"An Investigation into the Reputation of a Public Hospital"

A Thesis Submitted in Fulfilment of the Requirements for the Masters Degree in Business Studies by Research

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Declaration

The author hereby declares that, except where duly acknowledged and referenced, this research study is entirely her own work and has not been submitted for any degree or other qualification in *Waterford Institute of Technology* or any other third level institution in Ireland or abroad.

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Rita Bourke

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-Abbreviations-

CO	Customer Orientation
ECO	Employee Customer Orientation
OCO	Organisational Customer Orientation
H.S.E	Health Service Executive
WOM	Word of Mouth
SPSS	Statistical Package for the Social Sciences
CBP	Corporate Brand Personality
PSO	Public Sector Organisation
PHS	Public Health System
AMAC	Fortune's Annual Most Admired Companies
ORS	Overall Reputation Score
GMAC	Fortune's Global Most Admired Companies
ROIT	The Rotterdam Organisational Identification Test
OCB	Organisational Citizenship Behaviours
FA	Factor Analysis
PCA	Principal Component Analysis
DV	Dependant Variable
IV	Independent Variable

~Abstract~

Previous work in the reputation management literature has focused mainly on commercial organisations and the views of external stakeholders. However, important outcomes of reputation, such as both internal and external stakeholder satisfaction, are also important in public sector organisations. It is surprising therefore that little work in the literature thus far has focused on the reputation of public sector organisations. The notion of customer orientation is of particular relevance in the context of a hospital's reputation, as the interactions and experiences that external stakeholders such as patients and visitors have with customer-facing public service employees will influence their perceptions towards the organisation. To understand better the issues of reputation and customer orientation, and moreover how they interact, the aims of this study are to (1) investigate the reputation of a public hospital, and importantly, the drivers and outcomes of such reputation among different stakeholders, and (2) to explore the links between reputation and customer orientation in a public service context.

This study adopts a mixed methodology approach. Phase one involved a qualitative study of three focus groups (n=32) with the main stakeholders of a public sector hospital: patients and visitors, clinical staff and non-clinical staff. The overall aim of the focus groups was to explore the main drivers and outcomes of a public hospital's reputation. The second phase was a quantitative survey based study (N=650) which investigated the relationships between the perceived corporate reputation of the hospital as measured by the Corporate Character Scale, perceived employee and organisational customer orientation and; internal and external stakeholder satisfaction.

Findings from phase one of this study identified different drivers and outcomes of public sector organisation's reputation from those previously found in mainstream commercial literature. In line with previous published studies, the empirical findings from phase two of the study highlight that employee customer orientation (ECO) impacts external satisfaction. In contrast to previous work however, ECO was found to have an insignificant effect on employee satisfaction. Most importantly, this study finds that for both employees and external stakeholders, corporate brand personality mediates the relationship between ECO and satisfaction, that is, ECO influences perceived brand personality, which in turn influences satisfaction. This study concludes by providing an outline of the study's contribution to the literature together with a discussion of managerial implications and research limitations. Finally recommendations for future research are proposed.

~ Chapter One ~

INTRODUCTION

1.1 - Introduction

This chapter aims to familiarise the reader with the background, purpose and scope of the research dissertation**.** Specifically, the chapter presents the purpose of the study, justification for the study, questions arising from the research problem, the method of study and the usefulness and contribution of the findings to both the literature and managerial practice.

1.2 - Purpose of the Study

The overall purpose of this study is to investigate the reputation of a large public hospital. Specifically, the study aims to examine the drivers and outcomes with a particular focus on how customer orientation (CO) contributes to internal and external stakeholder views of the hospitals reputation and their satisfaction with the hospital.

Employment statistics indicate that the majority of the working population of developed countries work in a service organisation and that the single largest group are employed in the public sector. The healthcare sector in Ireland is the largest employer in the state and the H.S.E. (Health Service Executive) employs more than 100,000 staff (www.hse.ie), from a population of over 4 million (www.cso.ie). Despite this, the application of marketing concepts to the public sector is still a relatively new topic for researchers (Kotler and Lee, 2007). This is somewhat surprising as marketing ideas have been applicable to the non-profit sector since at least the 1970's and more specifically the healthcare sector since the 1980's (Kotler and Clarke, 1987).

Findings by Lovelock and Weinberg (1990) state that the marketing of many public services may inevitably be different from that in the private sector, as the defining characteristics of public services include the dominance of political rather than economic objectives and the primacy of the citizen rather than the consumer (Laing, 2003).

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Furthermore, what drives the reputation of a public sector organisation (PSO) may differ largely from that of a private sector organisation. Governments have seen how branding works for businesses and understand that its citizens live in a branded world. Despite the huge potential for the application of branding strategies in the public and non-profit domain, research has historically paid scant attention to this subject.

The associations that are made with a brand result from an accumulation of all the communication and experiences about and with that brand (Fombrun, 1996). Budgets for the overt promotion of positive associations with the corporate brand may be limited in the public sector and any attempts to improve perception through advertising is liable to criticisms as being a waste of public money. Brand building has therefore to rely on other methods, including managing the customer experience. This is reinforced by Hood and Henderson (2005) who state that the branding process helps to move the focus from transactional measures of service outcomes to a more relationship orientated model which is essential in the public services sector as frontline employees are required to be highly customer orientated. Moreover, governments may require organisations in public ownership to become more responsive to "the customer" and his/her needs, in other words to become more customer oriented, rather than to increase the number of customers, which is the common objective of the private sector.

The customer orientation (hereafter referred to as CO) of frontline employees will therefore influence the perceptions external stakeholders have of their experiences with the organisation (Brown, Mowen, Donovan and Licata, 2002; de Chernatony, 2006). High levels of CO enhance service users' views of the organisation's brand through positive interactions with the brand's employees, and result in greater overall satisfaction among both internal and external stakeholders (Rust, Zahorik and Keiningham, 1996, p. 391). Considering the healthcare sector, CO appears a particular concern. Given that most hospital patients cannot insightfully judge the value of the process technology used, they focus on the interpersonal interactions with professional service personnel (Darby and Daniel, 1999) thereby making the role of CO in promoting positive associations of special importance.

Through a review of the literature, it is evident that the role of branding in the public sector is under explored, particularly with internal stakeholders. In order to identify what drives

the reputation of a public hospital, this study obtains the perspectives of both internal and external stakeholders. A number of reasons exist for considering the employee perspective in understanding corporate reputation in the public services context. Employees can act as brand ambassadors (de Chernatony, 2006; Wallace and de Chernatony, 2008) and their interaction with external stakeholders will in turn shape the external view of the organisation's reputation (Bettencourt, Gwinner and Meuter, 2001). Specifically, the view that customer-facing employees have of their organisation is held to influence the impression that customers form of the organisation (de Chernatony, 1999). A number of models of corporate branding see the customer and employee perspectives as being inter-linked or even interdependent (Hatch and Schultz, 1997; Fombrun, 1996; Davies and Miles, 1998). Such alignment emphasises matching external brand image to internal views and values (e.g. de Chernatony, 1999; Hatch and Schultz, 2001). If customer-facing employees share a positive view of the organisation with customers, then a positive interaction between them is more likely to occur (Chun and Davies, 2006), making internal and external views critically important in the promotion of a positive reputation.

1.2.1 - Study Aims

This research study aims to make an applied and theoretical contribution by investigating the key drivers and outcomes of hospital reputation. This is a neglected issue in the literature thus far and is a significant area of applied research for managers given reputation's well-established impact on stakeholder satisfaction (Davies et al., 2003). The second aim is to investigate how employee customer orientation (ECO) and organisational customer orientation (OCO) impacts stakeholder satisfaction; as stakeholder views in service contexts are largely dependant upon the interactions and experiences among employees and external stakeholders. Furthermore, the study aims to investigate if reputation personality (or character) associations are affected by the presence of CO and if this in turn impacts stakeholder satisfaction.

1.3 - Justification for the Study

Despite calls for more research focusing on corporate reputation in a public sector context, relatively few studies have been conducted. Previous work on reputation has focused mainly on commercial organisations (Berens and Van Riel, 2004; Fombrun, 1996; Gotsi and Wilson, 2001; de Chernatony and Segal-Horn, 2003). It is equally important to study

reputation in the public sector as what drives reputation of a private sector organisation may differ largely from that of a public sector organisation. In relation to hospital reputation, previous work has focused mainly on statistical data about medical care or the ability of the hospital to meet patient expectations. By way of contrast, this study focuses on the three main stakeholder views, and is significant in identifying possible avenues where potential improvements can be made in order to increase service user satisfaction. Given the well-established relationships between internal stakeholder views and the effects on the views of external stakeholders, it is critical in a study such as this to investigate both internal and external stakeholder perceptions of the hospital's reputation. In order to do this, it was decided at the beginning of the study to conduct a qualitative study to enable an in-depth exploration of the stakeholders' attitudes and opinions towards the main drivers and outcomes of the hospitals reputation. Furthermore, little research has been conducted on CO in the public sector, and in particular, research in both the CO and reputation management literatures has failed to address the question of how CO may affect an organisation's reputation. The theoretical issue was also importantly supported in the focus group discussions where patients' needs and experiences at the hospital were discussed as drivers of hospital reputation.

1.4 - Research Objectives and Outcomes Arising from the Study Aims

In line with Malhotra's (1996) description "research objectives are specific, action-orientated statements of intent" (p.120). The specific conceptual and empirical research objectives of this study are as follows:

- To provide a critical assessment of the breadth and depth of the pertinent literature relating to healthcare marketing, reputation management and CO in order to develop a sound conceptual framework within which to conduct the empirical research.
- To identify what are the major influences on a hospital's reputation from the perspective of three stakeholder groups: clinical staff, non-clinical staff and service users;
- To identify the outcomes of both positive/negative reputation for a public sector organisation;

- To investigate how CO, at both employee (hereafter referred to as ECO) and organisational (hereafter referred to as OCO) levels, affects the reputation of the hospital from both the internal and external stakeholders perspectives;

In fulfilling these research objectives, it is envisaged that the study outcomes will offer contributions on a number of levels, namely:

- To provide health service professionals with policy guidelines as to how reputation can best be managed;

- To disseminate to external partners in the Health Service Executive and the academic community, through peer reviewed conference and journal publications; and

- To contribute to the relevant stakeholders, provide policy guidelines and ultimately aid in the development and delivery of a better service to healthcare users.

1.5 - Method of Study

The research design adopted for this study contains elements of both qualitative and quantitative research i.e. a mixed methodology approach. Green et al. (1989) define mixed method designs as those that include at least one quantitative method (designed to collect numbers) and one qualitative method (designed to collect words). The first phase of the research study aimed to obtain stakeholder views surrounding the main drivers and outcomes of hospital reputation and this was done by conducting three separate focus groups for each of the three stakeholder groups. The data is analysed using Nvivo and results highlighted the importance of CO practices to the organisations reputation. This leads to the second phase of the study, where the aim is to test the effect of CO on stakeholder perceptions of the brand and if this impacted stakeholder satisfaction and reputation. The second phase of the study is quantitative in nature and involves the administration and collection of survey questionnaires, which are analysed using the quantitative software package, SPSS.

1.5.1 Qualitative Research

A precise definition of qualitative research, provided by Malhotra and Birks (2000, p. 156), states that "*qualitative research is an unstructured, primarily exploratory methodology based on small samples, intended to provide insight and understanding*".

Qualitative work is undertaken with the three main stakeholder groups of a large public hospital in order to identify what influences, positively or negatively, the hospital's reputation. The method of qualitative research selected for this current study is focus groups. A focus group is "*an interview conducted by a trained moderator among a small group of respondents in an unstructured and natural manner*" (Malhotra and Birks, 2000, p. 161). Focus groups are deemed the most suitable form of qualitative research as they allow for an in-depth exploration of the attitudes and opinions of participants towards the hospital's reputation. A total of 32 stakeholders participated in the qualitative study. The qualitative stage of the research is employed first in order to explore the main drivers and outcomes of hospital reputation, which subsequently facilitated the design of the quantitative study (Silverman, 2006). It is also advised in the literature to conduct exploratory research first as it is known to provide insights into the research problem and enable the research problem to be more closely defined in subsequent studies (Chisnall, 2001).

1.5.2 Quantitative Research

The second stage of the empirical research involved a large-scale survey of the three main stakeholder groups. The survey contained a standardised measure of reputation 'The Corporate Character Scale' (Davies, Chun, Da Silva, and Roper, 2003; 2004), and measures of CO both at an individual and organisational level (Brown et al., 2002) and of stakeholder satisfaction, which were also derived from the literature.

Preliminary analysis of the results includes coverage of descriptive statistics and reliability and validity estimates. Descriptive statistics highlight stakeholder perceptions in relation to the corporate character dimensions, CO, and questions arising from the focus group findings. Subsequently, the hypotheses were analysed through conducting bivariate correlations and hierarchical regression. Analysis of hypothesis one highlights the effect of ECO and OCO on both internal and external stakeholder satisfaction. Finally, the Sobel

statistical test method was used to test the mediation relationships of hypotheses two, three and four.

1.6 - Contribution of the Research Study

This study offers new insight and understanding to theory in relation to CO and reputation, and provides insights into reputation management in the public healthcare context. It is important for managers to know how to manage reputation and the existence of CO within the organisation, as the two areas can lead to increased levels of satisfaction and confidence within the healthcare sector. CO is central to marketing. Its relevance to a publicly owned company goes beyond the idea of assuring tax payers that the public is getting value for money and specifically that organisations such as hospitals and schools are responsive to user views and needs (Whelan, Davies, Bourke and Walsh, 2008).

