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ISTANBUL GELISIM UNIVERSITY
INSTITUTE OF GRADUATE STUDIES**

Department of Business Administration

**THE IMPACT OF HEALTH SERVICE MANAGEMENT
ON PATIENT EXPERIENCE IN DERMATOLOGY AND
COSMETIC CLINICS**

Master Thesis

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DECLARATION

I hereby declare that in the preparation of this thesis, scientific ethical rules have been followed, the works of other persons have been referenced in accordance with the scientific norms if used, there is no falsification in the used data, any part of the thesis has not been submitted to this university or any other university as another thesis.

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SUMMARY

This study aimed to analyse the factors influencing patient experience and satisfaction in dermatology clinics, focusing on human, organizational, and financial aspects. The sample included patients aged 26 to 60 suffering from various skin conditions such as psoriasis, eczema, acne scars, and cosmetic treatments like Botox and laser hair removal. The results showed that emotional care and human interaction play a crucial role in patient satisfaction. Participants prioritized respectful and empathetic treatment from medical staff over purely technical skills. The study also revealed significant financial disparities among patients some were willing to pay premium prices for personalized care, while others (particularly elderly patients and those with chronic conditions) struggled with affordability, affecting treatment adherence.

Another key finding was the impact of post-treatment follow-up. Neglecting follow-ups left patients feeling abandoned, whereas simple calls or messages significantly boosted loyalty. Additionally, the study highlighted the challenges some groups (especially older adults) face with digital appointment booking, worsening healthcare access disparities.

The study recommends training medical staff in emotional intelligence, implementing flexible payment policies, and improving post-treatment follow-up systems. It also emphasizes the need for alternative booking channels to accommodate all patients while balancing technological advancement with a human-centered approach in healthcare delivery..

Key Words: Patient satisfaction, Dermatology clinics, Doctor-patient communication, Post-treatment follow-up.

ÖZET

Bu çalışma, dermatoloji kliniklerinde hasta deneyimini ve memnuniyetini etkileyen faktörleri insani, organizasyonel ve mali açılardan incelemeyi amaçlamıştır. Örneklem, 26-60 yaş aralığındaki sedef hastalığı, egzama, akne izleri gibi cilt sorunları yaşayan ve Botoks, lazer epilasyon gibi kozmetik tedaviler gören hastalardan oluşmaktadır. Sonuçlar, duygusal desteğin ve insani etkileşimin hasta memnuniyetinde kritik bir rol oynadığını gösterdi. Katılımcılar, teknik becerilerden ziyade sağlık personelinin saygılı ve anlayışlı bir yaklaşım beklediklerini belirtti. Çalışma ayrıca hasta grupları arasında belirgin bir mali uçurum olduğunu ortaya koydu—bazı hastalar kişiselleştirilmiş bakım için yüksek ücretler ödemeye razıyken, yaşlı hastalar ve kronik rahatsızlığı olanlar tedavi masraflarını karşılamakta zorlandı.

Tedavi sonrası takibin etkisi de önemli bir bulguydu. Takip sürecinin ihmal edilmesi, hastalarda terk edilmişlik hissi yaratırken, basit bir arama veya mesaj sadakati artırdı. Ayrıca, dijital randevu sistemlerinin (özellikle yaşlı hastalar için) erişimi zorlaştırdığı tespit edildi. Çalışma, sağlık personeline duygusal zeka eğitimi verilmesini, esnek ödeme seçenekleri sunulmasını ve tedavi sonrası takip sistemlerinin iyileştirilmesini önermektedir. Teknolojik gelişmelerin insan odaklı bir yaklaşımla dengelenmesi ve tüm hasta gruplarına uygun randevu kanallarının sağlanması da vurgulanmaktadır.

Anahtar kelimeler: Hasta memnuniyeti, Dermatoloji klinikleri, Hekim-hasta iletişimi, Tedavi sonrası takip.

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INTRODUCTION

The healthcare sector has experienced significant growth in recent years, with increasing numbers of health centers and clinics particularly in specialized fields like dermatology and cosmetic medicine government support for healthcare investments, and rising patient expectations driven by technological advancements. This has intensified competition among healthcare providers, who must now balance quality service delivery with cost efficiency to remain competitive (Butt and Run, 2010). In aesthetic medicine and dermatological care, patient satisfaction has emerged as a crucial performance metric, directly influencing patient retention, recommendations, and ultimately, a facility's competitiveness (Lin and Liang, 2011).

Healthcare service management presents unique challenges due to its intangible nature, simultaneous production and consumption, and variability based on provider-patient interactions factors particularly pronounced in cosmetic and dermatological services where outcomes are highly visible and expectations are personal (Javed & Ilyas, 2018). Since the 1980s, patient satisfaction has been recognized as a critical success factor, with patient feedback becoming increasingly important in service evaluation, especially in elective procedures like cosmetic treatments where patient experience heavily influences clinic reputation (Chanal, 2008).

The healthcare sector's dynamic nature requires specialized staff and advanced technology, increasing operational costs while facing growing competition—a trend especially evident in dermatology and cosmetic clinics where technological advancements rapidly change treatment options (Chanal, 2008). Modern marketing approaches emphasize optimizing customer experience cost-effectively, particularly important in today's cost-conscious healthcare environment and crucial for aesthetic practices where patients often pay out-of-pocket (Javed & Ilyas, 2018).

This study specifically examines how healthcare service management impacts guest experience and profitability in dermatology and cosmetic clinics, where the interplay between medical outcomes and patient satisfaction is particularly complex. While existing literature emphasizes doctor-patient communication, this research will incorporate direct observations of dermatology practice operations and case studies alongside literature review.

This research focused on examining the impact of health services management on guest experience and profitability in dermatology and cosmetic clinics. In the literature, studies focus on the importance of communication between doctor and patient and nurse and patient in health centers in terms of the nature of the service provided and the reflection of these interactions on patient satisfaction, patient loyalty, and improving guest experience. In this study, this experience will be highlighted through observation and case studies of dermatology clinics, in addition to reviewing relevant literature studies.

The first chapter of the study focused on key concepts such as health services, management and quality of health services, and health marketing. In addition, dermatology clinics and service management in clinics and health centers will be highlighted. The second section includes information about customer satisfaction, employee satisfaction, the benefits of customer satisfaction, measuring customer satisfaction, and the process of creating customer satisfaction in health centers. In the third section, it sheds light on the study methodology used, the study population, research methods and design, analyses, and the results reached by the researcher.

In the final part of the study, the general findings of the research will be highlighted, in addition to recommendations.

CHAPTER ONE

HEALTH SERVICE MANAGEMENT

1.1.The Concept of Service

Service is termed as an act, process or performance that requires investing in a large volume of assets, people, technology and material to create value and provide benefits to customers. It is not a tangible product that can be held and touched like consumer goods and therefore attracts with its characteristic of being experience able. Service is the complementarity of benefits to customers through temporary ownership instead of ownership in order to improve or maintain customer satisfaction (Gapenski, & Pink, 2011).

If the economic situation of today is examined, services are everywhere. In the simplest terms, individuals receive services from firms such as public transport for transportation, restaurants for eating, GSM operators for communication, banks for money transfer, cinemas and museums for entertainment as customers. The definition and extent of service is broad. Service includes all economic activities that have no physical product as an output, cannot be inventoried at the time of production, are exclusively consumed, and create added value in forms to fulfill a need. (Marley, et al, 2004). A service may be a profit-making business entity in the economic system or a non-profit organization, i.e., a restaurant, an insurance company, or a charity.

For example, a container shipping service is an economic activity that aims to make a profit. Its product is not a physical good, but a service to customers by transporting goods from point A to point B. A service can be a commodity product, such as the for-profit output of a service organization (Gapenski & Pink, 2011). The service sector is an industry comprised primarily of companies which generate their income through the sale of intangible services and products. Service sector companies are involved in retailing, transportation, distribution, food services and other service activities. The service sector is also known as the tertiary industrial sector (Rahmqvist &, Bara 2010). The service sector is the part of the economy that produces intangible goods. The service sector provides services, not real goods that you can hold. A few activities in the service sector include retailing, banks, hotels, real estate, education, health, social services, computer services, recreation, media, communications, electricity, gas and water supply. (Marley et al, 2004).

It is noted that service quality is also included in the literature along with the concept of service.

In fact, since services are meant to be of high quality in the present competitive economic climate, it is noted that quality is usually included in the definition of this concept.

Service quality is the aspect that the service should be capable of meeting the expectations of the customer and fulfill their needs and requirements. Service quality begins in the human mind of the customer and is ultimately evaluated by the quality of experience. Quality in services marketing is the perceived performance level of a service, but the biggest challenge in measuring service quality can be much more difficult than measuring the quality of the products (Kavuncubaşı, 2010) Superior service quality is most essential for a firm to place itself in the competitive service market. At the same time, customer orientation and consistent behavior are also most important. Service firms need to exhibit consistent quality in the desired market. A service firm's ability to be loyal to customers is dependent upon how frequently it generates value for them (Gapenski & Pink, 2011). According to Kolter and Keller (2012), services can be divided into the following five types:

Pure Tangible Product

A pure tangible product is a physical product with no related services. Such products are material and can be used independently without any additional support. Toothpaste, soap, rice, and clothing are examples. The most significant characteristic of such products is that their value is purely in their physical attributes—customers buy them for their functionality, durability, or appearance. Marketing efforts for pure tangible products are usually founded on quality, price, package, and delivery rather than post-sales services or customer service.

Tangible Goods With a Service

This type is for physical products with additional services to enhance their usability or performance. These are usually technology-driven products where the service component is crucial for optimal performance. Smartphone, smart TV, and cars are some examples. Even though the product is tangible, its full value arises from ancillary services such as software updates, service offerings, or warranty services.

The companies handling such products need to account for not only the quality of the tangible good but also for the reliability and availability of the associated services.

Products and Services (Hybrid Offerings)

This type of category has an even balance of physical products and nonphysical services, neither one outweighing the other. An ideal example is a restaurant: clients pay for both the meal (physical product) and the experience of dining, including atmosphere, wait staff service, and sanitation (nonphysical services). Additional examples are hotels, beauty salons, and gyms. Winning in this type of category relies on both quality products and high-quality service since customer satisfaction hinges on the flawless combination of both.

Services Supported by Goods

In this case, the primary product is a service but requires physical goods to facilitate delivery. Air travel is a case in point there is the primary service of moving individuals, but it requires airplanes (physical assets) to occur. Similarly, a hospital is providing healthcare services (intangible) but utilizing medical equipment, beds, and medication (physical) to facilitate them. Companies in this group must maintain both their service capabilities and the quality of supporting physical assets in sync to deliver smooth customer experience.

Pure Services

Pure services are entirely intangible and have nothing to do with a physical product. Examples of such services are medical check-up, consulting, babysitting, and education. The value here is not the material good but the expertise of the service provider, his/her time, and effort. Because these services are not tangible nor can they be stored, quality depends heavily upon the skills of the provider, customer contact, and reliability. Marketing for pure services often emphasizes trust, reputation, and customer testimonials due to their intangible (Miao, et al, 2020):

1-Standard customized services: Customized service is any service that's tailored to address the specific needs of individual customers. The math is simple – the closer the service comes to their needs, the more successful you'll be at service, sales and retention. The phrase "customized service" is employed in two ways.

2-Customer industrial services: Consumer service is the service provided to the final consumer, while industrial services are the services provided to the customer to shape his/her own final product. (Jandavath & Byram, 2016).

3-Personal impersonal services: It is the services that require personal contact with customers, such as haircuts and medical care, are personal services, while impersonal services are services that do not require personal contact with customers; power plants and hand security companies. The definition of service is a wide concept defined by various researchers and it is hard to get an exact definition. With the advancements of technology and the transition into the information age, which can be so freely accessed, the communication between human beings has intensified, and development of social-cultural values has made it possible for the service sector to grow. Service in its general sense is the act of satisfying and benefitting an individual or a company. In a better understanding of the service, it is vital to address its structure and some of its properties. (Miao et al, 2020).

1.2. Characteristics of Services

When planning their marketing strategies, businesses must consider five important characteristic features of services. These are the intangibility (intangibility), inseparability, variability, perishability and inability to own (Mucuk, 2001, 287).

1.2.1. Intangibility (Being Intangible)

The most basic widely recognized difference between goods and services is that services are intangible. The intangibility of a service means that the service cannot be grasped, seen, heard, measured with a unit of measurement, exhibited, packaged and transported. That is why services are labeled perishable. Services cannot be preproduced in bulk and warehoused. No way is it possible to hold the empty seats on a concert or plane and resell them the next day. (Jandavath & Byram, 2016). The value obtained from a service is based on experience. The client only specifies the quality and value of the service once purchased or while consuming or purchasing the service. (Chang et al, 2013).

1.2.2. Inseparability (Simultaneous Production and Consumption)

In the production of goods, since the production and consumption processes are separate from each other, the business and the customer only come face to face during the purchase of the goods. Production is usually not seen by the customer.

In service processes, the production, purchase and consumption of the service occur simultaneously. Therefore, the business and the customer interact throughout the production and presentation process, and the customer participates in the production process. For example, a person traveling to a place requires the personal participation of that person. This feature also causes the following situations. (Chang et al, 2013).

- Services cannot be delivered to customers through distribution channels. In this case, either the customers must go to the person or organization providing the service or the person providing the service must go to the customer.
- The satisfaction of the service to the customer, or in other words, the quality of the service, depends on the effectiveness of the customer as much as the effectiveness of the person providing it.
- In addition to the customer being served, other customers who will benefit from this service also witness the service production process.
- Mass production of services from a center is quite difficult. In some cases, it is even impossible.

1.2.3. Variability (Heterogeneity)

Their content can change with the person providing it, the customer, and time. In this case, it is very difficult to standardize them. For example, a haircut service varies from hairdresser to hairdresser, as well as from customer to customer. The basic production process of services is attained through human behavior. Therefore, even the products a person creates and offers can be different from each other. This difference could occur at intervals, buyer to buyer, producer to consumer, according to the producer-consumer relationship and the prevailing situation. This becomes an important reason in the emergence of quality control problems in companies (Butt et al., 2010).

1.2.4. Perishability

Perishability means that services cannot be stocked, stored, returned, or resold. Seats in a tour, empty rooms in a hotel mean lost capacity. This capacity that cannot be used at a certain time cannot be kept for later use or sale (Rahmqvist & Bara 2010).

Another reason that increases the perishability of services is the irregularity of demand in some services. The perishability of services and the variable demand require the service business manager to take precautions regarding service planning, pricing and sales efforts to match supply and demand (Rahmqvist &, Bara 2010).

1.2.5. Lack of Ownership

The lack of ownership in service means that the services cannot be owned. It is not ownership but the right to use for a certain period of time that is purchased. What is owned is not the service itself but the benefit obtained from the service. Here, users are dependent on the service producer while receiving and using the service (Mucuk, 2001).

Another characteristic of services is that the production process is labor-intensive. In labor-intensive businesses, relatively fewer technical tools, equipment and tools are used. In contrast, the time and effort spent by human resources are higher.

In addition to all dimensions related to the services they produce, service businesses should also consider factors such as efficiency, variability, consumption, continuity, trust, etc. while providing the service.

When we look at the developments in recent years, we see that there has been a very rapid change in terms of structural changes among sectors. Applications in the service class are no longer just services provided by service businesses, but have also gained importance in product-based businesses. Because the production of quality goods and services has been among the most important and current problems of businesses in recent years. Determining and associating quality with human performance is the starting point. Quality can be applied in the production process, decisions taken, products and services. Quality is more the ability of the needed goods or services to meet expectations (Butt et al., 2010).

1.3. The Concept of Health

The concept of health has been defined as a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. Making the definition exactly like this has brought the disease status to the forefront, human health has been evaluated in relation to this concept and everyone who does not have symptoms of disease or disability has been accepted as healthy. (Temgilimoğlu et al, 2012).

In 1948, the World Health Organization (WHO) has comprehensively developed a definition it made; by adding social and psychological concepts to the content of the concept of health, it has made a definition that is still valid today. According to this definition, health is defined as “Not only the absence of disease and disability, but also a state of complete physical, mental and social well-being” (WHO, 2019) Health studies have an important place among social policies. For this reason, the health services that people receive in a country should be considered as a result of social policies created and implemented by the state. (McGregor, 2001) Countries with a social state status have secured the health of their citizens within a legal framework. (Fatima, et al, 2018).

1.3.1. The Concept of Health Services

The definition of health services is defined as all the work done for the preservation of health and treatment of diseases. Health services have different meanings in different languages.

In an international conference held in Ottawa, the capital of Canada, in 1986, the “Prerequisites” and “main activity areas” necessary for health were determined. Accordingly; it is expected that there are certain conditions to be healthy. Health services are services provided without profit. (Ali et al, 2022).

Every individual in society should have sufficient income, receive adequate education, have adequate and balanced nutrition, have suitable environmental conditions, especially management should act in accordance with the principles of social justice by complying with equity in resource planning and service provision, and most importantly, a peaceful environment should be established. In order for individuals to have these opportunities, their states should create and develop health

policy, financing, and organization models that should take into account their own health problems, priorities, and resources. (Fatima et al, 2018).

When Blum's environmental health model is examined, it is revealed that health services are less effective than expected in the process of protecting and improving the health levels of individuals and society. In other words, having a strong and good health system in highly developed countries does not guarantee that the health status will be high. According to Blum's model, health managers and planners need to approach the concept of health from many perspectives and focus on important factors other than health services in order to increase the health levels of individuals in society. In addition to health services, other institutional services are also needed to protect and improve health. Accordingly, intersectoral cooperation is becoming more important and mandatory for preventive health services. (Ali, et al, 2022).

Healthcare is an intangible good and therefore cannot be touched, felt, traced, counted, or measured like products produced in a factory. Producing tangible products makes quantification possible as the product can be sampled and quality-tested in production and consumption. Because of their intangibility, though, healthcare quality becomes at the mercy of the service process and the customer-provider interaction (Laughlin et al., 2012).

