



Service Excellence in Dermatology

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DERMATOLOGY exists to serve others. The extent to which we serve extraordinarily well combined with prudent business practice will determine the level our success.

How many of us have thought of our careers in this way? How many of us think of ourselves as servants of our patients? How many of us strive to exceed the expectations of our patients? These opening statements and questions will be explored further in this essay on service excellence in dermatology.

Stephen Covey, in *The Seven Habits of Highly Effective People*, compares a principle of behavior to a “natural law,” explaining that a principle—like a natural law—is basically true and if one has the courage to act in concert with these principles of good behavior one will be a more highly effective person.¹ Similarly, there are principles related to excellent service in health care and, if we espouse these principles with conviction and commitment, we will develop practices that deliver excellent service.

Ten Principles of Service Excellence

Principle 1. We Work in a Service Industry

Health care is a pure service industry. Unlike manufacturing or agrarian industries, we make no tangible product. We produce no goods. We grow nothing. What we offer cannot be picked off a shelf at Wal-Mart nor can it be ordered “online” and delivered. All that we have to offer is our service!

Principle 2. We Should Strive to Provide the Best Service

Patients have choices. We all want our patients to choose us. If our product is “service,” then it follows that patients will choose us based on whether it is their belief that we provide the best service. The operative word is “choose.”

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Principle 3. Service Is Noticed When it Either Exceeds or Fails to Meet Expectations. Service that Simply Meets Expectations Usually Goes Unnoticed

This principle is perhaps the most important. Our brains are bombarded with a myriad of sensations and experiences each day and most are quickly forgotten. Usually, we remember events, often unexpected, that trigger an emotional response. To a wine connoisseur, it might be a very special wine. To the moviegoer, certain scenes remain vivid while others are forgotten. Similarly, a particularly rude clerk in a department store might be all that we remember a week or two after a shopping trip. This is equally true in health care. Our service is only memorable when it exceeds, or fails to meet, what our patients expect.

Principle 4. Our Goal Should Be to Exceed the Expectations of our Patients

The logic is quite simple. If we exceed the expectations of our patients, they will recognize or remember our service (care) as “the best” and they will choose us in the future for their dermatological care. They will be more likely to become loyal patients. Loyalty is an important concept to understand. In his article, “A Satisfied Customer Isn’t Enough,” Thomas Stewart describes the important difference from a business perspective between loyal and satisfied customers. Eighty percent of customers who described themselves as “satisfied” indicated that they would switch to a competitor if the competitor were more convenient.² On the other hand, loyal customers, as defined by Frederick Reichheld in his book *The Loyalty Effect*, are those who would remain with the service provider despite inconvenience of location or even service shortfalls. Loyal customers are also more likely to tell friends and family about the service they received, thereby amplifying their effect on business.³ Loyalty derives from perceived exceptional service. Our goal is patient loyalty, not the absence of complaints.

Principle 5. We Have Good People Working with Us

It is easy to blame service shortfalls on our coworkers. For example, we might think, “if only my receptionist weren’t so abrupt,” we would be perceived as providing better service.

Or, “if only my partner weren’t so abrasive with the office staff,” then we could develop a culture of service excellence. We often complain about our coworkers, but we rarely take positive initiative to actually work with them to elevate the level of service to our patients. People can, and will, do extraordinary things when they know their work is worthwhile. A desire for greatness, or excellence, exists within everybody. We have to be willing to take the harder yet more rewarding road of working to bring the best out of our people. It can be done.

Principle 6. Service Excellence Is a Skill that Can be Taught, Developed, and Learned. It Is not Genetic

While it might be true that some people have better inherent “people” skills, many of these skills are learned behaviors. For example, physician–patient communication is a skill set that can be taught. The Bayer Institute for Health Care Communication demonstrates through research data that improved communication skills can be learned and continuously improved on. Communication is analogous to a procedure that can be taught and then mastered through practice.⁴ Similarly, office personnel can learn behaviors that please patients, family members, and coworkers.