This current study makes three main academic contributions. Firstly, qualitative findings reveal that there is, as expected, different drivers and outcomes of public sector reputation from those previously found in mainstream commercial literature. Secondly, this study found that corporate brand personality mediates the positive link between ECO and satisfaction i.e. ECO influences brand personality, which in turn influences satisfaction. Thirdly, previous research that has measured reputation through use of 'The Corporate Character Scale' (Davies et al., 2003; 2004) has found agreeableness to be the dimension most strongly correlated to satisfaction. This study tested this scale among both employees and patients/visitors of a public sector hospital using a large sample (N=650). Findings reveal that, in line with previous published studies (Davies et al., 2003; 2004) agreeableness is the strongest dimension correlated to internal stakeholder satisfaction. However, external stakeholder findings contradict those by Davies et al. (2003; 2004) and find competence is the strongest dimension correlated to external stakeholder satisfaction. This offers new knowledge to public sector literature, in particular the healthcare industry.

Finally, the findings help marketers and public sector managers realise the importance of encouraging CO at an individual level and pursuing customer orientated tasks at an organisation level, as findings reveal that its presence can influence patient satisfaction at both the ECO and OCO levels and employee satisfaction at an organisation level. Furthermore, both the qualitative and quantitative stages of this research study reveal the

importance of ECO and OCO to the reputation of the organisation. Therefore, satisfying patient needs and also ensuring they have a pleasant/comfortable experience must be a priority for both customer-facing employees and management. Managers should also keep in mind, when recruiting new staff, the image of the organisation they want to promote. For example, there would be little point in recruiting someone with ruthless characteristics if you wanted your organisation to appear competent. The provision of personality tests at the interview process is a suggested method to overcome this.

1.7 - Organisation of the Dissertation

This chapter provides a backdrop to the research dissertation. An outline of the contents of proceeding chapters is now presented.

- Chapter Two – Marketing in the Public Sector and in Healthcare

This chapter presents a background to the importance of studying marketing in not only the corporate sector but also the public sector. Relevant literature from previous published studies on the importance of branding in the public sector and more specifically the healthcare industry is critically evaluated. The healthcare industry is becoming a more competitive industry, as a result how the organisation is perceived by both employees' and external stakeholders' is important to the organisations success; this is demonstrated throughout the literature review. Subsequently, the challenges that must be considered in relation to the areas of branding are discussed. Finally, literature in relation to social marketing in the healthcare sector is reviewed.

- Chapter Three –Reputation Management: Definition and Measurement

This chapter begins by defining reputation; furthermore, the importance of reputation in the services sector is discussed, as its' intangible nature means service organisations are evaluated on factors such as the reputation it possesses. The benefits an organisation can reap from having a positive reputation are also discussed. In order to maintain a positive or a neutral reputation, the gaps between the internal and external perspectives of the organisation must be kept to a minimum. For this reason, the areas of image (perception of external stakeholders) and identity (perception of internal stakeholders) are critically reviewed. Subsequently, the literature available on public sector reputation is critically assessed. The chapter concludes by examining the various methods of measuring reputation.

- Chapter Four – The Customer Orientation of Service Workers

This chapter focuses on explaining the importance of CO to service organisations, this is an important area to discuss as public sector managers are being advised to adopt more of a philosophy of the private sector. CO involves how the customer-facing employees of an organisation deal with its customers and meets their needs. The proceeding sections critically review the literature available on the outcomes, and antecedents of CO, as well as attitudes and behaviours in relation to CO. Subsequently, the methods of measuring CO are critically assessed. The chapter concludes with a presentation of the conceptual framework for the study including the empirical research objectives.

- Chapter Five – Research Methodology

This chapter begins with a review of the research questions and objectives. Subsequently, a brief summary of the research hypotheses is presented. The chapter then outlines the methodological foundations of the research study, followed by a discussion of the mixed methodology approach adopted. The chapter proceeds with a discussion of both secondary and primary research methods and then provides a detailed discussion of the study's research design. Details of data collection methods employed are then outlined, as well as justification for the methods chosen and the methods of analyses employed. A detailed summary of the initial data analysis techniques is then explained followed by an account of the methods used in the survey instrument. Finally, the limitations of this study are reported.

- Chapter Six – Data Analysis: Qualitative Findings

The purpose of this chapter is to present the qualitative findings obtained from the first phase of the primary research. The findings are broken down into the following: the drivers of a positive reputation, the drivers of a negative reputation, the outcomes of a positive reputation and the outcomes of a negative reputation. Three focus groups were conducted for each of the three stakeholder groups i.e. patients/visitors, support staff, and clinical staff. Therefore, the results are outlined separately for each individual focus group discussion.

- Chapter Seven – Data Analysis: Quantitative Findings

The purpose of this chapter is to present the quantitative findings obtained from the second phase of the primary research. This chapter begins with an outline of descriptive and preliminary quantitative findings. Subsequently, findings of the four hypotheses are presented in detail. Analysis is conducted through SPSS. The findings begin with regression and correlation analysis. Hypotheses two, three and four contain mediating relationships and mediation analysis for these hypotheses is conducted by use of the Sobel test.

- Chapter Eight – Discussion and Conclusions

The aim of this chapter is to analyse and summarise the findings from the previous two chapters and further, to develop a discussion which links primary research findings with existing published findings highlighted in the literature review. The chapter firstly presents a brief summary of the qualitative findings and is followed by a discussion of the qualitative findings. The next section briefly summarises the quantitative findings, consequently a discussion of these findings that concur with and dispute previous published findings is presented. The theoretical contributions of this study are then presented, followed by managerial implications and suggestions for future research.

1.8 - Implications of the Study

The findings of this study will be useful to management in the public healthcare sector and will contribute to the more efficient running of public hospitals. It is essential for a public sector organisation such as a hospital to uphold a positive reputation as the more positive view we hold of a healthcare organisation, the more likely we are to select one hospital over another if we have choice (Shahian, Yip and Westcott, 2000). It is also hoped that identifying how a public healthcare organisation can maintain a positive reputation will lead to an increase in service user confidence and satisfaction; the more confident one feels entering the same hospital the more likely their treatment will be successful (Health Service Executive Transformation Programme, 2007-2010).

Another important implication for managers resulting from this study is the importance of ensuring that employees and management are aware that both the needs and enjoyment dimensions of CO are important to patient satisfaction, and not the needs dimension alone.

Furthermore, the presence of both dimensions is important to improve employee satisfaction. The findings of this study emphasise the potential to promote greater CO and by doing so build positive associations with the hospital. In the commercial sector, training to promote CO is an option but one that may not be favoured here as many training programs rely upon a didactic approach (Whelan et al., 2008). Peccei and Rosenthal (2000) found that, even in the private sector, responses to CO programs are not homogeneous. In other words, assuming as many do that should the investment in such training be large enough that a positive effect will result, ignores the reality that some will pay lip service to CO initiatives and others will reject the idea both attitudinally and behaviourally. Resistance from front line service employees to the articulation of marketing concepts has resulted in a widespread failure to translate organisational commitment into reality in the public sector (Laing and McKee, 2001). A cognitively based approach to CO development is more likely to succeed in many public sector organisations, including those in healthcare and education, where employees might need evidence that being more customer oriented makes their efforts within their professional role more effective (Whelan et al., 2008). Overall the significance of this study lies in the belief that the presence of CO within the organisation can impact stakeholder perceptions of corporate reputation and hence increase stakeholder satisfaction towards the organisation.

1.9 – Conclusion

The purpose of this chapter is to introduce the reader to the research topic, objectives and research questions. This chapter also provides the reader with an overview of the research study and the areas covered throughout the dissertation. The following section presents the literature review and this is structured into three chapters. It covers relevant literature in the areas of marketing and branding, reputation management, and CO in the public sector with a specific focus on the healthcare sector. The literature review aims to offer an in-depth knowledge and critical understanding of published work to date in these areas, with a view to developing a sound conceptual framework upon which to draw relevant empirical research objectives.

~ Chapter 2 ~

Marketing in the Public Sector and in Healthcare

2.1 – Introduction

The aim of this chapter is to critically assess relevant published work in the public sector marketing literature. Despite the huge potential for the application of marketing, more specifically branding strategies in the public and non-profit domain, research has historically paid scant attention to this subject. Moreover, marketing has been traditionally associated with private profit making organisations. However, recent developments outline that it has important contributions to make to other social sectors' (Da Camara, 2007: 2008; Barrette and Becker, 2007; Andreasen, 2002). The chosen context for this specific study is the public healthcare sector, as this sector is the fastest growing service in both developed and developing countries worldwide and yet it remains underexplored (Dey, Hariharan and Brookes, 2006). According to Helfert, Henry, Leist and Zellner (2005) healthcare is one of the largest consumers of public spending; it is increasingly recognised amongst most countries as an important economic sector with a rapidly growing expenditure.

Today, healthcare organisations face significant pressures on costs, quality and clinical appropriateness. Organisational change management is high on the agenda, especially in the Irish healthcare sector where hospitals are striving to find ways to ensure their organisations will become more efficient and cost effective (Ennis and Harrington, 1999 p.1). Organisations are increasingly turning to marketing as a management function to handle such issues (Lega, 2005). It is important to study marketing in healthcare, as the industry is becoming increasingly competitive; how managers market their organisation and how stakeholders perceive the organisation is fundamental to the organisation's success. Raju, Lonial and Gupta (1995) emphasise the importance of marketing in the healthcare industry, they state that marketing has become a key management function that is responsible for being an expert on the customer and keeping the rest of the network organisation informed about the customer so that superior value is delivered.

Budgets for the overt promotion of positive associations with the corporate name may be limited in the public sector and any attempts to improve perception through marketing techniques such as advertising is liable to criticisms as being a waste of public money. As a result brand building is an important component of marketing in the public sector. While branding has become more prominent in the public sector, its role with stakeholders is underexplored. This study aims to investigate both internal and external stakeholder perceptions of the organisation. de Chernatony (1999) states that as well as measuring the consumers' attitude it is also essential to consider staff as to ensure strong brand performance staff will have to understand the brands vision and values and be totally committed to their delivery. Furthermore, employees can act as brand ambassadors (de Chernatony, 2006; Wallace and de Chernatony, 2008) and their interaction with external stakeholders will in turn shape the external view of the brand (Bettencourt et al., 2001).

This chapter aims to examine marketing in the public sector. Subsequently, literature surrounding branding in the public sector is reviewed; its importance and challenges will also be reviewed. Finally, the chapter concludes by reviewing the literature surrounding social marketing.

2.2- Marketing in the Public Sector

Previously healthcare organisations had been slow to embrace the importance of service marketing (Raju et al., 1995). However, the industry is changing rapidly, and many hospitals, especially those located in metropolitan areas, are making a concerted effort to apply the concepts and principles of marketing to their daily operations. Nowadays the marketing of healthcare services has become crucial to the financial success of physician practices and all healthcare organisations. Marketing has become an important external function in the health sector (Kennett and Henson, 2005).

Perception is everything when marketing a healthcare service, such as a hospital. It is how the public and patients view the hospital along with medical and support staff. According to Lega (2005, p.344), the definition of healthcare marketing should be broadened to encompass all types of activities supporting the different organisations in promoting their services. When defining healthcare marketing the author uses the current definition of marketing (American Marketing Association, 2007) and applies it to the healthcare context.

The definition is as follows '*Marketing is the activity, set of institutions, and processes for creating, communicating, delivering, and exchanging offerings that have value for customers, clients, partners, and society at large*'.

Marketing in the public sector is considered important in relation to core public services, such as health and education because it identifies customers' needs and wants. According to Paul and Hanna (1997), the marketing concept can have major benefits for healthcare organisations that implement it properly as it can identify new market opportunities, improve customer service, and increase profitability. Patients are now educating themselves with information and demanding that their healthcare needs be satisfied (Lega, 2005). In addition, marketing in the healthcare industry is important, as it is responsible for being an expert on the customer; ensuring superior value is delivered (Raju et al., 1995). Providing a valuable healthcare service will lead to satisfied customers; and further satisfied customers become loyal customers; becoming positive contributors to the success of their healthcare experience.

Moreover, it is important to study the marketing of a service, such as healthcare, as many service industries have surpassed manufacturing industries in terms of size and importance. The services sector is the largest employer in both Ireland and England. The health sector in Ireland is the largest employer in the State; and available statistics illustrate that the Health Services Executive (H.S.E.) employs more than 110,000 staff. The budget of almost €12 billion is the largest of any public sector organisation in Ireland (www.hse.ie).

According to Corbin, Kelley, and Schwartz (2001) the key to sustaining and expanding many of these services is to create public awareness and build customer satisfaction and retention. In order to do this, hospitals should exude traits of themselves such as trust, loyalty and reliability (Hood and Henderson, 2005). These traits should be their main focus in marketing as they are very important to customers; hospital managers should therefore create/promote a brand that depicts these traits. To have a successful healthcare organisation, marketing efforts must be focused on building a high level of trust and patient confidence (Kim, Kim, Kim, Kim and Kang, 2008). From the patient's perspective, trust has a significant impact on the experience of being a receiver of healthcare and on the development of competency with illness management (Thorne and Robinson, 2006). Patient confidence is important as the more confidence patients' have in a hospital and its

services, the more likely recovery is (Health Service Executive Transformation Programmes, 2007-2010).