Some aspects of healthcare quality, for instance, consistency, completeness, and efficiency, are difficult to measure beyond the opinion of the customer. Replicating consistent healthcare services that vary across producers, customers, locations, and time is usually difficult. This heterogeneity may result from services being provided by various professionals (e.g. doctors, nurses) to different patients with different needs. It is more difficult to standardize quality in service operations. Health care workers provide services in a different manner as factors such as experience, training/education, personal abilities and dispositions vary (Ali et al, 2022). Healthcare services are produced and consumed simultaneously and cannot be inventoried for future consumption. This means that quality control is difficult as the customer is unable to determine "quality" before purchase and consumption. Compared to manufactured goods, there is less possibility of an end-of-the-line quality control. Therefore, healthcare results cannot be guaranteed. (Rahman et al, 2021).

That is why in literature, it is defined as "the provision of care that exceeds patient expectations and achieves the highest clinical outcomes possible with available resources". Healthcare services also involve an ethical activity because they are dealing with human life and health. In health services, words like effectiveness, empathy, security and affordability also come to the forefront. Planning of health services is done according to a priority analysis of immediate needs and is closely associated with routine research and studies of health information systems in fields of medical care, hospitals, health centers and multi-service clinics for the provision of high and adequate levels (Laughlin et al., 2012). Health services primarily include research provided in order to enhance health and fight disease.

Health services are better expressed as all studies undertaken to protect the health of the people and, where necessary, to treat them and rehabilitate them Health Services are services provided with the objectives to eliminate a number of causative factors harmful to the health of human beings and protect society from effects of such factors, to treat the patients and rehabilitate the persons whose physical and psychological abilities and abilities lost value. The objectives of Health Services can be outlined as follows (Rahman et al, 2021):

1. **Preventive Care:** To reduce the incidence of diseases through immunization, health education, and early screening.
2. **Curative Care:** To diagnose, treat, and manage illnesses to restore health.
3. **Promotive Care :**To enhance overall health and well-being through nutrition, exercise, and healthy lifestyle programs.
4. **Rehabilitative Care:** To restore physical, mental, and social functioning after illness or injury.
5. **Palliative Care:** To relieve pain and improve quality of life for patients with chronic or terminal illnesses.
6. **Equitable Access:** To ensure all individuals receive fair and unbiased healthcare services regardless of socioeconomic status.
7. **Cost-Effectiveness :**To provide efficient healthcare services without unnecessary financial burden on patients or systems.

8. **Quality Assurance:** To maintain high standards of medical care through continuous monitoring and improvement.

9. **Health Education & Awareness:** To empower individuals and communities with knowledge for better health decisions.

10. **Emergency & Disaster Preparedness:** To provide immediate medical response during crises and public health emergencies.

There are three main objectives of the provision of Health Services. These are to provide everyone with the health service they need, to provide the needed service efficiently and to increase the quality of the service provided. In the provision of health services, it is an important issue to achieve medical efficiency at low cost. The provision of health services is affected by many factors and diversifies accordingly. Factors such as the monopoly status of the health market, developments in medical technology, the efficiency of health institutions, the quality and quantity of personnel can be given as examples of this situation (McGregor, 2001).

The importance of health services can be explained by the following elements (Ahmed et al, 2017):

Provision of sufficient medical human resources: doctors, nurses, technicians, laboratories and other assistants, because the doctor cannot perform all nursing, laboratory and administrative medical services alone.

A sufficient number of doctors, medical centers and institutions providing health services (health units, hospitals, laboratories, pharmacies, etc.).

Provision of medical services at all times, i.e., 24-hour work of health personnel, ensures continuous and uninterrupted healthcare delivery to meet urgent and emergency medical needs.

It is not enough to provide medical care only to increase the number of members of health teams, health units and hospitals, but also to provide high-quality conditions for medical work. It is important to determine the standards and foundations that determine the required level in each member of the medical team, equipment and devices, diagnosis and treatment and that must be provided.

1.3.2. Classification of Health Services

The classification of health services by purpose can be listed as follows.

1-Preventive Services: Services provided to protect individuals from injuries, sudden death and different diseases. It includes services such as gaining immunity against certain diseases, drug treatments, family planning, proper nutrition, stress management, prevention of psychological negativities, biological security. Since a preventive health service is in question here, it includes health services developed against all kinds of risks. (Ahmed et al, 2017).

The intensity level of the services in question also varies in case of an increase in the probability of people's diseases. Preventive health services aim to reduce the probability of life-threatening diseases and early diagnosis of serious medical conditions. Vaccines, blood tests and cancer screening examinations are among the most well-known preventive services. Therefore, the wise use of preventive services can increase the overall efficiency and effectiveness of a regional health service system. The increasing emphasis on preventive services has been an integral part of many health reform programs in the last decade. (Büyüközkan et al, 2011).

Preventive Health Services include activities provided to protect health and prevent diseases. These services aim to keep the society away from diseases and are provided by units established within the Public Health Directorates by the public. Preventive Health Services are based on the preventive medicine system. According to the WHO, preventive medicine; In addition to preventing the occurrence of physical and mental diseases with the organized efforts of the society, it is a medicine carried out by the whole society using all means to increase the health level of the society as a whole with the efforts of a physician responsible for the health of individuals and their families such as immunization, health education, etc. (Arab et al, 2012).

2-Curative Services: Curative health services come into play when preventive health services are insufficient. In this area, there are situations such as sudden illness and injury experienced by individuals. Relevant health services are applied for individuals to regain their former health. Health services provided for the purpose of treatment are an important point of health services in almost every environment. For this reason, it is an activity area that always stands out in the purpose and service policies of health institutions. (Arab, et al, 2012).

Curative Health Services constitute the next step above Preventive Health Services. It is a service type that includes special benefits rather than social benefits compared to Preventive Health Services. However, it also provides social benefits due to reasons such as increased productivity as a result of the treatment of diseases. Treatment services are health services provided using medical methods and appropriate technologies to diagnose individuals exposed to illness, accident and injury, provide treatment, reduce symptoms in the body and prevent deaths. These services focus on the individual. Therapeutic Health Services are services in the process of diagnosing and treating the disease and providing treatment after the disease or symptoms of the disease appear (Singh & Prasher, 2019).

3-Rehabilitation Services: Rehabilitation services are put into action to eliminate diseases that occur after some previously unknown disasters. Rehabilitation services are applied to eliminate psychological problems, disabilities and disabilities experienced in conflicts, earthquakes, floods, accidents and similar situations. One of the aims here is for patients not to return to social life in the medium and long term, but to start their duties within the economic system again. These services are divided into two main sections: medical and social. The methods of application are also separated according to the nature of the disease. Sometimes both health services are applied at the same time. (Setyawan et al, 2020).

The rehabilitation of the patient's social environment is seen as an "early strategy" to encourage the transformation of health and social services. The social rehabilitation of the patient is seen as the best way to meet the needs of many people in developed societies as well as in developing countries. (Singh, & Prasher, 2019).

Medical Rehabilitation; It is a service provided to improve the quality of life and to eliminate physical injuries and permanent disorders. Prosthetics, wheelchairs, crutches, glasses, hearing aids, etc. are services provided. Physical therapy and treatment hospitals, mental and mental health hospitals can be given as examples of institutions that provide medical rehabilitation. (Akdogan & Dortyol ,2014).

Social Rehabilitation; It includes all kinds of services to teach new jobs, find a job and adapt to individuals who have lost their previous work force or cannot work in a certain job due to their disabilities. Social rehabilitation provides opportunities to learn new jobs and gain skills for those who cannot work in their previous jobs. Various

pedagogical support programs are offered to individuals to adapt to their new situation. Centers for disabled individuals can be given as examples of institutions that provide social rehabilitation (Setyawan, et al, 2020).

1.3.3. Characteristics of Health Services

Health services have an important place in the service sector, even at the top. Today, resources allocated to the health sector in many countries are increasing. According to the 2007 data of the World Health Organization (WHO), a total of more than 4.1 trillion dollars have been spent globally for the health sector. Accordingly, the average expenditure per person in the world is \$639. In the countries of the Organization for Economic Co-operation and Development (OECD), where 18% of the world's population lives, the amount per person is \$2,716. Since the expenditures are so high and the results affect both individuals and societies, health is at the top of the services that societies are most sensitive to. (Akdogan ,& Dortyol ,2014).

Health services are defined as a permanent system organized throughout the country to meet the needs, requirements and demands of individuals and society by utilizing health personnel from different branches in health institutions, to provide health care for individuals and society with preventive and curative activities. (Fatima, et al, 2018).

Another definition of health services is; It is expressed as all planned studies carried out to protect the health of societies and individuals, to provide the treatment of patients and to ensure that those who do not fully recover can live without being dependent on others, and to increase the health level of the society. (Aldana et al,2001).

Health services have their own characteristics. These characteristics are listed as follows:

Health services are intensive labor and abstract services

The health sector is the area with the most technological developments after the space sector. Since the production and delivery of health services are generally carried out individually, labor maintains its weight and value, while mechanization is gradually increasing, patient care and surgical services are performed in a labor-dependent manner. (Fatima et al, 2018).

Technological developments in areas such as surgery, imaging, invasive cardiology, transplantation, oncology and genetics are also changing the content and expectations of the services. (Dubois et al, 2011)

Health services cannot be postponed and are urgent

It is not known when the need for health services will arise and there is no substitute. If the need arises, it is met immediately. Since there is no mass production, they are not stocked. They must be consumed as they are produced. (Aldana et al ,2001).

Specialization in health services is quite high

Due to the extensive knowledge required and the intensive use of technology, it has led to an increase in the areas of specialization in health services. (Jenkinson et al, 2002).

The output of health services cannot be measured

Since services are abstract, no tangible and material output can be obtained. This feature complicates the quality studies of health services and creates obstacles in cost calculations. (Ateş, March 2013)

Doctors determine the size and scope of health services.

One of the most important features that distinguish health services from other goods and services is the asymmetric information between the doctor providing the service and the patient. It is known that consumers do not have enough information about the service they will purchase in health services. Consumers do not have enough information about which institutions they should apply to, which doctor they will be examined by, which specialty they will go to, and which treatment methods are required. (Jenkinson et al, 2002).

Health services consist of complex subjects that can be known by people who gain expertise after a long period of time and who need to follow continuous education innovations. For this reason, as in other sectors, the consumer in the health sector cannot decide on the services they will receive. In addition, the consumer cannot give up purchasing a service that they are not satisfied with. The reason is that the slightest mistake in health can lead to irreparable bad results. For this reason, the patient or

consumer must trust the knowledge of the expert health worker and use this knowledge. (Temgilimoğlu et al, 2012)

There is no substitute for health services

When the price of a product increases, consumers will naturally try to substitute other goods for this product. For example, an increase in the price of beans may cause consumers to turn to chickpeas instead of the same product. However, health services cannot be replaced by another service, so there is no substitute. The patient must receive the treatment service recommended by the doctor. Health services cannot be replaced with any other service with low monetary value (Folk sector, Popular sector). This feature is one of the features that distinguishes health services from other service sectors. If a patient who needs to receive health services does not have any insurance, the fact that health services cannot be provided ignores the fact that health is a basic human right. (Temgilimoğlu et al , 2012)

The consumption of health services is random.

One of the features that distinguishes health from other services is that it is not known when the demand will arise. In addition to this situation, the cost of the disease is also large and uncertain. In other words, it is not possible to predict when and which disease a person will catch. Therefore, the state cannot completely leave the field of health services. Other characteristics of health services (cannot be converted into money, consumer behavior is irrational, cannot be tested in advance) (Temgilimoğlu et al, 2012).

1.4. Health Management

Management: The concept of management has maintained its importance since the creation of man and has never been off the agenda. In our age, scientific studies on management have led to the concept of management being established on a scientific basis. If we define the concept of management more concisely; “The concept of management is generally defined as dispatch and management. (Fatima et al, 2018).

The word dispatch refers to an activity directed towards a goal, while the word administration refers to the completion of an activity directed towards a goal in accordance with the available possibilities and conditions.” The concept of management has different scientific definitions. Management has been tried to be defined by assigning different meanings to each phenomenon. It is literally defined as

running a business. “In our language, the word administration, which is used synonymously with management, has the meaning of taking care of and controlling, as well as the definitions of behaving economically, tolerating, turning a blind eye, being sufficient, etc.” Various authors have divided management into periods. The most well-known of these are the classical and neoclassical, and the modern and post-modern periods. (Jandavath & Byram, 2016).

Classical period: According to the classical approach in the twentieth century, where Taylor, Fayol, Weber, etc. practitioners and thinkers are dominant, productivity is at the forefront and people are parts of the machine, like a producing machine. (Jandavath, & Byram, 2016).

Neoclassical period: The neoclassical approach period represented by Hawthorne, Argris, and Maslow in the 1930s can be considered as a reaction to the human-machine understanding of the previous period. Accordingly, social behaviors, technology, and environmental conditions should be evaluated together (Javed & Ilyas, 2018).

Modern period: “In this approach, if the events in management are evaluated within a system, the system approach is taken as the basis, and the approach based on the idea that there is no best organizational structure valid for every place and time, and that everything related to the organization depends on the conditions is taken as the contingency approach.”

Post-modern period: It includes contemporary management concepts and techniques developed for businesses to increase their competitive power and sustain their lives in today's conditions. It is the period when modern management techniques are developed to ensure that organizational structures adapt to this environment by monitoring the developments in the environment we are in (Javed & Ilyas, 2018).

Manager: The manager must make decisions and implement the decisions he/she makes in every activity carried out in order to achieve the determined goal or goals. From this perspective, the decision-making process experienced at the desired level is of great importance in ensuring that the activities carried out reach their goals. “The decision-making process, which is a process of management but directly or indirectly affects other processes, shows itself at every stage of activities in organizations as well

as at every stage of human activities.” After the concepts of management and manager, the concept of Health Management will be better understood. (Ratnawati, et al, 2020).

Health management: When health management is mentioned, the first thing that comes to mind is hospital management. If health management is perceived only as the management of health institutions, it will be perceived incompletely. The definition of health management is defined in the broadest way as follows: “It is the management of activities that will protect public health, treat diseases that will pose a problem for human life and affect the national economy and human power, establish Health and Social Aid Facilities and Organizations, prepare the necessary legislation, organize plans and programs for health problems, conduct research according to service types and train personnel as needed, and thus achieve health.” (Shafei, et al, 2019).

In addition to the definition of Health Management, the management of Health Institutions should also be defined. The management of health institutions is defined as: “A process that involves interrelated social and technical activities that emerge within a certain formal organization in order to achieve predetermined objectives through human and other resources.” Although health management or management of health institutions differs in terms of countries, when the management and managers are examined, the striking thing is the lack of professionalism. “When different country examples are examined in terms of the development of professional health management and the problems experienced in hospital management, it is generally seen that the lack of professional management is emphasized.” (Ratnawati et al, 2020).

The necessity of considering health management in terms of professionalism is education. The healthy functioning of management increases the importance of this functioning even more for the person who is at the head of an institution that directly provides health services. Education is a process. This process should be suitable for the information age in world conditions. (Shafei et al, 2019).

Health management education and training should not be seen as a one-time educational experience but as a continuous process and programs should be developed accordingly. This development process should be organized in accordance with the needs of the health system, which follows the stages of professional development. Education programs should cover all health workers with different levels of management responsibilities and from different disciplines. Necessary communication

networks and programs should be developed for health services research. (Tripathi, & Siddiqui, 2020).

1.4.1. Health management functions, resources

In order for the activities in the management process to take place, the manager must be able to use and benefit from technical skills. In addition to technical skills, he/she must also be able to benefit from human skills and conceptual skills. Here, the concepts of technical, human and conceptual skills, as well as the management of both human resources and information, physical conditions and tools, are encountered. “There are four important tasks in the management process, where activities that require different skills are carried out and are grouped as technical, human and conceptual. These functions, also called the functions of management, are planning, organizing, directing (executing) and control. (Tripathi & Siddiqui, 2020).

These functions are not independent of each other, they can be seen as cyclical activities that must be done continuously in a sequential and coordinated manner.” These four functions, which are considered indispensable for management, are cyclical activities that are individually related to each other. (Büyüközkan et al, 2011).

Management Functions vary according to authors and perspectives. They are divided into two as classical management scientists and contemporary management scientists. According to classical management scientists; “While evaluating the work and positions and the relationships between them in the foreground, the human element is accepted as data and the psycho-social character and psychological and social working conditions are not taken into consideration.” The theory that is being explained here puts forward the necessity of specifying exactly what will be done, how, when and in return for what, and the methods of definite punishment such as cutting the wages of those who do not comply with this rule and discipline, and firing them from their jobs. It argues that management will be ensured in this way and that people will comply with it. Due to these defenses, classical management has been criticized for being narrow-minded, limited, mechanical and bureaucratic. (Shah et al, 2020).

Classical management approaches are theories that try to reach a single management theory by explaining management functions and principles. Frederic Taylor, Henri Fayol, Lilian Gilbreth are the most important intellectuals. In addition, classical and contemporary approaches can be distinguished among themselves.

Gulick and Urwick, two management scientists, address management functions under the titles of Planning, Organizing, Personnel Management, Execution, Coordination, Communication and Financial Management. (Naidu, 2009).

The rapidly decreasing economic profit and the increasing need for production created on organizations; has prevented studies on this subject. The rapidly growing world economy could sell all of the production. Environmental pressures affecting management, viewed the human as just a machine, perceived the production machine as a whole. The effectiveness of the human, like the machine, was thought to be measurable and controllable (Javed & Ilyas, 2018).

After World War I, the falling demand and economic collapse in America and Europe required major structural changes in the USA. This period forced manufacturers to produce more with less human resources. The importance of automation and strategies such as the encouragement of a consumer society led to the importance of behavioral management theories. “The development of scientific management and the acceptance of this development among entrepreneurs and managers introduced an objective approach and engineering to management. Thus, other scientists also became interested in management, and this brought different perspectives to management.” Elton Mayo, who developed the behavioral school, states that the performance of the employee increases with increasing morale. This school, unlike the classical view that prioritizes the individual, envisions a collective structure. (Farzianpour et al, 2015).

1.4.2. Health management functions can be addressed in four main cycles planning

The first and basic function of management is planning. Problems are identified with the planning function. The goals and objectives of these problems are selected for the long-medium and short term. Where, why, how, with which tools and methods, when and where to reach are determined in this function. Planning is a planned course of action and the basic key to management, determining the ways to reach the goals, deciding in advance what to do. (Naidu, 2009).

