) Understanding the customer: This refers to the attempt of the service provider to discern the overall needs of the customer, as well as the customer's unique requirements, if any. This concept also refers to personalized attention and recognition of frequent customers by service providers.

10) Tangibles: This refers to the physical facilities and equipment associated with delivery of the service, as well as such attributes as the physical appearance of service employees.

Tenner and DeToro (1992) define the elements of service quality much more succinctly than do Berry et al. (1985), characterizing service quality in terms of only two elements. The first such element is "deliverables" - which are seen as those attributes the service actually provides the customer. The second element is termed "interactions" - which are defined as those characteristics of the staff and equipment that affect the service delivery process. According to Tenner and DeToro, these elements apply to all services.

Other authors have proffered diverse service quality elements. For example, Blanchard (1996) suggests that competing on the basis of superior service quality requires a firm to create a cadre of satisfied customers, who effectively extend the sales force through word of mouth endorsements. To attain this salutary state, Blanchard indicates that the company must have accomplished three tasks:

1) It must first have a shared vision with respect to its relationship with its customers.

2) The company must also thoroughly understand what its customers want.

3) The company must totally fulfill all customer wants, plus 1 percent.

Peters (1996) suggests that service quality can be defined in terms of customer knowledge and customer involvement. His suggestions for service quality improvements include:

1) a thorough knowledge of your customer,

2) engaging your customer in the service transaction,

3) treating every customer as a unique individual.

Similarly, Peters discusses service quality in terms of a service orientation, to which he ascribes the appellation "service with soul." Peters defines service with soul as the process by which service employees endeavor to go the extra mile, while harboring the specific intention of eliciting pleasure and delight in their customers. Peters observes that the entire world is now producing high quality products. So, one of the remaining avenues by which companies can differentiate themselves, is through high quality customer service. According to Peters, companies can accomplish this by:

1) recruiting and developing an employee team with a penchant for winning,

2) encouraging employees to develop a sense of entrepreneurialism,

3) making special efforts to do that which is required to cultivate the trust of service customers,

4) creating a simple service delivery system, and implementing it flawlessly.

Peters adds, however, that it is only the highly motivated service employee who can create a delightful experience for the customer. Therefore, highly motivated employees are an

absolute requirement for companies striving to provide high quality customer services (Stevens, 1996).

Norman (1984) also acknowledges that service employees are key personnel in the service delivery process. He believes that service quality is perceived at a specific point in time. That specific point in time is characterized as the "moment of truth." The moment of truth, is the point in time at which the service provider and the service consumer meet, in the course of their business interaction. At this point, according to Norman, the service provider and the service consumer, are linked in an isolated interaction with one another. Nothing of what transpires between them during the specific moment of the service interaction can be directly influenced by the service provider's employer. Rather, it is the ability, motivation, and training of the service provider, coupled with the expectations of the service consumer, which coalesce to create the service delivery process.

For Norman, the firm's overall level of service quality is the aggregate of all moments of truth. In some service oriented businesses, such as hospitals, these moments of truth may number in the hundreds or thousands daily.

Therefore, most services are, to use Norman's terminology, "personality intensive." Because of this personality intensive tendency, the level of quality supplied to the customer is the result of service employees' performances in particular situations. Because of this fact, management must understand that, when the level of service quality is so highly contingent upon the performances of employees (who generally have a high degree of discretion and latitude in influencing a given situation), there are definite performance implications for the organization's management.

These implications logically extend to the organizational structure of a service company. Norman (1984) observes, for example, that service is fundamentally a social process, and that it is within the scope of management to direct and control social processes. Even so, service organizations require higher quality management than do most other types of organizations. Management must be sensitive to the need of service organizations for highly motivated individuals who possess a high degree of freedom and latitude with respect to the execution of their responsibilities.

Because freedom and latitude tend to characterize much service employment, Bell and Zemke (1989) contend that high levels of service quality can only be attained when service organizations empower their employees. Empowering service employees is important because the quality of the interpersonal relationship implicit in the delivery of a given service is contingent upon many variables. One important variable is employee service orientation, and the possession of personality traits that engender reliability, supportiveness, and trust. Other important service employee variables include, clear-cut service expectations (e.g., goals, objectives, norms, and values), which allow service employees to more effectively focus their energies and more consistently affirm their personal commitment to superior customer service.

Grove and Fisk (1983) perceive the service encounter in ways similar to Bell and Zemke (1989). However, Grove and Fisk lean heavily on terminology from the entertainment industry. They see the service encounter as a kind of performance. During the service encounter, service employees play roles. The term role, in this context, is used to describe service employee interactions with the customer and

with each other during the course of a service encounter. The "stage setting" metaphor is used to describe the environment in which the service encounter takes place.

Bell and Zemke (1989) also use jargon from the theater. They contend managers of service employees must also attempt to manage the service outcome, in addition to the service delivery process. Directing the performance of a server, therefore, requires a management orientation strikingly different from that required to produce a product. Bell and Zemke believe that providing leadership for customer service employees demands many of the same skills required by directors or coaches to bring about top performance. The context in which a service is performed is less like that of a factory, and more like that of a theater or athletic arena. Service quality is more involved than product quality, primarily because it requires a sense of high self-esteem in the service provider. Service quality also demands that the service provider have self-control and the ability to dramatize emotions, in order to create the desired emotional facade.

Haskett (1986) is also aware that a positive public image is important for service companies. He describes

customer service as the corporate identity of employees, customers and other stakeholders. According to Haskett, top-rated service firms cautiously and deliberately attempt to imbue all of the firm's stakeholders with the imagery of a specific service culture.

Conversely, Hallowell et al. (1996) focus on the contribution of internal organizational aspects of service quality. Hallowell et al. conducted a recent study, the results of which suggest that managers may enhance the capability of their employees to provide quality services by focusing on "elements of internal service quality." These elements, according to the researchers, are characterized as follows: tools, policies and procedures, teamwork, management support, relevant training, and goal alignment (between the service employee and their management). The researchers believe that these elements are at least as important as pay and benefits for motivating top level service employee performance.

Albrecht (1987) discusses, in the jargon of thermodynamic theory, the process of positioning a specific service culture. As such, service culture is characterized by such terms as entropy and synergy. For many reasons,

according to Albrecht, the behavior of service employees is never totally congruent with the overall intentions management has for employees or the firm as a whole. At best, there is only a partial alignment. Albrecht depicts this ongoing misalignment as entropy. On the other hand, Albrecht points out that synergy is antithetical to entropy, and can overcome its negative effects. Thus, synergy is seen as the essential force underpinning such organizational phenomena as cooperation, collaboration, and the efficient interaction between human, physical, and financial resources. Synergy, according to Albrecht, is evidenced when management and service employees share a vision of success. The shared vision typically manifests itself in similar goals, values, and shared responsibilities for problem solving within the context of the organization. In essence, synergy is alignment among an organization's service employees, and between the organization's service employees and their management. Highly aligned companies tend to possess a highly focused customer concept. A highly focused customer concept is, in turn, typically associated with high levels of service quality.

According to Zeithaml et al.(1988), identifying the essence of service quality and determining how organizations might attain high levels of service quality, have become high priority topics for theory-based research. This is important, according to Desatnick (1987), because the delivery of consistently high levels of service quality is difficult. However, within various discussions of service quality, Desatnick observes a common theme, the focus of which is on how to motivate employees to implement service quality values and attitudes. According to Haskett (1986), management can assist service employees in fostering positive service values and attitudes through appropriate training, constructive performance appraisals, and thoughtful coaching.

Service Quality and Value Congruence

Mills (1986) has used the term "service orientation" to describe a situation in which both management and employee attitudes, values, and behaviors contribute to providing high quality services to customers. Values are mechanisms that give direction to service providers, particularly in the presence of uncertainty. For Mills, values are tantamount to a set of standards. He theorizes that these

standards help to focus the behavioral choices of service providers. This, in turn, results in greater levels of consistency in the provision of services.

King (1987) believes, however, that behavioral scientists have only begun to understand the dynamics of the customer service interaction. What is known, according to King, is that the quality of the service interaction is, to a great extent, dependent upon the employee. King (1984) characterizes service employees as resources of the organization, who cannot be treated like tangible products, for which quality can be controlled, assured, and engineered. According to King (1987), researchers must develop a thorough understanding of organizational capabilities, in order to create climates which support high quality customer service performance standards. The author speculates that service quality values, shared between managers and service employees, may help create such a climate.

Schnider (1980) describes empirical research, aimed at determining the extent to which the value orientation of managers may affect employees and customers. The author believes his research shows that the practices and procedures of an organization can culminate in a service

culture, through which customers and employees both benefit from higher quality services.

Braunlich (1990) carried out service quality research in a total of 20 luxury hotels in the United States, Canada, and the United Kingdom. His goal was to determine whether a relationship exists between the degree to which hotel managers and hotel service employees shared service quality values, and the quality of services provided by the employees.

