Antiservice and Healthcare Consumers: a Tale of Two Environments

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Most consumer behavior researchers and service marketing scholars believe that business firms seek to establish and maintain positive and long-lasting relationships with consumers. This perspective holds for many exchange relationships, but studies demonstrate that an antiservice mentality is more widespread than previously recognized, greatly impacting consumption and quality of life.

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EXTENDED ABSTRACT
Consumer researchers have expended considerable energy measuring, evaluating, and determining what we mean by quality service provision. An underlying precept is that service providers are concerned about consumer well-being in the form of satisfaction and subsequent perceptions of product offerings and companies’ images. Understanding differences between expected outcomes and actual quality and delivery are paramount so firms can gauge what they provide relative to what their consumers initially desired. One way of expressing this distinction is through some form of gap analysis that articulates differences between consumer expectations and performance. Such concerns demonstrate the importance of need fulfillment to organizations that seek long-term, positive relationships with their consumers.

Of course, even the best of intentions and implementations may not result in predicted outcomes, leaving consumers dissatisfied and marketers scrambling to rectify negative situations. Outcomes vary, but such service failures may cause consumers to experience several levels of frustration and anger that lead to vengeful feelings, thoughts, and actions. One possible way of adjudicating this situation is to offer consumers an opportunity to state their concerns, requiring service providers to listen to “recovery voices” and react accordingly. While recent research has questioned the extent of the service recovery paradox, or ability of service providers to improve on relevant metrics if they impress consumers with resolutions, it remains an important and recommended strategy. Once again, the underlying assumption is that service providers are dedicated to meeting their consumers’ needs as perceived by them.

Yet the literature shows that service providers also do things that by their nature create consumer dissatisfaction. One example is the use of various penalties and sanctions that include monetary fines and denial or removal of services. Clearly, such punitive actions lead to the same negative outcomes, but they are justified as costs associated with running profitable businesses. While such penalties are on the rise and significantly improve revenues especially in industries such as banking and airlines, usage is confined to certain service providers where these actions have become standard procedures. A more extreme case involves service sabotage by actors within firms designed explicitly to inhibit or destroy service experiences. An apt moniker for such dysfunctional behavior is “antiservice.”

How widespread antiservice is across providers and how deeply it penetrates within particular firms is mostly unknown. One study found that 90% of organizational informants believed that service sabotage was an everyday event. Thus, any form of remediation that follows is an unnecessary consequence of improper employee performance. This organizational climate begs the question: Is it possible for service providers to be perceived as going to the service sabotage extreme and using antiservice beliefs and actions to guide their service delivery strategies? If so, what is the result? To this end, we addressed these research questions by an ethnographic investigation of service provision and delivery across healthcare services in two different environments: the radiology department of a large, rural teaching hospital and the health complex in a maximum security prison. While these situations differ in their levels of restriction of choice, together they provide a unique continuum of possible antiservice actions.

Both investigations involved participant observation, interviews, and extensive in-situ relationship-building over an eighteen-month period. In one case, the researcher is a radiology resident and, in the other case, the researcher is a professor in a degree-granting prison program. While these contexts are quite different, they involve what scholars describe as “captured” consumers who believe that they have little choice once embedded in the delivery systems. For example, “patients” in a teaching hospital who are referred to the radiology unit are given little choice but to navigate the various stations and procedures placed before them as obstacles to compliance to frontline healthcare providers. Inmates, on the other hand, are devoid of healthcare choices and alternatives as they seek to understand and utilize the limited options available to them. Together, they offer a novel representation of levels of captivity that may be ripe for antiservice.

The few investigations that have looked at the “dark side” of service delivery have had little to say about why antiservice or consumer sabotage happens. Our results suggest that, to varying degrees, an oppositional culture may develop that dehumanizes patients and inmates, treating them as either an assembly line (hospital) or unworthy of quality services (prison). Of course, no one would seek such treatment, but they have little choice because of their captive situation and resulting power imbalance in favor of hospital/prison employees. This causes counterfactual thinking that culminates in an “us versus them” mentality. Consequences include negative affective states that place the blame on service providers for an absence of concern for the well-being of the consumers under their charge. They experience a lack of certainty and self-efficacy about important services that impact essential aspects of their lives, which conclude in a dearth of agency. An outcome for the hospital may be a lack of compliance with recommended health protocols, and for the prison the inmates may turn to the illicit healthcare market to meet their needs and desires.

REFERENCES