Principle 7. Service Improvement Occurs Best at the Work Unit Level by Teams of Individuals who Best Understand the Issues of Their Work Environment

Service excellence is not static. Patient expectations change over time just as our expectations change. For example, how many of us are satisfied with gas stations that have pumps that don’t accept credit cards? Yet, 10 years ago we were all satisfied without them. Once we experience a service, we become familiar or accustomed to it. As we improve service delivery, patients have higher expectations and we need to continuously improve to deliver exceptional care. Such improvement efforts are best accomplished by teamwork where everyone is working toward a common goal.

Principle 8. Measurement of Service from the Customer’s Perspective and Timely Feedback of Data to the Work Unit Should Drive Process Improvement

We cannot have an accurate understanding of how we are perceived by our patients without asking them. We all have “blind spots.” Systematic measurement of service will help us identify areas of service strength and areas in which our patients perceive we can improve. Ideally, the measurement tool should be benchmarked against a database of similar practices so that we can compare our practices with others. Inherent in any survey tool are biases, and comparing practices that use the same methodology can provide valuable insight. For example, we might be deluded into thinking that a 90% good or excellent rating is “good enough.” If, however, comparative ranking indicated that such scores placed our

practice in the 25th percentile in patient satisfaction, we would be less satisfied. Ideally, the tool would measure specific areas such as physician- or provider-perceived quality and communication skills, waiting times, convenience in making appointments, confidentiality, and nursing skill. This data can serve as a catalyst for the office staff to brainstorm and implement processes for improvement.

Principle 9. Physicians Must Lead

Physicians are the leaders in health care. Our office personnel look to us for direction. We cannot abdicate the responsibility for service improvement to others. We cannot send our nurses, secretaries, and receptionists to “charm school” and expect that our offices will provide exceptional service. Just as we lead the work unit in the delivery of care through our technical expertise or diagnostic acumen, so too must we lead the health care team in the area of service improvement.

Principle 10. We Should Celebrate Success Rather than Punish Shortfalls

Positive reinforcement of behavior is more effective than negative reinforcement in obtaining desired behavior on a consistent basis. It is more effective and certainly kinder to praise someone for doing something “right” rather than to criticize him/her for doing something “wrong.” Praise raises self-esteem and positively reinforces that desired behavior. If praise is public—performed in an office meeting or within earshot of other employees—we can also amplify its effect by reinforcing desired behaviors in the minds of other coworkers. On the other hand, criticism is often hurtful and lowers self-esteem, and if done in public, can adversely affect morale. Even “constructive criticism” is rarely perceived as constructive.

After we internalize and commit to these principles of service excellence, what is the implementation process?

Implementation of Principles of Service Excellence

Service excellence is a perception by our patients. What patients perceive and what we perceive are often not the same. Since we are in the business of serving and satisfying the needs of others, it is incumbent on us to do what we can to ensure that both our patients and we perceive that they are receiving great care.

During medical training, physicians are taught the intellectual and technical aspects of care. We concentrate largely on enhancing our diagnostic and technical skills. These skills serve as the foundation for providing care to our patients. Without outstanding clinical, diagnostic, and technical skills, we cannot provide outstanding care. This article is not meant to lessen the importance of this aspect of our care of patients but rather to emphasize that in the minds of our patients outstanding care does not end with diagnostic and technical care. The provision of health care is experiential and as such involves also the systems and processes involved in care, the environment in which the care is delivered, the amenities

offered with the care, and the behaviors and communication skills of those delivering the care.

Using the 10 principles of service excellence as a framework, we will discuss each of these areas: (1) efficient systems and processes, (2) a pleasing environment, (3) amenities, (4) consistent behavioral and communication skills.