Service quality values were measured by a semantic differential instrument developed and validated by Braunlich (1990). This instrument was administered to hotel service employees and the hotel's management staff. The degree of difference between the mean scores of service employees, and the mean scores of their managers, was used as a measure of shared service quality values. The smaller the difference between the service quality value scores, the higher the presumed degree of value congruence. Service quality was measured by Likert-type service quality comment cards, placed in the rooms of hotel guests. These cards were completed by the guests on a voluntary basis. Statistical analysis of the results from all 20 hotels in the study showed a significant negative relationship, with respect to

the size of the difference in service quality values, between managers and their employees, and the level of service quality ratings provided by hotel guests.

According to Braunlich (1990), the study's results support the hypothesis that, the greater the degree of shared service quality values between hotel managers and hotel service employees, the greater the level of customer satisfaction with the quality of services provided by the hotel service employees.

Health Care Service Quality

The Kaiser Family Foundation released the results of a 1996 nationwide survey of 2,006 adults. Its researchers attempted to determine the priority level that Americans assign to the quality of health care, relative to other factors influencing their purchase of health care services. For this sample of Americans, the highest priority on which they based their selection of a health care plan was, by a wide margin, the perceived level of health care service quality. A much lower relative priority was given to such variables as cost and the choice of doctors (Scott, 1997).

Understanding the elements of high quality health care services is a precursor to improving the quality of patient care. Quality improvement is important, because quality service delivery undoubtedly will be the basis of much future competition in the health care industry (Tacceta-Chapnick and Rafferty, 1997). Research indicates, for example, that hospitals with a reputation for providing high quality care in a single patient department, can create feelings of good will among residents of the community in which the hospital is located. Such goodwill can often translate into increased hospital referrals, including increased referrals to many of the hospital's other departments (Murray et al., 1996).

In order to maximize health care service quality, the values and requirements of the health care customer must always be given high priority, and must serve as a motive force for structuring health care resources and health care personnel management (Willis, 1996).

The health care customer was the central focus of research carried out by Williams and Calnan (1991). The object of their research was to locate and define, in three separate health care disciplines, those essential elements

of patient service quality. The three health care disciplines studied by Williams and Calnan were: general medical practice, dental practice, and hospital care. Their results pointed to the following elements, as being key aspects of high quality health care service delivery:

1) the flow of services,
2) timeliness,
3) accommodations,
4) anticipation, and
5) communications.

The research results achieved by Williams and Calnan roughly corresponded to the results obtained in similar service quality studies conducted by Martin (1986) and Parasuraman et al. (1985).

Data from a survey of 298 patients, at a southeastern Army hospital, were used by Bowers et al. (1994) for evaluating patient satisfaction with the quality of health care services. The data were subjected to multiple regression analysis, the results of which suggested to researchers that health care consumers were unable to adequately assess the technical quality of the health care services they had received. Therefore, such variables as

physical facilities, hospital medical equipment, care outcomes, and employee expertise, were not reliable predictors of patient satisfaction. Researchers determined, rather, that hospital patients defined the quality of the health care services received, in terms of the provider's empathy, caring, reliability, responsiveness, and communication skills. These results suggested to Bowers et al., that ignoring the patient's perspective in matters of patient service quality, is likely to predispose a hospital to complaints of tardy, unresponsive, and uncaring patient services.

The admonition that patient perception cannot be ignored, is corroborated by the research of Molloy (1994). In a study of nursing homes, Molloy (1994) found that, in order to attract and retain satisfied customers, nursing homes must develop a reputation for providing friendly, attentive, and responsive patient services.

Patient service quality is also an important issue in other countries. Brown et al.(1995) carried out a study of customer satisfaction with the emergency room services, at a pediatric hospital in Adelaide, Australia. The study was characterized by its authors as descriptive research, in

which the parents of children (with non-life-threatening illnesses) using emergency department services were asked to complete a questionnaire. The questionnaire instrument was designed to measure the extent of parent satisfaction with the quality of services provided to their children. Results indicated that the majority of parents were satisfied with the quality of patient services. However, less satisfied parents ascribed their lack of satisfaction with hospital services to long waiting times, insufficient staff, and unsatisfactory communication between themselves and hospital care providers. The researchers believe these results suggest that, in order to enhance customer satisfaction, careful attention must be given to maintaining reasonable waiting times, adequate staffing levels, and enhanced staff communication with emergency department customers.

A similar study of 155 women, Moliner and Moliner (1996) used SERVQUAL and SERVPERF instruments (both of which are standardized service quality measurement questionnaires) to measure the perceived quality of patient services provided at a Family Planning Clinic in Burriana, Spain. Results of multivariate data analysis showed that 63.3% of

total variance in perceived service quality could be explained by six factors:

1) a high degree of personal attention from the care provider,

2) little bureaucracy,

3) modern facilities and equipment,

4) a perception of staff professionalism and competence,

5) accessibility of services, and

6) the perceived reputation of the facility.

The authors concluded that it is very important to measure the quality of health services from the user's point of view (i.e., the most important issue in health care marketing is customer quality perceptions).

Imanaka et al. (1993) carried out a study in which questionnaires were sent to 1,695 outpatients of a general hospital in Tokyo, Japan. The questionnaire return rate was 77.2%. Questionnaire data were subjected to multiple regression analysis. Results suggested to Imanaka et al. that patient satisfaction and intention to continue using the hospital's services were a function of patient perceptions of the following:

1) the results of the treatment(s),

2) the physician's technical competence and communication skills,

3) physician warmth and commitment to the patient, and

4) reputation of the hospital and the physician.

It is apparent from these studies that quality health care management is an important topic internationally. In the United States, much debate presently centers around how the health care system can be reformed. Specifically, this debate centers around how cost cutting can be carried out, so as to assure continued access to services, without simultaneously jeopardizing the quality of health care services (Anderson and Zwelling, 1996). Anderson and Zwelling suggest that one solution to the dilemma of health care reform is for hospitals to direct limited financial resources toward those quality improvement projects with the greatest impact on perceived service quality.

A hospital's human resources are also important potential contributors to quality improvement efforts. Research carried out by Fralic et al.(1991) highlighted the importance of patient service employees in delivering high

quality patient services. Mallison's (1991) research focused on the key role of hospital nurses in delivering high quality patient services. Research conducted by Rapert and Babakus (1996) found that a quality orientation, manifested by patient service employees and their management, was one of the factors which clearly differentiated low-performing from high-performing American general service hospitals. Alban (1994) contends that hospital managers have a very important role to play in fostering an environment where team work is practiced to help ensure the delivery of high quality patient services. Alban suggests, moreover, that value congruence between employees and their managers may also be an essential ingredient in creating high levels of hospital service quality.

Hospital Service Quality and Value Congruence

Raines (1992) conducted research, the results of which suggest that values provide guideposts and standards for hospital services. The theoretical basis for this research was the human values framework promulgated by Rokeach (1973). Data were obtained from a random sample of 331 members of the National Association of Neonatal Nurses.

Study results include a finding that nurses identify a hierarchy of job related values, all of which guide their day-to-day nursing practice at the hospital.

Spangler (1991) carried out values research with Anglo-American and Philippine-American nurses in an American hospital context. Subjects of this qualitative research were nine Anglo-American nurses and ten Philippine-American nurses at a 200-bed American general hospital. Results showed significant differences between the two groups of nurses, differences which directly impacted their nursing practices. For example, Anglo-American nurses characterized appropriate nursing care as the promotion of patient self-care, assertiveness in the nurse patient relationship, and controlling situations. Conversely, Philippine-American nurses thought patient care was best characterized by an obligation to care (manifested in a style of nursing care which prioritizes attention to the physical comfort of the patient), respect for the patient, and forbearance of the patient.

Spangler (1991) also found that value differences were a source of nurse-to-nurse conflicts. In this regard, according to the researcher, the traditional wisdom of the

American hospital environment prescribes that Philippine-American nurses adopt the values of their Anglo-American counterparts, since a more homogeneous value system among the two groups of nurses is needed. Even though the researcher concedes that value diversity elicited conflict between the two groups of nurses, the researcher suggests that both groups could benefit from learning nursing care-related values from each other.

Alban (1994) believes it is incumbent upon hospital managers to help foster an environment where teamwork is practiced and excellent patient services are the result. Alban also posits that the degree of value congruence between employees and their managers may be an essential ingredient in creating high levels of hospital service quality.

Dodson (1996) carried out empirical research to determine whether the extent to which managers and hospital service employees share service quality values is related to the quality of services provided by the hospital service employees. For his research, at a university teaching and research hospital in the southeast, Dodson surveyed 19 hospital departments, all of which provided face-to-face

patient services. Dodson measured service quality values with a semantic differential instrument, developed and validated by Braunlich (1990), and adapted by Dodson for hospital research. Dodson measured patient service quality with an instrument developed and validated by Pyzdek (1994), and adapted by Dodson for his research.

