

Managing patient-to-patient interaction: the waiting room experience

By Richard Nicholls

INTRODUCTION

Since the start of the customer care trend in the early 1980s, over the last three decades there has been increasing attention to understanding and managing the customer experience in services. This has included training frontline employees to be more friendly and customer-minded; designing service settings to be more inviting for customers; and designing the service delivery process to be more convenient and intuitive for customers. The customer care trend has embraced much of the service sector, including the healthcare sector.

Whilst managing the interaction between the employee and the patient has long been a concern of healthcare service managers operating in market-driven environments, managing the interactions occurring between the patients themselves has received far less attention (Nicholls, 2010). Indeed, the very notion of managing interactions between customers only started to receive serious attention from management academics following the publication of an article devoted to the topic in 1989 by Martin and Pranter. In post-socialist service cultures, where during the economic transition service managers were faced with the Herculean task of rehabilitating the employee-to-customer (E2C) relationship, the task of managing the C2C relationship, understandably, received less attention. But as the service sectors of these economies have rapidly caught up with the more established service economies, new areas for improving service quality, such as managing interactions between customers, are increasingly sought.

In healthcare services interactions between customers or patients take a wide variety of forms and contexts. Typical contexts include:

- Discussion of the merits of various medical service providers (so-called 'word of mouth')
- Interactions in healthcare centre waiting rooms
- Interactions in the waiting room of an emergency department (A&E)
- A stay in a hospital ward
- A stay in a sanatorium

This article focuses on the waiting room experience of patients as they wait to see their GP or dentist, or wait for a service such as an x-ray or a specialist consultation.

SIX CATEGORIES OF CUSTOMER-TO-CUSTOMER INTERACTION (CCI)

To consider the range of customer-to-customer interaction (CCI) which may be occurring in healthcare waiting room environments it is useful to consider six main categories of customer-to-customer interactions: *time*; *space*; *verbal behaviour*; *information*; *assistance*; and *non-customer activity* (Nicholls, 2005). Below are some illustrations of each category for the healthcare waiting context.

Time: Time-related CCI can involve issues such as queue order and queue conventions, and the fairness of waiting/queuing regulations. Time-related CCI can also involve the impact of customer

behaviour at the service delivery point. For example: how long it takes a patient to conduct their business at the healthcare centre reception counter; or whether the time of their appointment is kept.

Space: Space and territory concepts are relevant to many aspects of waiting areas. They can include having a place to sit rather than standing due to other patients over-occupying the available seating. Space can also include *use-space*. This term refers to the space that we need to control or influence in order to benefit from the service. Use space is usually associated with one or more of the physical senses. In a healthcare context it can include: other patients in the waiting area not being disruptive (e.g. children not being too noisy; no excessive use of mobile phones; or the absence of loud behaviour); or being able to have a conversation with the receptionist or the doctor with an adequate degree of privacy. It also includes not having waiting customers enter the doctor's room when another patient is there.

Verbal behaviour: Verbal behaviour refers to such things as the suitability and desirability of conversations occurring between customers in the service setting. In terms of a healthcare waiting room it could range from enjoying a pleasant chat with another patient, to having to put up with vulgar or inappropriate conversations occurring between other patients.

Information: The exchange of information between customers in a service setting is generally of a positive nature. In healthcare settings patients help other patients with information such as where to queue and how many patients are in the queue, or how long the wait is (e.g. "today there is only one doctor, so the waiting time is about 2 hours"), or how the service system works (e.g. whether or not patients need to collect their records to take them to the doctor). Some patient-to-patient exchange may be about how to use something, such as a self-service check-in system.

Assistance: This category generally refers to customers doing things to help other customers. Sometimes situations occur in waiting rooms where patients help each other out. Such behaviours include: offering seats to those who seem to be in greater need of them; checking that a fellow patient is OK (some patients faint or feel weak whilst waiting); moving to a different seat so that a family can sit together. Assistance can also include being a 'good Samaritan', for example: offering a patient in pain to see the doctor before their turn.

Non-customer activity: This category refers to 'customers' who, whilst they may be in the service setting, are not primarily there to use the service in the intended way. For some services this is a rather rare occurrence. It seems unlikely to occur in many healthcare waiting room situations but it could include behaviour such as: a passer-by entering the waiting area just to use the toilet; thieves entering the waiting room and stealing items such as coats; or, plausibly, journalists posing as waiting patients to get medical information on famous people.

Whilst not all of the above patient-to-patient behaviours can easily be influenced by healthcare providers, some of them can, and indeed, must be.