Implementation of Principles of Service Excellence: Systems and Process Improvement

An exceptional health care experience is efficient. For example, patients desire ease of making an appointment, convenience in parking, ease and efficiency of registration, timeliness of the physician visit, accuracy and availability of medical records, coordination of care, ease of check out, and accuracy of billing. Measurement and feedback (principle #8) should be used to identify processes that our patients perceive as less than ideal. Each of these aspects of the care experience involves multiple steps. While certain processes are in part dependent on systems over which personnel have little control, eg, computer hardware, most process shortfalls can be corrected or modified to overcome patient-perceived shortfalls. The leader should emphasize the need to work to improve those aspects of care over which we have at least some control. The team (principle #7) can identify process steps within an identified system weakness that can be improved on or circumvented to overcome the problem. A spirit of openness and teamwork during regular office meetings will lead to effective team change. In a smoothly functioning office, systems will be continuously improved on through this teamwork approach. To reemphasize, process improvement occurs best at the work unit level by teams of individuals who best understand the issues of their work place. The receptionists best understand the issues at the front desk. The secretaries best understand the issues in the back office. Billing personnel best understand billing issues. Doctors and nurses best understand the issues related to direct patient care. By using measurement and feedback to identify areas for improvement from the customers' (patients, family members, referring physicians) perspective and then using the collective wisdom of the group, the office staff will continuously improve.

Implementation of Principles of Service Excellence: Environment

Patients who receive care use their senses to process their care experience. They see certain things; they hear certain things; they smell, taste, and touch certain things. What they sense enters their brains to be computed in the total experience. Their choice of us for their health care will be based on whether they perceive that they have received the best care (principle #2). Their perception is based on their processing of sensations, past experience, and beliefs. They will notice an environment of care that is different from what they expect (principle #3). While the actual care delivered may be no

different, the perception of care in a soothing, meticulously clean, beautifully decorated, relatively calm office will likely be better than in a messy, dirty, and loud environment. The food in a dirty restaurant might be as good as that in a clean one but will not be perceived to be so. After working months or years in a certain setting, we may become accustomed and less sensitive to our surroundings. With time, "the garbage collector no longer smells the garbage."

One way to approach environmental improvement is to lead a "five senses tour." After leading a discussion among office personnel about the importance of what patients sense in their total experience, assignments are made to each person to focus on one of the senses. For example, ask someone to start at the front door and slowly walk like a patient through the office and write down all that they see. Look at the office through the eyes of a patient. Such a coworker might notice a messy reception desk with a smudged glass partition, a coworker who is not professionally attired, dirty carpet, out-of-date magazines, a bulletin board with notices for coworkers haphazardly arranged and in view of patients, a half-drunk cup of coffee. A team member assigned to "hear" what a patient would hear might report back doors slamming, a doctor loudly calling for a nurse, a secretary answering questions on the phone within earshot of an office patient. One or more coworkers are assigned each of the five senses to experience as a patient. This exercise can be performed anonymously with the lead physician collating written reports. Alternatively, assignments can be made with everyone's knowledge and collation can occur at a team meeting. With limitations, we control and can change much of our environment.

Implementation of Principles of Service Excellence: Amenities

Amenities can make the difference between a good or exceptional experience. We live in a country in which businesses entice us with amenities: Santa Claus at the mall, "free" coffee at the car dealer, a sample shampoo at the hairdresser, a "complimentary" appetizer from the chef. When offered as a substitute for poor service or product, amenities have little or possibly even a negative effect. When added to an already good experience, amenities can enhance an experience. In our practices, we should think of amenities similarly. How can we enhance an already good experience for our patients? Coffee or tea is appreciated on a cold day in a calm and soothing atmosphere. A messy side table with a coffee pot and Styrofoam cups in a hectic and loud office might not enhance the experience. Up-to-date magazines arranged neatly on side tables, a basket with sample lotions, a sample starter tube, and dressing supplies for a small wound are but a few examples of low-cost but appreciated amenities that can enhance a practice. Involving staff in the development and execution of amenities can reap rewards in terms of higher patient satisfaction and staff pride.

Implementation of Principles of Service Excellence: Behavioral Standards and Communication

The final aspect of care—behavior and communication skill—can be the most difficult to lead in the office setting, and yet it is the most important element because it has the largest impact on a patient's perception of the care they received. Every patient wants to feel like an individual. People dislike feeling like they are “just a processed number.” Each patient's opinion (perception) of whether or not we “really care about him/her” comes directly from the face-to-face interactions with the people who deliver the service.