Dodson (1996) administered the patient service quality instrument to a random sample of 30 patients, in each of the 19 departments. Dodson also administered a service quality values instrument to the managers/supervisors and patient service employees in each of the hospital's 19 departments. Random selection of managers was not used, because there were fewer than 30 managers in each of the 19 hospital departments. Random selection of patient service employees was used only when there were more than 30 patient service employees in a department.

The degree of congruence between managers/supervisors and their patient service employees was calculated for each of the 19 departments. The service quality level rating for each of the 19 hospital departments was defined by Dodson (1996), as the average patient service quality questionnaire score for each of the 19 respective departments. Service

quality value congruence scores were compared to patient service quality ratings by statistical methods. However, Dodson was unable to establish an empirical link between the degree to which managers and employees shared service quality values and the level of perceived patient service quality. He suggested that more conclusive results might be obtained at a small, private hospital in another region of the country.

Since Dodson's (1996) research, there has been no attempt to establish a linkage between shared service quality values and patient service quality in a hospital environment. Nevertheless, patient service quality continues to be a matter of great concern in the health care community, primarily because patient satisfaction is a key mechanism for ensuring future hospital referrals and thereby future hospital revenues (Taccetta-Chapnick and Rafferty, 1997).

Summary

A variety of literature, obtained from cognitive psychology, organizational behavior, marketing, medicine, nursing, hospital management, and several other disciplines,

has been used to develop this chapter. Justification for such an eclectic representation of literature is rooted in the fact that the health care industry is, for all practical purposes, a service industry. As such, the health care industry is characterized, during the service delivery process, by intensive interactions between health care employees and health care customers. Ultimately, it is the perceived quality of these complex interactions which constitutes the degree of satisfaction felt by patients receiving health care services. High levels of service quality, as measured by patient satisfaction, are increasingly essential, if hospitals are to succeed financially in an ever more competitive environment.

This literature review demonstrates that the concepts, constructs, and terminology of service quality are quite numerous and varied. Even so, this reviewer has observed that the literature presented here tends to reflect common threads of thought about service quality and service employees. The most salient of such threads could be labeled: attitudes, personal values, organizational values, job values, and role ambiguity/uncertainty. As the literature presented in this chapter has already shown,

understanding the behavioral dimensions of service quality is an increasingly recognized means of improving service customer satisfaction. Older prescriptions for enhancing service quality, by measuring it and controlling it, as one would control products on an assembly line, are gradually being supplanted with new approaches. Some of these new approaches focus on shared values. The presence of such shared values appears to foster organizational cultures with vastly improved service orientations.

The relationship between value congruence and organizational performance outcomes has been the focus of research conducted with samples of industrial production employees (Adkins et al., 1996; Meglino et al., 1992; Meglino et al., 1989), and among luxury hotel employees (Braunlich, 1990). Dodson (1996) unsuccessfully attempted to establish a link between manager/employee value congruence and patient service quality, at a large university research and teaching hospital in the southeast. A search of the literature reveals, however, that no one has sought to replicate or extend Dodson's research into other health care environments, such as a small, private hospital in another region of the country.

CHAPTER III

METHODOLOGY

Chapter Three provides an in-depth discussion of the specific steps by which the research hypothesis presented in Chapter I was tested. This chapter also contains operational definitions of key concepts. Moreover, it contains a specific discussion of questionnaire instruments used for the two key operational measures in this research: 1) patient service quality, and 2) service quality values. Finally, this chapter provides an in-depth description of the data collection process and describes statistical techniques used for data analysis.

Sampling Procedure

A sample of recently discharged hospital inpatients from a small (< 150 beds) private hospital in the State of Washington was used by this researcher to develop patient service quality data. These data reflect the degree to

which patients are satisfied with the hospital services provided to them (see Appendix A). Therefore, all respondents in the patient sample are recent recipients of services from one of the hospital's seven nursing units.

These nursing units are as follows: Intensive Care Unit (ICU), Obstetrics and Gynecology Unit(OB/GYN), the Medical and Surgical Unit (MEDSURG), the Pediatrics Unit (PEDS), the Rehabilitative Care Unit (REHAB), the Restorative Care Unit (RCC), and the Alcohol and Drug Treatment Unit (ADTU).

A service quality values instrument (see Appendix B) was given to all full-time patient service employees and all managers/supervisors working in the seven nursing units listed above. Employees and managers from the respective nursing units were identified through a computerized database provided by the hospital's human resource department. A nonprobability sampling method was used because of the relatively small number of hospital managers and employees directly involved in patient services. Even though it was assumed that most employees in the hospital's seven nursing units had jobs requiring significant interaction with hospital patients, additional steps were taken to ensure that only those nonmanagement respondents

with significant patient contact were included in the sample. Consequently, the nonmanagement/nonsupervisory nursing unit employees receiving the service quality values questionnaire were instructed to complete it only if they spent at least 25% of their time on the job interacting with patients. Managers and supervisors working in the hospital's seven respective nursing units were instructed to complete the questionnaire only if they had been in their present jobs for at least three months.

Operationalization of Concepts

The object of this research is to determine the extent to which service quality value congruence, between hospital patient service employees and managers, is related to perceived patient service quality.

Definitions of the key terms utilized in this research are as follows:

A hospital is defined as an organization whose mission is to deliver medical, surgical, and other such restorative care to ill and injured individuals.

A nursing unit is a subunit of a hospital characterized by specific patient interactions intrinsic to the process of delivering health care services. It is a distinctive treatment unit, which may encompass one or more hospital departments.

A patient is defined as a person, over the age of 18, treated in one of the hospital's nursing units. This definition also refers, in effect, to the adult parent of a child treated in one of the hospital's seven nursing units, who is asked to complete a patient service quality questionnaire on behalf of their child.

Patient service employees are defined as nonmanagerial/nonsupervisory employees. These employees work in association with one of the hospital's seven nursing units, and spend at least 25% of their time on the job interacting with patients.

Managers are defined as those hospital staff members formally designated as managers or supervisors, who manage or supervise the day-to-day work of patient service employees.

Service quality values are personal attitudes or dispositions toward service quality-related concepts. Patient service employees and their managers/supervisors typically manifest somewhat similar service quality values. Service quality values may serve as standards for delivering the type patient services that will be perceived by customers as being of high quality.

Patient service quality is a hospital patient's perception of actual care received. A patient's rating of health care services is based on their perceptions of the actual service provided; discounted by their personal standards and expectations of what the care should have been.

Operational Measures of Variables

Patient service quality and service quality values are the two variables for which operational measures have been created in order to carry out theory-based, empirical research. The research design requires that, in each of the hospital's seven nursing units, empirical measurements of service quality values are obtained from patient service

employees and their managers/supervisors. In addition, empirical measurements of perceived patient service quality are obtained by sampling recently discharged patients from each of the hospital's seven nursing units.

Patient Service Quality

Patient service quality for each of the hospital's seven nursing units is measured by utilizing the average service quality rating ascribed to a respective nursing unit by a sample of its recently discharged patients.

Dodson's (1996) patient service quality research at a large university hospital in the southeast (see Chapter II) employed an instrument developed by Pyzdek (1994) for measuring patient service quality among a sample of recently discharged hospital patients. The Pyzdek instrument used in Dodson's university hospital research consists of 14 items. The instrument features Likert-type scales of 1 through 5. A value of 1 represents a "strongly disagree" response, whereas, a "strongly agree" response is assigned a value of 5. Responses of "disagree," "neither agree nor disagree," and "agree," are given values of 2, 3, and 4 respectively.

This instrument was deemed by Dodson (1996) to have

demonstrated an acceptable level of validity and reliability. As such, Dodson reported a Chronbach alpha value in excess of 0.7 for the Pyzdek instrument. Dodson measured patient service quality for each of the 19 hospital departments in his study by calculating the mean instrument score of all respondents in a respective department.

A Likert-type instrument is one of the most widely used of all multiple-item scales. Its popularity among researchers is due to its many advantages over other scales. In the first place, a Likert-type scale offers respondents a greater range of choices than simply "yes" or "no." Therefore, if a variable is assumed to vary over a continuum, rather than simply being present or absent, a Likert-type scale can be a valuable tool for measuring that variable. Likert-type scales are "summated" rating scales, in which a respondent's overall score is calculated by summing the number values of the items that are answered. Moreover, data produced by a Likert-type scale allow more powerful statistical techniques to be used than would be the case with only nominal (e.g., yes or no) data (Monette et al, 1986).