Despite the call for more marketing in the public healthcare sector, several downsides may exist. Marketing in public health systems (PHS's) often raises fears among politicians and regulating bodies as organisations push to improve their market share there may be an escalation in service prices and expenses (Lega, 2005 p.341). Marketing is often seen as a waste of money, contributing significantly to the escalation of costs in the system. However, there is an existing difference in marketing private and public services. The widely shared view is that instead of maximising profits, share or volume, the role of the public sector marketer has been said to be maximising the sum of benefits to society, whereas the role of the private sector is to maximise profits (Lega, 2005).

In order to depict the necessary traits to have a successful healthcare organisation, the organisation's marketing efforts must be focused on building a strong brand. According to Kotler (1997) the able management of brands has come to be considered the "art and cornerstone of marketing". When engaging in branding, organisations are trying to build a certain image and associate certain attributes to their service.

2.3- Branding in the Public Sector

Branding in public sector services is important as government agencies and their administrators are under increasing pressure to improve performance and demonstrate a positive return on investment of resources and taxpayers' money (Kotler and Lee, 2007). A brand can be defined as '*a name, term, sign, symbol, or design, or combination of them which is intended to identify the goods and services of one seller or group of sellers and to differentiate them from those of competitors*' (Kotler, 1991 p. 442). Stride and Lee (2007, p.113) define branding in the non-profit context as '*a method for developing the organisations visual identity in a consistent manner*'. According to Wæraas (2008) hospitals, universities, and various government and regulatory agencies seek to express their identities and their values through vision and mission statements, core values, slogans, and logos.

Branding is an important area in the services sector as there is a high level of interaction between employees and customers. It is important for an organisation to align the customer and employee perspectives (Hatch and Schultz, 1997; Fombrun, 1996). Such alignment emphasises matching external brand image to internal views and values (de Chernatony, 1999; Hatch and Schultz, 2001). If customer-facing employees share a positive view of the organisation with customers, then a positive interaction between them is more likely to occur. The associations made with a brand can be assessed in a number of ways including that of brand personality (Keller, 1998). Brands are imbued with human characteristics, thereby to uncover stakeholder views of the hospital in this study, the brand as a person metaphor is adopted.

Despite the huge potential for the application of brand strategies in the public and non-profit domain, research has historically paid scant attention to this subject. A new vocabulary consisting of terms such as branding, corporate communication, image and reputation has emerged in the public sector. This study has chosen to obtain views on branding from both staff and patients of the hospital as according to de Chernatony (1999), as well as measuring the consumers' attitude towards branding it is also essential to consider staff. To ensure strong brand performance staff will have to understand the brands vision and values and be totally committed to their delivery.

2.3.1 Why Use Branding in The Public Sector?

Despite the many challenges and concerns of adopting branding in the public sector, many organisations still choose to adopt various marketing strategies, in particularly branding. The first reason as to why branding is chosen in the public sector is that public sector organisations must appeal to several different publics, not merely consumers (Ritchie et al., 1999). A consistent brand is a means for communicating organisational values to each of these publics. Secondly, public sector organisations mostly provide services that are intangible in nature and difficult to verify, brands provide trust and reduce uncertainties. Thirdly, public organisations often receive much more public scrutiny than private firms; a strong brand will create goodwill and protect the organisation from the media and vagaries of public opinion.

There is also heightened competition in the public sector for financial and human resources, a strong brand will assist in maintaining top-of-mind awareness, thus increasing

the likelihood of obtaining scarce resources. Public sector organisations also suffer from the phenomenon of 'image spill over', in which public perception of an individual public organisation is determined by the average image of all similar organisations. Branding helps public sector organisations carve out a unique position for themselves in the public mindset, preventing negative images from other public organisations spilling over to the individual organisation (Ritchie et al., 1999).

Furthermore, branding plays a special role in services such as healthcare because strong brands increase trust in intangible products; enabling consumers to better visualise and understand them. Brands offer some measure of assurance that the provider of the good or service will deliver consistently on its promises, and is therefore worthy of trust. This helps to overcome barriers of uncertainty that might otherwise prevent people from becoming customers (Ritchie et al., 1999). In order to keep the brand successful, trust must be a standard that hospitals and employees offer their patients. When patients issue complaints, both the hospital and its employees must do their best to respond to the complaints and thereby maintain or rebuild trust.

Governments have seen how branding works for businesses and understand that its citizens live in a branded world, therefore governments must move with the times. Branding is a form of communication and communication is essential in the public sector, commercial brandings aim is to get people to buy or act into things, in the case of the public sector branding it is used to buy into a change in behaviour (Colyer, 2006). A recognisable and trusted brand in the public sector may make it more likely for a citizen to participate in a program or persuade someone to comply with guidelines and laws (Kotler and Lee, 2007). Branding also reduces customers perceived monetary, social, or safety risks in buying services, which is an obstacle to evaluating a service correctly before purchase (Kim et al., 2008 p.75).

2.3.2 Challenges of Branding in the Public Sector – The Need for Strong Values

The above literature makes a strong case for engaging in branding in the public sector but is branding in the public sector making it become too commercialised? Ritchie et al. (1999) state that if an organisation appears too commercialised, key audiences may find little to distinguish the organisation from profit driven businesses and be unwilling to offer their trust and support as a result. Clohesy (2003, p.131) suggests that 'non profit organisations

are as liable to institutional hardening and bureaucratisation as any other institution … and … they can commercialise their services because they face the same economic pressures to survive as any other businesses'.

Sternberg (1998) states that techniques developed for the profit sector contribute to the over commercialisation of public services, this may result in the sector loosing its unique nature, its identity and its values (Stride and Lee, 2007 p.108). According to de Chernatony and Dall'Olmo Riley (1998, p.427) values lie at the heart of the branding concept and they therefore define it as 'a complex multidimensional construct whereby managers augment products and services with values and this facilitates the process by which consumers confidently recognise and appreciate these values'. Stride and Lee (2007) perceive values as being important in the non profit sector as they play a highly distinctive and important role in the definition and understanding of non profit organisations. In the case of differentiating the public sector from the corporate sector, the public sectors dependence upon values as opposed to profits is of particular importance.

Values in the non-profit sector allow for the ability to create highly effective intangible brand dimensions, capable of offering considerable emotional and self expressive benefits to a wide range of stakeholders (Stride and Lee, 2007). Despite this, research by Stride and Lee (2007) found that the values based element of the brand appears to be neither well defined across differing stakeholder groups, nor is it proactively promoted in a consistent manner as an integral component of brand development and management. The challenge or the solution for non profit brand manager is to first attain the identification and then the effective management of those values that drive organisational behaviour and provide meaning to both internal and external stakeholders (Stride and Lee, 2007). It seems likely therefore, that brand managers in public organisations will need to look to new, distinctive remedies if non-profit branding is to mirror the development of the commercial branding experience, progressing from management of the intangible aspects of the brand to the effective management of intangible values.

There are other challenges that arise in relation to branding in the public sector. Similar to Sternberg (1998), Wæraas (2008) discusses identity as one significant challenge. Identity plays a major role in branding and is the fundamental starting point for the corporate brand proposition. Many public organisations engage in a search for a consistent definition of

their identity but face several challenges in doing so. Wæraas (2008) argues that it is difficult for most public organisations to become coherent corporate brands primarily because they have inconsistent sets of values and are often characterised by several different identities. Public organisations are, by their nature, inconsistent and complex entities that are difficult to incorporate as one single identity definition. As a result, a single holistic identity is not required in the public sector as one set of values may downplay their strengths, reduce the problem of requisite variety and ultimately diminish their chances of creating positive brand images. Wæraas (2008) calls for a corporate branding definition that better matches the typical characteristics of public sector organisations. This is consistent with research by Stride and Lee (2007) who found that brands in the non-profit sector are mainly viewed as visual identities incorporating tangible dimensions such as logos, names and visual designs. However there is little to suggest that the intangible elements of branding such as image and personality are being explored in any systematic way within the public sector context, thereby reinforcing the value of the current study to public sector practice and academia.

Another challenge in the public sector is based on the broader area of marketing and is suggested by Walsh (1994) who states that marketing is a determination of mission and strategy in the commercial sector; however marketing has little to say about these processes in the public sector as they are matters for communal democratic determination. According to Walsh (1994) the central question of politics and the organisation of the likes of healthcare cannot be settled on the basis of consumers' expression of wants. For marketing to work in the public realm, he feels governments will need to be clear on the psychological base of its citizens otherwise it won't be effective. Another major challenge is that brands require substantial and ongoing commitment of financial and human resources, organisations may not consider this to be the best use of their money, time and focus, particularly when these are scarce and the demand for services is high.

There has also been notable reluctance on the part of public sector organisations to embrace concepts of marketing, this may be due to the fact that competition is emphasised rather than collaboration, and marketing concepts from this perspective appear essentially inimical to the ethos of the public sector. Resistance also exists from front line service employees to the articulation of such marketing concepts and has therefore resulted in a widespread failure to translate organisational commitment into reality (Laing and McKee,

2001). These negative aspects can be daunting, and suggest that branding may be a poor approach for organisations that are unable or unwilling to manage the risks involved (Ritchie et al., 1999). One risk that non-profit organisations face is that effort is often put into creating the brand but insufficient resources assigned to developing and maintaining it. After a brand has been created it is essential that is it sustained through reinforcement of brand name recognition and further elaboration of message and meaning (Ritchie et al., 1999).

There is not enough focus in the public sector on brand management. A key component of brand management is brand equity. According to Keller (1993, p.1) brand equity is defined in terms of *'the marketing effects uniquely attributable to the brand – for example, when certain outcomes result from the marketing of a product or service because of its brand name that would not occur if the same product or service did not have that name i.e. brand equity allows managers to assess the effect of branding and if the money they are allocating to branding is getting a positive return'*. Christodoulides and de Chernatony (2004, p.168) state that one of the most commonly cited definitions of brand equity is that by Aaker (1991) who states that 'a set of brand assets and liabilities linked to a brand, its name and symbol, that add to or subtract from the value provided by a product or service to a firm and/or to that firm's customers'.

According to Kim et al. (2008, p.76) the literature reveals five factors that influence the creation of successful brand equity in hospital marketing; trust, customer satisfaction, relationship commitment, brand loyalty, and brand awareness. According to Morgan and Hunt (1994, p.23) 'trust exists when one party has confidence in an exchange partner's reliability and integrity'. Customer satisfaction occurs when the consumer has good experiences; the repurchase rate is high when consumer's expectations are exceeded. Customers who have confidence in an organisation will continue to buy its products or services that satisfy them. According to Chaudhuri (1997), commitment is also a key characteristic in successful marketing relationships in the public sector. The commitment level has been found to be one of the strongest predictors of the voluntary decision to remain in a relationship; in order to attain the trust and satisfaction of patients, physicians need to establish a relationship that meets patients' expectations of being supported and actively involving them in decision making. Morgan and Hunt (1994, p. 23) define commitment as an exchange partner believing that an ongoing relationship with another is

so important as to warrant maximum efforts at maintaining it; that is, the committed party believes the relationship is worth working on to ensure that it endures indefinitely.

Brand loyalty occurs when a customer has a preference to buy a single brand, or a particular brand name in a product class, the consumer repurchases the brand and resists switching to another (Chaudhuri, 1997). Loyalty is defined by Dick and Basu (1994) as 'the strength of the relationship between an individual's relative attitude and repeat patronage. The relationship is seen as mediated by social norms and situational factors. Cognitive, affective, and conative antecedents of relative attitude are identified as contributing to loyalty, along with motivational, perceptual, and behavioural consequences'. Aaker (1991) proposes measuring brand equity through price premiums, brand loyalty, perceived quality, and brand awareness (Kim et al., 2008). Brand awareness includes consumer recognition, recall, top of mind awareness, knowledge dominance, and recall performance of brands, as well as brand attitude. Brand awareness tends to influence consumer decision-making as it affects the strength of brand association. Brand awareness relates to the likelihood that a brand will come to mind and the ease with which it does (Keller, 1993). Satisfaction and confidence, two outcomes of social marketing, are important in creating brand awareness in the public healthcare sector. As a result the literature surrounding social marketing will next be critically reviewed

2.4– Social Marketing

Social marketing is defined by Kotler (1971, p.5) as *'the design, implementation and control of programs seeking to increase the acceptability of a social idea, cause or practice among a target group'*. Social marketing is used to improve some individuals personal welfare and that of their society, it is necessary because many members of the public engage in unsafe behaviour and it is thought that marketing techniques could aid in the analysis, planning, and execution of programs designed to influence their behaviour (Bang, 2000)

Bloom and Novelli (1981) state that both profit making and public, non-profit, making organisations can engage in social marketing. Social marketing is also known to encourage people to do something that will be beneficial to more than just them i.e. society (Andreasen, 1995; Bang, 2000). This research study aims to identify the drivers and

outcomes that form a positive or negative reputation and the empirical results will allow managers to make improvements to increase public satisfaction and confidence within our healthcare system.

For the non-profit sector the main objective is the achievement of some organisational mission, typically involving the pursuit of a significant social objective. As a result it is important to look at some of the theory surrounding the area of social marketing. According to Stead, Gordon, Angus and McDermott (2007) social marketing is unique in that it takes learning from the commercial sector and applies it to resolving social and health problems. The most distinguishing characteristic of a corporate social marketing campaign is its focus on persuading people to engage in a socially beneficial behaviour (Bloom, Hussein, and Szykman, 1995 p.10).

Social marketing is unique in that the suppliers absorb the values of the customer in some way, they not only produce the goods or programs for their intended customer but they also change or modify their ideas according to their needs and opinions (Leathar and Hastings, 1987). Social marketers must also face unique challenges compared to their commercial sector counterparts. These challenges include negative demand for their products/service (e.g. taking medications), less flexibility in modifying products to meet consumer demands, asking people to change complex habits and adopt behaviours with intangible benefits (Bloom et al., 1995).