If planning is done, one is prepared for events. Therefore, planning is the first and most important stage of the management process. Tools and ways are decided to reach the goals. In this process, a mistake will cause the work to be done in other

functions to be wrong. For this reason, plans should be prepared for different situations and, if possible, flexible plans should be made. Planning directs activities towards determined and agreed goals. For planning, data and information that can be used are needed. This data can sometimes be collected within the institution and sometimes in the environment close to the institution. "With the planning function, in short; (Farzianpour et al, 2015).

- Evaluation of the external environmental conditions in which the organization lives,
- Analysis of the possible effects of developments in the external environment on the organization,
- Review or re-determination of organizational goals and objectives in light of the developments experienced,
- Determination of the necessary tools and strategies to achieve the determined organizational goals are carried out." Considering that planning for health management will directly affect human health and since it is impossible to compensate and reverse the mistakes that will be made, it has a special importance among the management functions.

Organizing: It is the work of bringing together organizational powers such as manpower, capital, equipment, etc. that are given to the manager's use in order to achieve the determined goals. "It can also be said to be a coordinated human effort system." The Health Manager must organize very well so that the work performed by all employees within the organization should be aimed at general organizational goals and should be instrumental for these goals. While implementing the organization's plans, the organization function requires dividing, grouping and coordinating the work. Within this structure, the definition of authority and responsibility relationships of the managers working, the division of labor, the determination of how the coordination form will be, and the design of the information system are carried out. This structure will cause the expected results of many activities to be carried out in health institutions to be more positive. (Ferreira & Marques, 2020).

With the latest regulation related to organization in Health Management, more local decision-making mechanisms have been created, especially the General Secretariat of Public Health and Public Hospitals and the organization and decision-

making units have been created in the lowest units with duties and structures. The active units in the field and the organizational structures connected to each other have been gathered under one roof. For example, all hospitals in the province were included in a separate category, and health organizations providing primary care services were included in a structure. This organizational structure made it more active to channel resources to a certain structure and use them systematically. It strengthened coordination and brought together material and spiritual tools in a certain order. (Akdogan & Dortyol, 2014).

Directedness: It is the mobilization of material and human resources for the realization of goals. The existence of sufficient resources, for example, having sufficient personnel and resources, does not mean anything on its own. These need to be mobilized to achieve their goals. There needs to be a manager who organizes resources and personnel in line with the goals and provides direction in line with the goals of the organization. “The directedness function covers all activities related to the human element (conflict management, behavioral change, etc.) (Farzianpour et al, 2015).

In addition to basic processes such as communication, motivation, and leadership.” In the concept of directedness, there needs to be a manager and employees. Here, there needs to be a subordinate-superior relationship and a legal infrastructure on the basis of this relationship. Superiors give written or verbal notifications to their subordinates about their orders and what they need to do, and progress is made towards the goals in line with these orders. “The main purpose of the directing function is to ensure that organizational resources are used effectively in line with organizational goals.” For this purpose, the activity that the manager will do is to give orders to the people he has placed at various levels of the organization in line with these goals in order to implement the plan. If the directing function is successful, it ensures that the work carried out in the planning and organizing stages is accomplished. Otherwise, it will be a failure. (Rahman et al, 2021).

Motivation is a factor that directly affects employee performance. It is the job of ensuring that employees adapt to the same goal and with maximum power. There is no job that human beings cannot overcome due to their nature. It is popularly described as a cure for death. Very high efficiency is achieved by directing motivated individuals to the same goal. “Research has shown that employees with high motivation use 80-

90% of their talents in their jobs.” Unmotivated individuals do not fully reflect their talents on the job. Managers should make an effort to direct employees by using motivating factors. For this, the priority needs of individuals should be determined and planning should be done accordingly (Ahmed et al, 2017).

It is a difficult job to motivate public employees to act for the benefit of the institution and to keep them at work in the long term. In addition, health services are a service class that requires high effort and intensive use of technology. Therefore, service quality emphasizes the motivation levels of employees as much as the use of modern and high technology. Creating an environment that will involve employees in working efficiently, ensure that they take responsibility, and motivate them to solve problems and reward their success is at the forefront of the work that needs to be done. Studies conducted in this field have been addressed under the titles of motivation and motivation factors, job satisfaction and job satisfactions. Studies include determining the factors affecting motivation levels in health services and determining the level of effect. “As a result of factor analysis, it has been determined that organizational characteristics play a more important role than individual characteristics on the satisfaction levels of assistant chief physicians with their jobs.” (Fatima et al, 2018).

Leadership is another concept that needs to be processed in the concept of Direction, along with the concept of Motivation. The concept of leadership or leader can be defined in various ways. It is defined as the process of a person influencing and directing certain individuals or groups in order to achieve their goals, the conditions of which have been determined. Therefore, leadership is actually a process related to the activities carried out by the leader. The leader is the person who directs the group to act in line with a certain purpose, shows where to go and influences others. Although the terms leader or manager are sometimes used instead of leader, they are different words in real meaning. Leadership is innate. In other words, leadership is a gift from God. The manager is an appointed, officially accepted person. “A leader is a person who can influence others, sets goals and missions, that is, shows the way. (Ali et al, 2022).

Control: Control is the last function of the management process. Every work done by management must definitely have a return. Control acts as a valve against deviations. It is a mechanism that continuously evaluates the quality and return of the work done and whether the activities carried out contribute to achieving the determined

goals. The control function allows us to show the results and re-direct ourselves accordingly if necessary. Quality-control systems in health management, patient-care plans and regular evaluation of patient information can be given as examples of the work done within the scope of the control function (Fotaki & Boyd, 2005).

Control is perceived as a mechanism frequently used by managers who apply strict rules. However, there must be control in every job and it is not necessary to comply with strict rules to do this. It is essential for managers to create a control mechanism to ensure that they do not fulfill all the jobs and to follow up on the compliance of the jobs done with the mission and vision. This importance increases even more in health services provided for the most important effects on human life. It is necessary to understand whether the health service provided with the control mechanism is complete, compliant with the rules and of high quality. “A control process includes four stages (Ali et al, 2022):

1. Determining the activities carried out and setting the success standards of each activity,
2. Measuring the realized situation,
3. Comparing the realized situation with the standards,
4. Taking corrective measures if there is a deviation from the standards.”

The most important goal of a health manager operating in the private or public sector who should know well and who the health institution has or can establish relations with should be to gain and maintain the understanding, sympathy and support of those he/she has established or can establish relations with. He/she should aim for a higher quality, faster and more efficient management. Management functions are the most important data leading to this goal.

1.4.3. The area of responsibility of health management

All institutions and organizations in a country's health system and all management events belonging to all sub-organizations of that system are evaluated within the scope of health management. All functions such as planning, organization, direction and control, which are included in the management functions, are included in the area of responsibility of health management. The political will that provides organization in the area of responsibility of health management is the political will. (Gapenski & Pink, 2011).

The top of this management approach, which is established in countries and is in our country, is the Ministry of Health. "The Ministry of Health, which is the primary authority in the formation of health policies and the implementation of the policies formed, has the authority to decide on the use of resources transferred from the budget approved by the parliament and the making of investments." The most important indicator of the socio-economic level of states is to determine the areas of responsibility of health institutions, to establish them, to provide the necessary equipment needs and most importantly, to ensure their planning, organization, direction and control and supervision. "In other words, the activities of planning, organization, execution, coordination and supervision of health services constitute the area of responsibility of health management." (Chang et al, 2013).

1.5. Healthcare Facilities and Management

Healthcare services in countries generally are produced by public and private health institutions and organizations. Healthcare enterprises differ from other enterprises due to their characteristics. Undoubtedly, hospitals also aim to make a profit, but; since the main purpose is not profit, organizations providing services in the health sector are considered non-profit enterprises. However, non-profit organizations also need financial resources to survive. For this reason, non-profit organizations have also entered the business to create resources. However, since most organizations do not consciously carry out these commercial activities, they are far from the modern marketing approach (Singh, & Prasher, 2019).

Hospitals are structures where personnel from many areas of expertise come together and require intensive communication, sharing and coordination rather than a chain of command. In our country, health services are provided by public hospitals, private hospitals, local governments and non-governmental organizations, different institutions of different ministries and health institutions belonging to minorities in the country. One of the most important duties of the state is to provide health services to every individual. For this reason, every citizen has the opportunity to benefit from public hospitals (Rahman et al, 2021).

It is divided into two as public and private health institutions according to the administrative structure to which it is affiliated. Second Level Official Health Institutions are hospitals where patients are hospitalized and provided with diagnosis

and treatment services. These are oral and dental health centers under public administration, integrated district hospitals, state hospitals and their affiliated neighborhood polyclinics, branch centers and medical centers. Second Level Private Health Institutions are hospitals opened by legal entities, licensed according to the private hospital regulation, and medical centers and branch centers that provide outpatient diagnosis and treatment services (Laughlin et al., 2012).

Derivative health enterprises

They are basically hospitals where treatment services are provided. However, polyclinic services that require specialized knowledge that cannot be treated in the first level are also provided. Inpatient treatment institutions also provide polyclinic services in addition to inpatients. Due to the poor referral chain in the first level, excessive congestion occurs in institutions that provide second and third level services (Fotaki & Boyd, 2005)

Private hospitals

They are hospitals established and operated by entrepreneurs in order to make a profit. In our country, private hospitals have not only provided higher quality health services to patients, but have also forced public hospitals to compete and provide quality services. For this reason, the development and growth of private hospitals should be supported. Private hospitals belonging to private individuals and institutions, and foundation hospitals belonging to foreigners and minorities are grouped into four groups. Especially in recent years, with the establishment of foundation universities and the contribution of medical faculties, the number of foundation hospitals among private hospitals has increased (Çetin, 2020).

Polyclinics

Polyclinics are private health institutions consisting of at least two physicians, one or more medical branches or general practitioners as a clinic, where dental services can be provided if desired, regardless of the distribution of medical branches. The centers consist of medical centers, private branch centers and diagnostic centers. (Butt et al., 2010).

Clinics

A clinic is a place of work where a physician does not perform surgical and interventional medical practices in order to freely practice his profession. Any person with a medical degree can open a clinic after obtaining legal approvals in each country (Fotaki & Boyd, 2005).

Laboratories

Institutions that perform outpatient diagnosis and treatment in healthcare services have the authority to open and operate laboratories and diagnostic centers. Requested examinations and radiological examinations can be performed under the responsibility of the physician who looks after the patient. The responsibility here belongs to the physician (Büyükoçkan et al, 2011).

1.6. Leadership in Healthcare Services

In the healthcare sector, the term "leadership" is related and employed synonymously with "management." Therefore, this chapter provides an overview of the concept of leadership in the healthcare sector and employs both management and leadership since both terms are considered in terms of healthcare services (Butt et al., 2010)

Management generally includes planning, organizing, controlling, budgeting, implementation and appraisal. It provides efficient use of resources to achieve organizational goals. Management has been termed unique in the way that it does not have universal application but instead is context-dictated, i.e. the policies, organizational form and values that exist within which it is exercised. There are several schools of thought in management; among them is the traditional or bureaucratic (scientific) school of management, which emphasizes the existence of a well-defined management arrangement based on hierarchical chains of authority with control over employees and responsibility for performance (Büyükoçkan et al, 2011). In the healthcare sector, management practices have revolved around employee involvement in job design (participation, self-management), employee motivation, fulfilling employees' needs, and improving workplace quality of life. Numerous other generic management theories have been followed, including institutional theory, open system and resource dependency theories, the strategic management perspective, and organizational ecology (Laughlin et al., 2012).

Though management and leadership in the healthcare sector are two different disciplines and areas of practice, practically it becomes difficult to differentiate between the two terms .

In some contexts, management functions may also practice leadership, and leadership functions might assist in management. Moreover, managers and leaders should operate within various contexts, not just their typical roles, and echo the perception that they (managers and leaders) are supposed to be everything to everyone. (Ratnawati, et al, 2020). Moreover, the concept of "distributed leadership" that suggests that one need not necessarily be on formal management grade to be classified as a "leader" waters down the meaning of argument around the management/leadership topic. Leadership and management, like any other corporation, are supreme positions in health care, more so in the context of reform movements, types of services rendered, quality of service and resource allocation.

As we already stated, one formula does not suit effective management and leadership, and contextual factors such as the political system and socio-economic factors have an important contribution to the results (Javed & Ilyas, 2018). Therefore, the distinction between leadership and management is due to variations in roles and functions, while the reality is that a role is automatically chosen unconsciously and not necessarily defined in the organization. A role comes into existence and grows due to the vacancies to be filled. (Singh & Prasher, 2019). The dichotomy between leadership and management in the profession is gradually eroding with the changing social conditions in the health care environment.

Consequently, managers (usually trained managers, professional health care managers) hold management positions, fulfill management roles and practice leadership.

Alternatively, professionals who are non-management-trained such as doctors and nurses are able to practice leadership. Amongst changes that strongly impact the social backdrop of care health is increased non-clinical management function that plays in the planning, management and organisation by adhering to the model of clinical leadership. Health care practitioners provide health leadership in healthcare in clinical settings for the purposes of providing quality and effective as well as safe care. (Singh & Prasher, 2019). Such operations normally take place along with roles of non-

clinical leadership and management. Thus, in the health care industry, a managerial framework that is dominated by general educated managers is being replaced with a combined (collective) leadership system for the effective delivery of health services. Earlier, managers in the health field have been undertaken by individuals from a medical background and termed as 'chief physicians.'

But in today's private and public sectors, professional leadership talents can also be utilized (Miao et al, 2020). There have been many research studies on health leadership and management. Most of them have focused on the identification or assessment of the core competencies required for effective performance in leadership and management roles by health leaders and managers. Competency-focused, health management and the ability of leaders to drive changes in health care organizations have become relevant in recent times.

1.7. Dermatology or Cosmetic Clinics and Health Service Management

Dermatology, also known as dermatology, is the medical department that deals with skin problems. The dermatology department is divided into various subgroups according to specific areas. Medical dermatology deals with the diagnosis and treatment of skin diseases such as psoriasis, acne, and rosacea. Surgical dermatology specializes in minor and major surgical procedures, from skin biopsy to mole removal, from skin cancer surgery to removing cysts on the skin. Sub-branches of dermatology such as venereology, pediatric dermatology, derma to pathology, photo dermatology are also specialized for different skin problems. Cosmetic dermatology, another field of dermatology, deals with problems related to the appearance of the skin. Problems such as wrinkles, hair loss, skin blemishes and the procedures that provide solutions to these problems fall within the scope of cosmetic dermatology (Edmonds, 2022).

Cosmetic Dermatology Concept

A healthy, glowing skin appearance is a situation that almost everyone dreams of. Cosmetic dermatology; It is the field of dermatology that applies procedures to make the skin look healthier and younger. In the cosmetic dermatology department, which is becoming increasingly well-known today, the points that people are unhappy about their skin are tried to be improved. The procedures applied in cosmetic dermatology are generally not as heavy operations as surgery. The procedures applied in this field of dermatology are generally simpler and risk-free.

The conditions that fall within the scope of cosmetic dermatology can be listed as follows (Ratnawati, et al, 2020):

- Equalizing skin tone,
- Eliminating wrinkles,
- Removing hair on the face and body,
- Reducing subcutaneous fat tissue,
- Rejuvenating the skin,
- Removing tattoos,
- Cellulite treatment,
- Improving acne and acne scars.

Procedures Applied in Cosmetic Dermatology

Cosmetic dermatology, which aims to improve the appearance of the skin, applies different procedures for this purpose. Some of the applications performed by cosmetic dermatologists are as follows (Edmonds, 2022):

Botox Injection

Botulinum toxin injection is a procedure that reduces wrinkles on the skin. Botulinum toxin is a substance produced by the Clostridium botulinum bacteria. This toxin stops the release of a substance called acetylcholine, which is responsible for muscle contraction, at the neuromuscular junction. Since wrinkles are formed as a result of repeated muscle contractions, Botox injection temporarily relaxes the muscles and reduces the appearance of wrinkles. Since Botox loses its effect over time, the injection process must be repeated at certain intervals. (Frederick et al., 2007).

Skin Fillers

Fillers are one of the procedures performed to make the skin look younger. Fillers can be applied to hollow or hollow areas, lines and wrinkles on the skin. The effects of fillers on the skin are seen immediately. Different substances can be used for fillers. The substances used in this procedure can be listed as follows (Kim, 2022):

- Hyaluronic acid fillers,
- Synthetic wrinkle fillers,

Collagen wrinkle fillers,

Autologous wrinkle fillers obtained from the patient's own blood or fat.

Exfoliation Treatments

Exfoliation means cleansing the skin from dead skin. Dead skin accumulation on the skin can cause many problems. Exfoliation is very effective for skin renewal. Different methods can be used to cleanse the skin from dead skin (Edmonds, 2022):

Physical Exfoliation: It is a process that allows the application of abrasive substances to the skin surface to get rid of dead skin.

Microdermabrasion: It is a procedure in which substances containing tiny crystal structures are sprayed onto the skin surface. With microdermabrasion, the crystals penetrate to the middle surface of the skin and thus the dead layer on the upper surface of the skin is effectively removed.

Chemical Peeling: It is a process in which chemical substances, usually acidic in structure, are applied to the skin to exfoliate.

Laser Treatment: This process, which is performed using light energy, stimulates collagen production in the skin while exfoliating.

Intense Pulsed Light (IPL) Therapy

IPL therapy, which is applied with filtered light beams of different wavelengths, is a procedure that stimulates collagen production in the skin. IPL therapy is an effective method for correcting many skin problem (Swami et al., 2009):

Age spots,

Freckles,

Birthmarks,

Varicose veins,

Broken blood vessels on the face,

Rosacea,

Sun spots,

Laser Epilation

Laser epilation is a procedure that is increasingly preferred in society. In this procedure, concentrated laser beams are sent to the hair follicles, delaying and stopping hair growth in the roots. Repeated sessions are needed for laser epilation to yield effective results. The number of sessions required to achieve permanent results varies depending on the person's hair structure and hormonal status. In laser epilation, the first sessions are usually performed at closer intervals, while the time between sessions increases as the process progresses. Different devices with different features can be used in laser epilation depending on the hair structure and color. (Frederick et al., 2007).