For this dissertation research, Likert-type scale data are used to measure patient service quality (Appendix A). The patient service quality data are obtained from questionnaires sent to the homes of recently discharged hospital inpatients. Those patient questionnaires that are returned constitute raw data, which are tabulated, analyzed, and published quarterly by a private vendor - Press, Ganey Associates Inc. It should be noted that Press, Ganey Associates Inc. are also the developers of the questionnaire with which these raw data are obtained (Appendix A). The, so called, "Patient Opinion Survey" shown in Appendix A, consists of 54 Likert-type items, all of which are intended to measure one aspect of patient service quality. An average of their responses to the instrument's 54 items, is a given respondent's patient service quality rating for the nursing unit in which they received treatment.

Press, Ganey Associates describe their patient service quality questionnaire (Appendix A) as a valid and highly reliable instrument, with a Chronbach alpha in excess of 0.95 (Press, Ganey Associates Inc., 1995). Very soon after checkout, this questionnaire is mailed, along with a stamped return envelope, to the homes of all newly discharged

hospital inpatients. According to the hospital's quality officer (to whom the questionnaires are returned), the return rate of this questionnaire averages approximately 30%. The hospital's quality officer apprised this researcher that approximately 800 Patient Opinion Survey questionnaires were sent to discharged inpatients in the calendar quarter during which this dissertation research took place. A total of 244 of these were returned, which represents a response rate of approximately 30.5%.

The staff of Press, Ganey Associates typically analyze and process, as a whole, the three-month collection of patient questionnaires shipped to them by the hospital. This procedure, which is quickly carried out at the end of each calendar quarter, results in timely statistical reports published four times per year.

Because each nursing unit's patient service quality score is based the average response of its patients to the same questionnaire items (Appendix A), numerical comparisons can be made within and among the seven respective hospital nursing units.

It should also be understood that scores on the 1-5 Likert-type scale are converted by statisticians at Press,

Ganey Associates to a 0-100 scale. The vendor believes this device facilitates the interpretation of data, as well as greater ease of comparison. Thus, a Likert scale score of 1 is given a score of 0, 2 is given a score of 25, 3 is given a score of 50, 4 is given a score of 75, and 5 is given a scale score of 100 (Press Ganey Associates, 1993).

This researcher utilized, as a measure of the dependent variable, patient service quality data published by Press, Ganey Associates proximal to the time frame during which the service quality values questionnaire data (measuring the independent variable) were gathered from hospital employees and managers.

Service Quality Values

In this dissertation research, service quality values are measured by a semantic differential instrument developed by Braunlich (1990) for research in the luxury hotel industry, and subsequently adapted by Dodson (1996) for measuring service quality values in a hospital environment (Appendix B). This instrument has been thoroughly validated, and has a calculated Chronbach alpha of 0.95.

The semantic differential format used for this instrument was developed by Osgood, Suci, and Tanenbaum (1957). One of the advantages of the semantic differential instrument is that it is relatively quick and easy to respond to and is readily adaptable to other studies. Such flexibility is attributable to the generalized nature of the adjectives in the scale (Monett et al., 1986).

A semantic differential instrument (see Appendix B) offers the respondent one or more attitude objects (also called concepts) and a set of polar opposite adjectives (typically between 5 and 10) with which to differentiate the attitude object. Attitude objects are usually words or short phrases which the respondent is asked to differentiate. As can be seen in Appendix B, attitude objects typically appear at the top of a set of scales. Response variance and instrument reliability often increase as the number of instrument attitude objects increases (Monett et al, 1986).

Because a thorough search of the literature yielded no specific instrument for measuring service quality values in a hospital context, Dodson (1996) adapted the Branulich (1990) instrument for this purpose. In order to accomplish the adaptation, five of the six attitude objects from

Braunlich's (1990) instrument were changed. These changes are as follows:

1) "service to the customer" was changed to "service to the patient,"

2) "customer satisfaction" was changed to "patient satisfaction,"

3) "hotel customers" was changed to "hospital patients,"

4) "the 'regular' customer" was changed to "the 'regular' patient,"

5) and "this hotel" was changed to "this hospital." Neither the list of polar opposite adjectives used to differentiate the six attitude objects, nor the seven response alternatives for each of these adjectives were changed when the Braunlich (1990) instrument was adapted by Dodson (1996) for use in a hospital setting.

This researcher did not change Dodson's (1996) attitude objects, polar opposite adjectives, or response categories, when using the instrument for research (see Appendix B).

The semantic differential instrument presented in Appendix B is scored by assigning a score of 1 to the negative adjective end of the scale and a 7 to the positive

side of the scale. Responses falling in between these two response extremes are scored 2 through 6 respectively.

The arithmetic mean of the score given to each of the 9 polar opposite adjectives is the score for one attitude object (i.e., one service value). For example, respective scores of 1,2,3,4,5,4,3,2, and 1, for the 9 polar opposite adjectives under the attitude object "service to the patient," yield a service to the patient value score of: (1 + 2 + 3 + 4 + 5 + 4 + 3 + 2 +1)/9 = 25/9 = 2.77. Similarly, this mean score, when combined with mean scores of the instrument's 5 other attitude objects, and divided by the total number of attitude objects (6), yields an overall "service quality values index" score. For example, if the mean score of 2.77 is combined with five other service value scores of 3.43; 5.21; 3.53; 4.56; and 3.67, the resulting service quality values index score is (2.77 + 3.43 + 5.21 - 3.53 + 4.56 + 3.67)/6 = 23.17/6 = 3.9.

The mean service quality values score for each nursing unit is calculated by summing the service quality values index score of each respondent, and dividing this sum by the total number of respondents in the nursing unit. Thus, in the unlikely event there are only 3 respondents in a nursing

unit, whose service quality values scores are 3.9, 4.7, and 6.4 respectively, the service quality values score for that nursing unit is (3.9 + 4.7 + 6.4)/3 = 15/3 = 5.0.

To assess the degree of value congruence between nursing unit managers/supervisors and nursing unit patient service employees, the process described in the preceding paragraph is carried out separately for the cohort of management/supervisory employees and the cohort of nonmanagement patient service providers. This results in two separate service quality values scores for each nursing unit, one score for nursing unit managers/supervisors, and one score for nursing unit patient service employees.

The degree of value congruence (V) between nursing unit management/supervisory employees and nursing unit patient service providers is calculated by using a mathematical expression similar to one suggested by Dodson (1996). This expression is as follows:

$$V = 7 - |P - M| \qquad (1)$$

Where 7 = the largest attainable value on the semantic differential response scale, and *P* = the mean score for patient service employees in the nursing unit, and *M* = the mean score for nursing unit managers/supervisors.

Value congruence (*V*) for a given nursing unit is calculated by subtracting the absolute value of *P* - *M* from the number 7. The number 7 is used in the above expression because, as stated earlier, 7 is the largest value attainable on this particular semantic differential response scale. As such, by subtracting the absolute value of the difference between employee and management mean scores from 7, the value congruence score is always positive.

Collecting Service Quality Values Data

Every manager/supervisor and full-time nonmanagement employee in each of the hospital's seven nursing units was given a service quality values questionnaire (see Appendix B). A nonprobability method of sampling was used because the hospital's nursing units are characterized by a relatively small number of employees. For example, each nursing unit typically has four or fewer managerial/supervisory

employees. Moreover, none of the nursing units have 30 or more full-time nonmanagement employees who spend at least 25% of their time directly interacting with hospital patients. A total of 123 questionnaires were sent to patient service employees and their managers/supervisors in the hospital's seven nursing units.

These questionnaires were transferred to appropriate managers in the hospital's seven nursing units. It should be noted that the hospital is sponsored by the Catholic church, and is administered by an order of Catholic Sisters (with the assistance of full-time professional managers and administrators hired by the hospital). The Sister in charge of patient service quality, mission, and hospital public relations, discussed this research project with the hospital's management. She gave her personal endorsement of the project at a monthly "all hospital managers meeting." Previous employee surveys endorsed by the Sister achieved response rates in excess of 70%. The average response rate for the seven nursing units in this study, however, was 60.1%, which produced 74 usable questionnaires.

Managers were given bundles of questionnaires to take back to their respective nursing units. Each questionnaire

was folded inside a 6" x 9" Manila envelope. The envelopes contained a "memo," specifically designating who should complete the questionnaire and where it should be sent after completion (see Appendix B). The bundles of envelopes were wrapped in a removable paper sheath, on which was written the name of the specific nursing unit section to which the questionnaire was destined. Each questionnaire was numerically coded so the researcher would know from which nursing unit it had come. Each questionnaire also asked the respondent to indicate whether they were a management/supervisory employee or whether they were a nonmanagement/nonsupervisory employee.

All respondents, whether management or nonmanagement employees, were asked to send the completed questionnaire via the hospital's internal mail system, to the assistant administrator of human resources. This researcher collected the completed questionnaires from the hospital's human resource office and personally scored each. The researcher also tabulated and carried out a statistical analysis of the questionnaire data.