Social marketing can be used when the organisation wishes to improve its reputation. If employees care about the issue surrounding their organisations social marketing program, they may feel more satisfied working for the company, which as a result may lead to higher employee morale, higher productivity and lower turnover (Bloom et al., 1995). The company's reputation can increase as the customer deals with satisfied employees and a firm that is socially responsible. These indirect benefits of social marketing have a more lasting effect on the corporation's bottom line (Bloom et al., 1995).

2.4.1 Social Marketing in the Healthcare Sector

Focusing on the use of social marketing in healthcare, it can help healthcare leaders encourage their patients to continue to utilize beneficial health services and follow their

providers recommended health guidelines. There is renewed interest in the use of health education to motivate people to utilize preventive health services and adopt healthier behaviours, which can lead to reduced healthcare expenditures associated with costly hospitalisation and long term care (Bloom et al., 1995). Public and private healthcare leaders can also apply the social marketing approach in their efforts to enhance and successfully market their programs. Social marketing can provide both public and private health administrators with a wide variety of tools for listening to healthcare consumers and then developing responsive, comprehensive programs designed to truly meet their needs and expectations (Bloom et al., 1995).

The definition the author is using for the purpose of this research study is that by Kotler (1971, p.5) which states '*Social marketing is the design, implementation, and control of programs seeking to increase the acceptability of a social idea, cause, or practice in a target group(s). It utilises market segmentation, consumer research, concept development, communication, facilitation initiatives, and exchange theory to maximise target group response*'. This definition is thought to be the most comprehensive definition in the reviewed literature.

2.5– Conclusion

The adoption of private sector based approaches to the organisation of public services in many western economies has forced a fundamental reconsideration of the potential contribution of marketing to the delivery of public services (Laing, 2003). Thus, this chapter critically reviewed the published studies in the public sector/healthcare marketing literature. Subsequently, the chapter identified challenges an organisation may encounter whilst adopting branding in the public sector. Finally, literature surrounding social marketing is evaluated. Despite this chapter identifying the huge potential for the application of branding strategies in the public and non-profit domain, research has historically paid scant attention to this subject. Thus, this study identified a gap in the literature that it plans to eliminate through conducting a research study within the subject area of branding/reputation in a public sector hospital.

Marketing and branding studies thus far, as can be seen from proceeding discussions, have tended to focus on external stakeholders. The next chapter proceeds with a review of the relevant studies in the allied reputation management literature. Reputation offers a more

concrete conceptualisation for this study as it accounts for the importance of the views of internal stakeholders in driving external stakeholder's perceptions of the organisation.

~ Chapter 3 ~

REPUTATION MANAGEMENT: DEFINITION AND MEASUREMENT

"It takes 20 years to build a reputation, and five minutes to ruin it"
Coined by Warren Buffett, (Fisher and Demos, 2006).

3.1 - Introduction

The aim of this chapter is to critically review published work in the reputation management literature that is relevant to our investigation of hospital reputation. This chapter further develops our understanding of how brands can be perceived both internally and externally – *otherwise known as reputation*.

Previous research on hospital reputation has focused on statistical data about medical care or the ability of the hospital to meet patient perceptions (Linder-Pelz, 1982; Finkelstein, Singh, Silvers, Neuhauser and Rosenthal, 1998). By way of contrast, this study will consider views of three stakeholder groups and investigate service users' perceptions of both overall hospital reputation and, staff perceptions of reputation. When building a reputation two important areas that contribute are corporate identity and image. Many researchers (Davies et al., 2003; Chun, 2005) see corporate image and identity as 'elements of reputation rather a synonym'. In the following sections the meaning of these two terms is examined. Subsequently, this study will also contribute to the area of reputation management by focusing on the public sector and applying this to hospital management. Finally, the chapter concludes with a critical assessment of the measures of reputation.

3.2 - Reputation Management Defined

Many authors consider the terms corporate image and corporate reputation as identical and they are often used interchangeable (Caruana, 1997). This is known as the analogous school of thought (Gotsi and Wilson, 2001), it views corporate reputation as synonymous with corporate image. The other school of thought, known as differentiated school of

thought, considers the terms to be different and interrelated (Gotsi and Wilson, 2001 p.25). Gotsi and Wilson (2001) discuss the two schools in depth.

The analogous school of thought has been criticised for failing to refer to the concept of corporate reputation and using the terms corporate image and reputation interchangeably. The differentiated school of thought has three dominant views. The first considers image and reputation as diverse yet separate concepts. The second view believes a firm's corporate reputation is only one dimension towards the creation of its corporate image. The third view explores the other side of the relationship and argues that a firm's corporate reputation is largely influenced by the numerous images held by its constituencies. Many theorists view corporate image as a falsehood or imitation of reality and hence is not a true reflection of the company's reality. Their view, therefore, is that organisations should focus on the management of corporate reputations and not on corporate images (Gotsi and Wilson, 2001). The differentiated school of thought that views corporate image and reputation as interrelated seems to be the most popular thought and the other views seem to be a bit extreme.

Fombrun (1996, p.78-79) interprets reputation as 'the overall estimation of a firm by its stakeholders, which is expressed by the net affective reactions of customers, investors, employees and the general public' (cited in Gotsi and Wilson, 2001). Similarly, Post and Griffin (1997) suggest taking a multiple stakeholder approach when defining reputation. A corporate reputation represents the net emotional reaction to the company's name. In contrast, Gray and Ballmer (1998, p.697) define corporate reputation as 'a valued judgement about the company's attributes by its constituents' this definition almost completely excludes affective components. Hall (1992) integrates both aspects of affective and cognitive components, he defines corporate reputation as the following '*a company's reputation consists of knowledge and the emotions held by individuals*' (p.138).

Fombrun (2001) highlighted that there are diverse perceptions of reputation. He characterised reputation as follows; the result of corporate branding in the area of marketing, a signal about future actions and behaviour, a pledge that justifies and promotes expectations of a principal about the actions of the agent in the field of principle agent theory, a kind of goodwill in accounting, the manifestation of a corporate identity in the field of organisation theory and a potential market entry barrier in the field of management.

3.3 - The Importance of Reputation

The drivers of competitive advantage no longer solely consist of tangible assets, but also intangible assets (Schwaiger, 2004; Carmeli and Tishler, 2004). Reputation is an intangible asset that is essential to the success or failure of any organisation. Therefore it is crucial to study the effects it can have on both the organisation and its stakeholders. According to Hall (1992, p.135), intangible resources range from the intellectual property rights of patents, trademarks, copyright and registered design, through contracts, trade secrets, public knowledge, know-how, networks, organisational culture and reputation. Furthermore, Carmeli and Tishler (2004) describe characteristics of intangible elements as less flexible, hard to accumulate, not easily transferred, and they can affect multiple users at the same time, serve as inputs and outputs and are not consumed when in use.

Intangible assets are vital to create market entry barriers, in order to foster customer retention, and thus strengthen a firm's competitive advantage (Schwaiger, 2004). In a study conducted by Hall (1992) on CEO's in the UK, he found out that company reputation is one of the most important contributors to success and that reputation is the intangible asset that would take the longest to replace from scratch. This highlights to managers the importance of ensuring every employee is disposed to be both a promoter and a custodian of the reputation of the organisation that employs them. This is of particular importance in service organisations, such as a hospital.

According to Schwaiger (2004) and Carmeli and Tishler (2004) organisations are increasingly recognising the need for intangible assets such as corporate reputation in order to achieve business goals and to stay competitive. Increasing competition in the global economy highlights the need for sustainable competitive advantage. Reputation management is an intangible asset and involves understanding an individuals or organisations reputation and taking action to have a positive impact on their reputation. A favourable reputation creates competitive advantage when competitors are not able to match the prestige and esteem it creates and enables an organisation to attain sustained superior outcomes (Schwaiger, 2004; Carmeli and Tishler, 2004). A reputation is important because the way in which the public perceives a company is crucial in determining its success (Berens and van Riel, 2004).

Reputation has potentially important implications for service firms. Previous studies have found that a good reputation enhances profitability because it attracts customers to products, investors to securities and employees to its jobs; in order to maintain a superior reputation, management should be always thinking and trying to do the right thing (Fombrun, 1996; Keller, 2000). Customers now want to know about the company, not just the products. Reputations are therefore important as they reflect the behaviour the company exhibits on a daily basis. According to Fombrun corporate reputation is a collective assessment of a firm's past behaviour and outcomes that depicts the firm's ability to render valued results to multiple stakeholders. Corporate reputation thus reflects a firm's relative standing, internally with employees and externally with other stakeholders, in its competitive and institutional environment (Bromley, 2002 p.36). When researching reputation, multiple stakeholder perceptions must be considered. As a result, this research study aims to examine the three main stakeholder groups within the hospital.

It is also important to examine the views of the main stakeholders of an organisation as an organisations' corporate reputation is affected by the action of every business unit, department and employee that comes into contact with another stakeholder and therefore it is the job of every employee to protect and enhance their company's reputation (Gotsi and Wilson, 2001). Studies conducted by Gotsi and Wilson (2001, p.99) found that there is also a pivotal role of staff in the corporate reputation management process and presents ways through which organisations can encourage commitment, enthusiasm and consistent staff behaviour in delivering the brand values.

3.4 - The Benefits of a Positive Reputation

It is crucial for an organisation to have a positive reputation (Fombrun, 1996; Schwaiger, 2004). A positive reputation provides many benefits including premium prices for products/services, lower costs of labour due to stronger employee satisfaction and reduced labour turnover costs, improved loyalty from employees and customers, greater latitude in decision making and a cushion of goodwill when crises hits'. Reputation of service organisations stems from the guarantee of a reliable service and is built from the credible actions of both management and the company. Davies et al. (2003) state reputation is important in services, as the concept of quality is less easy to define for a service than for a physical product. Maintaining a positive reputation is especially important for service

organisations such as healthcare; if a hospital holds a good reputation then it leads to its stakeholders having confidence in the service they receive and being satisfied with what the organisation offers affecting their overall health, as a result it is necessary to continuously research this area and to contribute to existing knowledge. Da Camara (2007: 2008) found that public authorities are becoming aware of the need to manage public confidence, which is essential, as it will determine patient attendance. Davies et al. (2003) also suggest that a service organisation with a positive reputation would lead to stakeholders having a confidence in the service they receive. Confidence is very important for patients especially in the recovery stage; if they are confident in the service they receive they are then more likely to recover quicker. As a result, reputation is important in the public healthcare sector.

Reputations are a source of competitive advantage, as rivals simply cannot replicate the unique features and intricate processes that produce these reputations. According to Fombrun and Gardberg (2002) a corporate competitive advantage must be maintained due to four trends in the business environment, these being: the global interpenetration of markets, media congestion and fragmentation, the appearance of ever more vocal constituencies and the commoditisation of industries and their products.

As there is no specific definition for public sector reputation, this study must adopt a definition based on the commercial sector and apply it to a public sector context. From a critical assessment of the literature available on corporate reputation, a definition by Fombrun and Rindova (1996) is deemed the most appropriate for this study as it states; '*A corporate reputation is a collective representation of a firm's past actions and results that describes the firm's ability to deliver valued outcomes to multiple stakeholders. It gauges a firm's relative standing both internally with employees and externally with its (other) stakeholders, in both the competitive and institutional environments*' (Fombrun and Van Riel and Balmer, 1997 p.10).

3.5 - Internal and External Views

One of the primary challenges faced by contemporary organisations stems from the breakdown of the boundary between their internal and external aspects, Davies et al. (2004) state that any gaps that exist are seen as a potential cause of a crisis. Kennedy (1977) was the first to carry out an empirical study in which employees were proven to have a

significant influence on the ways external stakeholders perceive an organisation. Too many firms tend to focus on what customers think, to the exclusion of what employees think (Davies and Chun, 2007). Due to the increasing levels of interaction between organisational "insiders" and "outsiders" there is a need to combine factors that drive reputation in relation to both internal and external stakeholders (Hatch and Schultz, 1997). The purpose of this study, therefore, is to investigate what influences reputation from the perspective of three stakeholder groups within a public sector hospital. Consequently, understanding the key drivers of a hospitals reputation is a central part of this study as hospital reputation is an important factor in deciding between hospitals.

According to Chun and Davies (2006), there are two emerging issues in the literature that looks at the internal and external perspectives. The first being the alignment perspective, this emphasises matching external brand image to internal views and values (p.138). The second perspective is identified as the stakeholder perspective, this holds that a marketer should expect to find that what satisfies employees and customers about a corporate brand will differ (p.138). The shareholder perspective, rather than the alignment perspective, is mostly referred to throughout previous published studies (Chun and Davies, 2006; Fombrun, 1996). Resolving issues between the internal and external perspectives is an important task in the organisation, as marketing managers must decide how to promote their brand both internally and externally.

Prior work in both branding and reputation management literature has focused on managing internal and external views of the corporate brand (De Chernatony, 2001; Chun and Davies, 2006; Hatch and Schultz, 1997). The Corporate Character Scale (Davies et al., 2003) assesses the internal and external views of reputation; it compromises of seven dimensions; agreeableness, enterprise, competence, chic, ruthlessness, machismo and informality (Table 3.2, pg.50). The model highlights any gaps that exist between the internal and external perceptions of the company's reputation. Gaps can be created if management have a different view of what their organisation stands for, compared with employees' views and what customers actually experience (Davies et al., 2004 p.126).