Tattoo Removal

Cosmetic dermatologists can perform laser tattoo removal. Side effects such as scarring, changes in skin texture, burns or other wounds that may occur as a result of tattoo removal are less common after procedures performed by cosmetic dermatologists. The number of sessions the tattoo removal process will take varies depending on factors such as the color of the tattoo in question, how deep it has penetrated into the skin, and how long it has been on the skin. Tattoo removal can be applied to many people without any problems. However, people with health problems that weaken the immune system, pregnant women and breastfeeding women may not be suitable candidates for tattoo removal. (Swami et al., 2009).

Non-Invasive Fat Removal

People are born with a certain number of fat cells. These fat cells grow and swell when weight is gained, and shrink when weight is lost, but the number of cells does not change. Non-invasive fat removal is done by killing fat cells using cold, heat, ultrasound waves or various injections. In this way, the number of fat cells in the body and therefore the amount of fat is reduced. Non-invasive fat removal can be a reasonable option for people who cannot get rid of unwanted fat despite diet and exercise. (Edmonds, 2007).

Sclerotherapy

Some people may develop spider veins on their legs due to behaviors such as sitting for long periods of time, genetic factors and some other reasons. The appearance of spider veins can be disturbing for the person. In this case, sclerotherapy is an

effective method in treatment. In sclerotherapy, concentrated saltwater solution is injected into the spider vein. As a result of this injection, the vein shrinks and disappears. Sclerotherapy is especially effective in the treatment of small-sized and superficial spider veins. (Tam et al., 2012).

Micro Needling

Micro needling is a method used to improve skin problems such as age spots, wrinkles, lines, uneven skin texture and cracks. In this procedure, small-sized needles are inserted into the skin. The damage to the skin caused by the insertion process stimulates various mechanisms and activates the pathways that allow the skin to renew. This procedure, which basically uses the body's self-renewal mechanism, also increases the production of collagen and elastin in the skin. (Kim, 2022).

The skin is the largest organ of the body. Therefore, people who neglect their skin health also endanger their general health. The appearance of the skin is also one of the biggest factors affecting a person's quality of life. In the presence of a problem related to the skin, which is so important in terms of both health and aesthetics, the problem should not be ignored and a dermatologist should definitely be consulted. We wish you healthy days. (Tam et al., 2012).

1.8. Healthcare Management in Dermatology and Cosmetic Clinics

Dermatology and cosmetic clinics represent a unique model in the healthcare sector, combining specialized medical practice with elective cosmetic services, posing unique management challenges. These clinics face particular complexities stemming from the nature of the services provided, which combine medical treatment for dermatological diseases (such as eczema, psoriasis, and skin cancers) with cosmetic procedures (such as Botox, fillers, and laser treatments). Patient motivations and expectations differ radically between the two conditions. Successful management in these clinics places special emphasis on the overall patient experience, starting with a friendly welcome, continuing with comprehensive consultation sessions that accurately explain the procedures, risks, and expected outcomes, and ending with a comprehensive after-care system. (Edmonds, 2007).

This is due to the elective nature of many of these procedures, which makes patient satisfaction a determining factor in the clinic's continuity. These clinics face a double challenge: keeping up with rapid technological developments in the field (such

as advanced lasers and AI-powered skin analysis techniques) while maintaining quality and medical safety standards, all within a highly competitive and ever-changing environment where patients can choose from dozens of clinics. This is where patient relationship management (CRM) strategies and smart marketing strategies that rely on transparency and credibility come into play, focusing on building a reputation through real results and reliable patient testimonials, rather than relying on exaggerated advertising. Successful clinics understand that effective management must balance medical efficiency with marketing effectiveness, as every satisfied patient becomes not just a returning customer but also an ambassador for the clinic in their social and media environment. (Kim, 2022).



CHAPTER TWO

PATIENT EXPERIENCE

2.1. The Concept of Experience

The concept of consumption began to be addressed from an experiential perspective in the 1980s. Concepts such as experience, consumption experience, and change in economic value have all been reflected in marketing science over time, and the concept of experiential marketing has emerged. Since its inception, the concept of experiential marketing has shown itself in many areas in order to gain competitive advantage and create loyal customers by businesses. In marketing literature, experience and the concepts derived from it, customer experience and customer experience management, have increasingly begun to attract attention and have been addressed differently by various authors. While Pine and Gilmore (2000) point out the importance of customers in understanding what experience means, Klaus and Maklan (2007) claim that a company does not make a choice whether to engage with customer experiences or not. However, what is certain is that all consumption actions inevitably create an experience in the minds of customers (Hulten, 2011).

The foundations of the experience idea were originally made by Halbrook and Hirschman (1982). Academics have outlined the experiential nature of consumption and defined a general structure that depicts common consumer behavior measures. They have spoken about discrepancies between the experiential view, which points to the symbolic, aesthetic, and hedonic nature of consumption, and traditional information processing legacy. Later, Pine and Gilmore (1998) in their Harvard Business Review article entitled "Welcome to the experience economy" explained how economic value has changed over time and how commodities, goods, and services have transformed into experiences. They emphasized businesses to "think experientially" in trying to meet the demands of contemporary customers.

They described how business firms that offer unforgettable experience to their consumers reinforce their services and products and presented recommendations for providing distinctive experience. There is not a single shared definition of English literature terminology concerning experience. There were several studies by various scholars on the issue in the literature. Experience took different meanings in different domains and science disciplines. Whereas experience is considered objective and

closely related to experiments in science and philosophy of science, it is considered subjective in philosophy. Whereas sociology and psychology define experience as cognitive and sensory process and activities, anthropology and ethnology define it as the way people live life as part of a culture.

According to the Turkish Language Association dictionary, experience is expressed as “the totality of information acquired by a person over a certain period of time or throughout life, experience, expertise”. These interdisciplinary perspectives have influenced how marketers conceptualize experiences. Many researchers have conducted studies to clarify the concept of experience in marketing literature (Başar and Hassan 2015 and Deligöz and Ünal 2017). In this way, concepts such as “experience”, “experience economy”, “consumer experience”, “experiential marketing” have emerged. There are many definitions in the literature to explain the concept of experience from a marketing perspective.

2.1.1. Experience economy

Pine and Gilmore (1998) explained how economic value evolves by likening the entire history of economic progress to the stages of making a cake or pie for a birthday celebration. Accordingly, in the agricultural economy, mothers organized celebrations by making a birthday cake from scratch with flour, sugar, butter, and eggs. As the product-based industrial economy progressed, mothers began to make birthday cakes by purchasing pre-mixed and packaged ingredients. Later, when the service economy took hold, mothers (especially busy-working mothers) ordered cakes that were ten times more expensive than packaged products from bakeries or patisseries.

Now, parents do not make birthday cakes or parties, but instead spend more money and make arrangements with companies that will make their children experience an unforgettable event, and have them make the birthday cake and all the organization. This is exactly the concept called the experience economy.

The first stage of the classification put forward by Pine and Gilmore (1998) regarding economic offerings consists of commodities. It is formed by processing materials obtained from the world of commodities, plants and minerals. Products (goods) are formed from tangible and intangible activities that the customer can choose to purchase by processing commodities as raw materials, which is the second stage of the classification. The third stage, the service stage, consists of the combination of

tangible goods and intangible services. The last stage is called the experience stage. Accordingly, the things that remain in people's minds are their experiences. In this regard, it can be said that the service sector, which is not dependent on tangible offerings, is superior to other sectors. Experience is at least as different from services as services are from products. When an individual receives a service, they purchase a series of intangible activities.

However, when they receive an experience, they also purchase a pleasant time with a series of events that the business stages in a way that will attract their attention individually (like theater) and that will be remembered. In the concept called the experience economy, customers are not only interested in products, but also focus on the experience provided by products and services. Pine and Gilmore (1998) have argued that the experience itself is not material and that people attribute a value to the experience. Therefore, creating unique/unforgettable/valuable experiences for customers has become an important issue for businesses. Businesses are charging their customers more for the products and services they offer in order to create an experience. For example; “(as a commodity) the value and price of coffee (as a commodity) increases visibly in the process from the producer to the packaged and sold to the market (goods), from the coffee being served in a cup in a café (service) to the same coffee being served on the beachside of a 5-star hotel (experience)”.

Pine and Gilmore (2000) have argued that commodities can be measured in terms of their value, goods are material, services are immaterial, and experiences are memorable. According to the post-modern perspective, consumers are intelligent, articulated, and free-thinking individuals. Customers who are expected to make a purchase choice for rational reasons may sometimes make meaningless choices when convinced by an interesting experience. As the level of welfare increases, concepts such as entertainment, pleasure, happiness, and feeling comfortable become more important to customers, and having an experience in this direction may affect customers' selection preferences.

2.1.2. Consumption from an experiential perspective

The differentiation of the needs and characteristics of today's consumers has necessitated looking at the concept of consumption from a different perspective. The experiential perspective is one of these different perspectives. In the short history of

consumer behavior, while rational choice (microeconomics and classical decision-making theory) was initially emphasized, later the irrational purchase needs approach (supported by some motivational research) began to be used in these logical flow models (e.g., Howard and Sheth 1969). Later, an approach called the information processing model emerged; this approach viewed the consumer as a logical thinker who solves problems to make a purchase decision. According to the traditional perspective, the purpose of consumption is to meet the needs of consumers and that consumers' choices are based on cost-benefit analysis (Brauer, et al, 2018).

Holbrook and Hirschman (1982) in their article titled “Experiential Dimensions of Consumption: Consumer Fantasies, Feelings, and Entertainment” argued that various researchers have observed that the “information processing model” based on the assumption of rational decision-making neglects entertainment activities, sensory and emotional responses, and aesthetic pleasures. They stated that consumption, encompassed by the experiential perspective, has begun to be seen as a structure that includes a continuous flow of fantasies, feelings, and entertainment. They mentioned the differences between the traditional approach, the information processing model, and the experiential approach.

In addition to decision making and the experiential approach in consumer behavior, Mowen (1988) mentioned a third perspective, the behavioral approach. Accordingly, consumer behavior is affected by environmental stimuli. These factors may include social and cultural norms, environmental pressure, and environmental factors. The behavioral approach argues that environmental factors, not internal processes, are effective in making sense of customers' actions. For example, a study investigating the effect of music on consumers revealed that the tempo of the music playing in a retail store encouraged customers to purchase.

According to the decision-making perspective, consumers are interested in the objective features and physical benefits of products, while in the experiential perspective, hedonic consumption, which emphasizes the aesthetic, abstract and subjective features of products and services, is dominant (Hirschman and Holbrook, 1982). In the experiential perspective, the purchasing phenomenon is categorized as impulsiveness, unplanned purchases and variety seeking. According to the behavioral perspective, decision-making, rather than focusing on emotions or experiences, suggests that behaviors are directly affected by environmental factors.

The definition of the consumer has also changed with the change in perspectives. Stuart and his colleagues (2006) argued in their study investigating the concept of the “new consumer” that new consumers are active, knowledgeable, demanding and, above all, experience seekers.

2.1.3. Dimensions of Experiential Marketing

In recent years, growing attention has been directed toward the concept of customer experience, particularly in the emotional context of service delivery. Numerous studies have explored consumer satisfaction and the various factors that influence it. Although satisfaction is widely accepted as a core construct in service evaluation, there is still no academic consensus on how it should be defined or measured (Giese & Cote, 2000; Villodre, Calero, & González-Gallarza, 2014). This ambiguity has led to deeper investigations into its components.

Some researchers argue that service quality is predominantly cognitive, while satisfaction encompasses both cognitive and affective elements (Oliver, 1993). As a result, scholars have proposed distinguishing between cognitive satisfaction—based on analytical judgments—and affective satisfaction—shaped by emotional reactions to the service experience (Cronin & Taylor, 1992; Vinagre & Neves, 2008). This dual perspective is particularly relevant in sectors like healthcare, where the interaction between technical service quality and emotional perception is highly nuanced.

In healthcare systems—especially those in dermatology and cosmetic services—there has been a growing realization that understanding how patients experience care is as essential as providing the care itself. The concept of “patient experience” has thus emerged as a critical component of quality assessment and strategic development (Wolf, Niederhauser, Mashburn, & LaVela, 2014). Traditionally, health services were structured from an internal perspective focused on operational efficiency. However, incorporating the patient’s viewpoint offers valuable insights into improving both the service process and its outcomes (Reinares-Lara, Rodríguez-Fuertes, & Garcia-Henche, 2019).

Despite this recognition, significant methodological limitations persist in how patient experience is captured and interpreted. Sofaer and Firminger (2005) highlighted that most evaluation tools assume patients are entirely rational actors who can accurately process and report every aspect of their healthcare journey. Coulter et

al. (2014) expanded on this by arguing that merely collecting experience data is insufficient unless it is strategically used to improve service delivery and patient satisfaction.

To address these challenges and enrich the understanding of consumer experience, researchers have turned to experiential marketing as a conceptual and practical framework. According to Schmitt (1999), there are five strategic experiential modules (SEMs) that marketers can design to engage customers: sensory (SENSE), affective (FEEL), cognitive (THINK), behavioral (ACT), and social-identity experiences (RELATE). These experiences are delivered through various touchpoints, including communication, visual and verbal identity, product environment, and digital platforms, with the ultimate goal of crafting a holistic and immersive brand experience.

These are the five dimensions explored in the following sections:

- Emotional Dimension FEEL:

In dermatology and cosmetic clinics, the emotional dimension plays a vital role in shaping patient satisfaction and loyalty. Patients are not only seeking visible physical improvements but are often driven by deeper psychological motivations, such as enhancing their self-confidence, improving self-image, and achieving a sense of emotional well-being. As a result, how a clinic makes patients feel emotionally can be just as important—if not more so—than the technical outcome of the treatment itself.

When staff members display genuine empathy, actively listen, and offer emotional reassurance, patients tend to feel more secure, respected, and personally connected to the service provider. This emotional bond fosters a sense of trust, which becomes a foundation for long-term satisfaction and patient loyalty. In many Middle Eastern cultures, for example, personal warmth and emotionally rich interactions are not only appreciated but expected, making emotional engagement a key driver of positive word-of-mouth and return visits.

According to Schmitt (1999), emotional experiences create strong affective links between consumers and service providers. These connections often lead to repeated interactions and enduring brand loyalty. The emotional dimension in experiential marketing aims to trigger a range of emotional responses—from mild comfort to strong feelings of pride or joy—by addressing the internal states and personal values of patients.

To effectively tap into this dimension, clinics must understand the emotional triggers that resonate with their audience. Strategies such as personalized communication, emotionally attuned service delivery, and even storytelling techniques can be used to evoke authentic emotional responses. Ultimately, emotionally rich experiences in aesthetic clinics can transform the patient journey from a clinical transaction into a meaningful and memorable relationship

- Cognitive Dimension THINK:

In the increasingly competitive environment of modern healthcare, institutions must go beyond basic service provision and adopt strategic marketing approaches that align with their internal capabilities and market dynamics. According to Zajac (1994), healthcare organizations that fail to identify strategic opportunities, target the right patient segments, or integrate marketing with other operational functions risk losing connection with their most valuable asset — their patients.

Within this strategic context, understanding the cognitive aspects of patient experience becomes vital. The cognitive dimension relates to how patients process information, form judgments, and evaluate their interactions with the clinic. Reinares-Lara, Rodríguez-Fuertes, and García-Henche (2019) emphasize that while both cognitive and emotional dimensions are key contributors to satisfaction, they are distinct and must be addressed separately, as each affects the patient experience differently. It is not about determining which is more important, but about recognizing their combined influence on decision-making and loyalty.

Moreover, how patients mentally encode and recall their experiences significantly shapes how satisfied they feel. Redelmeier and Kahneman (1996) found that patients do not assess their medical experiences as a sum of all events but rather judge based on how the experience ended and the average emotional tone throughout. This finding is echoed by Reinares-Lara et al. (2019), who observed that patients often disregarded delays or discomforts when the final stage of the care process was handled positively and professionally. Such insights highlight the importance of managing not only the content of information but also the timing and emotional framing in which it is delivered.

By aligning cognitive engagement with strategic marketing practices, healthcare institutions can foster deeper patient understanding, trust, and ultimately, long-term satisfaction and loyalty

- Sensory Dimension SENSE:

The sensory dimension of experiential marketing focuses on stimulating the five senses: sight, sound, smell, taste, and touch. By creating rich sensory experiences, brands can differentiate themselves and leave lasting impressions. In practice, this might involve visually appealing environments, ambient music, calming scents, or high-quality materials that enhance the overall feel of the service. A well-designed sensory experience can build brand recognition and provide subtle but consistent reinforcement of the brand image (Schmitt, 1999).

Schmitt, B. H. (1999). *Experiential marketing: How to get companies to sense, feel, think, act, and relate to your company and brands*. New York: The Free Press.

In the context of healthcare services, especially in dermatology and cosmetic clinics, these sensory elements become even more critical in shaping how patients perceive their experience. For instance, dim lighting, warm color schemes, and gentle aromatherapy have the potential to transform a typical clinical visit into an atmosphere that feels closer to a spa. Such thoughtful design choices do not merely serve aesthetic purposes; they contribute to patient comfort and emotional relaxation.

Importantly, real patient feedback often emphasizes the impact of sensory details—such as background music—on their overall sense of calmness during treatment. Several participants have reported that soft, soothing music played during their consultations made them feel more at ease, less anxious, and more connected to the environment.

Moreover, cultural preferences must also be taken into account when designing sensory environments. Patients in the Gulf region, for example, may prefer settings that reflect elegance, luxury, and opulence, while others may be more responsive to minimalist aesthetics or environmentally conscious design. These cultural nuances influence what is perceived as comforting or high quality.

Ultimately, a well-designed sensory environment does more than please the senses; it reduces anxiety, improves perceived service quality, and strengthens brand distinctiveness. Even subtle enhancements—like gentle music, refined scent diffusers, or soft, high-thread-count linens—can significantly elevate the patient’s overall journey through the clinic.

- Behavioral Dimension ACT:

ACT marketing focuses on influencing consumers’ behavior and physical actions. It seeks to inspire lifestyle changes or promote new ways of doing things. For example, a brand may encourage users to adopt healthier habits, explore new routines, or engage with products in interactive ways. This dimension often relies on aspirational messaging, role models, or motivational themes that align with the desired identity of the consumer. The ultimate goal is to translate engagement into tangible behavioral outcomes (Schmitt, 1999).