Statement of the Hypothesis

The reason for gathering these data, of course, is for use in hypothesis testing. Kerlinger (1986) suggests that the principal use of inferential statistics in research is to test research hypotheses. The hypothesis being tested in this research project can be stated as follows:

HO: The null form of the hypothesis is: There is no significant relationship, with respect to service quality value congruence between hospital managers/supervisors and patient service employees, and the perceived quality of services provided by these employees.

H1: The research form of the hypothesis is: There is a significant relationship, with respect to service quality value congruence between hospital managers/supervisors and patient service employees, and the perceived quality of services provided by these employees.

Data Analysis

Separate mean service quality values scores were derived for the management/supervisory employee cohort and

nonmanagement/nonsupervisor employee cohort in each of the hospital's seven nursing units. The specific procedure for deriving these scores is detailed in the "Operational Measures of Variables" section of this chapter.

The absolute value of the difference between the mean service quality value scores of managers/supervisors and patient service employees in a given nursing unit is the value congruence score for that nursing unit. A value congruence score (the independent variable) is calculated in this fashion for each of the hospital's seven nursing units.

Patient service quality scores for each of the hospital's seven nursing units (the dependent variable) are derived from the patient service quality averages published by Press, Ganey Associates (see the "Operational Measures of Variables" section of this chapter). This dissertation research used patient service quality data published in closest chronological proximity to the period during which the service quality values data were gathered from questionnaires administered to hospital staff.

For each of the hospital's seven nursing units, its "patient service quality score" (the dependent variable) is compared to the nursing unit's "service quality value

congruence" score (the independent variable). The method used for ascertaining the correlation between these two variables is least squares regression.

The object of least squares linear regression is to obtain a straight line that best fits the data (Hamburg, 1983). The equation describing such a straight line designates the best fitting linear relationship between the *X* and *Y* values (Williams, 1986). The linear model fitted in this research project is shown below in Equation 2:

$$Y_i = a + bV_i + \varepsilon_i \qquad (2)$$

In Equation 2, the *Y* term designates the mean patient service quality score, which is the dependent variable. The *V* term in this equation designates the degree of service quality value congruence between managers/supervisors and patient service employees (the independent variable).

An analysis of regression results was conducted to determine whether the *b* value of the regression equation (i.e., the slope of the regression line) differs significantly from 0. The null hypothesis is that the value

of the slope of the regression line, *b*, is not significantly different from 0. The research hypothesis is that the value of the slope of the regression line, *b*, is significantly different from 0. The null hypothesis and research hypothesis can also be expressed as follows:

$$H0: b = 0$$

$$H1: b \neq 0$$

The rejection region for the null hypothesis is at the .05 level of significance (.025 on each tail of the distribution).

All statistical calculations for this research were carried out using Minitab statistical software.

CHAPTER IV

RESULTS

Data obtained from service quality values questionnaires (see Appendix B) and from patient service quality questionnaires (see Appendix A) are the focus of this chapter. These data, presented in aggregate form, have been subjected to both descriptive and inferential analysis, the results of which are also presented in this chapter.

Calculations

Table 1 delineates the degree of service quality value congruence, V, between patient service employees and their managers/supervisors, in each of the hospital's seven nursing units, as well as presenting the average patient service quality rating for each of the hospital's seven nursing units.

Table 1. Operational Measures for Each Nursing Unit.

Nursing Unit	V	Average Patient Service Quality Rating
1	6.57	90.40
2	6.28	87.70
3	6.42	87.50
4	6.71	87.20
5	6.82	85.60
6	5.59	84.60
7	6.87	84.10

A linear equation was suggested by Dodson (1996) for modeling the relationship between the variables shown in Table 1. This linear model, which assigns a quantitative value for service quality in each hospital nursing unit to the variable Y_i (where i designates the nursing unit), and which predicts service quality as a function of V_i, is shown in Equation 1:

$$Y_i = a + bV_i + \epsilon_i \qquad (1)$$

The estimated parameters (*a and b*) of the linear model formulated in Equation 1 are shown in Table 2. The calculated *t*-statistic for the slope of the regression line *(b)*, as well its corresponding significance level, are also presented in Table 2.

Table 2. Results of Regressing Patient Service Quality Rating Scores on Value Congruence Scores.

Parameter	Estimate	*t*-statistic	Significance
b	0.590	0.270	0.798
a	82.930		

Regression Results

The slope of the model is estimated to be 0.590, and the y-intercept is estimated to be 82.930. Therefore, the linear model, which estimates service quality as a function of the degree to which management and patient service employees share service quality values, is as follows:

$$y_i = 82.930 + 0.590 V_i + \epsilon_i \qquad (2)$$

The fit of this linear model is illustrated by the information presented in Figure 1. As such, the linear model estimated by Equation 2 is shown as a straight line in Figure 1. Moreover, actual data from the seven nursing units in the study are represented by the solid bullets.

It is necessary to determine whether the estimated slope of the regression line, 0.590, is significantly different from zero, at a significance level of $\alpha = 0.05$. For a two-tailed *t*-test, with 5 degrees of freedom (7 - 2), and a significance level of $\alpha = 0.05$ (0.025 on each tail), the critical *t* values are -2.57 and +2.57.

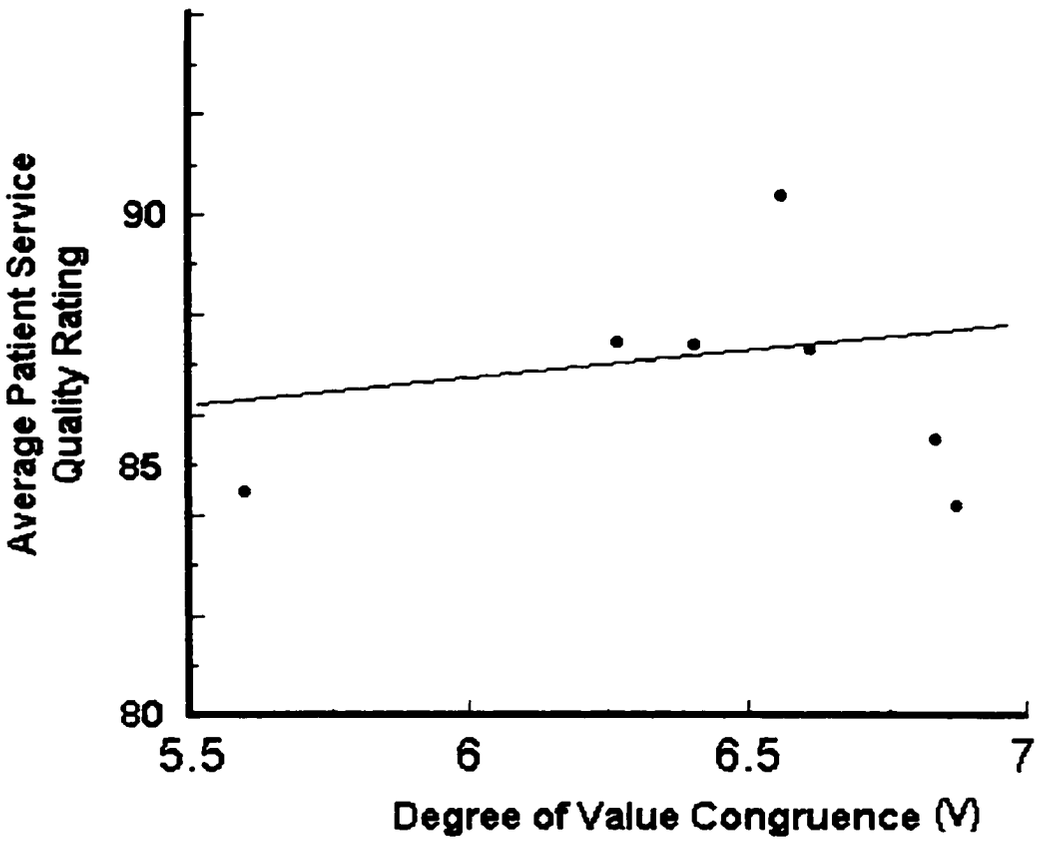

Figure 1: Least Squares Regression Model.

The computed *t*-statistic, 0.270, falls within the critical region. The null hypothesis, therefore, cannot be rejected. In other words, this study does not provide sufficient evidence to conclude that *b* is not equal to zero. As such, there is not enough evidence generated by the results of this study to conclude that a statistically

significant relationship exists between patient service quality ratings and the degree to which patient service employees and their managers/supervisors share service quality values.

It should be noted that the results of this research are consistent with those obtained by Dodson (1996), in research conducted at a university research and teaching hospital in the southeastern United States.

Analyzing and Interpreting Results

As was mentioned in the above paragraph, Dodson's (1996) research failed to reject the null hypothesis of no relationship between service quality value congruence and patient service quality. In an effort to explain why his hospital research generated negative findings, Dodson implicated one of the research instruments used by Braunlich (1990). In this regard, Dodson speculated that, because Braunlich used a customer service quality instrument, the validity and reliability of which had not been scientifically established, instrument bias could be

responsible for Braunlich's research results (i.e., Braunlich reported a statistically significant link between management/employee service quality value congruence and customer service quality in luxury hotels).