In relation to internal views, Fombrun and Wiedmann (2001) suggest that employee's rate reputation more positively than any other stakeholder group because of their high commitment and dependency towards their employer (Helm 2007, p.244). Recent research

by Helm (2007) also found that employees hold a higher view of the firm than customers, but the highest ratings tend to come from the firms private investors. This may be due to the fact that consumers do not have detailed knowledge about numerous characteristics of the firm compared to other stakeholders, leading to a narrow view in relation to reputation. In comparison, employees are better informed and consider more details when evaluating a firm's reputation (Page and Fearn, 2005). Employee views tend to transfer to customers through the appropriately termed process of emotional contagion; this includes body language and facial expressions (Davies and Chun, 2007). Gotsi and Wilson (2001) found that people and their talent are increasingly being recognised by organisations as their most important assets towards building a favourable corporate reputation.

From an external view, what managers do inside a firm can affect how the customer is treated and how the customer regards the service provider (Davies et al., 2004). A long-term relationship of trust between the services brand and the customer informs and reinforces the corporate culture in which the brand and the service delivery are embedded (De Chernatony and Segal-Horn, 2003). Corporate reputation is portrayed by frontline staff; this means employees must be encouraged to live the brand and enhance the organisations reputation (Gotsi and Wilson, 2001). Companies often seek to create a positive internal view so as to create a positive external view.

Gotsi and Wilson (2001) suggest that staff and their behaviour represent the reality of the organisation to the customers and therefore if their behaviour does not live up to the expectations created through the organisations external communication campaigns, the organisations overall reputation will be damaged. Participants in their study also suggested that organisations needed to ensure that there is no gap between what organisations' are saying in the outside world and what people believe inside the business.

Furthermore, Davies et al. (2003) work on companies' internal and external values found that management did not try to form similarities between the values being promoted inside and outside the organisation. The human resource function and marketing function had not been consciously working towards a set of similar values, despite the fact that there were many parallels in the respective values from both perspectives (Figure 3.1). For example, they had been aiming intuitively to align the two but not realised they needed to make the process more overt. They wanted innovation to be valued inside the company and to also

be associated with the corporate name in the marketplace (Davies et al., 2003). They want to look after their employees, so that their employees would look after customers, while also wanting to be seen as being friendly and helpful on the outside. Inside they wanted trust and respect between employees. The company's marketing department statement projected the following values; the company would be trusted, admired, and liked (Figure 3.1).

Figure 3.1: Internal and External Values

Human Resource perspective   **Marketing perspective**

Be energetic, innovative   ↔   Innovative and modern

Look after our people so they
look after our customers   ↔   Friendly and helpful

Trust and respect each other

Support each other and praise   Honest and down to earth
more than criticise

Enjoy work, celebrate success   Efficient and simple

                                 Ethical and community
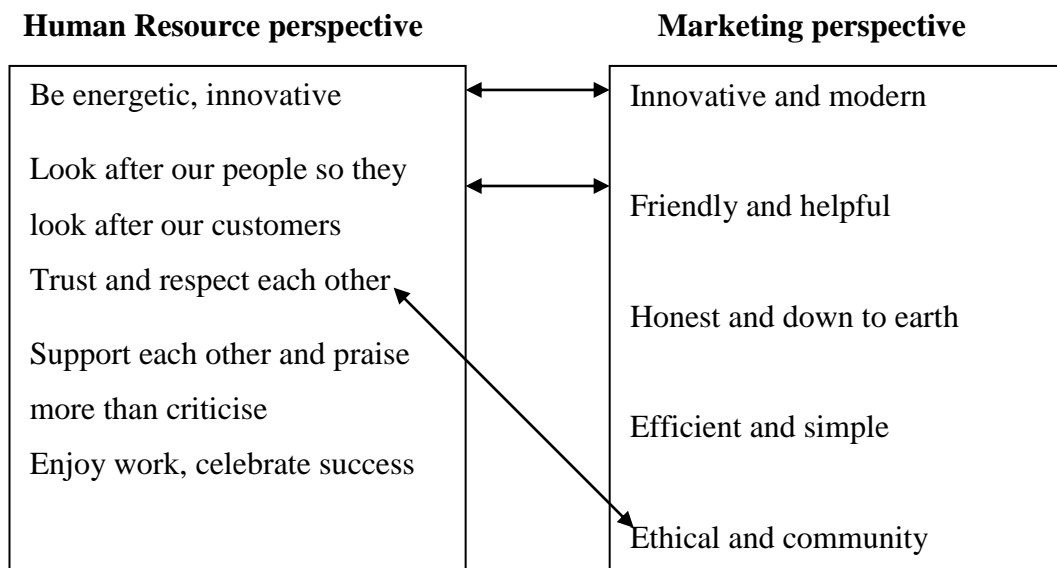
Source: Reproduced from Davies et al. (2003)

According to theorists Kowalczyk and Pawlish (2002), corporations have always dealt with multiple groups from employees, shareholders and the financial community to suppliers and government bodies. Each group has traditionally been treated individually. Today however, this is no longer possible. There is a requirement for some form of coherence in projecting the identity of the corporation. Kowalczyk and Pawlish (2002) also found that managing the corporation's brand or reputation might involve reaching inside the corporation and better projecting and communicating values to external stakeholders.

3.5.1 The Reputation Paradigm

Chun (2005) discusses the reputation paradigm. According to Chun (2005, p.92) the term 'paradigm' is usually used in the literature to explain various groups of approaches to a certain field of study. Within the reputation paradigm, there is no one source as yet which describes the entirety of the concept of reputation. There is a general consensus by both

practitioners and academics that the internal and external aspects of corporate reputation cannot be treated independently. As a result, the distinction between the different perspectives of corporate reputation is becoming unclear and less useful for understanding the reputation paradigm. The three schools of thought within the reputation paradigm adopted by Chun (2005) are evaluative, impressional and relational. Stakeholders can typically be grouped as internal and external. The 'evaluative' and 'impressional' schools are mainly concerned with single stakeholder interests; the relational school is based upon stakeholder theory, which recognises that different stakeholders may have different expectations of a company (Freeman, 1984, cited in Chun, 2005). This implies that the relational school focuses on the views of both the internal and the external stakeholders interests (Chun, 2005). The impressional school of thought refers to terms such as image, identity and personality, which suggest that it looks at perceptions rather than financial performance.

When studying internal and external views in relation to reputation, the terms image, identity and reputation are used interchangeably (Davies and Chun, 2002). This study proposes to examine the three concepts separately.

3.5.2 Corporate Image

In earlier studies the concept was known as corporate image rather than the term corporate reputation. Martineau (1958) referred to the term image as '*the sum of functional qualities and psychological attributes that exist in the mind of the consumer*' (Cited in Gotsi and Wilson, 2001 p.25). Image is taken to mean the view of the company held by external stakeholders, especially that held by customers (Davies, 2003; Bromley, 2000; Hatch and Schultz, 1997). Brown and Dacin (1997) state that employees have a construed image; this is how they believe the market sees the organisation. Kotler and Lee (2007, p.15) describe the process of creating an image in an organisation as '*the process beginning with the decision of how the organisation wants to see itself (Brand identity), it then manages how the organisation is actually seen (Brand image)*'. A strong image can help attain benefits such as heightened awareness and understating of features, spirit and brand personality, which can all result in increased usage.

A favourable corporate image can boost sales through increased customer satisfaction and loyalty in addition to attracting both investors and future employees. Dowling (1986)

defines an image as the '*set of meanings by which an object is known and through which people describe, remember and relate to it*' (Pina et al., 2006 p.176). Corporate image, according to Marwick and Fill (1997, p.398), can be said to be 'the *totality of a stakeholders perceptions of the way an organisation presents itself, either deliberately or accidently*'.

Corporate image begins with a company's internal stakeholders and how they perceive the company. External stakeholders can then develop an image of an organisation depending on their image of these same internal stakeholders, this is more so the case with customer facing employees (Davies and Chun, 2002). Alvesson (1998, p.98) considers the term corporate image as '*only meaningful when there is a certain distance between the observing group and the object in question*'. He therefore considers the term corporate image to apply only to the company's external audiences. According to Davies and Chun (2002) corporate image is conceptualised, as the way in which an organisation's members believe external stakeholders perceive their organisation or the way the organisations managers' would like outsiders to view the company. The external corporate image is based on perceptions held by all of the organisations stakeholders. Corporate image relates to both tangible and intangible characteristics such as functional, physical, and emotional characteristics associated with the firm (Davies and Chun, 2002).

In the past, image has been associated with retail stores. Worchester (1972) subcategorised corporate image into product reputation, customer relations, employer role and ethical reputation (Chun, 2005). According to research by Chun (2005, p.95) reputation was regarded as an independent variable, later regarded as a dependent variable, it resulted from being a good employer, offering a good service and being honest and reliable. With regard to external stakeholders, the main focus is on customers, therefore image is not associated with what the company believes, but what the customer believes or feels from their experiences and observation. Further, Gray and Balmer (1998) propose that corporate image is created through well-conceived communication programmes, whereas corporate reputation evolves as a consequence of consistent performance. The main distinctions between image and reputation are that stakeholders can form an image without any real experience with the organisation, reputation is deeper, and it implies something grounded in experience (Chun, 2005). Reputation is more durable than image. Images may be altered relatively quickly as a result of organisational changes or communication programmes,

whereas reputation requires more nurturing through time and image consistency (Chun, 2005).

3.5.3 Corporate Identity

According to Davies et al. (2003, p.61) identity is taken to mean '*the internal, that is the employees view of the company and reputation is taken to be a collective term referring to all stakeholders views of corporate reputation, including identity and image*'. Identity was similarly defined as being influenced by the experiences of employees at work (Hatch and Schultz 1997; Bromley, 2000). Brown and Dacin (1997) point out that corporate identity is how people inside the organisation see it; it is their mental associations held about a company, mental associations include attribute associations, beliefs, emotions and evaluations, corporate evaluation and identification.

Melewar and Jenkins (2002) state that there is a lack of consensus in relation to the definition of corporate identity, as a result organisations' may find corporate identity hard to manage. Balmer (1998, p.985) states that corporate identity encapsulates 'a company's ethos, aims and values; presenting a sense of individuality that can help to differentiate the organisation within its competitive environment'. Melewar and Jenkins (2002) found both practitioner and academic based definitions of corporate identity. A practitioner-based definition is one by Marwick and Fill (1997, p.397) who emphasised corporate identity as '*the organisations presentation of itself to its various stakeholders and the means by which it distinguishes itself from all other organisations*'. An example of a academic based definition is one by Van Riel and Balmer (1997) which is slightly more complicated but similar in meaning, Van Riel and Balmer (1997) defines corporate identity as 'the self presentation of an organisation, rooted in the behaviour of individual, organisational members expressing the organisations "sameness over time" or continuity, distinctiveness, and centrality' (p. 290).

Corporate identity and organisation identity are interdependent, but are not synonymous. According to Hatch and Schultz (1997), organisational identity refers to the employees' perceptions of the organisation. It refers to what stakeholders perceive, feel and think about their organisation. It is assumed to be a collective, commonly shared understanding of the organisations distinctive values and characteristics. Corporate identity refers to visual cues such as name, logo or symbols, or the strategic cues of identity such as vision, mission and

philosophy. Researchers have stated that corporate identify should reflect the characteristics or corporate personality rooted in the behaviour of members' of the organisation (Balmer, 1997). As a result of an organisation possessing strong corporate identity the following occurs: consumers are inclined to use the organisation's products and services (retail customers), to wade with the organisation (industrial customers), to purchase stock in the company (shareholders), to work for the company (employees), to provide a sympathetic legal framework (government), and to speak well of the organisation (the media and local communities) (Balmer and Wilson, 1998).

According to Hatch and Schultz (2001), image and identity should be aligned so that employees' values and behaviours align with the desired values for the corporate brand. Brown et al. (2006) developed four viewpoints in relation to identity, image, and reputation. *Viewpoint one* – 'Who are we as an organisation?' this point focuses on identify and looks at how inside organisational members perceive the organisation. Each individual holds their own associations with regard to the organisation; these associations tend to differ among members and may have been created by the experiences in the organisation. *Viewpoint two* – 'What does the organisation want others to think about it?' this focuses on intended image, which is how the organisation wants the firm to be positioned in the mind of its key stakeholders. The choice of which attributes to communicate is up to the firms managers. *Viewpoint three*- 'What does the organisation believe others think about it?' these are labelled as construed associations. Managers ask the question; what do our suppliers think of us, customers etc.?? *Viewpoint four* – what do stakeholders actually think about the organisation? Reputation is the associations that the stakeholders outside the company hold. This viewpoint is the reality and may be influenced by a variety of outside sources.

Identifying any gaps that appear between the two terms discussed above is an important task for any organisation. In particular, it is crucial for a service organisation either public or private, to recognize gaps may exist as the interaction between employees and customers is always in existence. There appears to be a general view that any gaps that do exist should be reduced (Davies and Chun, 2002). Chun (2005) led on to state that reputation crises could be prevented by the monitoring of gaps between what employees think and what others think, as potential problems can be avoided.

For the purpose of this research study, the author has chosen to take the meaning of the terms image, identity and reputation as that given by Davies et al. (2003). Image is taken to mean the view of the company held by external stakeholders especially that held by customers. Identity is taken to mean the internal, which is the employee's view of the company. Finally, reputation is taken to be a collective term referring to all stakeholders' views of corporate reputation, including identity and image.

In summary, it is evident from the reviewed literature that the terms image and identity should not be used interchangeably. Image is the perception of external stakeholders, whereas identity is the perception of the internal stakeholders. The ever-changing fast environment requires public sector organisations to monitor their reputation and remain constantly alert to stakeholders. The next section will review the area of reputation in the public sector.