In the context of healthcare—particularly in cosmetic clinics—this behavioral dimension takes the form of encouraging patients to actively participate in their care. This may include adopting skincare routines, using digital tools to track progress, enrolling in loyalty programs, or attending follow-up consultations. By involving patients in these practices, clinics not only promote healthier behaviors but also strengthen the patient’s sense of responsibility and ownership over their treatment outcomes.

Such involvement has been linked to improved compliance, better clinical results, and deeper, long-term relationships between patients and the clinic. Providing practical tools—such as printed instructions, mobile apps, or visual progress charts—can further empower patients and reinforce positive behavioral habits.

It is also important to consider the role of cultural context in shaping behavioral preferences. Some individuals prefer to be hands-on and actively engaged in their treatment, while others may rely more heavily on professional guidance and expect the clinic to lead the process. Regardless of the approach, behavior-based interactions enhance customer involvement and increase the personal relevance of the experience, ultimately leading to stronger emotional and brand connections

2.2. The Concept of Patient Experience and Its Importance

Patient experience includes the interaction of patients with the healthcare system, including health plans that begin before they enter the healthcare institution, practices provided by physicians, nurses and other healthcare personnel, and services provided by the healthcare facility. There are three critical areas in the implementation of patient experience. The first of these areas is that the concept of patient experience provides the entire healthcare organization, the realization that people are more interested in emotional experiences than rational experiences, and in addition, patient experience is concerned with intuitive perceptions (Chatterjee et al ,2012).

The understanding of patient experience has been formed with the foundations of the customer experience philosophy that began in other sectors. The foundations of the customer experience concept were laid with the article “Welcome to the Experience Economy” published in 1998. According to marketing literature, traditional marketing is a system that attracts customers with affordable products, has few product varieties, and focuses on the benefits of the product by the customer. This marketing perception has gradually given way to the experiential marketing approach. The main theme of experiential marketing is to provide the customer with experiences that will make them feel special and different (Deloitte, 2016).

Following these approaches, the concept of “Customer Experience” entered the marketing world and many definitions were made. In its most concise definition, customer experience is the interaction between the organization and the customer. Schmitt described customer experience as a process-oriented approach and stated that it is different from the concept of satisfaction. Another definition is that customer experience is a subjective and emotional concept, and can vary depending on the service and product received. The mutual interaction and importance of information between customers and the organization form the basis of experience (Kırılmaz, 2013).

If we bring all these definitions together to a common point, customer experience is defined as all the outputs that are different for each person, divided into two as spiritual and physical, appeal to customer emotions, give the power to manage the market, and provide economic benefits. In healthcare institutions, the concept of customer consists of patients. Customer experience has emerged as patient experience in healthcare institutions. Since losing health creates unhappiness, patient experience

in healthcare institutions should be examined and implemented more sensitively. Patient expectations and the degree to which they are met, such as patients' appointments, communication with the physician, the physician's sufficient information to the patient and the fact that this information is sufficient for the person, form the basis of patient experience. Dr. According to Foster, patient experience is defined as the totality of objective and subjective feedback of the patient during the care or treatment process. (Palmer, 2010).

The most important step in providing patient-centered care is patient experience. The health organizations adventure that starts with the appointment of the patients continues when they are discharged, and the experience gained by the patients individually during this process is used as a good method to determine the quality of health care. Patient experience is used to measure the quality and performance of health services and to guide improvement efforts. The philosophy of patient experience is used to evaluate the quality of care as well as patient safety and clinical effectiveness on patients. (Kondasani, & Panda, 2015).

Evaluation of health services is essential in improving the quality of medical services. Traditionally, technical and physical reports were taken into consideration, while patient evaluations were neglected. However, recently, health systems have started to take into account not only clinically effective and evidence-based evaluations, but also evaluations that are acceptable and useful to patients. All kinds of data from patients are the basic feature of patient-centered care. (Hwang, and Seo, 2016).

Patient feedback reported directly by patients is known as the best measure of their quality of experience. It is presumed by most that asking patients to describe in detail what happened in a given care episode is better than asking patients to rate satisfaction on broad categories of measurement. Patient experiences and views combined are important to provide transparency in healthcare or to guide payment policies. Studies have proven that some clinical outcomes intersect with patient-reported experience (Audet, Davis, Schoenbaum, 2006). In the past, there has been a broad difference between those who provide and those who receive care.

This disparity is brought about by the fact that recipients of the service are largely unable to comment upon the services that they receive. Patients' needs and concerns,

however, require respect as part of a humane and high-standard healthcare system. There is also a need to highlight areas within the service where it needs improvement and obtain opinions from the patients in order to monitor its performance and quality. Certain governments and regulatory authorities have now indicated a need to monitor patients' views on services (Audet et al, 2006). Patient surveys are standard practice in Western countries to assess patients' experience. For example, in the UK NHS (National Health Service), patient experiences are assessed regularly with a common assessment tool and action is taken on the results.

Once again, in the United States, patient opinions are gathered by patient experience surveys developed by the Agency for Healthcare Research and Quality and Centers for Medicare and Medicaid Services. In order to achieve patient satisfaction goals, it is really important to understand the reasons that are covered in patient evaluations. Patient experience in health care is a key indicator of how effectively the health care system is functioning. Therefore, improving patient experience in health organizations has become a high priority for both policy makers and clinical leaders. (Yimeret al,2020). Previous studies (Safran et al,2006).

Conducted in other healthcare facilities have shown that negative experiences with healthcare as reported by the patients are associated with slower recovery from illness and reduced likelihood of adhering to treatment programs. As a result, negative patient experiences have serious effects on patients' health and also on increased healthcare costs when patients seek additional healthcare services due to failure to recover and failure to adhere to treatment programs. Studies in patient experience that are reported in the literature are varied in two aspects.

It would not be wrong to say that this disparity comes solely from an academic perspective.

The first is the discovery of patient experience from a "public health" perspective, and the second is from an "experiential marketing" perspective. While the patient experience surveys conducted by a public health perspective include experience with the constructs such as "satisfaction, contentment, service quality", the experiential marketing perspective includes experience with the construct of "experience economy". The first perspective is prevalent throughout the literature. Surveys employed in satisfaction research have positive scores and are insensitive to

some of the problems of service delivery. Conversely, it is observed that studies in healthcare facilities from an experiential standpoint are very rare. (Wong et al,2015). Furthermore, beyond any doubt, among the benefits of competition to health organizations across the globe today is to give special experiences to their patients. In this, patient experiences are measured and then it is determined how experiences are related to satisfaction and loyalty (Renedo ,2014).

2.3. Difference Between Patient Experience and Patient Satisfaction

The concept of patient experience is used to evaluate the quality of care and performance of healthcare institutions and to shed light on improvement processes. Since patient satisfaction measurement provides less specific information for the quality improvement process in healthcare institutions, it aims to examine the experience in depth. The concepts of satisfaction and experience are often used interchangeably, but when examined in depth, the desired goal is different. (Renedo ,2014).

Satisfaction is a phenomenon that is stuck between the expectations of patients from healthcare institutions and their experiences. Patient satisfaction forms the basis of the institution and is the most important tool for maintaining its continuity. The greatest goal of healthcare institutions is to continue the diagnosis and treatment process in patients with the least number of errors, as well as to ensure the satisfaction of patients and their relatives by meeting their emotional expectations. In its simplest form, customer (patient) satisfaction in healthcare institutions is defined as “receiving service in line with the requests of customers or providing service above their expectations”. Patient satisfaction is affected by the expectations and preferences of patients in different groups regarding the care they will receive and the perceived quality of care. (Wong, et al,2015).

When examining patients' satisfaction levels, healthcare businesses question whether patients are satisfied or not. When measuring experience, satisfaction is measured as well as the degree of their experience with the service they receive. For example, when patients are asked to evaluate their waiting times for a doctor, the answer they give is satisfaction, while the experience is measured by asking how many minutes they waited. While waiting for a certain amount of time for a doctor is a very satisfying situation for some patients, it is considered a dissatisfying situation for a

patient who has never waited in their previous experiences. In addition to these questions, questioning waiting times aims to collect data that supports improvement efforts based on patient waiting times for a doctor and to reflect the experiences on satisfaction by improving them (Butcher & Banh ,2020).

One of the questions that should be asked when measuring patients' experiences with healthcare is whether patients' reports about their healthcare experiences reflect the quality of care. Healthcare providers express some concerns about patients' feedback, especially feedback evaluating "patient satisfaction". They claim that patient feedback is not reliable due to patients' inadequate health literacy and information asymmetry. They believe that patient satisfaction measurement results result in "happiness" that is easily affected by factors independent of the care process. (Wong et al, 2015).

2.4. Measuring Patient Experience in Healthcare Facilities

It is the questioning of how often patients experience what they experience in healthcare facilities where they receive care and the existence of necessary factors such as materials and human resources for care.

The need of researching patient experience comes from (Butcher & Banh ,2020):

- Patients are the only ones who experience the care process and are actually experts in the subject,
- They are the key to evaluating the quality of care in healthcare facilities,
- Patient experiences are directly related to health outcomes,
- Patients have a direct say in healthcare decisions.

The different language of communication between the patient and the physician affects the course of treatment, its outcome and therefore the quality of treatment. It has been observed that patient feedback is not only medical feedback focused on nursing care and physician communication, but also includes patient experiences under the title of accommodation services that do not require health care, such as room, bed, companion and meal service. On the other hand, when patient experience is evaluated in terms of health care, it includes the involvement of the patient and their relatives in the care process, providing sufficient and accurate information about their treatment, effective communication, and sharing their experiences in terms of health care. Patient

experience measurement surveys measure the level of impartial and accurate information that patients receive about their illness and treatment. (Sedianingsih, & Prasetyo, 2016).

Surveys have begun to be used in many European countries, primarily in the United States (US), as well as in Australia, Canada, and New Zealand. The purpose of these surveys is not to measure how satisfied patients are with their care, but how they experience and perceive care. Patient experience surveys do not focus on activities, but rather investigate how frequently patients experience health needs in the care they receive and whether critical aspects are recognized. (Kevrekidis et al ,2018).

Patient experience can be measured in general, as well as being examined in two ways: outpatient healthcare patient experience and inpatient healthcare patient experience. Outpatient patient experience includes faster and shorter patient experiences. On the other hand, the inpatient experience, which is the experience where patients and their relatives come into more frequent and frequent contact with all healthcare professionals and areas due to long treatment periods, is also important for improving quality processes and increasing patient satisfaction. (Firuzan, 2017).

Patient experience is a multifaceted inquiry and examination process such as waiting time, pain management, and training. As a result of the studies conducted, a harmonious relationship was found between patient experience and patient safety and effectiveness, and it was concluded that patient experience should be considered the most important step in increasing the quality of care. In a different study examined, it was determined that physicians who received communication skills training were more likely to be in harmony with the patient. As a result of studies conducted in 389 health organizations s in Europe, patient experience data are used more in clinical quality and patient safety measures and in evaluating the quality of care. (Arab et al,2012).

Using data to increase quality and satisfaction in healthcare institutions Patients' experiences during the diagnosis and treatment process in healthcare institutions are the most important step in measuring and evaluating the quality of care. Many European countries, especially the UK and the US, have made arrangements to measure patient experiences at a national level, and the results are announced to the public annually, and businesses examine each other's results, contributing to the identification of areas open to improvement. (Firuzan, 2017).

Following patient experience studies conducted in the UK, strategies such as the establishment of national guidelines, the public disclosure of data related to quality of care, and the development of audit programs have led to improvements in primary health care services. Collecting patient experience data alone is not meaningful. A satisfaction level is not questioned as in satisfaction surveys, and what is important is to correctly examine patient experience data, including satisfaction, which is complex in nature, and to initiate improvement processes with a multidisciplinary team. It has been determined that in order for the care provided in healthcare businesses to be equal, it will be beneficial to address and discuss the positive and negative aspects of the criteria by the entire business in order to increase the effectiveness of patient experience measurements (Wong et al,2015).

2.5. Profit Analysis Based on Patient Experience in Health organizations

The success of health organizations enterprises can be measured by their ability to keep up with innovations and developments in a tough competitive environment. This success is possible with the existence and sustainability of a healthy financial structure. It is essential for enterprises to work with a stable operating profitability in order to sustain their existence (by renewing). Therefore, profitability analyses are indispensable tools for health organizations enterprises in the control and supervision of their financial structures and performances. (Gregory, and Austin ,2021).

The customer group of health organizations s with the characteristics of a service enterprise consists of patients. Patients expect to receive quality health services and have their examinations, tests and treatments performed. One of the main duties of health organizations s is to provide quality health services to patients and ensure that their treatment processes are completed positively. For this purpose, health organizations s, as institutions that constantly renew their assets according to technological and scientific developments, must constantly control and increase their income, and therefore their profits. One of the profitability analyses that can be performed by health organizations enterprises is patient-based profitability analysis. The two important elements of patient-based profitability analysis are patient-based cost and patient-based income. (Gill & White, 2009).

In health organizations s, patient-based health service costs must be calculated according to cost accounting rules and approach. The cost of the health service

provided to the patient is collected (or accrued) from the Social Security Institution, contracted institutions or paid, and income is obtained from the patient. Profit calculations and analyses can be performed on a patient basis using the costs and incomes resulting from health services. (Başar, and Hassan, 2015).

As a result of the profitability analysis, health organizations will have evaluated patient processes and carried out the audits and controls of both costs and income. Health organizations enterprises, just like other profit-oriented enterprises, must find and implement methods and ways to reduce their costs in order to increase their profitability. Because the diagnosis and treatment fees received from patients cannot be increased outside of the competitive conditions and the prices determined by the Ministry. Therefore, processes where costs are high and diverse should be re-analyzed and costs should be tried to be reduced. For example, if the medical materials used in the health organizations can be supplied to the health organizations at lower prices, a significant cost reduction will be achieved. In the next section of the study, details about patient-based income and patient-based cost, which form the basis of patient-based profitability analysis, are included. Patient-based income was evaluated based on public health organizations. (Ghattas & Al-Abdallah 2020).

• Patient-Based Income

The patient-based income obtained by health organizations enterprises varies according to the patient's social security. As such, we can divide patients into three groups according to their social security. These are (Gregory & Austin, 2021):

- Patients subject to SGK (Sosyal Güvenlik Kurumu - Social Security Institution)
- Patients from official institutions other than SGK (banks, private insurance, etc.)
- Paid patients.

The Social Security Institution pays the invoice amounts declared by health organizations for the health services they provide, according to the principles of the Health Implementation Circular (SUT). In outpatient treatments, a per case (package) fee is paid and the examinations listed in Annex-2/A-2 in SUT are paid in addition to the per case fee. In addition, examinations performed in the same branch within the first 10 (ten) days following the first examination date in polyclinic applications are

considered control examinations and no additional fee is charged. For inpatients, the package payment system or the payment per service system is applied according to SUT. In the package payment system, a fixed fee is paid regardless of the cost of the health service, medicine and medical supplies provided. (Ağırbaş, 2014).

• **Outpatient Income**

Outpatient income is the income obtained from the relevant examinations and medical procedures as a result of the health service provided to patients who apply to health organizations polyclinics for examination and treatment. Outpatient income items consist of examination, laboratory, radiology, pathology, nuclear medicine, interventional procedure, ECG, ECO, etc. laboratory test income. Different amounts of income are obtained depending on the patient's social security. For example, if the patient's social security is subject to SGK, the income obtained is according to the SUT principles; if the patient is affiliated with another institution outside SGK (private insurance, bank, etc.), the income is obtained based on the contract prices. (Gregory & Austin ,2021).

In the outpatient payment application of SGK patients; for each outpatient application, payments are made to health institutions based on the amounts in the SUT Annex . Inpatient income includes bed fees, surgery, procedures performed in the clinic and operating room, anesthesia, medicine, medical supplies, blood and blood products, consultation, laboratory, radiology, pathology, nuclear medicine, endoscopy, ECG, ECO, etc. laboratory test income, intensive care treatment, dialysis, physical therapy and other medical application income. As in outpatient patients, patient incomes vary according to their social security. However, among these, the largest share of patient income is made up of patients with SGK. (Buccoliero, et al,2017).

In second and third level health institutions, if the inpatient health services are included in the SUT Annex ANNEX-2/C List, income is provided according to the "payment based on diagnosis-based procedure" method; if it is not included in the SUT Annex ANNEX-2/C List, income is provided according to the "payment per service" method. (Ağırbaş, 2014).

• **Cost Per Patient**

Health organizations s provide a wide range of health services and these services are not homogeneous. The diversity and heterogeneous structures of these services

make cost calculations difficult in health organizations. In particular, the fact that the variety of services varies from patient to patient makes it even more difficult to calculate the cost of patient-based healthcare services. For example, the examinations and treatments applied to 50 patients who apply to a polyclinic may differ. Therefore, all expenses incurred for healthcare service production must be distributed correctly to patients. Correct distribution will be achieved if the correct cost calculation methods are used. When calculating healthcare service costs, a cost calculation method appropriate to the functional structure of health organizations enterprises must be applied. (Wong, et al,2015).

Using inappropriate cost methods will cause both cost analyses and profitability analyses to be made and interpreted incorrectly. Wrong investment decisions made by health organizations managers based on these results and evaluations may cause serious financial losses to health organizations. Cost calculations are a tool that provides health organizations managers with reliability in controlling expenses within the health organizations, preparing budgets, calculating unit costs, planning future investments and making important and strategic decisions about the health organizations. One of the most ideal methods that can be applied in patient-based cost calculations in health organizations enterprises is the order cost system.

As its name suggests, the order cost system is a method in which the costs incurred from the production of a specific job (product or service) for which an order is received to the delivery process to the person who placed the order are calculated. It is also a cost calculation technique used to determine the costs of the product group separately in enterprises that produce in certain batches and produce products of a very different type or quality from the others in each batch.

Considering the features such as the change and diversity of the health service provided from patient to patient and the implementation of non-standard treatments, it is clearly understood that the order cost system is suitable for calculating costs on a patient basis. In this system, each patient is considered an order and the costs of the patient's different treatment stages are calculated separately. These costs are recorded on the patient cost card and all expenses charged to the patient are seen in detail on the cost card. As a result of the addition of the costs of all treatment stages of the patient upon the termination of the health service, the cost per patient is calculated. Thus, the income obtained as a result of the health service provided to the patient will be

compared with the calculated cost, and the profit per patient will be calculated. (Brauer et al ,2018).