For his research, Dodson (1996) used a patient service quality instrument developed and validated by Pyzdek (1994). Dodson reported that the instrument's Chronbach alpha was in excess of 0.78. Dodson was quite confident, therefore, that measurements generated by the instrument were both accurate and reliable.

It is <u>not</u> thought that a failure of the present study to reject the null hypothesis is due to any biasing effects of the instrument used to measure patient service quality. Indeed, the 54 item questionnaire used to measure patient service quality in the present study (Appendix A) possesses face validity, construct validity, and criterion validity (Kaldenberg, 1996). The questionnaire also possesses a Chronbach alpha calculated to be in excess of 0.95 (Press, Ganey Associates, 1996), indicating a very high level of reliability.

Dodson (1996) also speculated that his results may have differed from those obtained by Braunlich (1990), by virtue of the fact that he was able to use random sampling, with nearly a 100% patient response rate, while the respondents in Braunlich's nonprobability sample returned their service quality instruments on a voluntary basis.

In the Braunlich (1990) study, nonprobability sampling from a population of hotel guests, was essentially unavoidable, because of constraints placed upon the researcher, who could not personally contact or compel a paying hotel customer to complete the service quality instrument. Kerlinger (1986) concedes that nonprobability sampling methods are often necessary, and that the implicit weaknesses of nonprobability sampling can be attenuated by careful selection of samples, as well as by the replication of such studies with other samples.

Dodson (1996) also speculated that Braunlich's (1990) results might have been biased by the service quality instrument's low hotel guest response rate. Braunlich (1990)

did not, in fact, report a response rate for his service quality instrument.

It should be noted that the return rate for the service quality instrument (Appendix A) used in the present study was approximately 30.5%. Even so, it is not thought that the patient service quality instrument response rate was, in itself, a particularly significant influence on the outcome of the present study. The patient service quality instrument response rate did not significantly color or compromise the research and, therefore, cannot be held accountable for present study's negative results. Dodson (1996), it must be noted, reported a virtual 100% response rate for his patient service quality instrument, and obtained essentially the same results as the present study, (i.e., a lack of evidence for rejecting the null hypothesis).

Braunlich (1990) and Dodson (1996) both discuss, at length, the role of customer quality-related expectations in influencing service quality ratings. The role of customer quality-related expectations is delineated in a number of service quality models (e.g., Lewis and Booms, 1983;

Gronroos, 1982; Smith and Houston, 1982). These models all have in common the basic tenant that service quality perceptions are largely a consequence of the extent to which the level of actual service matches the customer's subjective expectations of what the level service should have been.

Dodson (1996) also considers the possibility that his negative results might be attributable to the fact that customer expectations were higher among hospital patients than among luxury hotel customers. He implies that lower standards of satisfaction among hotel customers in the Braunlich (1990) study may have led to Braunlich's research finding of a significant link between value congruence and perceived service quality. However, Dodson offers no supporting evidence from his research, or from the data obtained in luxury hotels by Braunlich.

In the opinion of this researcher, to adequately assess customer expectation levels, and thereby fairly evaluate Dodson's contention that his research subjects may have had higher service quality-related expectations than Braunlich's

subjects, data would be required from research beyond the scope of Dodson's (1996) study. Indeed, Tenner and DeToro (1992) observe that customer expectations can only be understood thoroughly by examining data generated with instruments specifically designed to measure customer expectation levels.

Dodson (1996) also speculates that the inability of his research to establish an empirical basis for rejecting his null hypothesis might have something to do with its being conducted in 19 departments of only one hospital. Dodson's research design contrasts markedly, in this respect, with Braunlich's (1990) study, in which the responses of research subjects were taken from 20 luxury properties of the Four Seasons Hotel chain. These hotels, moreover, were located throughout the United States, Canada, and England.

Dodson (1996) suggests that top management at the southeastern university research and teaching hospital in which his research took place, may have exerted such strong influence on the entire hospital, that patient service quality levels, in the departments he studied, were

precluded from manifesting sufficient amounts of variation, for the hypothesized relationship between patient service quality and service quality values to be detected.

In the opinion of this researcher, Dodson's (1996) speculation, pertaining to the hospital-wide influence of top management, places him on the right track toward offering a plausible explanation of why his results were at variance with those obtained by Braunlich (1990). Dodson is correct, therefore, in assuming that value homogenizing influences exerted by top hospital management have the potential to confound results from this type of values research. However, Dodson may be missing the point, by appearing to suggest that management influence is implicated only to the lack of variation in patient service quality scores. A more accurate statement, in the opinion of this researcher, is that the influence exerted by upper level hospital management is probably a factor in a lack of variation in value congruence scores as well. There is, in fact, a body of literature specifically proclaiming the ability of upper management to strongly influence the values

of management and nonmanagement employees alike (Norman, 1984; Haskett, 1986; Hallowell, et al., 1996).

Empirical evidence from Dodson's (1996) own study, and from the present study, seems to illustrate management's ability to exert standardizing influences on patient service quality scores and on value congruence scores as well. For example, when this researcher calculated a coefficient of variation (*CV*) for the value congruence and patient service quality scores generated by Dodson's research, it became evident that the dispersion of his patient service quality scores (8.4%) was greater than the dispersion of the value congruence scores (6.0%). Conversely, the dispersion of patient service quality scores in the present study, as measured by the coefficient of variation, was 2.5%. However, this was less than the dispersion of value congruence scores in the present study (7.0%).

The point suggested in the above paragraph is that Dodson (1996) is probably correct in assuming that high-level hospital management can exert hospital-wide influence, potentially confounding research results, by dampening

variation in service quality scores from the hospital's patient service departments. Even so, results presented in the preceding paragraph seem to show that upper management's influence can dampen variation in value congruence scores as well.

Chapter V

SUMMARY, DISCUSSION, AND SUGGESTIONS FOR FUTURE RESEARCH

Summary

A fundamental objective of this research has been to investigate the relationship between service quality value congruence and perceived patient service quality at a small, private hospital in the Pacific Northwest.

In this research, value congruence was defined as the difference between management/supervisor service quality values and those of front line patient service employees. The smaller this difference, the greater was assumed to be the level of value congruence.

Service quality values were measured by administering a semantic differential instrument developed by Braunlich (1990) and adapted by Dodson (1996) for research in a hospital context. Each of the six attitude objects comprising this instrument was differentiated by nine pairs of polar opposite adjectives arrayed on a seven-point scale

(Appendix B). The resulting score, in essence, a service quality values score, measures the respondent's disposition toward service quality-related concepts. Patient service employees and managers, working in the hospital's seven nursing units, completed a service quality values instrument (Chapter III details criteria for inclusion in this sample).

Patient service quality data were obtained from questionnaires sent to hospital inpatients subsequent to discharge from the hospital (Appendix A). The discharged patients were asked to return their questionnaires to the hospital in stamped self-addressed envelopes, which were in turn sent to Press, Ganey Associates (a hospital vendor) for further processing. Press, Ganey Associates, on a quarterly basis, provides the hospital with quantitative results from the data gathering process. These results are promulgated in the form of computer generated statistical reports.

Discussion

This research project has sought to answer the question: is there a relationship between the degree of

value congruence between patient service employees and their managers and the quality of services provided by patient service employees? Despite the fact that such a relationship was established empirically in the hotel industry by Braunlich (1990), results from the present study do not support its existence in a hospital context. As such, regressing patient quality ratings for the hospital's seven nursing units on corresponding service quality value congruence scores, did not produce a statistically significant result.

Even though this negative outcome is consistent with the negative results obtained by Dodson (1996), it is troublesome because it is inconsistent with research results obtained in the hotel industry by Braunlich (1990). The present study's negative outcome is also at variance with a body of corporate culture research literature. For example, Deal and Kennedy (1982) concluded from their research that shared values between management and employees are typically an integral element of an organization's overall effectiveness.

Schneider's (1980) research pointed to the fact that service value congruence in an organization is strongly related to the presence of a service culture which, according to Schneider, produces benefits for customers and employees alike. Schneider observed that service quality values tend to incorporate themselves into an organization's culture, thereby influencing employee behavior in ways that ultimately result in high quality services and high levels of customer satisfaction.

Suggestions for Future Research

In the opinion of this researcher, a strong argument exists for replicating the present study. The replication should be carried out, however, in a hospital context where the influence of upper management is not as likely to confound research results by attenuating variation in the sample's value congruence and patient service quality scores.

Dodson (1996) suggests, in this regard, that results constituting evidence for rejecting the null hypothesis

might be obtained by research conducted in an alternate hospital context. He lists several such hospital contexts, which he believes may be appropriate environments in which to carry out this research.