3.6 - Reputation in the Public Sector

Research in the area of reputation in the public sector has remained rather neglected and while service branding has been a growth area since the 1960's, the influence on the public sector has been limited (Luoma-aho, 2007; Kotler and Lee, 2007). This further emphasises a gap in the literature, which this study plans to address. The term 'public sector' covers those organisations in public ownership and includes central government departments and agencies, local authorities, the health service, armed forces and other public corporations (Kearsey and Varey, 1998). Reputation in the public sector is an important area to research because public sector organisations are often knowledge based industries and their reputation greatly depends on stakeholders' perceptions of their services (Padanyi and Gainer, 2003). In contrast, Luoma-aho (2007 p.126) suggests that not all stakeholders can assess the reputation of certain public sector organisations, as their existence may often be known while their actual functions are not.

A public sector service, such as a hospital, should consider reputation as vital as Hibbard, Stockard and Tusler (2005, p.1150) state that if a hospitals reputation is affected, it may eventually experience market share declines via consumer choice, purchaser choice, or physician referral. Furthermore a declining hospital reputation may pose other challenges such as recruiting and retaining qualified physicians and nurses. Reputation can also affect

a hospitals ability to maintain legitimacy and professional standing so it is important to investigate how it is affected and how it can be best managed.

To have a strong reputation, the public sector service must be successful and valued. Successful services depend on good internal communication to support consistency in delivering the service experience (Padanyi and Gainer, 2003). How a service is delivered appears to be a contributor to its reputation (Sergeant and Frenkel, 2000). Critically, an organisation with highly customer orientated frontline workers is likely to deliver a high-quality service. The outcome of being highly customer orientated is the development of positive customer performance perceptions and favourable behavioural outcomes (Hartline et al. 2000). Service firms with renowned customer orientated reputations have developed corporate cultures that demand these behaviours from their employees. A customer-orientated firm also leads to a better understanding of its customers (Brady and Cronin, 2001). The personal relationship between the service salesperson and the customer, rather than the purchase itself leads to satisfaction or dissatisfaction in service purchases. This identifies the importance of the customer contact personnel learning more about the customer and being more empathetic to the customer needs when representing the firm (Philips, Tan and Julian, 2006). If the customer contact personnel are in emotional disequilibrium, it could result in a poor service experience for the customer and poor service performance by the firm, thereby highlighting the importance of emotional dissonance in the service encounter (Stock and Hoyer, 2005).

To maintain a solid reputation, public sector organisations (PSO's) cannot afford to differ too much from each other; their products and services are dictated by legislation, this limits the amount of uniqueness that is available (Jarrar and Schiuma, 2007). There is a struggle between managerialism and isomorphism: on one hand there is a need to outshine other organisations to create a reputational advantage, and on the other hand there is a need to maintain legitimacy (Luoma-aho, 2007). Reputation in the public sector is affected by experiences – stakeholders with more experience probably know the organisation better and can thus evaluate it more accurately.

According to Jarrar and Schiuma (2007), public sector organisation's feel the need to increase their accountability and customer focus orientation in order to improve efficiency and performance; the reason for this being frontline employees have the majority of

encounters with customers in a service organisation. All employees, therefore, need to understand their organisation's values, recognise their roles, and be committed to delivering the service brand (Heskett, 1987; de Chernatony and Horn, 2003). Therefore, organisations that desire a good reputation need to concentrate on how their employees deliver the service. Gilmore and Carson (1996) suggest that a service organisation relies more heavily on its customer service management than does a product organisation. They state that the marketing department does not determine a service brand's personality, but rather the customer facing staff and their supporting colleagues have a greater impact on brand perceptions. From a consumer's perspective, it is not the institution that is important but the individuals with whom stakeholders engage. The public sector should then be encouraged to give voice to the people who actually deliver their services and focus on their employees being highly customer orientated. CO in public sector services is important as customers find it hard to evaluate a service in comparison to a product; therefore, strong focus on intangible elements occurs.

The outcomes of a service are mainly intangible and according to Cinca, Molinero, and Queiroz (2003) so too are the objectives. Cinca et al. (2003) states that the public sector services objectives are relatively intangible; examples are to create a secure environment, to raise the cultural level of the population and to impart justice. Intangibility is important in public sector organisations'. Public sector organisation's (PSO's) have multiple objectives of non-financial nature, and hence have to make more intensive use of such intangibles such as human resources and knowledge (Cinca et al., 2003). Resources and final products of public sector organisations, such as services and information are intangible. Overall, theoretical contributions in relation to the public sector remain rather scarce, as a result this study aims to contribute to our understanding of the links between reputation and CO in the public sector, the idea that CO may drive the reputation the organisation possesses is highlighted in the qualitative stage of this study.

3.6.1 Hospital Reputation

According to Hibbard et al. (2005) if a hospitals reputation is affected, it may eventually experience market share decline via customer choice, purchaser choice, or physician referral. Considering this, exploring what drives hospital reputation and the outcomes of reputation is an important issue. A declining hospital reputation may pose several challenges, one being the difficulty in recruiting and retaining qualified clinical staff.

Improvements are constantly required to maintain a positive reputation. It is important to study hospital reputation as it has been shown to be an important factor in deciding between which hospitals to attend (Shahian, Yip, Westcott and Jacobson, 2000). Hibbard et al. (2005) suggests three different mechanisms appear to drive hospital quality improvements - regulation, professionalism and market forces.

According to an article by the Healthcare Collector (2006) on hospitals, marketing and maintaining your reputation is vital. The article also states that surveyors J.D. Power and Associates found that 75% of patients use reputation-related information as their primary criteria in selecting which hospital they attend; therefore studying reputation in the healthcare industry is essential. Hospitals need to enhance the quality of patient care and effectively communicate their performance to the communities in which they operate. The study that this article examines is the 2005 National Hospital Service (NHS) performance study; it is based on the responses of 2,500 patients. The study measured overall patient satisfaction in five categories: dignity and respect, speed and efficiency, comfort, information and communication and emotional support. However, an article published by Healthcare Strategic Management (2006) states that hospitals should study their reputation by surveying all stakeholders and not just patients; hence this study considers both employees and patients/visitors.

According to Herbig and Milewicz (1993), a corporation's reputation involves trust that the corporate creates by keeping its promises in a decided manner. Research conducted by Satir (2006) illustrates the following determinants to affect customers perceptions of corporate reputation; service quality, communication and trust. Research by Power (2005) illustrates the importance of a positive reputation to a hospital, the study found that 48% of patients say that the hospitals overall reputation is their primary criterion for selection. According to the article by Power (2005) patients now have more choice in the healthcare provider they choose, because of this hospitals need to continue to enhance the clinical and experimental quality of patient care and effectively communicate their performance in the communities they serve. Quality is a major determinant of reputation; Shaw (2007) states that hospitals are increasingly using quality improvement efforts to position themselves in the marketplace and differentiate themselves form their competitors.

While reputation will ultimately depend upon whether a patient's treatment is successful or not, the success of many treatments will rely upon the confidence the patient has in the hospital. *Hospital reputation (assessed by the number of out of area referrals) has been shown to be an important factor in deciding between hospitals (Shahian et al., 2000). Reputation has often been assessed by the ranking of hospitals; an approach that has been critiqued as it can provide limited insights into what management can or should do in response (Green, Wintfield, Krasner and Wells, 1997). Previous* work on hospital reputation has tended to focus on statistical data about medical care, for example, whether the hospital was a teaching hospital, how many beds it had, and the type of operations conducted (F*inkelstein et al., 1998), or the ability of the hospital to meet the patient's expectations (Linder-Pelz, 1982a,b). By way of contrast this study will reveal what drives hospital reputation by exploring the perceptions of three main stakeholder groups.*

To accomplish this however, a measure of reputation is needed that can be applied across all stakeholders groups. This will allow comparison between the multiple stakeholder groups' perceptions (Helm, 2007). The following section will critically evaluate the available measures of reputation that organisations can use.

3.7 - Measures of Reputation

There is no clear and concise definition of reputation available, therefore there is no one-way to measure reputation. Rather several different measurements have been developed and they will each in turn be presented and critically assessed in this section.

Although 96% of CEO's consider corporate reputation a vital component of business success, less than 20% have instituted a method for measuring their organisations reputations. The personal reputation of a CEO can account for up to half of corporate reputation (Cribbs, 2003). Such factors contributing to their reputation include: credibility, code of ethics, internal communication, good management, and motivating and inspiring employees.

The growing interest in reputation has led to the development of a variety of different construct measures. The proliferation of different measures of corporate reputation has raised the question of whether or not a standard measure can be established. Until 1997, 'Fortune's Annual Most Admired Companies' (AMAC) is the only reputation ranking

available on a global level and it is still restricted to US firms. Only in 1997 did Fortune publish results of a survey on the 500 Global Most Admired Companies (Schwaiger, 2004). Berens and Van Riel (2004) described Fortunes annual 'Most admired companies' and the Reputation Institute's 'Reputation Quotient' as rankings of companies based on a cluster of different corporate associations that represent different stakeholders' expectations regarding the activities of a company. A third dominant approach is 'The Corporate Credibility Scale' which was developed by Newell and Goldsmith (2001) and measures the perceptions of an organisations honesty, reliability and benevolence as predictors of corporate behaviour and indicators of reputation. Davies et al. (2003) developed a well-published measure 'The Corporate Character Scale'. This scale measures corporate reputation using indicators that represent personality traits of people that may be attributed to organisations and critically is validated through numerous published studies as a measurement scale to assess both internal employee views and external stakeholder views. The review and critique begins with Fortune's AMAC.

3.7.1 Fortunes Annual 'Most admired companies'

The best-known league tables of reputation ranking are that from the USA Fortune magazine. Fortune magazine regularly polls business executives and analysts as to the reputation of leading companies. Fortunes list is composed of Americas largest 1000 companies based on revenue and the twenty-five largest US subsidiaries of foreign-owned companies. To generate the rankings 10,000 executives, directors, and securities analysts select the five companies they admire most, regardless of industry. To create the industry lists the executives, directors, and analysts are asked to rank companies in their own industry on eight criteria: quality of management, quality of product/service, innovativeness, long-term investment value, financial soundness, employee talent, use of corporate assets and social responsibility. The *'overall reputation score (ORS)'* is the arithmetic mean of the attributes respondents provided on eight 11-point scales. General Electric (GE) is the world's most admired company for the sixth time in eight years. In the Top 500 of Americas largest corporations it ranked sixth in 2007.

3.7.1.1 Critical Assessment of Fortunes Annual 'Most admired companies'

A major weakness of this measure is that it includes an appraisal by business people, not customers, of the financial performance of the companies included in the survey. It is also overly reliant on the financial performance of companies. This is reinforced by Caruana

(1997 p.109) who states 'All but one of the items (i.e. community and environment responsibility) appears to be directly influenced by the raters' perception of the financial potential of the firm', indicating that the *Fortune* corporate reputation index measures little beyond performance. This is reinforced by Davies et al. (2003) who suggests that such measures have no theoretical foundation, are too heavily focused on financial performance and their samples are too narrow and often exclude important stakeholders such as employees and customers. Another criticism is that small companies are not included. If management is seeking to improve reputation this measure is of no help to them. A form of bias may also exist as the measure tends to be influenced by past financial performance (Schwaiger, 2004). The overall scope of the measure is far too narrow and is restricted to commercial organisations.

Fombrun, Gardberg, and Sever (2000) found limitations of league table surveys such as Fortunes AMAC. The limitations include biased sampling frames, target firms selected by size of revenue, restriction to publicly traded companies, collusion because of the sector membership of respondents, over-representation of senior managers, directors, and financial analysts in samples, and finally respondents may lack direct experience relevant to some attributes.

3.7.2 Fortunes Annual 'Global Most Admired Companies'

Schwaiger (2004) conducted a lot of work on the measures of corporate reputation. Fortune's GMAC (Global Most Admired Companies) is performed by *Hay* group consultants. *Hay* divides the global 500 into 24 industries and 13 countries, using a sample size of 5000. The 8 items used are those presented in the Fortune AMAC measure being innovativeness, quality of management, long-term investment value, community and environmental responsibility, ability to attract, develop and keep talented people, quality of products or services, financial soundness and corporate assets with the addition of the "company's effectiveness in doing business globally". The ORS is the arithmetic mean of these nine attributes (Schwaiger 2004). Other similar measures include 'Britain's Most Admired Companies' from *Management Today* or 'Asia's Most Admired Companies' by *Asian Business.* The only differences seem to be in terms of the sampling frame or items used (Chun, 2005).

3.7.2.1 Critical Assessment of Fortunes Annual 'Global most admired companies'

A major criticism is that again only experts are asked their perceptions and these may differ significantly from other stakeholder's views. Furthermore, Fryxell and Wang (1994) suggest the measure is highly influenced by past financial performance and therefore thought to be extremely problematic with respect to validity aspects (Schwaiger, 2004). Thus, using past information may have a unique effect on current reputation.

3.7.3 The Reputation Quotient

Measuring reputations accurately is crucial if they are to be managed. In 1998, the Reputation Institute invited the market research firm of Harris Interactive to collaborate in creating a measure of perceptions of companies across industries with multiple stakeholder segments. From conducting research, both firms realised that people justify their feelings about companies on one of twenty attributes that they grouped into six dimensions. The dimensions being Emotional Appeal, Products and Services, Financial Performance, Vision and Leadership, Workplace Environment and Social Responsibility. The survey is designed to capture the concept of the "halo" around a company's performance, which means exploring impressions rather than facts (Cribbs, 2003).