In order for the order cost system to be successfully implemented in health organizations and profitability analyses to be performed, the patient flow processes in the health organizations must be analyzed very well. All expenses incurred in the units to which the patient applies for treatment from the time he/she enters the health organizations to the time he/she leaves the health organizations must be reflected to the patient. If the processes are not analyzed well, the data in the cost cards created in the order cost system will be incorrect and therefore the patient's cost will be calculated incorrectly. (Brauer et al ,2018).

Thanks to the patient-based cost cards created with the order cost method, the costs of patients who have the same diagnosis and treatment or surgery can be compared and audited. For example, two patients with similar characteristics (same gender, age group, no chronic diseases) who apply to the cardiology clinic with a diagnosis of heart failure are given similar medical tests and treatments. If there is a significant difference between the total costs incurred as a result of the health service provided to these patients, cost analyses can be performed to determine what kind of expenses are higher for the patient with the higher cost. Thus, the excess (avoidable) expenses that may arise in other patient groups will be reduced with the measures to be taken, and profitability per patient will be increased. In particular, tests that are not paid by the Social Security Institution and are performed on the patient unnecessarily cause both an increase in the health organizations's cost burden and a decrease in its profitability. (Chatterjee et al, 2012).

2.6. Patient Experience

2.6.1. Patient experience in cosmetic and dermatological clinics

The patient experience in cosmetic and dermatological clinics is the cornerstone of the success of these clinics. Patients attach great importance to the quality of service, cosmetic results, and psychological comfort during and after treatment. The patient experience includes all aspects related to their visit to the clinic, such as (Gill & White, 2009):

1. Quality of care: Patients expect professional and accurate care, whether medical or cosmetic.

2. Comfortable environment: Providing services in a comfortable and calm environment enhances patient satisfaction and contributes to a positive treatment experience.

3. Clear communication: Explaining medical and cosmetic procedures in a clear and understandable manner helps patients make informed decisions and reduces anxiety associated with cosmetic procedures.

4. Expected results: Patient satisfaction depends largely on whether the results match their expectations. Therefore, a clear explanation of the expected results is an essential part of the patient experience.

A positive patient experience enhances the clinic's reputation, which increases the chances of patients returning again or referring their friends and acquaintances, which directly enhances profitability.

2.6.1.1. Service Quality and Patient Satisfaction

Service quality has long been a central theme in health service evaluation, yet it remains a complex and multifaceted concept. As several scholars have observed, there is no single, universally agreed-upon definition of service quality, as it can be understood through different theoretical lenses. Reeves and Bednar, for example, outlined four major perspectives: quality as excellence, value, conformance to specifications, and meeting or exceeding expectations. Each view offers insight into the nature of quality but also presents specific challenges, particularly in service industries where customer perceptions play a dominant role (Hernon, Nitecki, & Altman, 1999).

In healthcare, service quality is often divided into two main components: the technical dimension, which refers to the accuracy and competence of clinical procedures, and the functional dimension, which relates to how the service is delivered to patients. Given that most patients lack medical expertise, their judgments are usually shaped more by the functional aspects—such as staff responsiveness, attentiveness, and communication—than by clinical outcomes themselves (Al-Neyadi, Abdallah, & Malik, 2018).

One of the most widely used tools to assess service quality in healthcare is the SERVQUAL model. This model was originally developed by Parasuraman, Zeithaml, and Berry (1988) as a structured framework for comparing customer expectations and perceptions across five key service dimensions: tangibles, reliability, responsiveness, assurance, and empathy. Its widespread adoption across industries reflects its simplicity, applicability, and diagnostic power (Parasuraman, Zeithaml, & Berry, 1988).

Each of these five dimensions captures a specific aspect of patient experience. Tangibles refer to the physical facilities and appearance of personnel; reliability indicates the ability to perform promised services accurately; responsiveness reflects the willingness to assist patients promptly; assurance is the demonstration of knowledge and courtesy; and empathy involves offering personalized care and understanding (Al-Neyadi, Abdallah, & Malik, 2018).

However, despite its popularity, SERVQUAL has received methodological criticism, especially regarding its reliance on difference scores (i.e., subtracting expectations from perceptions). Researchers argue that this indirect method reduces measurement reliability and narrows score variance, ultimately affecting the validity of the results. Furthermore, the ambiguity in how expectations are measured—whether ideal, predicted, or minimum—adds to the difficulty of interpreting outcomes (Oh, 1999).

An alternative model that addresses some of these issues is the expectancy-disconfirmation framework. In this model, satisfaction arises when patients compare their expectations directly with their perceptions of actual performance. If the experience meets or exceeds expectations, satisfaction occurs; if not, dissatisfaction is likely. This model places emphasis on subjective, emotional reactions rather than objective calculations, making it more suitable for capturing the nuanced nature of healthcare experiences (Oh, 1999).

Empirical studies further reveal how specific quality dimensions affect satisfaction and loyalty. One such study conducted in hospitals found that only reliability and responsiveness significantly predicted patient satisfaction, while other dimensions such as empathy, tangibles, and assurance were less influential. The same study confirmed that satisfaction was directly linked to patient loyalty, while variables

such as age and marital status had no significant impact—though gender showed some influence (Meesala & Paul, 2018).

In addition, internal organizational practices play a key role in shaping service quality. For example, high-performance work systems (HPWS) have been shown to influence employee behavior, operational efficiency, and ultimately the perceived quality of care. When employees are engaged and systems are well-coordinated, patients report higher satisfaction and a stronger sense of loyalty to the healthcare institution (Lee, Lee, & Kang, 2012).

Finally, it is important to distinguish between service quality and satisfaction, despite their close relationship. Service quality is a broader, ongoing evaluation based on accumulated expectations and experiences, while satisfaction is more transaction-specific and emotionally driven. A patient may feel satisfied with one encounter but still perceive overall service quality as lacking, or vice versa. Therefore, both constructs must be addressed to ensure a comprehensive understanding of patient experience (Hernon, Nitecki, & Altman, 1999).

2.6.2. Medical services management in cosmetic and dermatology clinics

Medical Services Management in Cosmetic and Dermatology Clinics plays a vital role in achieving operational efficiency and ensuring quality of care. The main tasks of management are (Alharbi & Almutairi, 2020):

1. Organizing patient appointments: To ensure that there are no delays in providing services, which enhances patient satisfaction and gives a positive impression.

2. Resource Management: From the use of medical materials to technology, everything must be managed efficiently to ensure high-quality services without extra costs.

3. Staff Training: Continuous training of the medical team and clinic workers on the latest cosmetic techniques and methods helps improve results and ensure excellence in providing care.

4. Continuous quality assessment: By obtaining patient feedback, management can improve the services provided and address any problems that may arise.

Effective management of medical services leads to a superior patient experience, which enhances the profitability of the clinic. Cosmetic and dermatology clinics that manage their services effectively not only benefit from increased patient satisfaction but also from an improved reputation and increased demand for their services.

Cosmetic and dermatology clinics in the Kingdom of Saudi Arabia have witnessed significant development in recent years, in line with the major transformations in the healthcare sector in the Kingdom within the framework of Vision 2030. The demand for cosmetic and dermatology services has increased as a result of rapid economic growth, increased awareness of the importance of beauty care and skin health, and the development of the country's health infrastructure. Cosmetic and dermatology clinics in Saudi Arabia vary between clinics that provide non-surgical cosmetic services, such as filler injections, Botox, and laser techniques, and clinics specializing in skin treatments, such as treating acne, skin problems, and skin pigmentation. Many of these clinics provide advanced services by using the latest global technologies in the field of cosmetics and dermatology (Al-Sheikh & Aldhafferri, 2021).

2.6.3. Patient experience in Saudi cosmetic and dermatology clinics

In Saudi Arabia, the patient experience has become the focus of attention in cosmetic and dermatology clinics. This experience is based on providing a comfortable and distinguished environment for patients, with a focus on providing care with the highest quality standards. The patient experience is improved through (Al-Sheikh & Aldhafferri, 2021):

1. Excellent customer service: Clinics are keen to provide an integrated service starting from the moment the patient is received until the follow-up stage after treatment.

2. Transparency in communication: Patients receive clear and comprehensive information about the procedures and expected results, which enhances their confidence in the clinic.

3. Attention to personal results: Clinics provide customized services based on the patient's individual needs, which increases the level of satisfaction and satisfactory results.

4. Advanced technology: The use of modern devices and advanced technologies enhances the effectiveness of treatments and leads to an improved patient experience.

The profitability of cosmetic clinics in Saudi Arabia depends largely on providing integrated services that meet the needs of the middle and upper classes. With the increase in demand for non-surgical cosmetic and dermatological procedures, clinics have been able to achieve higher profitability. Factors that affect the profitability of cosmetic clinics include:

1. Increasing demand: With the increase in awareness of cosmetic options and the availability of financial capabilities, the profitability of these clinics has increased.

2. Reliable results: Clinics that provide satisfactory results play an important role in enhancing their reputation and attracting more customers, which is directly reflected in profits.

3. Comprehensive services: Clinics that offer a wide range of treatments, whether cosmetic or dermatological, generate greater income as a result of attracting a larger number of patients.

4. Advertising and marketing: Good marketing and excellent services contribute greatly to improving profitability, as many clinics promote themselves through social media

2.7. Relationship between Patient Experience and Health Service Management

The relationship between patient experience, profitability and health service management is an important aspect that directly affects the performance of health institutions and their ability to continue providing high-quality medical care. With the major changes taking place in the health sector, patient experience has become one of the most important indicators of success and profitability for hospitals and health centers. Growing awareness of the importance of improving patient experience has prompted institutions to rethink how to manage their health services to enhance profitability and provide integrated health care (Alharbi & Almutairi, 2020).

The patient experience includes all interactions that a patient undergoes within a health institution, starting from receiving them, through the medical services provided, and ending with care after leaving the hospital. Studies indicate that a positive patient experience plays a major role in improving their level of satisfaction with the health

care they receive, which is positively reflected in profitability. A patient who is satisfied with the service he received often returns to the health institution in the event that he needs future medical services, and he may also recommend it to his friends and relatives, which enhances the institution's reputation and increases its revenues. (Alharbi & Almutairi, 2020).

On the other hand, a negative patient experience can lead to negative outcomes, such as not returning to the hospital or providing negative reviews that affect the reputation of the healthcare institution. With the increasing reliance on online patient reviews and personal recommendations, the patient experience has become an important role in attracting new patients and retaining existing patients, making it a key focus in improving profitability. There are several strategies that hospitals can adopt to improve the patient experience. First, providing personalized care is one of the most important factors that contribute to improving the patient experience. Patients feel comfortable when they receive special attention from the medical and administrative staff, which increases their satisfaction. Allocating time to listen to patients' needs and responding to their inquiries helps strengthen the relationship between the patient and the hospital, which is reflected in the patient's evaluation of his experience and increases the chance of his return in the future. (Pine and Gilmore, 2000).

Second, developing the infrastructure and improving the treatment environment within the hospital contribute greatly to the patient experience. A clean and comfortable environment that provides privacy for the patient is an integral part of comprehensive healthcare, and helps relieve the psychological stress and pressure that the patient may feel during the treatment period. Third, investing in technology plays a vital role in improving the patient experience. Modern technology such as electronic appointment management systems, electronic medical records, and smartphone applications that allow patients to easily book appointments or communicate with doctors, contribute to improving the flow of service and reducing the time taken to provide care. These factors lead to improved patient satisfaction with the service provided and thus enhance the profitability of the hospital (Al-Sheikh & Aldhaffer, 2021).

2.8. Description of the Studied Clinics

2.8.1. General context of the studied clinic

The study was conducted in a specialized dermatology and cosmetic services clinic in the Kingdom of Saudi Arabia. This clinic represents a common model in the private healthcare sector, offering both medical and cosmetic services to a diverse patient population, combining traditional dermatological treatments with modern cosmetic procedures such as Botox, fillers, and laser therapies .

The clinic is distinguished by its central location in a bustling urban area, attracting a diverse demographic in terms of income, education level, and healthcare needs. It features a modern medical environment in terms of design and equipment and follows a digital administrative system for patient registration and medical record management .

2.8.2. Organizational and administrative features of the clinic

The clinic operates on an appointment-based system, with patients being received by a receptionist who manages the electronic booking system and provides initial information. There is a clear separation between cosmetic and dermatological departments, but administrative procedures are unified, with patient data entered through a centralized platform that includes medical history and the type of service requested .

In terms of human resources, the clinic has a specialized medical team consisting of dermatologists, cosmetic technicians, and healthcare assistants, all working on a shift basis to cover weekdays. The staff is characterized by gender and cultural diversity, enabling the team to interact effectively with a broad patient base .

2.8.3. Services Provided

The clinic offers the following services :

-Medical Dermatological Services: Treatment of chronic conditions such as psoriasis and eczema, management of fungal and bacterial infections, and follow-up for moderate to severe acne cases .

-Cosmetic Services: Include skin rejuvenation treatments, laser sessions for hair removal or pigmentation correction, Botox and filler injections, and cosmetic skincare .

-Consultation Services: Initial case assessment, treatment plan development, and addressing patient inquiries regarding the effectiveness and potential side effects of procedures .

2.8. 4. Infrastructure and patient experience

The clinic features air-conditioned, modernly decorated waiting areas with awareness screens displaying information about cosmetic procedures. Appointments are managed electronically, reducing waiting times, though delays may occur during peak hours. Some patients described the initial registration process as slightly complicated, particularly for those with limited education or elderly patients, while others found it smooth due to cooperative staff .

The checkout process involves visiting the receptionist to schedule follow-up appointments or complete payment. While some participants expressed satisfaction with this process, others noted a lack of privacy when discussing costs or cosmetic services .

2.8. 5. Record of activities of the clinics

- Establishment of the Patient Experience Department

A specialized department was launched to systematically manage patient feedback, monitor service quality, and address client concerns directly—reflecting a shift toward patient-centered care.

- Definition of roles and responsibilities for front desk staff

Clear job descriptions were developed to ensure consistent service delivery, eliminate role confusion, and enhance overall reception efficiency.

- Recruitment and training of reception staff

New staff members were hired and trained in key areas such as communication skills, complaint documentation, internal workflows, and professional email etiquette ensuring readiness to deliver high-quality service.

- Recruitment of qualified medical professionals

The clinic expanded its team by hiring dermatologists and cosmetologists, supporting service diversification and ensuring clinical competency aligned with patient expectations.

- Operational restructuring and spatial improvements

Administrative restructuring began, including revising internal layouts, adding waiting areas, side tables, and signage contributing to a smoother patient flow and better comfort.

- Introduction of electronic fingerprint attendance system

This system was proposed and implemented to enhance accountability and monitor punctuality among staff, promoting discipline and operational efficiency.

- Implementation of uniforms and employee ID badges

Uniforms for reception and cleaning staff, as well as ID badges, were introduced to create a professional image and improve patient trust and staff visibility.

- Development of marketing strategies targeting patient loyalty

Loyalty-focused strategies included seasonal offers, bundled services, and personalized client gifts emphasizing retention of existing patients as a primary revenue source.

- Contracting with marketing and digital health platforms

The clinic collaborated with marketing agencies and health service apps to attract new clients, improve visibility, and expand market reach.

- Analysis and resolution of patient complaints

A more focused and structured approach was adopted to track and analyze complaints, allowing for informed adjustments such as modifying service durations based on client and staff feedback.

- Enhancement of clinic aesthetics and branding

Interior décor, branding posters, and visibility tools such as external signboards were introduced or improved to enhance the clinic's appearance and patient perception.

- Adoption of national healthcare accreditation standards (CBAHI)

Full implementation included proper waste segregation, drug storage protocols, sterilization procedures, accessible facilities, instructional signage, and display of legal documentation all aligning with regulatory and quality standards.

- Establishment of quality assurance and performance tracking system

A simplified QA system was designed to monitor key indicators such as bookings, cancellations, reasons for withdrawal, and staff productivity enabling data-driven decisions.

- Conducting customer satisfaction surveys and feedback analysis

Structured surveys and informal feedback were analyzed to guide service improvements and strategic planning related to patient experience.

- Improvement in clinic rating and patient retention indicators

A measurable rise in online ratings (e.g., Google Reviews) and patient visits highlighted the positive effect of administrative quality improvements on customer satisfaction.

CHAPTER THREE

METHODOLOGY OF THE STUDY

3.1. Research Method

This study adopts the qualitative research methodology as the optimal theoretical and methodological framework to achieve its objectives, as this approach enables it to dive into the depths of patients' subjective experiences and understand them in their natural context. The research relies on the interpretivist philosophy that sees social reality as a multi-layered construction that is shaped by the interaction of individuals with their environment. In this framework, we are not looking for absolute truths, but rather multiple meanings that patients construct through their experiences with health services.

The qualitative approach was chosen because it is well suited to study complex social phenomena that are difficult to quantify, such as perceptions of quality and experiences of interaction with health systems. This approach provides methodological flexibility that allows for adaptation to the changing field context, and enables the researcher to capture nuances in individual experiences that quantitative approaches may miss. The research relies on the principle of theoretical saturation, where data is collected until a point is reached where new interviews do not add new substantive information.

3.2. Research Design

The research follows an in-depth descriptive case study design that allows the studied phenomenon to be understood in its natural context. This design relies on the principle of methodological triangulation by collecting data from multiple sources (interviews, medical records, field notes) to ensure the comprehensiveness of the results. The research tools were carefully constructed, as the semi-structured interview guide was designed to include three main themes: The experience of interacting with the administrative system, the evaluation of the quality of the medical service, and the extent to which the service met preconceived expectations.

The interview questions were formulated in an open-ended manner that incentivized participants to narrate their experiences with richly detailed anecdotal

accounts. For example, instead of asking: “Was the service good?” the question “Tell me in detail about your experience from the moment you entered the clinic until you left” was asked. The last part of each interview was dedicated to exploring any unexpected aspects that the participant might raise. Each interview lasted between 45 to 60 minutes and was conducted in a location of the patient's choice to ensure their comfort during the conversation.

3.3. Research Population

The study population includes all individuals who received any type of services in dermatology and cosmetic clinics in Saudi Arabia during the time period specified for the research (From 2/9/2024 to 4/12/2024). This community is characterized by a large demographic diversity that reflects the demographics of the area served by the clinic. In terms of age, patients range from adolescents at the age of sixteen to seniors in their seventies. There is also a clear diversity in educational levels, from illiterate to holders of advanced degrees.