The first prospective context, according to Dodson (1996), is a private hospital, especially one having dramatically fewer beds than the large university research and teaching hospital from which he drew his sample. Dodson also suggests that research conducted at hospitals located in areas of the United States, other than the southeast, could produce markedly different results.

Even so, the present study was conducted at a small private hospital in another region of the United States (see Chapter III). It failed, nevertheless, to produce sufficient evidence for rejecting the null hypothesis. The inabiliy of Dodson's (1996) study, and of the present study, to reject the null hypothesis is unlikely, therefore, to be a consequence of hospital size, funding base, or geographic location.

Finally, Dodson (1996) suggests that an attempt be made to replicate his research at a health maintenance organization (HMO) patient care facility. It is the opinion of this researcher, however, that there is little evidence (nor does Dodson offer any specific evidence) of special characteristics that would render research conducted at a specific health maintenance organization (HMO) hospital more likely to produce results that support rejecting the null hypothesis.

In the opinion of this researcher, when considering future research designed to test the relationship between value congruence and patient service quality in a hospital setting, there is probably little point in continuing the practice of selecting research subjects from only a single hospital. Dodson's (1996) study, as well as the present study, have both employed this research strategy. However, both studies have produced decidedly negative findings. Moreover, these findings seem to be inconsistent with established theory (Mills, 1986; King, 1987; Alban, 1994) and with earlier empirical research, such as that conducted in the hotel industry by Braunlich (1990).

Why Braunlich (1990) was able to establish this link in the hotel industry, while Dodson (1996) and the present study were unable to do so in a hospital context, is a logical question to ask. As such, it seems appropriate to consider which aspects of Braunlich's research design might have facilitated his being able to reject the null hypothesis. It is thought that a critical difference in Braunlich's research design may have been that his service quality values and customer service quality data were gathered by sampling the staff and customers of 20 separate hotels.

It seems likely, therefore, that the degree of variation in Braunlich's (1990) service quality values scores, and in his customer service quality scores, was more pronounced than variation among the 19 hospital departments in the Dodson (1996) study, or among the seven nursing units in the present study. Consequently, the conventional statistical methods employed by Braunlich, which included t-tests, Chi-square tests, and Pearson product-moment correlations, measured greater levels of variation than

existed in Dodson's study or in the present study. It seems likely, therefore, that it was the degree of variation among the 20 hotels in his sample that helped produce the statistically significant results reported by Braunlich.

Conversely, the lower levels of variation evidenced in Dodson's (1996) sample, and in the present study, were not likely to be deemed significant by conventional statistical techniques. This suggests that future research should be designed to measure research variables in several separate hospitals. In other words, data for service quality value congruence and perceived patient service quality should be obtained from separate hospitals, rather than from several patient service sub-organizations within a single hospital.

Those who have conducted research in a hospital context understand the daunting challenges it presents. One of the most formidable difficulties is associated with securing permission from appropriate hospital officials to gather the required data. Obtaining such permission is not easy, nor is it likely to become any easier in the foreseeable future.

Research, such as that described in this dissertation, should probably be attempted, therefore, only by those with a personal entree (e.g., employed as a high-level hospital administrator), or by persons whose sponsors can ensure cooperation and access to several hospitals simultaneously.

It is suggested that prospective researchers consider approaching the top management of a large health maintenance organization (HMO) to secure simultaneous access to several of the HMO's hospitals. Similarly, permission to conduct research in several hospitals simultaneously might be obtained by approaching the top management of a large private chain of "for profit" hospitals.

With respect to health maintenance organization hospitals and private for profit hospitals, prospective researchers should be prepared in advance for the constraints and conditions likely to be placed upon them. Since quality-related information is very often a competitive tool in today's hospital environment, researchers would be wise to anticipate that restrictions may be placed on publishing the identity of the hospital(s)

in which such data are gathered. Restrictions may also be placed on the form in which the data are allowed to be published, if the open publication of research results is allowed at all.

Hospital vendors, such as Press, Ganey Associates, are involved in the continuous development of tools designed to support managerial decision making in a health care context (Press, Ganey Associates Inc., 1995). To encourage hospital participation in the development new surveys and other instruments, Press, Ganey Associates offer discounts on services, if the hospital will, in turn, aid them in developing new health care survey instruments (Press, Ganey Associates, Inc., 1995). Any vendor who could offer hospitals incentives to participate would probably be well positioned to secure the cooperation of several such hospitals in value congruence/service quality research.

Another avenue that could be pursued by individuals attempting to secure permission to conduct hospital service quality research, involves soliciting the cooperation of appropriate religious organizations. Some religious

organizations, of course, sponsor and administer health care facilities. For example, the Catholic church operates a number of hospitals located throughout the United States. Such hospitals may have limited budgets and little extra money to spend on quality-related research. They may, therefore, welcome an opportunity to share the researcher's results - information which these hospitals might not otherwise be able to afford. Moreover, individuals who administer and operate hospitals with religious affiliations are sometimes imbued with an unusually strong sense of social and community responsibility, which may increase the researcher's odds of obtaining permission to conduct worthwhile research.

Although the author of this dissertation is obviously endeavoring to point out potential difficulties associated with conducting patient service quality research in hospitals, this should not be construed as an attempt to dissuade others from conducting such research. It should be seen, rather, as an effort by the author of this doctoral dissertation to apprise future researchers of impediments likely to be encountered. The prospect of understanding more

about the power of shared values to leverage, often at very little cost, the level of patient service quality, is simply too compelling and too important for future research to be truncated or placed in abeyance.

APPENDIX A

PATIENT SERVICE QUALITY INSTRUMENT

Discharge Date _____ Unit ___

Our Lady Of Lourdes
520 North Fourth Avenue
Pasco, WA 99301

PATIENT OPINION SURVEY

INSTRUCTIONS: Please rate the following services you received while in our hospital. Circle the number that best represents your feeling. If you had no experience with a particular item, skip to the next question. Also comment on any negative or positive experience you might have had in each area. When you've completed the survey, please mail it back to us in the enclosed envelope. THANKS!

General Questions (fill in)

1. Your room number? _____
2. Number of days in hospital? _____
3. Your first stay here? (Yes/No) _____
4. Were you admitted through the emergency room (Yes/No) _____
5. Have a roommate? (Yes/No) _____
6. On a special diet here? (Yes/No) _____
7. Your sex? (Male/Female) _____
8. Your age? _____

A. Admissions	very poor	poor	fair	good	very good
1. Speed of the admissions process	1	2	3	4	5
2. Courtesy of admissions personnel	1	2	3	4	5

Comments (describe good or bad experience): _____

B. Your Room	very poor	poor	fair	good	very good
1. Cheerfulness	1	2	3	4	5
2. Daily cleaning	1	2	3	4	5
3. Courtesy of the person who cleaned your room	1	2	3	4	5
4. Room temperature	1	2	3	4	5
5. Noise level in and around room	1	2	3	4	5
6. How well things worked (T.V. lights, call button, bed, etc.)	1	2	3	4	5

If there is an equipment problem, please specify item in your comments.
Comments (describe good or bad experience): _____

C. Diet and Meals	very poor	poor	fair	good	very good
1. Explanations given about your diet (if on a special diet)	1	2	3	4	5
2. Temperature of the food (cold foods cold, hot foods hot, etc.)	1	2	3	4	5
3. Quality of food	1	2	3	4	5
4. Likelihood of getting the food checked on menu (Please answer only if you were here two or more days)	1	2	3	4	5

Comments (describe good or bad experience): _____

D. Nursing Care	very poor	poor	fair	good	very good
1. Friendliness of the nurses	1	2	3	4	5
2. Promptness in responding to the call button	1	2	3	4	5
3. Nurses' attitude toward your calling them	1	2	3	4	5
4. Degree to which the nurses took your health problem seriously	1	2	3	4	5
5. Amount of attention paid to your special or personal needs	1	2	3	4	5
6. Degree to which nurses kept you adequately informed about tests, treatment, and equipment	1	2	3	4	5
7. Technical skill of the nurses	1	2	3	4	5

Comments (describe good or bad experience): _____

E. Tests and Treatments	very poor	poor	fair	good	very good
1. How well your blood was taken (quick, little pain, etc.)	1	2	3	4	5
2. Courtesy of the person who took your blood	1	2	3	4	5
3. How well IVs were started (quick, little pain, etc.)	1	2	3	4	5
4. Courtesy of the nurse who started the IV	1	2	3	4	5
5. Length of time you had to wait in the X-ray department	1	2	3	4	5
6. X-ray technicians' concern for your comfort	1	2	3	4	5
7. Adequacy of explanations of tests and treatments	1	2	3	4	5

Comments (describe good or bad experience):

F. Other Services	very poor	poor	fair	good	very good
1. Volunteers	1	2	3	4	5
2. Physical Therapy	1	2	3	4	5
3. Respiratory care	1	2	3	4	5
4. Social services	1	2	3	4	5
5. Pastoral Care services	1	2	3	4	5
6. Staff who transported you to and from your room	1	2	3	4	5