To lead a process of behavioral standard setting, it is first necessary to understand the difference between attitude and behavior. To make a simple distinction, attitude is what's “inside” a person, while behavior is what's “outside.” Attitude is private; behavior is public. Attitude is thought; behavior is action. Attitudes cannot be expected; behaviors can. As human beings living in society, we have learned certain behaviors that are acceptable and others that are not. Similarly, in the office we can establish certain standards of acceptable behavior. To exceed the expectations of our patients, though, we should strive to set standards of behavior that are not just acceptable, but are pleasing to them. How should we set behavioral standards? Who should set them? How should we reinforce them to maximize compliance? We return to the Principles of Service Excellence to answer these questions.

Principle # 9 states that physicians must lead. This is particularly true in setting behavioral standards. For maximum effectiveness, not only must the physician(s) lead the effort to establish office behavioral standards, for credibility she/he must display consistently professional standards. To agree on a standard whereby your office staff should smile and introduce themselves by name to your patients and not do so yourself will be demoralizing to your coworkers and will actually send a very clear message that says, “this is all optional and not really very important.” Your coworkers watch what you do more than they listen to what you say.

While there are many methods to implement behavioral standards into a practice, using the team approach (principle #7) works well. The physician leader should first introduce the concepts of standards. He/she can explain the difference between attitude and behavior and use examples from outside the work place to illustrate. For example, most office personnel can relate to, and offer examples of, department store clerks who display exceptional or objectionable behaviors. Using such examples, the leader can segue into a discussion of perceptions (principle #3) and then introduce the notion that behaviors are learned (principle #6). With planning and forethought, such an office meeting will be not only

productive but also fun. The physician leader might consider asking for help in leading such a session from another physician in the office or a nonphysician opinion leader. Brainstorming among all office personnel can lead to the development of standards of behavior at all levels: secretarial, physician, reception, and nursing. Standards should be written, agreed on, refined as necessary, and reinforced over time. To emphasize the importance of behavioral standards, performance evaluations can be written that include compliance with the standards as one measure of performance. Attachment 1 is an example of standards set by one dermatology office. These can be used as a starting point if desired. The leader should recognize, however, that each office has somewhat different challenges and the standards should be modified to address such office-specific issues.

Finally, communication is a specific aspect of behavior. Communication can be taught, developed, and learned. While it is true that some people are inherently better communicators than others, all can improve. Recognizing that patient care can be enhanced by a physician who is skilled in communication, many medical schools now teach physician-patient communication skills. The Bayer Institute for Health Care Communication recognizes—and cites research to support—that enhanced communication leads to improved health outcomes, reduced malpractice, improved patient and physician satisfaction, and increased profitability.⁵

Summary

Service excellence is attainable but requires leadership and hard work. It is important for the physician leader to understand that perceived service excellence is complex and multifaceted. The physician who combines outstanding diagnostic and technical skills, an office run with efficient processes, a pleasing environment, carefully chosen amenities, and personnel who behave and communicate exceptionally will truly have a practice in demand. Our customers—patients, family members, referring physicians—are the judges and predictors of our success.