Socially, the community includes patients from different economic strata, with the clinic providing services to those who are financially well-off and those who are covered by government health insurance. There is also a diversity in the types of medical conditions between chronic skin diseases (psoriasis, eczema), acute conditions (skin infections), and cosmetic services (laser hair removal, Botox injections). This rich diversity in the indigenous community provides fertile ground for understanding how different patient segments interact with the same administrative system.

3.4. Study Sample

The study sample was selected using a random sampling method, which aimed to demonstrate maximum diversity within the small sample size of 15 clients at the clinic under study. Consent was obtained from all participants after a thorough explanation of the research objectives and procedures. The researcher emphasized the participant's right to withdraw at any time without any impact on the services they receive. Complete confidentiality was ensured by using pseudonyms and removing all information that could identify the participants.

3.5. Data Analysis

First, the data was analyzed descriptively, and a SWOT analysis was conducted to identify the strengths, weaknesses, opportunities, and threats in the clinic under study. The interview data was then analyzed in several stages, beginning with extensive data preparation. The interviews were transcribed and recorded immediately after they were conducted, preserving the participants' original expressions. The transcription process was accompanied by analytical notes recording the researcher's initial impressions and observations. In the second stage, the transcripts underwent in-depth thematic analysis by the researcher to analyze the qualitative data.

The analysis began with a careful, repeated reading of the transcripts to identify the primary analytical units. Coding and summarization were then applied within broader categories such as "registration experience," "medical staff interactions," and "service expectations." Finally, five key themes were extracted that capture the essence of patients' experiences. To ensure the reliability of the findings, several strategies were applied: Participants were verified, confirming that their views were accurately represented. The researcher ensured that all steps of the analysis were thoroughly documented to provide a clear audit trail for other researchers to follow.

3.6. Limitations of the study

The study faces several methodological and practical limitations that should be taken into account when interpreting the results:

1. Limitations related to the sample: The small sample size (15 participants) limits the generalizability of the results, although the selection of purposeful cases partially mitigated this issue. Also, relying solely on volunteers may lead to selection bias towards more satisfied or dissatisfied patients.

2. Limitations related to data collection: The study's primary reliance on self-report has the potential for recall bias, especially with regard to past experiences. Also, conducting the interviews in the clinic may affect the honesty of the answers due to the participant's feeling of insecurity.

3. Analytical Limitations: Qualitative analysis is inherently somewhat subjective, despite measures taken to ensure objectivity. The inability to disentangle the influence of different factors (e.g. personality traits, circumstances surrounding the visit) limits the accuracy of the results.

4. Time limits: The data collection period was limited to one week and may not reflect seasonal changes in work pressure or service quality. Also, the study was not able to track the evolution of patients' opinions over the long term.

5. Contextual limitations: The results reflect the reality of a single clinic with its own circumstances, limiting the transferability of the results to other contexts with different resources or administrative policies.

3.7.Ethical Considerations in Research Interviews

Research interviews require strict compliance with ethical factors to protect the rights of participants and ensure study integrity. Informed consent was obtained from all the participants prior to data collection, meaning that they were fully aware of the purpose of the study, the fact that they volunteered, and their right to withdraw from the study at will without any consequences. Anonymity was protected through coding all the responses participants were assigned pseudonyms (e.g., P1, P2) in place of personal identifiers. Interviews were even conducted in a secluded setting to prevent unauthorized access to confidential information. Additionally, the researchers minimized potential harm through omission of intrusive questions and allowing participants to omit any topic they were not comfortable discussing. All procedures were reviewed for ethical issues, adhering to research guidelines on human subjects (e.g., principles of respect for persons, beneficence, and justice from Belmont Report). Such measures were designed to make the study scientific in character and maintain participants' dignity and welfare.

3.8. Findings

3.8.1. Descriptive Analyses

Table1 .Sample demographics & treatment preferences

Category	Subgroup	Count	Percentage (%)	Examples/Observations
Age (years)	20-29	3	20%	Young adults (e.g., acne, laser hair)
	30-39	4	26.7%	Mid-career (e.g., Botox, fillers)
	40-49	2	13.3%	Mixed concerns (e.g., anti-aging)
	50-60	6	40%	Older adults (e.g., psoriasis, diabetic care)
Gender	Female (F)	12	80%	Dominant in cosmetic treatments
	Male (M)	3	20%	Focus on acne scars, skin tags
Treatment	Cosmetic	9	60%	Botox, fillers, skin tightening
	Dermatological	4	26.7%	Acne, eczema, psoriasis
	Medical Care	2	13.3%	Mole removal, diabetic care

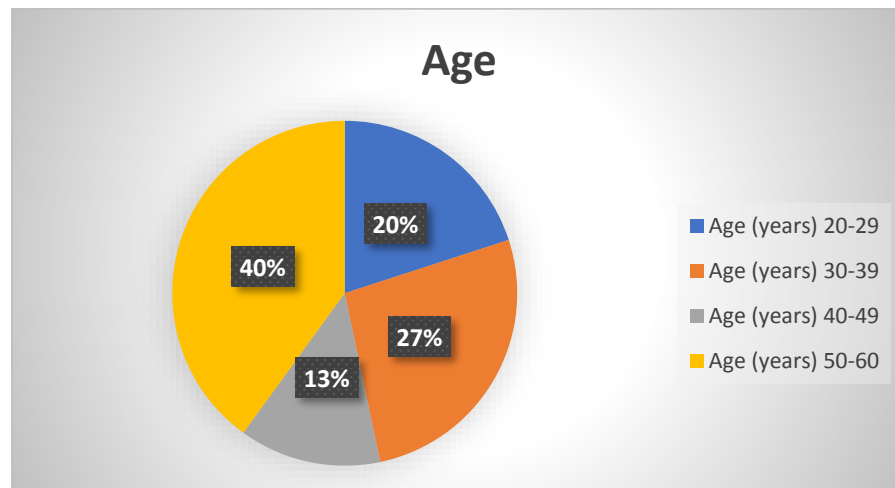


Figure 1. Age Distribution

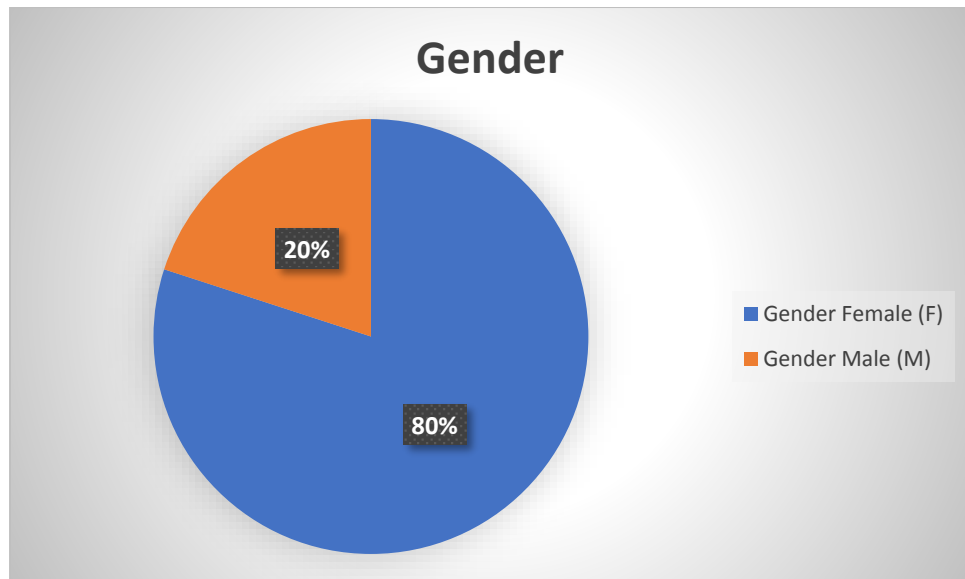


Figure 2. Gender Distribution

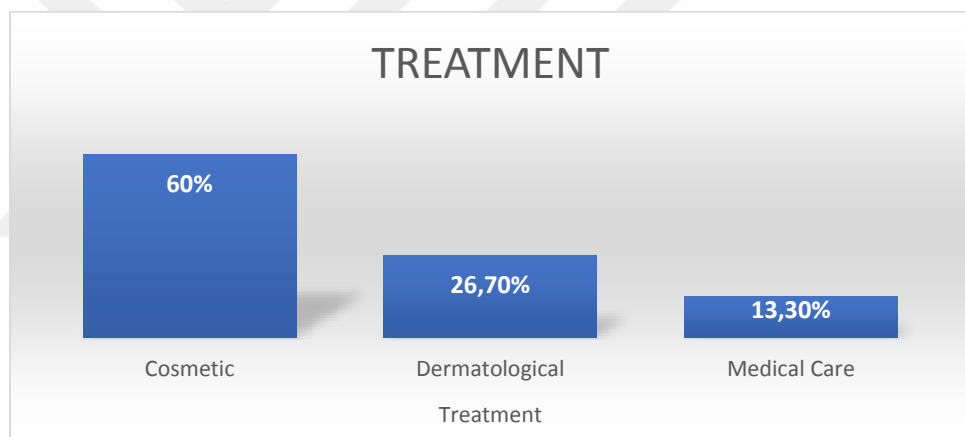


Figure 3. Treatment Type Distribution

The table and figures confirm an overwhelmingly female (80%) patient base, with a strong focus on cosmetic treatments like Botox, fillers, and skin rejuvenation demonstrating a high concern for appearance. Age distribution shows a strong bias towards the older patients (40% 50-60 years old), who require treatment for such ailments as psoriasis or diabetes management in addition to anti-aging treatments. Younger patients (20-29 years, 20% of sample) will request solutions for acne, laser hair removal, while middle-aged segments (30-49 years) cover both cosmetic and dermatological needs. Men, although a smaller segment (20%), will request utilitarian dermatology (e.g., removal of moles, acne scarring). Pain points of value like privacy

invasions, ambiguous aftercare, and accessibility hurdles (e.g., complex online appointment for seniors) represent opportunities for clinics to set the patient experience bar higher. Cosmetic demand dominance (60% of treatments) suggests clinics to optimize these services and address logistics gaps (e.g., follow-ups, visual consent aids) frustrating patients by age group.

3.8.2. Thematic Analysis of Clinic Patient Interviews

This is a thematic analysis of clinic patient interviews using the NVivo qualitative data analysis tools. This analysis includes identified themes, supporting quotes, and visual representations such as a thematic map.

This analysis examines the qualitative responses of 15 diverse patients visiting a clinic in Saudi Arabia for various treatments (cosmetic, dermatological, and chronic disease treatment). The goal is to identify key themes related to their experiences across different touch points: booking, arrival/reception, consultation/interaction with medical staff, treatment process, environment, emotional state, post-visit support, and overall satisfaction/value. The analysis summarizes patient quotes to illustrate each theme.

The analysis follows the principles of thematic analysis, which include data familiarization (interview transcripts), initial coding of key concepts, searching for potential themes, reviewing and refining themes, defining and naming themes, and reporting. The focus is on identifying patterns in patients' experiences and perceptions.

3.8.2.1. Coding

Table 2. Codebook (Themes & Sub-themes)

Main Theme	Subthemes	Example Quotes
1. Booking & Registration	<ul style="list-style-type: none"> - Digital vs. phone booking difficulties - Confirmation delays - Assistance for illiterate/older patients 	"I couldn't book myself because I don't read or write." (60F)
2. Reception & Check-in	<ul style="list-style-type: none"> - Warmth of staff - Efficiency vs. delays - Personalized touches (drinks, name recognition) 	"The receptionist greeted me by name." (50F)
3. Doctor-Patient Interaction	<ul style="list-style-type: none"> - Clarity of explanations (visuals, simple language) - Time constraints - Trust-building 	"He explained my condition slowly, using simple words." (60F)
4. Treatment Experience	<ul style="list-style-type: none"> - Privacy concerns - Comfort during procedure - Reassurance during treatment 	"Someone entered the room during my procedure." (34F)
5. Clinic Environment	<ul style="list-style-type: none"> - Cleanliness & ambiance - Noise levels - Accessibility (older patients) 	"The place was clean but noisy and crowded." (60F)
6. Post-Treatment Support	<ul style="list-style-type: none"> - Follow-up communication - Aftercare instructions (written/verbal) 	"They called after the visit, which made me feel cared for." (44F)
7. Cost & Affordability	<ul style="list-style-type: none"> - Perceived value - Financial strain (students, retirees) - Discount requests 	"It was expensive for someone in my situation." (60F)
8. Emotional Experience	<ul style="list-style-type: none"> - Anxiety vs. comfort - Feeling respected/ignored - Confidence in results 	"At first, I felt lost." (60F)

Table 3. Patient Analysis Matrix

ID	Age and gender	Treatment required type	Treatment	Top 3 Codes	Key Quote
P1	60F	Psoriasis	Form-filling help, Visual aids, Cost concern	"They drew pictures for me"	6/10
P2	22F	Acne	Instagram booking, Fast results, Student discount need	"My skin cleared in 2 weeks!"	9/10
P3	34F	Botox	Privacy breach, Doctor explanation, Loyalty gift	"Someone walked in mid-procedure"	5/10
P4	38F	Fillers	WhatsApp booking delay, Private room, Price increase	"No confirmation until I called"	7/10
P5	44F	Botox/Fillers	Reception uncertainty, Visual consent, Swelling worry	"Will people notice my lips?"	6/10
P6	55F	Botox	Tablet registration, No delays, Natural results	"Done in 30 minutes - amazing!"	10/10
P7	26M	Acne scars	Website booking, Coffee service, Payment plans	"The diagrams built trust"	8/10
P8	31M	Skin tags	Phone booking, Past records access, Background music	"Nurse played my favorite songs"	9/10
P9	29F	Laser hair	App booking, Parking confusion, Hurried feeling	"Wished they'd explain more during"	6/10
P10	50F	Diabetic care	Long hold time, Name tags, Bright lighting	"Doctor showed instruments clearly"	7/10
P11	47M	Mole removal	Diabetes protocol, Follow-up scheduling, Special consent	"They remembered my condition"	9/10
P12	32F	Skin rejuvenation	Email instructions, Digital progress screen, Music	"Felt like a spa"	9/10
P13	60M	Eczema	Online struggle, Hard chairs, Senior discount need	"Website wasn't for old eyes"	4/10
P14	36F	Skin tightening	Instagram booking, No water offered, No follow-up	"Great doctor but poor aftercare"	6/10
P15	50F	Anti-aging	Name greeting, Treatment history printout, Music option	"Almost perfect - just needed water"	8/10

The following table provides detailed feedback from 15 patients (P1 to P15) who underwent various dermatological and cosmetic treatments, ranging from psoriasis and acne to Botox, fillers, and diabetic skin treatment. Each entry documents the gender and age of the patient, their specific treatment needs, and significant aspects of their clinic experience such as booking channels (Phone, WhatsApp, Instagram), comfort factors (music, visual aids), and pain points (privacy breaches, waiting time). The "Top 3 Codes" column distills recurring themes in their feedback, e.g., demands for speedy outcomes, aftercare issues, or appreciation for personal touches (e.g., nurses playing a patient's favorite music). Direct quotes, e.g., P3's dismay at someone entering the room during a procedure or P6's delight at a 30-minute Botox procedure, add affective richness. Satisfaction scores (on a scale of 4/10 for poor digital accessibility to 10/10 for seamless service) reveal clear strengths (e.g., streamlined treatments, thoughtful amenities) and weaknesses (e.g., aftercare, elder-friendly systems). Together, the data gives a clear picture of patient priorities speed, privacy, personalization and actionable recommendations for the clinic to enhance its quality of service.

Table 4. Coding Matrix

Theme	Frequency
Booking Experience	15
Medical Interaction	15
Environment & Atmosphere	13
Cost & Accessibility	13
Patient Emotions	10
Post-Treatment Support	12
Reception & Staff	12

Table 4 above reports patient complaint summaries by main themes, showing how often each issue was raised across interviews. The numbers tell us about the care topics most important to patients and where clinics need to make improvement priorities.

The two most frequent themes medical interaction and booking experience (both mentioned 15 times) capture areas of pain. All patients across the board complained of appointment system difficulties, especially older patients with digital exclusion. Another significant factor was how doctors communicated: when they spoke quickly or mumbled, most did not feel heard, but when they listened and used visual aids, trust was built.

Hot on their heels (13 mentions apiece) were concerns about clinic ambiance (noise, cleanliness, privacy) and financial barriers, specifically chronic and older patients. These are grounded, everyday issues with immediate impact on comfort and access. Less frequent but still prominent were emotional states (10 mentions), receptionist behavior (12 mentions), and inadequacies in post-treatment follow-up (12 mentions) an area often overlooked in the face of the impact on patient confidence.

This is a pattern of a clear needs hierarchy: patients esteem accessible systems, powerful physician-patient relationships, and welcoming spaces prior to nuance such as follow-up phone calls. The matrix not only enumerates complaints but also indicates where small interventions (such as training staff in empathy or adding privacy screens) may disproportionately boost satisfaction.

3.8.2.2. Comprehensive patient experience map

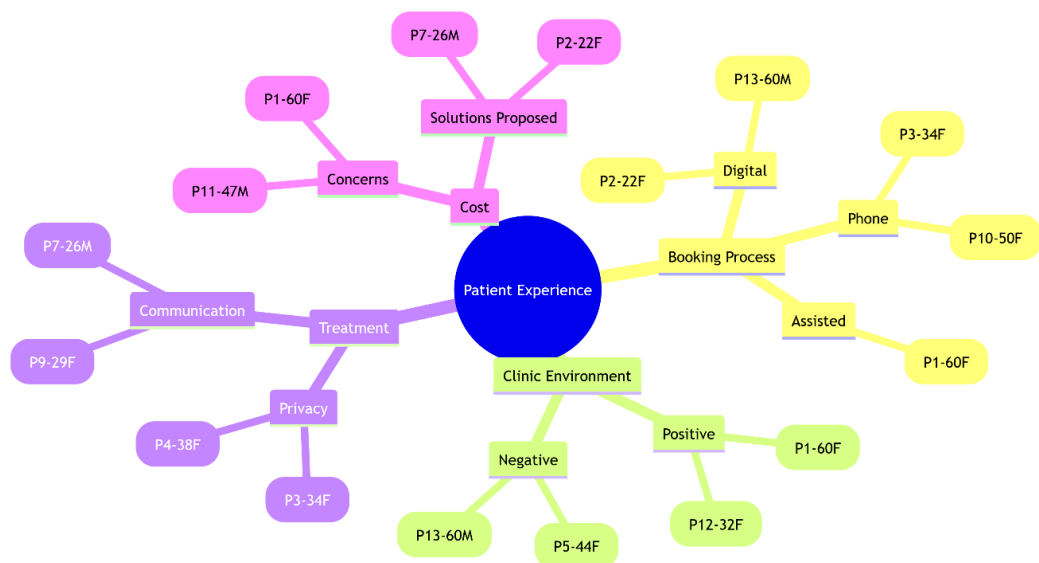


Figure 4. Comprehensive patient experience map

Going into a clinic is a daunting task especially if you are already dealing with health concerns. Our patients' accounts tell both the little things that matter and the infuriating barriers that they face.