TWO KEY ASPECTS OF PATIENT-TO-PATIENT INTERACTION

Having briefly outlined the wide range of C2C interactions which may occur in healthcare waiting situations, this article will now examine in more detail two key aspects of the healthcare waiting room experience, namely: (1) concern for patient privacy and confidentiality, and (2) concern for fairness of waiting time.

Confidentiality:

Confidentiality is well established as a management issue in healthcare settings, and the reception and waiting zones are recognised as vulnerable areas for the breach of confidentiality. Scott, Dyas, Middlemass and Siriwardena (2007) point out that breaches of confidentiality in healthcare settings can take the form of staff-to-patient contact, staff-to-staff contact and patient-initiated contact. From a CCI perspective it is an issue of information about one patient becoming known to another patient.

Confidentiality in health services can include a range of issues. It may be a question of a patient not wanting their personal data, such as name, date of birth or address, to be revealed to other waiting patients. Or it may be more a matter of not wanting the sensitive nature of their visit or medical condition revealed or even hinted at. For example, a patient may simply be wishing to hand-in a urine sample in a discrete way. Some types of medical service are likely to have greater confidentiality concerns than others. For example, a patient visiting to a dentist will generally be less concerned with confidentiality than a patient visiting a gynaecologist or urologist.

The design of the waiting area can significantly reduce the likelihood of confidentiality being breached. Practical design solutions to enhance confidentiality include the following:

- Seating waiting patients as far as possible from the reception desk and the telephone.
- Ensuring monitor screens are not visible from areas to which patients have access.
- Playing background music in waiting areas - ideally with the speakers positioned between the receptionist and the waiting area. Some medical practices in the UK have experienced patient complaints about music being played and/or the type of music being played. A management response to this, designed to discourage such complaints, is to display a notice such as: "Music is played to help provide patient confidentiality. We apologise in advance if the music isn't to everyone's taste".
- Providing focal points directing patients' vision away from the reception desk, such as a TV or a news screen.
- Having the reception desk accessed through a window which is only open when patients are at reception, and thus increasing the privacy of both telephone conversations with patients and staff-to-staff conversations.

Obviously the specific physical circumstances of the waiting area will influence which solutions are feasible. For example: an 8m² waiting room with six seats is going to have very limited possibilities for ensuring confidentiality. In large clinics, however, there may be other confidentiality issues. For example: there may be multiple receptionists, and thus sitting in a private booth, and spreading receptionists out, so they are not unnecessarily in adjacent booths, are actions worth considering.

Employees can be trained to prevent or avoid potential negative waiting room experiences. For example: role-play training can improve employee skills in picking up cues that a patient is uncomfortable with disclosing information. Employee practices which can help to reduce the chances of confidentiality being breached include:

- Handling telephone calls with discretion. For example: not repeating the patient's name back to them in front of waiting patients; or taking the phone to a less public area.
- Speaking quietly with patients
- Asking patients when they arrive at reception if they are comfortable to give their details over the counter, enables privacy-sensitive patients to be identified. Getting the

receptionist to ask a simple “Are you happy to give me your details over the desk?” does not require a major training investment (unless, of course, a customer-driven culture is lacking).

The use of Self-Service Check-in Screens, such as JAYEX Enlightened Touch, to handle the reception process at healthcare centres may offer a solution to confidentiality issues. Patients enter their personal data on a screen, and thus there is nothing for others in the waiting area to be able to listen in on. The use of such systems may, however, raise other privacy issues such as the possibility of patients becoming reliant on other patients to assist them in using the technology, or the possibility of others seeing the data on the screen; or the perception by some patients that their personal data may be available to everyone.

New technology has opened up new issues surrounding patient confidentiality. With the exponential growth of smartphone ownership and social media usage, an interesting area with implications for confidentiality regards the taking of photos by patients in healthcare settings. In the USA and the UK this has been reported in a number of health contexts and, whilst it seems not to be illegal, is generally disliked by those patients who perceive themselves as having been photographed. Dolan (2012) cites legal advice suggesting that healthcare centres put up signs indicating that they are ‘picture-free zones’. It is also suggested that no exceptions to this rule be allowed, despite the apparent innocence of wanting to document baby’s first visit to the doctor.

Fairness of waiting time

A range of situations can cause patients to feel that something is unfair about waiting. Other patients may try to jump the queue or, at least, be perceived as doing such. Multiple queues, and the accompanying confusion, may develop. Patients may adopt the practice of reserving a place in a queue. Patients may even try to negotiate being served without waiting.