An index was created to sum up peoples perceptions and they named this 'The Reputation Quotient'. Both the Reputation Institute and Harris Interactive have created over 100,000 interviews with this instrument, indicating it is a valid instrument and is now a standardised measure for assessing corporate reputations. This measure is a relatively new alternative to the most admired list. The quotient is calculated from a list of twenty attributes representing 6 dimensions. The reputation quotient uses more criteria than those in the Most Admired Survey. This measure, unlike the most admired list, includes employees, investors and customers.

3.7.3.1 Critical Assessment of the Reputation Quotient

A major strength of the measure is that it is used with multiple stakeholders, whereas many approaches have focused on and been developed to understand the internal view only.

A major weakness of the reputation quotient is that some of the questions regarding the attributes can be responded to with more confidence by some participants' than others.

3.7.4 The Rotterdam Organisational Identification Test (ROIT)

The questionnaire was adapted by Van Riel and Balmer (1997) and aims to test the impact of the following variables on employee identification with the company; job satisfaction, management style, corporate culture and perceived organisational prestige. The scale is a standardised measurement to assess actual corporate identity; it is easy and cheap to apply. The ROIT questionnaire consists of a number of elements divided into six groups. The complete questionnaire consists of 225 likert statements. In addition to testing the above variables, it also includes questions about employee communication and personal and organisational characteristics.

3.7.4.1 Critical Assessment of the Rotterdam Organisational Identification Test

The main criticism of the ROIT scale is that it does not reveal the nature of the corporate identity of a company but only provides information about the consequences of a given corporate identity.

3.7.5 "GESAMTREPUTATION"

"GESAMTREPUTATION" was created by the German Manager Magazin. Since 1987, the magazine has conducted surveys on corporate reputation. According to Schwaiger (2004), in 2000 the authorised agent performed a random CATI survey of approximately 2,500 executives who were asked to rate the top 100 German companies on eleven point rating scales, similar to those used by Fortune magazine. In opposition to American studies, the German study found that reputation is not dominated by financial performance and similar to the reputation quotient a company's size and ownership affects corporate reputation.

3.7.5.1 Critical Assessment of "GESAMTREPUTATION"

Schwalbach (2000) found, in relation to this measure, that the reputation level varies over time, and the measure was not unique as it was so similar to the measures used by Fortune magazine. As a result the measure offers little by way of additional contribution from existing measures. Findings were also similar to American studies in that the companies with the highest reputation scores were car manufactures.

3.7.6 Leveraging Corporate Equity

Gaines-Ross (1998) developed this reputational measure. They regarded it as valuable as each corporation receives a single corporate equity score based on key components of a

corporate reputation. Equity is based on the perceptions of those influential executives outside the corner office and across all industries. Wartick (2002) stated the following in relation to measuring equity;

- The measured equity of a company takes into account all components of a corporate reputation.

- Both attitudes toward the company and behaviour that is directed in support of that corporation are measured.

The leveraging corporate equity measurement looks at factors such as trust and supportive behaviour and focuses on decision makers as participants. The method used for this measure was mail questionnaires; the sample included 25,000 senior and middle management subscribers to Fortune. Randomly chosen executives with titles of Vice President and above were drawn evenly across all company sizes. The survey asked executives to rate ten companies in a given industry. Ratings were obtained for 250 companies representing 25 industries in the business-to-business field. In order to obtain the company's Corporate Equity Score, Gaines-Ross (1997) saw it as necessary to study the five major components of corporate reputation, these being: awareness, familiarity, overall impression, perceptions and supportive behaviour. The main findings of this research are as follows; high corporate equity pays off both financially and strategically, well-led companies drive support and raise equity, high corporate equity is harder to lose than gain, corporate equity needs to be managed over time, high corporate equity companies are effective communicators about themselves and finally, high equity companies spend more dollars and effort on corporate advertising.

3.7.6.1 Critical Assessment of Leveraging Corporate Equity

A strong point of this measure is that it seems to rely less on financial performance than Fortune's AMAC measure did. It also gets at the strength of reputation by asking about supportive behaviours. However, a major weakness is that the measure was only tested with executives. Therefore the results are not based on the responses of all employee levels nor were external stakeholders involved in the testing of the measure.

3.7.7 The Aaker Scale

Jennifer L. Aaker (1997) developed a scale to measure brand image. Aaker's first stage of research was the generation of brand personality dimensions using 309 candidate traits, Aaker went on to compile these traits and managed to reduce them to 114 traits. Tests were carried out on 631 subjects, asking them to rate 37 brands across the 114 personality traits. Aaker assessed the results by using test-retest correlations and Cronbach's Alphas. Aaker's research study produced a valid, reliable and general brand personality scale. The scale consists of 42 items along five dimensions labelled; sincerity, competence, sophistication, excitement, and ruggedness (see Table 3.1), much of the items were drawn from psychology literature (Davies, Chun, Da Silva and Roper, 2001). The scale was tested on product brands, corporate brands and service brands. Pina et al. (2006) state consumers often perceive minimal differences between competing service brands, making it difficult to choose between them.

Table 3.1: Dimensions of Brand Personality

Dimension	Brand Personality Traits
Sincerity	Down to earth, family orientated, small, town, honest, sincere, real, wholesome, original
Excitement	Daring, trendy, exciting, spirited, cool, young, imaginative, unique, up-to-date, independent, contemporary
Competence	Reliable, hard working, secure, intelligent, technical, corporate, successful, leader, confident
Sophistication	Upper class, glamorous, good looking, charming, feminine, smooth
Ruggedness	Outdoorsy, masculine, western, tough, rugged

Source: Aaker (1997)

3.7.7.1 Critical Assessment of the Aaker Scale

One of the criticisms of the Aaker scale is that a lot of the expressions used are within American culture and this limits the scale to being culturally specific. Another major issue is that branding scales are not designed to work with both customers and employees, let alone other stakeholders. Further, Aaker ensured her sample was representative in the United States; however, the scale does not take into account cultural aspects. Therefore the scale is known to be limited in its use internationally. Aaker's scale was also limited in its measurement; it only measured externally, that is, external stakeholders rather than internal

stakeholders or both. A major criticism of the scale is that it only includes positive personality dimensions and no negative dimensions'. Levi-Strauss and Levi jeans sponsored the original work on the scale. Moreover, Levi's sponsoring the scale might unduly influence the ruggedness dimension. The ruggedness dimension is the weakest of the five dimensions and one that is associated with jeans (Keller 1998, cited in Davies et al., 2003).

3.7.8 The Corporate Personality Scale

The Corporate Personality Scale was developed by Davies et al. (2001) to measure both the image and identity of a firm. The Corporate Personality Scale (Davies et al., 2003; 2004) was validated with both customers and employees and exclusively with corporate brands, thus making it an appropriate construct for service organisations such as a hospital. The decision to adopt a projective technique like the personification metaphor was guided by their objectives to create a measurement tool that was generic, diagnostic and equally applicable to both employees and customers (Davies et al., 2004). This scale is similar to that used in human personality research by Aaker (1997). The major difference is that The Corporate Personality Scale measures both the internal and external perspectives, whereas Aaker only examined external perceptions throughout the reputation literature, reference is constantly made to the gaps that exist between employee and customer views of the corporate brand (Davies and Chun, 2002). There is generally a view that the two perspectives should be aligned or at least reduced (Hatch and Schultz, 2001).

The personification metaphor was used to define a scale with seven dimensions; it identifies five major and two minor dimensions of corporate character. The seven dimensions of the Corporate Personality Scale derived from studies of employee and customer perceptions of the identity and image of 15 organisations, with a sample of over 4,600 respondents in total. The most common dimensions across the various brand personality scales are competence, agreeableness and enterprise (Chun and Davies, 2006); such dimensions correlate with both employee and customer satisfaction (Davies et al., 2003). An original list was created with 114 items, reduced to 49. The five dimensions were then subjected to trait analysis as to identify different facets; Table 3.2 displays all these items. These traits of corporate personality are words or phrases that are commonly used to describe an organisation, drawn from those used to describe humans (Davies et al.,

2004). Respondents are asked to imagine the entity being assessed has come to life as a person. The scale uses a five-point likert scale from 'strongly agree' to 'strongly disagree'.

Table 3.2: Dimensions of the Corporate Personality Scale

	Facets	49 items
Agreeableness	Warmth/empathy	Cheerful, Pleasant, Open, Straightforward
	Concerned	Reassuring, Supportive, Agreeable
	Integrity	Honest, Sincere, Socially-responsible, Trustworthy
Competence	Conscientiousness	Reliable, Secure, Hardworking
	Drive	Ambitious, Achievement-orientated, leading
	Technocracy	Technical, Corporate
Enterprise	Modernity	Cool, Trendy, Young
	Adventure	Imaginative, Up-to-date, Exciting, Innovative
	Boldness	Extrovert, Daring
Chic	Elegance	Charming, Stylish, Elegant
	Prestige	Prestigious, Exclusive, Refined
	Snobby	Snobby, Elitist
Ruthlessness	Egotism	Arrogant, Aggressive, Selfish
	Dominance	Inward-looking, Authoritarian, Controlling
Machismo	NA	Masculine, Tough, Rugged
Informality	NA	Casual, Simple, Easy-going

*Source***:** Davies et al. (2001)

Agreeableness was found to be the most important dimension, which puts emphasis in reputation literature on trust and social responsibility. Chun and Davies (2006) suggest that agreeableness correlates strongly with satisfaction and organisational commitment, indicating that an organisation seen to be socially responsible will build and enhance their reputation more rapidly.

The *competence* dimension is the second most significant dimension in explaining staff and customer satisfaction. Employees will be pleased to be associated with a reliable, secure and leading organisation. Job security with this type of organisation will have a positive effect on employee satisfaction (Chun and Davies, 2006). This dimension should be considered cautiously by organisations when managing their corporate reputation and imagery.

Enterprise echoes the human personality trait of extroversion. The enterprise organisation is also seen as innovative and exciting (Chun and Davies, 2006). An organisation wishing to be perceived in this way is advised to employ a younger looking customer-facing workforce. This could however cause many problems. Competitors can often copy a firms cost strategies, in order to prevent replica many organisations seek to be different and constantly change. Customers enjoy this as they like variety, however it can be stressful for employees.

The *ruthless* organisation is inward looking and controlling. In an organisation that displays this trait, staff tend to have little or no opportunity to use their own initiative. Ruthlessness is seen as a negative trait and has a negative impact on employee and customer satisfaction. A certain level of control is important in a service organisation to have a uniform level of quality that will ensure a predictable customer experience. Too much control can lead to much criticism.

The *Chic* dimension emphasises prestige. It is employee's views of how outsiders see the organisation (Chun and Davies, 2006). The less attractive side is that of snobbishness; organisations need to ensure they do not alienate customers or employees who do not wish to be associated with this trait. The chic dimension was left out for this context, as 'Chic' type insights did not come out of the qualitative work as being significant therefore it was decided not to include the dimension in the quantitative study. Further, the chic dimension was not included in the quantitative study because it was felt that the traits associated with this dimension were not relevant to the public healthcare sector. The public sector covers all social classes therefore it would not be necessary to include a dimension that relates to a prestige and snobby image.

Machismo and *Informality* are two minor dimensions. They could not be left out, as they are important in certain contexts and cultures. Machismo reflects the gender dimension of corporate character. It is a tough type of organisation. The suggestion of an informal organisation brings to mind a firm that is not strictly rule bound and allows its employees to dress down. Many organisations give emphasis to their informal culture so staff may seem more approachable.

Satisfaction is viewed as a major outcome of reputation and both terms are interlinked. Satisfaction is defined by Anderson, Fornell, and Lehmann (1994) as 'the cumulative evaluation of what a company provides over time, thus one bad incident can be ignored if the sum total of previous experience is still positive'. Employees and customers may have different issues regarding satisfaction; satisfaction can also be sub-divided into economic and non-economic. When measuring the satisfaction of employees or customers, the satisfaction of the organisation as a whole is measured. According to research by Davies et al. (2003) agreeableness and competence correlate most strongly with satisfaction.

3.7.8.1 Critical Assessment of 'The Corporate Character Scale'

The main criticism of The Corporate Character Scale is its use of a personification metaphor "imagine if the company was to come to life as a person", in a similar manner to Aaker's Brand Personality Scale. While the Brand Personality Scale has been criticised for being culturally biased towards the US, a similar argument could be leveraged against the Corporate Character Scale as being biased towards the UK. However, the culture based criticisms of Aaker's Scale are more extreme than those of the Corporate Character Scale in that, the Aaker scale uses words with very specific meanings within American culture that may represent unknown or very different ideas to respondents internationally (for example, items such as western, cool, small town). On the other hand, while some traits, included in the Corporate Character Scale, are not related to personality (for example, masculine, technical, corporate etc.), these items nonetheless measure aspects of an organisation's image and are viewed as potentially important items for the measurement of a large public hospital organisation. The final criticism of the scale is that there is an issue of reliability with two of the seven dimensions. Machismo and Informality did not obtain a high score for the Cronbach's alpha statistic; the figures for the dimensions were 0.62 and 0.60 respectively.

Despite this, Davies and Chun (2002) state that The Corporate Personality Scale has many advantages. A strong point of this scale is that it helps us understand the complexity of what a brand is through a medium we are more familiar with, that being the personality of a human. A major advantage of the scale is that it is validated for the measurement of both image and identity of a corporate brand or reputation, thus allowing any gaps between employees and external stakeholders in the current study to be measured with items familiar and validated in previous studies within the British Isles (Chun, 2005). Finally, and

importantly for the current study, the Corporate Character Scale includes both positive and negative dimensions for the measurement of internal and external stakeholder views, and this is important in the context of the public healthcare service. Therefore, while not withstanding the criticisms of both personality scales, given this study is conducted in the British Isles and that the Corporate Character Scale is validated for multiple stakeholders including both positive and negative dimensions, it was deemed on balance the more appropriate measurement scale option in the context of the current study.