Comments (describe good or bad experience):

G. Visitors and Family	very poor	poor	fair	good	very good
1. Courtesy of the people at the information desk in the lobby	1	2	3	4	5
2. Adequacy of visiting hours	1	2	3	4	5
3. Accommodations and comfort for visitors	1	2	3	4	5
4. Nursing attitudes toward your visitors	1	2	3	4	5
5. Information given your family about your condition & treatment	1	2	3	4	5
6. Visitors' rating of the hospital cafeteria	1	2	3	4	5
7. Proper attire worn by individuals taking care of you	1	2	3	4	5
8. Courtesy of the people at the nurses' station	1	2	3	4	5

Comments (describe good or bad experience):

H. Your Physician	very poor	poor	fair	good	very good
1. Amount of time your physician spent with you	1	2	3	4	5
2. Physician's concern for your questions and worries	1	2	3	4	5
3. How well the physician kept you informed about treatments	1	2	3	4	5
4. How informative physician was in dealing with your family	1	2	3	4	5

Comments (describe good or bad experience):

I. Discharge	very poor	poor	fair	good	very good
1. Hospital's concern not to discharge you too soon	1	2	3	4	5
2. When you were told you could go home, the time you had to wait before you were able to leave the hospital	1	2	3	4	5
3. Advice you were given about how to care for yourself at home	1	2	3	4	5
4. Courtesy and assistance you received from the business office	1	2	3	4	5

Comments (describe good or bad experience):

J. Some Final Ratings	very poor	poor	fair	good	very good
1. Overall cheerfulness of the hospital	1	2	3	4	5
2. Overall cleanliness of hospital	1	2	3	4	5
3. Staff concern for your privacy	1	2	3	4	5
4. Staff concern for spiritual needs	1	2	3	4	5
5. Staff sensitivity to the inconvenience that health problems and hospitalization can cause	1	2	3	4	5
6. Likelihood of your recommending this hospital to others	1	2	3	4	5

Comments (describe good or bad experience):

THANK YOU FOR MAKING A DIFFERENCE. You have the option, if you wish, of giving us your name and address. This information is welcome but not necessary.

APPENDIX B

SERVICE QUALITY VALUES INSTRUMENT

MEMO

To: Our Lady Of Lourdes Health Center Employees and Managers
From: Morris D. Davis
Subject: Quality Values Questionnaire
Date:

The enclosed questionnaire is being used for hospital service quality research. It should be completed by those **FULL-TIME nonmanagement** and **management** employees working in the hospital's patient service departments. Please note that the **FULL-TIME nonmanagement** employees completing this questionnaire should have jobs in which at least 25 percent of their time, on average, is spent interacting with patients. **Managers** and **supervisors** completing the questionnaire should have been in their present position for at least 3 months.

To ensure that your responses remain anonymous, please seal your completed questionnaire in the brown envelope. Do not place your name on the questionnaire or the envelope. Use this hospital's internal mail system to send the sealed envelope to: **ASSISTANT ADMINISTRATOR, HUMAN RESOURCES.** The unopened envelopes will subsequently be turned over to me, so that I can perform a statistical analysis of the data they contain.

Data contained in these questionnaires will be aggregated. As such, no individual response to a questionnaire item can be identified. The aggregate data are essential for my doctoral dissertation research project and should also be useful to Our Lady Of Lourdes Health Center in its quality enhancement efforts. If you have any questions, please contact me at 946-0415.

I hope each and every one of you will accept my sincere thanks for your co-operation in this research!

Please check one of the following boxes prior to filling out the remainder of this answer sheet.

- ❑ **Management/Supervisory Employee**
- ❑ **Nonmanagement/Nonsupervisory Employee**

For Office Use Only - Do not mark in this space
Department:

Directions

On your answer sheet, there are words in **bold** letters at the TOP of each section. You will also notice that there are pairs of opposite words underneath the **bold font** words. Between each of the pairs of opposites, there are 7 spaces. You are to place an "X" in one of the 7 spaces to indicate your feeling about how the word at the top fits on the scale.

In the following example, a check has been placed to illustrate how someone would place marks if the person believed a tiger was something very bad, somewhat fast, and halfway between kind and cruel.

Tiger

Good |-----|-----|-----|-----|-----|-----|--X--| Bad

Fast |-----|-----|--X--|-----|-----|-----|-----| Slow

Kind |-----|-----|-----|--X--|-----|-----|-----| Cruel

On your answer sheet, place your check marks rapidly. What is wanted is your first impression. There are no "right" or "wrong" answers. Be sure to make only one check mark for each pair of opposite words. Do not skip any pairs of words. Do not put your name on this answer sheet.

MY JOB

Pleasant	|-----|-----|-----|-----|-----|-----|-----|	Unpleasant
Dishonest	|-----|-----|-----|-----|-----|-----|-----|	Honest
Strong	|-----|-----|-----|-----|-----|-----|-----|	Weak
Important	|-----|-----|-----|-----|-----|-----|-----|	Unimportant
Unfriendly	|-----|-----|-----|-----|-----|-----|-----|	Friendly
Fast	|-----|-----|-----|-----|-----|-----|-----|	Slow
Positive	|-----|-----|-----|-----|-----|-----|-----|	Negative
Unfair	|-----|-----|-----|-----|-----|-----|-----|	Fair
Inferior	|-----|-----|-----|-----|-----|-----|-----|	Superior

SERVICE TO THE PATIENT

Pleasant	|-----|-----|-----|-----|-----|-----|-----|	Unpleasant
Dishonest	|-----|-----|-----|-----|-----|-----|-----|	Honest
Strong	|-----|-----|-----|-----|-----|-----|-----|	Weak
Important	|-----|-----|-----|-----|-----|-----|-----|	Unimportant
Unfriendly	|-----|-----|-----|-----|-----|-----|-----|	Friendly
Fast	|-----|-----|-----|-----|-----|-----|-----|	Slow
Positive	|-----|-----|-----|-----|-----|-----|-----|	Negative
Unfair	|-----|-----|-----|-----|-----|-----|-----|	Fair
Inferior	|-----|-----|-----|-----|-----|-----|-----|	Superior

THIS HOSPITAL

Pleasant	|-----|-----|-----|-----|-----|-----|-----|	Unpleasant
Dishonest	|-----|-----|-----|-----|-----|-----|-----|	Honest
Strong	|-----|-----|-----|-----|-----|-----|-----|	Weak
Important	|-----|-----|-----|-----|-----|-----|-----|	Unimportant
Unfriendly	|-----|-----|-----|-----|-----|-----|-----|	Friendly
Fast	|-----|-----|-----|-----|-----|-----|-----|	Slow
Positive	|-----|-----|-----|-----|-----|-----|-----|	Negative
Unfair	|-----|-----|-----|-----|-----|-----|-----|	Fair
Inferior	|-----|-----|-----|-----|-----|-----|-----|	Superior

PATIENT SATISFACTION

Pleasant	|-----|-----|-----|-----|-----|-----|-----|	Unpleasant
Dishonest	|-----|-----|-----|-----|-----|-----|-----|	Honest
Strong	|-----|-----|-----|-----|-----|-----|-----|	Weak
Important	|-----|-----|-----|--- -|-----|-----|-----|	Unimportant
Unfriendly	|-----|-----|-----|-----|-----|-----|-----|	Friendly
Fast	|-----|-----|-----|-----|--- :-----|-----|	Slow
Positive	|-----|-----|-----|-----|-----|-----|-----|	Negative
Unfair	|-----|-----|-----|-----|-----|-----|-----|	Fair
Inferior	|-----|-----|-----|-----|-----|-----|-----|	Superior

HOSPITAL PATIENTS

Pleasant	I-----I-----I-----I-----I-----I-----I-----I	Unpleasant
Dishonest	I-----I-----I-----I-----I-----I-----I-----I	Honest
Strong	I-----I-----I-----I-----I-----I-----I-----I	Weak
Important	I-----I-----I-----I-----I-----I-----I-----I	Unimportant
Unfriendly	I-----I-----I-----I-----I-----I-----I-----I	Friendly
Fast	I-----I-----I-----I-----I-----I-----I-----I	Slow
Positive	I-----I-----I-----I-----I-----I-----I-----I	Negative
Unfair	I-----I-----I-----I-----I-----I-----I-----I	Fair
Inferior	I-----I-----I-----I-----I-----I-----I-----I	Superior

THE "REGULAR" PATIENT*

Pleasant	-----	Unpleasant
Dishonest	-----	Honest
Strong	-----	Weak
Important	-----	Unimportant
Unfriendly	-----	Friendly
Fast	-----	Slow
Positive	-----	Negative
Unfair	-----	Fair
Inferior	-----	Superior

* A Frequently or Chronically Hospitalized Patient

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