References

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Addendum

Standards for Service Excellence

Key: ALL—all personnel in the department

SEC—secretarial personnel

REC—front office receptionist

NUR—nursing or medical assistant personnel

PHYS—physician

1. ALL: Answer telephone within four rings.
2. ALL: Use standard greeting. Example: "Dermatology. _____ speaking. May I help you?"
3. SEC: Use a prepared standardized phone response to common questions. Questions and answers can be printed on cards. Members of the Department will identify responses.
4. SEC/REC: Do not answer telephone and immediately place the caller on hold. Example: "Dermatology is busy. Can you hold please?" Wait for the response—after the caller has been on hold, respond, "I'm sorry to keep you waiting. This is _____. May I help you?" If the hold time is going to be longer than 30 seconds, offer to return the call rather than keeping the patient on hold.
5. ALL: If the call is transferred, inform the caller of the transfer and identify the section with which the caller will be speaking. Clarify what to do if the call has been disconnected. For example: give Appointments' toll-free number, 1-800-, or give the Department secretary's number, (XXX) XXX-XXXX, or Dermatology Appointment Secretary's number, (XXX) YYY-YYYY.
6. ALL: Standards for follow-up calls: Be sure to let the caller know that you will do your best to have requests taken care of that day, but that medical records might be necessary. A late afternoon call might not see action until the following day. Assure patient that follow-up is taken seriously. Ask if patient is satisfied with this action.
7. ALL: End conversations with pleasant words. Example: "Thank you for calling, Mr. Smith. We will see you when you arrive for your appointment on _____."
8. REC: Greet and acknowledge patient and family immediately upon arrival in the clinic.
9. ALL: All staff will introduce themselves with their title/position to patients and families. Example: "Good morning, Mrs. _____. My name is _____. I'm your nurse." Introduce any assistants, for example, residents, nurses, or med students, who will be involved with the patient. Maintain eye contact with the patient.
10. ALL: Dress professionally. All staff will wear uncluttered name badges at eye level on their coats or jackets.
11. ALL: All staff will ask the patient's family name and will use that name throughout contact with the patient and family. For example, use formal title "Mrs. Johnson" rather than familiar "Mary." Use first names or nicknames only when patient is a personal friend or requests to be addressed by a certain name.
12. NUR: Allow patients to remain in the reception area to avoid long waits in treatment rooms. If patient is in a treatment room, give the option of an open door or a closed door while waiting to see the physician. For new patients, generally do not have patients disrobe until after the physician has spoken with them. When patients do disrobe, inform them to keep underpants, bras, and socks on. Provide patients with a patient gown and a sheet. Instruct them that the open area of the gown goes toward the back. Ask patients to "crack the door" when ready for physician. Use the privacy curtain behind the door.
13. ALL: When discharging patients from the clinic, end the interaction with, "Is there anything else I can do for you?" Acknowledge when you will next see them.
14. ALL: When possible, staff will personally escort patients and family to a destination, especially when conveyance is not available. If staff encounters someone in the hospital who is lost or confused, try to escort that person to his/her destination.
15. ALL: Knock gently on the door to patient treatment areas, crack the door, identify yourself, and await permission to enter.
16. PHYS: If sensitive examinations are in progress, the physician should apprise the patient that the examining room door will be locked to avoid intrusion.
17. NUR/PHYS: Staff must keep the patient/family informed at least every 15 minutes while patient waits in treatment room or office. If the doctor is behind, inform additional patients in the reception area of impending delays.
18. NUR/PHYS: Sensitive infectious disease information should be shared by the physician only with personnel who are in direct contact with the patient to allow for the necessary precautions including disposable instruments.
19. PHYS: Staff should clearly explain procedures to patients and ask permission before carrying out procedures.
20. NUR/PHYS: Comprehensive clear information on follow-up instructions to patients and family, with both printed material and verbal explanations, should be given by the nurse and/or physician.
21. ALL: Be certain you are out of hearing range when discussing patients. Issues of treatment, examination, billing, or other private matters should be discussed well out of earshot. Avoid loud conversations and excessive levity in the hallways.
22. ALL: Accept responsibility for neatness and lack of clutter in work areas and offices. Avoid chewing gum, drinking, or eating in front of patients.
23. PHYS: Call patients following surgery. Call patients with laboratory and biopsy results. Document date and call on chart.

24. ALL: Greet fellow employees. Assume responsibility for your job and assist other employees with their job responsibilities when time permits. Be responsible for one another.
25. ALL: Work as a team and encourage coworkers by your actions to strive to attain standards for service excellence.
26. ALL: Complete the Standards for Service Excellence Self-Evaluation on a quarterly basis. Discuss your perception of the Department's compliance with the standards at the Quarterly Meeting.
27. ALL: Always feel free and open to make suggestions so that Dermatology can better meet patient and family needs.