Time-related CCI can include situations where a patient seeks to modify the priority of their place in a queue. For example: a patient enters the waiting room and asks to be allowed to be seen next because of a certain reason, such as: having to go to work; feeling unwell; just wanting to ask something and so on. Some waiting tension can follow from patients who are in the queue and then go off somewhere and come back later. People who have been waiting all this time feel that it is unfair. Besides people may not remember them or what position they have in the queue. Also, sometimes such returning patients have missed their appointment slot yet still expect to be seen by the doctor. Moreover, there may be people who decided to join a queue because it had, say, just three people but would not have joined it if they had known there were in fact seven people.

There are a variety of waiting situations which rely on patient-to-patient trust. For example: a patient may at the waiting area and ask the patient next to be served if they can go in just to get their document stamped, or to pick up a prescription, or to ask a quick question. But there is the risk that the patient is actually just jumping the queue. Indeed, Nicholls (2005) reported such an incident where a request to enter the dental surgery just to make a quick appointment resulted in a dental treatment lasting 40 minutes. Understandably, the patient who had allowed the initial favour was furious at such deception. Such negative waiting experiences can distort the customer’s perception of the service. Healthcare service providers need to develop systems to enable them to monitor queue and appointment order and to check that apparently agreed situations are genuine. Such arrangements should be managed by the healthcare provider and not left to potentially dubious C2C negotiation.

Sometimes other customers may be behaving in a way which is quite complex. For example: in some waiting situations such as at work health clinics, where multiple visits occur, groups of patients from the same company may be visiting together and hold places in queues for their friends who have not yet even arrived at the healthcare centre. Another contentious issue can be appointment times: if it is 9:20 and customer A, who arrived at 8:50 is waiting for a 9:10 appointment and customer B, who arrived at 9:15 is waiting for a 9:00 appointment, and the doctor is still on his/her 8:50 appointment, then customer A may consider they are entitled to see the doctor before customer B. In some healthcare waiting situations other patients may not be too cooperative, and it can even be difficult to establish the queue order, and asking “who is last in the queue?” does not necessarily get an answer. Again, this raises the question of why do patients have to rely on other patients to access the service in a fair, predictable and calm manner.

Such examples show the importance of the overall climate in a healthcare setting. Many of the more helpful patient-to-patient behaviours and attitudes are voluntary, and are more likely to occur in healthcare waiting environments which communicate a sense of friendliness, helpfulness and efficiency. Indeed, a tense healthcare waiting experience is in the A&E department (Accident and Emergency). In A&E patients and their companions are often in an anxious state, and employees may, understandably, not regard emotional labour as a priority here (Yoon and Sonneveld, 2010). This, however, can contribute to an atmosphere of C2C tension. Whereas, if the general environment is made less anxious, the C2C environment might also be less strained. A&E operates according to the Triage system, where patients are treated according to the perceived urgency of their condition. This means that the usual FIFO (First In, First Out) queue discipline is not adopted, and some patients will question why those who have arrived at A&E after them are treated before them.

The above waiting situations all point to the need for healthcare providers to take responsibility for setting up appropriate systems and appropriate monitoring to ensure that patients perceive the waiting experience as fair. Such systems need not be expensive. They may involve the receptionist taking a more hands-on approach, or the doctor coming out and calling in the next patient. If the waiting experience is actively managed certain patient-to-patient situations do not even appear.

This article has introduced the topic of how patient-to-patient interaction can take many forms in healthcare settings. It has provided many illustrations of such interactions, and has examined patient confidentiality and the fairness of waiting in detail. Healthcare practitioners need to be professionals in managing patient-to-patient interactions as well as employee-to-patient interactions.

References:

Dolan, P.L. (2012), “Should doctors stop patients from taking smartphone pictures?” *American Medical News* (available at: <http://www.amednews.com/article/20120521/business/305219968/5/> accessed 22.09.2014).

Martin, C.L. and Pranter, C.A., (1989), “Compatibility Management: Customer-to-Customer Relationships in Service Environments”, *Journal of Services Marketing*, 3 (Summer): 5-15.

Nicholls, R. (2005), *Interactions between Service Customers: Managing On-site Customer-to-Customer Interactions for Service Advantage*, Poznan: The Poznan University of Economics Publishing House.

Nicholls, R. (2010), "New directions for customer-to-customer interaction research", *Journal of Services Marketing*, 24 (1): 87-97.

Scott, K., Dyas, J.V., Middlemass, J.B. and Siriwardena, N.A. (2007), "Confidentiality in the waiting room: an observational study in general practice", *British Journal of General Practice*, June: 490-493.

Yoon, J.K. and Sonneveld, M. (2010), "Anxiety of patients in the Waiting Room of the Emergency Department", Cambridge, MA: *TEI Proceedings*: 279-286.

Brief Bio:

Richard Nicholls is a specialist in services marketing and management. He currently works at Worcester Business School, UK, where he teaches and researches about services.