For the majority of the younger patients, like Sarah (22), online booking was straightforward. "I saw them on Instagram, and it was all two minutes!" she explained. But not for everyone, like Mr. Al-Mansoori (60), with technology getting in the way. "I had to get my daughter to do it for me—the website wasn't made for a person like me."

Once inside, the atmosphere sets the tone. A clean, calming space with soft music put Layla (32) at ease: "It felt like a spa, not a hospital." Yet, for others, the experience was less soothing. Ahmed (47) noticed how "the reception area was so loud, I could barely hear the nurse call my name."

Privacy and good communication were standout requirements during treatment. Rania (34) still recalls the embarrassment when "a nurse came in during my Botox injection—it broke the mood." Meanwhile, Dr. Hassan's tendency to draw diagrams was applauded by Omar (26): "He didn't lecture; he showed me precisely what he'd do."

Price was at the back of most people's minds. Retired teacher Fatima (60) admitted, "I worry if I can afford my next visit." Even those who could afford to pay, like banker Noor (44), wanted transparency: "Just tell me the price upfront so I'm not surprised."

These patients aren't data points, though they're human beings in need of care that respects their needs, whether that's a less noisy waiting room, a clearer price list, or a doc who takes the time to tell them. The best clinics don't just fix conditions; they observe the human being behind them.

3.8.2.3. Analysis of the Answers According To Theme

1. Booking Experience

The study highlights strong contrasts in patients' ability to cope with appointment booking systems, mainly conditioned by age and digital literacy levels. Less educated older patients, such as P1 (60F, treatment for psoriasis), struggled very much, with one individual actively stating "I couldn't book it myself because I don't

read or write." This group inevitably required family intervention or staff assistance to perform simple administrative tasks. The case of P13 (60M, eczema follow-up) corroborates this problem once more, his heartfelt observation that clinic websites "weren't made for old eyes" highlighting the lack of age-friendly digital interfaces."

Easier, tech-enabled patients like P2 (22F, acne treatment) and P6 (55F, Botox), conversely, reported problem-free interactions with digital interfaces, booking appointments "in minutes" through Instagram or tablet systems. This big difference serves to underscore a basic accessibility shortfall in healthcare administration. The numbers suggest that current systems fail to support patients on the digital literacy level, potentially violating fair principles of access to care. Potential solutions include implementing voice-based technologies, dedicated phone hotlines staffed by trained representatives, and in-person kiosk support to enable all patients to book themselves easily and with dignity without needing help.

A review of tech-friendly consumers' experience with online booking platforms reveals overwhelmingly positive but mixed results. P7 (26M, removal of acne scars) praised the website of the clinic as easy to use and useful in delivering graphical explanations, how "the diagrams built trust before arrival." Similarly, P8 (31M, removal of skin tags) enjoyed personal service received when booking over the phone, when staff helped in selecting a suitable specialist from among them, personalized to his needs.

However, some instances disclosed reliability issues that negatively affected the user experience. P4 (38F, filler injections) was nervous when her WhatsApp appointment went unconfirmed until she initiated contact, alleging "I didn't receive confirmation until I called." Such communication lapses in digital systems can erode patient trust and cause unnecessary anxiety. These findings show that although the online platform as a whole is suited for technology-oriented patients, clinics must have robust confirmation procedures, live status reports, and fail-safe notification mechanisms to ensure reliability keeps up with convenience.

Patient feedback can help to hone booking procedures. P9 (29F, laser hair removal) identified a need for more informative acknowledgement messages, including logistical details like parking information. P13 (60M) advocated specialist

telephone support particular to older patients, the need for "extra patience" when communicating with less technology-savvy ones.

These recommendations align with existing principles of universal healthcare design. The evidence suggests that ideal booking systems should incorporate:

- Multi-channel access (app, phone, face-to-face)
- Proactive notification of status
- Age-convenient interfaces
- Full logistical detail
- Training staff to support vulnerable groups

2. Medical Interaction

Quality of medical consultation was seen as a significant determinant of patient satisfaction, and communication style conditioned very dissimilar encounters. P1 (60F) had excellent understanding where professionals used pictures ("They showed me pictures of my psoriasis"), and P11 (47M, diabetic mole removal) valued the careful explanation of instruments and techniques. These examples demonstrate how tailored communication strategies can bridge health literacy gaps.

Alternatively, P9 (29F) had felt rushed during her laser treatment consultation and wanted more explanation being done in the process. P3 (34F, Botox) had suffered suboptimal care when staff members had broken into her procedure, disturbing trust and concentration. These experiences go to highlight the ways in which time pressure and environmental factors can undermine otherwise top-notch medical care.

The essence of healthcare is not so much in clinical outcomes, but in the way patients feel in the process. Our interviews reveal profound insights into what truly governs satisfaction the moments of rapport, the gestures of comprehension, Patients repeatedly emphasized that technical proficiency is not what constitutes a good physician it's the ability to connect. P11 (47M, diabetic mole removal) lit up describing his physician: "He didn't just talk about my wound; he asked how diabetes affects my life." This holistic approach made him feel seen as a person, not a case. Similarly, P6 (55F, Botox) praised her doctor's patience: "She showed me before-and-after photos so I'd know exactly what to expect."

But there are still gaps. P9 (29F, laser hair removal) had her worries dismissed during a hasty consultation. "I had questions, but the doctor kept looking at the clock," she confessed. Those seconds stay with you long after the consultation, wearing away trust. The moral? Time is the most precious commodity in medicine. Even 30 extra seconds to query, "What concerns you most about this treatment?" can make all the difference.

The evidence suggests that exemplary medical communication must include:

- Visual aids for complex information
- Specifically procedure-related informed consent protocols
- Interruption-free treatment environments
- Pace-matched explanations
- Frequent oral reassurance during procedures

3. Clinic Setting and Its Psychological Impact

Physical clinic design significantly influenced patient comfort and sense of quality care. P12 (32F, skin rejuvenation) described overwhelmingly positive surroundings with "spa-like ambiance and calming music," while P5 (44F, fillers) found the lobby "noisy and chaotic," increasing pre-treatment tension. Privacy concerns emerged specifically, with P3 (34F) feeling uncomfortable when staff entered during her Botox treatment, contrasting with P4's (38F) pleasure in having her private treatment room.

These findings point to the importance of intentional clinic design with aspects such as:

- Noise dampening and soundproofing
- Transparent signage navigation
- Personal treatment rooms
- Comfortable waiting areas
- Standard privacy policies

4. Financial Value and Accessibility

Price became a significant obstacle for certain patient groups but one that was readily accepted by others when paired with excellent service. P1 (60F) complained about the price of psoriasis treatment as compared to her pension, while P13 (60M)

actually requested senior discounts. Some younger patients like P2 (22F) requested student price concessions.

Interestingly enough, patients like P6 (55F) and P11 (47M) willingly paid premium prices when topped with top-notch service, whereupon P6 said her "flawless 30-minute experience" was worth the dough. This contradiction suggests that while cost is a genuine hindrance for some, value perceived serves to contribute to financial problems where the standard of care is excellent.

Suggestions made by patients include:

- Sliding scale fees according to income
- Discount programs for students/seniors
- Transparent payment plans
- Reward benefits for repeat visitors
- Transparent value communication within pricing

5. Emotional Journey through the Care Experience

Patient testimonies show how emotional experiences also followed predictable paths based on engagement with staff and environments. Initial bad impressions, e.g., feeling "rushed and unwelcome" by P13 (60M) at reception, led to ongoing distrust difficult to overcome. Conversely, P15 (50F, anti-aging) felt valued when being greeted by name and built immediate rapport.

The results identify how small things like P11's (47M) nurse departing on his preferred music can turn fear to calm. The results highlight the importance of:

- Trauma-informed care education
- Regular warm welcomes
- Personalized comfort interventions
- Emergency emotional support policies
- Staff education in empathy

6. Post-Treatment Engagement and Continuity of Care

Follow-up care resulted in an unexpected but critical component of the patient process. P14 (36F, tightening skin) bemoaned the lack of post-treatment check-ins, while P11 (47M) praised the clinic's effort in scheduling his next diabetic care appointment.

The contrast between these experiences suggests that standardized follow-up processes would significantly enhance patient satisfaction and clinical outcomes. Proposed enhancements include:

- Automated 24-hour check-in messages
- Follow-up appointments scheduled before discharge
- Detailed post-treatment care instructions (hard copy and online)
- Exclusive channels for post-treatment queries
- Patient satisfaction surveys



CONCLUSION AND RECOMMENDATIONS

The essence of health care is not only clinical results, but also in the emotions of the patient during the treatment process. Our interviews reveal deep insights into what it actually means to be contented moments of connection, acts of compassion, and the unwritten certainty that someone actually cares.

A clinic visit can be intimidating for the majority of patients, especially older patients or patients who have little exposure to medical systems. Patient P1 (60F, psoriasis), who found reading and writing difficult, reported that she was reassured when a nurse noticed she was reluctant to complete forms and explained each question carefully. "She didn't make me feel ashamed," she said. Contrast this with patient P13 (60M, eczema), who was made to feel neglected when staff hurried her through her test. "They treated me like a number," she said. These stories all lead to a simple truth: the first five minutes set the tone for the entire visit. When receptionists smile, glance at someone, or simply say, "I'll help you with this," they transform fear into confidence. Patients again and again emphasized that technical skills do not equal a good doctor, but that communicating makes it so. Patient P11 (diabetic mole removal at age 47) lightened up when he spoke of his doctor: "He did not just talk about my wound; he asked how diabetes impacts my life." By working with the entire person, instead of curing an issue, this made him feel like a person, not just an illness. Similarly, P6 (age 55, Botox injections) praised her doctor's patience: "She showed me before and after pictures so I knew just what to expect".

Nevertheless, there were shortcuts. P9 (29, laser hair removal) had her concerns dismissed in a rush consultation. "I asked questions, but the doctor kept looking at the clock," she admitted. These moments linger on long after the consultation is over, eroding trust. Lesson learnt? Time is the scarcest commodity in medicine. Even taking 30 seconds to ask, "What worries you most about this treatment?" can be the difference.

Satisfaction is often a matter of those seemingly small things. Patient P8 (31M, skin tags) still recalls the nurse who recommended playing his favorite music during treatment. "It made me forget that I was in a clinic," he described. Patient P12 (32F, skin rejuvenation) felt more at ease when her physician warned her beforehand about

each laser pulse: "She would say, 'You'll feel warm now—that kept me from shivering'".

On the other hand, P3 (34F, Botox) was unable to overcome her discomfort when a staff member entered mid-procedure. "It broke the illusion of safety," she acknowledged. These experiences are meant to remind us of a fundamental principle: dignity is in the details. A warm blanket, a courtesy before a cold stethoscope goes against bare skin, or a tightly shut door these are respects.

Financial pressure looms over the majority of patients' lives. Patient 1 (60 years old) whispered, "I don't shop for groceries so I can afford psoriasis creams." For her, a 10% discount gives her some leeway. In contrast, Patient 7 (26 years old, acne scars) justified the astronomical cost of his treatment by saying, "I took an hour mapping out my scars with me".

This disparity reveals a bitter truth: When care appears tailored, patients stretch their wallets. When care appears transactional, each dollar hurts. Clinics with transparent payment structures (like Patient 7's, which partnered with Tabby) or reward systems (as Patient 6 had) mitigate this sting while building good will.

The relationship can continue beyond payment. Patient 14 (36, skin tightening) was bewildered when no one phoned to follow up on her after her PRP treatment. "What if I swelled? Who would I call?" Conversely, Patient P11 (47 million) was treated like royalty when his clinic called 24 hours after the procedure. "The nurse playfully said, 'How's our special patient?' I laughed".

This contrast presents an implicit medical norm: Care does not stop when the bill comes. A two-line WhatsApp (e.g., "Hope you're doing well! Answer yes if you have any questions") is free, but it produces loyalty.

In an era of AI bookings and robot surgeries, our study reveals a surprising fact: People remember how you care long after they've forgotten your credentials. The most satisfied patients whether Patient P6 gives their Botox injections 10/10 or Patient P8 is effusive about their nurse's play list share one thing in common: being treated like a human being, not a chart. To clinics that care: Teach your staff not only procedures, but emotional intelligence as well. Measure not just in cure rates, but in how many patients can say, "They treated me like family."* This is the measure that's changing healthcare.

The findings of this study reveal several important conclusions about patient experience in dermatology clinics worthy of serious notice in the face of existing studies. The digital divide between healthcare accesses emerges as a persistent issue, notably affecting older and less technology-literate patients. This is consistent with the most recent international trends identified by the World Health Organization (2024), which reported that almost 40% of over-60-year-old patients all over the world have considerable difficulty accessing digital health platforms. The syndrome also appears to be especially heightened in specialty settings like dermatology, where appointment systems are increasingly shifting to solely digital interfaces.

In terms of clinical engagement, our results confirm long-standing recognition of the established relationship between patient satisfaction and physician communication style. A 2023 meta-analysis by Thompson et al. for the *Journal of Patient Experience* demonstrated that physicians who use visual aids and plain, non-jargon language receive 35% more satisfaction ratings. But our study provides more insight to that knowledge by demonstrating how environmental factors - such as violations of privacy or a clinic's noise levels - can significantly undermine even the most capable physician's effort at communication.

The cost of care was found to be intriguingly paradoxical. While some patients were willing to pay top dollar for perceived high-quality care, others in actuality lurked behind true financial limitations. The paradox validates the work of Anderson and colleagues (2023) in *Health Affairs*, who noted a growing "two-tier" perception in outpatient specialty care. Of most concern is our finding that financial limitations disproportionately affect chronic disease patients, putting treatment adherence and outcome at risk.

The post-treatment process was identified as an area that needed immediate focus. Our findings support the research of Singh et al. (2024), who discovered that inconsistent follow-up protocols are one of the most frequent complaints among ambulatory care facilities. This is especially true in dermatological interventions where effective aftercare plays a crucial role in clinical results.

The experiential dimensions outlined in Schmitt's (1999) framework were clearly reflected in the responses of several participants in this study. For example, one patient noted how the subtle background music playing throughout the clinic contributed to her overall relaxation. She stated that "the treatment room features soft, calming background music that created a great vibes to me"

This reaction strongly aligns with the sensory (SENSE) dimension, which emphasizes the importance of appealing to the five senses in enhancing the customer experience. The patient's increased comfort and perceived emotional value demonstrate how carefully designed sensory cues can impact satisfaction beyond clinical performance.

In another case, a participant shared how the dermatologist took time to walk her through the treatment plan using realistic before-and-after photos and clear, jargon-free language. She expressed that "what made me say yes to the treatment was how honest the doctor was... she showed me actual results and made sure I understood everything before I decided." This reflects the cognitive (THINK) dimension of experiential marketing, where engaging the patient intellectually and providing transparent, knowledge-based communication enhances trust and decision-making. The clarity and honesty in information delivery appeared to elevate the patient's confidence and overall satisfaction with the process.

Another compelling finding relates to how patients interpret the service environment through the lens of identity, lifestyle, and cultural alignment. One patient described her experience in the clinic as "not just medical, but luxurious, like I was in a spa." She highlighted the interior design, scent diffusers, and warm lighting as factors that made her feel "special, pampered, and proud to be here." This resonates with both the RELATE and SENSE dimensions. On one hand, the clinic successfully appealed to her senses, while on the other, it positioned itself as part of a desired lifestyle aligning with her aspirations and social self-image.

These findings also underscore the relevance of functional service quality, as emphasized in the SERVQUAL model (Parasuraman et al., 1988). While patients did acknowledge the importance of clinical competence and treatment results, the emotional connection, personalized attention, and interactive experience were consistently valued more highly. In other words, patients were more impacted by how they felt during the experience than by the technical skills themselves. This shift in priority highlights the growing expectation that healthcare especially in cosmetic and dermatological settings must deliver not only medical excellence but also emotionally engaging, identity-affirming experiences.

RECOMMENDATION

Given the result of the study, we recommend the following 10 key improvements:

1. Diversify appointment booking methods by offering telephone, WhatsApp, in-person, and online options, while ensuring staff are available to assist elderly and less tech-savvy patients.
2. Redesign clinic waiting areas to promote calm and relaxation by incorporating elements such as soft background music, comfortable seating, ambient lighting, and luxurious aesthetics.
3. Train medical and support staff in emotional intelligence, patient-centered communication, and full-cycle care from the initial appointment to payment and follow-up.
4. Use visual aids and clear explanations during consultations to help patients understand treatment options, especially by showing realistic before-and-after images to build trust.
5. Provide personalized aftercare instructions both verbally and in writing, ensuring clarity and patient understanding of post-treatment protocols.
6. Introduce flexible payment options, including installment plans, senior discounts, and corporate partnerships to enhance financial accessibility.
7. Improve patient privacy protocols, ensuring that examinations and intimate procedures are conducted without interruptions and in private, quiet spaces.
8. Install in-clinic screens and signage to display services, pricing, directions, and promotional offers, and use WhatsApp for automated, yet personalized, messages about treatment and booking.

9. Establish a feedback and experience tracking system, allowing patients to rate their experience and enabling the clinic to perform regular analysis for continuous improvement.
10. Offer comfort-enhancing features such as massage chairs, soft scents, entertainment options, or interactive activities in the waiting area to elevate the overall patient experience.



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