3.8 – Conclusion

This chapter critically reviewed published studies in the reputation management literature. It defined reputation management, discussed the internal and external perspectives and examined how reputation is measured with regard to multiple stakeholders. The chapter concluded with the view that reputation is important and essential in all organisations. Particular emphasis should be given to services as they are harder to evaluate and more dependant upon successful interactions between employees and external stakeholders, making the role of CO especially important. Therefore, the reputation they possess can be a good indicator of the level of service a customer can expect to receive. To measure reputation, the chapter concluded that 'The Corporate Character Scale' is the most reliable method, and therefore has been chosen for this study.

The next chapter discusses CO. The aim is to investigate its impact on reputation as customer orientated employees can act as brand ambassadors (de Chernatony, 2006; Wallace and de Chernatony, 2008) and their interaction with external stakeholders will in turn shape the external view of the brand. Critically, the view that customer-facing employees have of their organisation is held to influence the impression that customers form of the organisation (de Chernatony, 1999).

~ *Chapter 4* ~

THE CUSTOMER ORIENTATION OF SERVICE WORKERS

4.1 – Introduction

As the previous chapter has highlighted, managing an organisations reputation is crucial to its success. However, while CO has been well established in published studies of commercial organisations, no studies have examined its role in public sector organisations thus far. Furthermore, it is important to investigate this area as an organisation's employees may impact its reputation; therefore it is important to know how to manage the employee-customer relationship. Customers experience with employees and the CO of frontline service employees will influence the perceptions external stakeholders have of their experiences (Brown, Mowen, Donovan and Licata, 2002). High levels of CO enhance service users' views of the organisations brand through positive interactions with the brands employees and result in greater overall satisfaction among both internal and external stakeholders (Rust, Zahorik and Keiningham, 1996 p.391). The purpose of this chapter is therefore to critically assess studies in the CO research stream and their relevance to the current study.

Although there is no known studies on CO and its links to reputation in public sector services, the available literature on CO, reputation management and the services sector arena offers the potential to develop a framework for understanding the importance of CO in the services sector and importantly, how it can impact customers perceptions and effect the organisations overall reputation. Appleby (1992) pointed out that the need for CO in the public sector was raised as long ago as 1945 (Chen, Yu, Yang, and Chang, 2004). This chapter outlines and critically discusses CO in the services sector, investigates what drives CO, as well as the outcomes of being customer orientated, and how the concept can be measured. The chapter begins by defining CO.

4.2 - Defining Individual and Organisational Level Customer Orientation

Rather than examining how the marketing function is implemented at an organisational level, many studies concentrate on investigating the implementation of the marketing concept at an individual level, commonly known as customer orientation (Brady and Cronin, 2001; Donovan et al., 2004). CO involves listening to customers and engaging in dialogue, and this usually occurs between customers and frontline employees. Brown, Mowen, Donovan and Licata (2002, p.111) defined CO as *"an employee's tendency or predisposition to meet customer needs in an on-the-job context"*. It is composed of two dimensions, firstly the needs dimension, which represents employees' beliefs about their ability to satisfy customer needs. Secondly, the enjoyment dimension, which represents the degree to which interacting with and serving customers, is enjoyable for an employee.

CO is the set of beliefs in sales that says that customer needs and satisfaction are the priority of an organisation (Drucker, 1994). It focuses on dynamic interactions between the organisation and its customers as well as competitors in the market and its internal stakeholders. It involves a continuous improvement in business processes. It is the business seen from the point of view of its final result, that is, from the customer's point of view (Drucker, 1994). Hennig-Thurau (2004, p. 465) found that customers may not remain loyal to the service organisation due to superiority of performance but rather because of commitment he or she has developed to the service provider and its employees, thus reinforces the importance of studying CO among employees and throughout the whole service organisation.

Furthermore, based on Narver and Slater's (1990) work on the effects of market orientation on profitability, OCO is defined as the 'degree to which the climate or culture of the organisation is conducive to meeting customer needs' (Grizzle, Zablah, Brown, Mowen and Lee, 2008). OCO can be expected to influence satisfaction (Rust et al., 1996). The level of CO possessed by employees will depend on how customer orientated the organisation is (Stock and Hoyer, 2005). This can also influence their satisfaction, as employees in a service environment should be more satisfied if they feel supported by their employer's attitude towards customers (Whelan et al., 2008). In the context of this study patients will be more satisfied if they perceive that the organisation is more orientated

towards them, and, their views of the policies of the organisation will influence their perceptions as to the orientation of its employees (Whelan et al., 2008).

4.3 – The Impact of Customer Orientation on Service Organisations

The characteristics of services are unique in comparison to products; as a result Bowen and Schneider (1985) made some recommendations to traditional managerial functions, which will enable managers to have a more customer orientated organisation. They suggested that employees should be involved in planning and organising service activities, it should also be recognised that the work environment has a major influence on how customers experience the service, as the work environment has been found to impact employee satisfaction and this satisfaction may pass onto the customer during the service delivery, and finally there should be great recognition in that the firm's human resource practices can ultimately have an affect on the service experience (Hartline and Ferrell, 1996).

A CO strategy empowers employees and gives them more discretion to accommodate varying customer needs and problems. CO can offer a rational and strategic means for managing the internal work environment, the workforce are the ones that hold the key to a competitive advantage (Cardy, 2001). According to Hartline (2000) "having it your way" is the essence of a customer-orientated service strategy. Furthermore, it is a widely held view that a customer-orientated firm is more likely to deliver exceptional service quality and create satisfied customers (Macintosh, 2007 p.150). This traditional path suggests that CO leads to greater satisfaction with the service, which leads to greater loyalty. High levels of loyalty and satisfaction will enhance the level of reputation that the organisation embraces (Macintosh, 2007). The effect CO, at both an individual and organisational level, has on an organisation's main stakeholders and reputation is a major contribution of this research study.

Thomas, Soutar and Ryan (2001) state that the level of CO held by a service employee directly impacts the firms' relationships with its customers. As a result it is important to measure salespeople's activities. The most well known measure is that developed by Saxe and Weitz (1982) known as the selling orientation-customer orientation (SOCO) scale. The scale measures the CO of salespeople and consists of twenty-four statements describing ways in which a salesperson might act with a customer. According to Saxe and Weitz

(1982, p.343) customer orientated selling is a behavioural concept that refers to '*the practice of the marketing concept at the level of the individual salesperson and customer'*. As the number of service organisations' continues to increase, frontline workers and customers need to be at the top of management concern (Anderson, 2006). McDonald, de Chernatony, and Harris (2001, p.338) define a service as '*an activity which has some element of intangibility associated with it. It involves some interaction with customers or property in their possession, and does not result in the transfer of ownership'*.

Chun (2005) suggested that in a service business, the frontline workforce have the most contact with customers, therefore to improve reputation, basic organisational activities such as the work practice of the frontline workforce may need to be changed. If a customer facing employee and the customer share a positive view of the organisation then a positive interaction between them is more likely to occur (Chun and Davies, 2006). In the context of public health services this interaction will increase both service user confidence and satisfaction. According to Hartline et al. (2000) customer contact employees are the representatives of a service firm; customers often base their impressions of the firm on the service they receive from those customer contact employees. If a hospital is highly customer orientated, the service users (patients) will be satisfied and therefore being customer orientated will have a positive impact on the organisations reputation. In order to ensure that employees have a high level of customer service, training should be a continuous process within the organisation. Employees should be sent to training seminars to refresh their customer service skills. Training will be a cost effective service within the organisation as fixing problems and preserving loyal customers costs less than constantly trying to find new customers (Hiebeler, Kelly and Ketteman, 1998). As employees in a healthcare setting deal with customers who are confused, anxious and hesitant to ask questions, a detailed training program ensures that employees know and understand customer expectations.

Despite the many positives of CO, it may have a negative impact on employee performance in the public sector. Paarlberg (2007) suggest that this may be due to the fact that government organisations may have multiple and different customers across a range of hierarchical levels. The existence of multiple customers with often competing demands may negatively affect employee attitudes and behaviour. However, in the health sector, service workers being close to their client and knowing they are contributing to improving

their health can be a highly motivating factor, which may result in the service worker being highly committed to their job (Paarlberg, 2007). In the public sector, being customer orientated may provide psychological, social, and cognitive benefits to the employee, which as a result may improve employee performance.

The culture of the organisation can be a major factor in determining how customer orientated it is (Bellou, 2007; Hartline and Ferrell, 1996; Slater and Narver, 1994). Findings by Castro and Rio (2005) suggest that there is a relationship between the existence of market orientation and the commitment of employees to the organisation, as well as their satisfaction levels with the job. Additionally, they found the more market orientated the firm, the greater the knowledge of their customers they possess, hence leading to greater perceived quality and positive customer evaluations of the service. Kennedy et al. (2002) also found that there was a desirable relationship between market orientation and employee commitment and satisfaction. In addition to findings by Kennedy et al. (2002), previous theorists (Donovan et al. 2004; Hennig-Thurau, 2004) found that a highly customer orientated organisation does not provide satisfied and committed employees alone; the organisation must also have a good working environment.

Now that a clear understanding of CO has been outlined, the outcomes of engaging in such a practice will be detailed. To develop a four-dimensional conceptualisation of CO (i.e. pamper, read, personal relationship and deliver) Donovan, Brown and Mowen (2004) used extensive qualitative research and measured development efforts. They examined the outcomes of service workers enhanced CO and identified the three main outcomes as being: organisational commitment, job satisfaction and organisational citizenship behaviours (OCB's). Of special importance is that the outcomes of CO may impact stakeholder views of the organisation and in turn influence the reputation held by the organisation. The following section will discuss these outcomes.

4.4 - The Importance of being Customer Orientated

Theorists in service marketing and management have noted the importance of retaining service workers to the success of service organisations. Donovan et al. (2001) believe that CO does not just promote better job performance with the service worker, but it also affects service worker job satisfaction and commitment to the organisation which can then be

transferred to the customer they come in contact with. In agreement with this, Sergeant and Frenkel (2000) state that customer contact employees are the face of the firm for the customer, and interaction between the two is therefore likely to affect customer satisfaction and hence repeat business and firm reputation. Philips et al. (2006) state many high contact services involving direct interactions with customers require service providers to manage how they present their emotions during the service encounter; this is particularly relevant to the healthcare sector. In a healthcare setting, a clinician who displays negative emotions when in contact with a patient may affect how the patient perceives the organisation.

A firm that desires to be highly customer orientated must focus on recruiting the right staff. According to Licata et al. (2003), recruiting the right person to the right job leads to satisfied employees as well as satisfied customers, who are less likely to switch service providers. It is important to put those employees with high levels of CO in high-customer-contact positions and vice-versa (Lovelock, 2001; Philips et al., 2006; Brown et al., 2001). Kohli and Jaworski (1990) also highlight the importance of CO in the organisation, by arguing that organisations that are market orientated, i.e. those that track and respond to customer needs and preferences, can better satisfy customers and hence allow the organisation to perform at higher levels. More specifically, when focusing on the public sector, Cowell (1989) stated adopting a customer orientated approach at the organisational level will provide public sector organisations with the tools required to reduce criticism from interest groups and the media, as the focus on the public at an organisational level will help them be better organised for satisfying such needs (Cited in Cervera, Molla and Sanchez, 1999).

It is suggested that strong customer relationships with a firms' service personnel and positive attitudes towards the service will lead to genuine customer loyalty (Bove and Johnson, 2000). In the case of hospitals, a customer will have a strong relationship with one in particular service worker i.e. a patient and doctor relationship. Genuine loyalty to the service firm will be an outcome of high personal loyalty between the service worker and customer, and therefore be dependant on the continued availability of the service worker (Bove and Johnson, 2000). Brady and Cronin (2001) further stipulate that customer orientated firms will outperform competitors by meeting customer needs by providing services of superior value and hence greater satisfaction towards the firms service delivery.

Customer retention is also economically more advantageous than constantly seeking new customers, therefore relationship building and maintenance is important for overall business performance (Bove and Johnson, 2000). However a major downfall exists, a customer can be loyal to a service firm and this may have several positive outcomes but sometimes in situations where a valued customer only develops a strong relationship with one service worker it can have drawbacks. The loyalty may only remain with the firm as long as the employee is available to the customer i.e. if an employee leaves a customer may follow.

Customer orientated service personnel do not aim for an immediate sale, which would fulfil their own short-term self interest, instead their goal is for the long-term and involves concentrating on what is best for the customer and fulfilling their needs (Dorsch et al., 1998). The work revolves around the customer; they possess strong product knowledge, can read customer needs, demonstrate high empathy towards the customer, and adapt their personality and style to the customer's desires. The downside to this is that there is a cost incurred in this selling approach. An opportunity cost arises when short-term sales are sacrificed and the focus lies in maintaining customer satisfaction for the possibility of future sales (Saxe and Weitz, 1982; Bove and Johnson, 2000; Cross et al., 2007).

4.5 Outcomes of Customer Orientation – Satisfaction, Commitment and OCB-Altruism

Research to date has not investigated how customer views of employee groups can impact upon views of organisational reputation, and consequently outcomes such as customer satisfaction. Donovan et al. (2004) predict CO results in high levels of job satisfaction, commitment and organisational citizenship behaviour's and therefore highlights the value of hiring and retaining employees that are customer orientated in a firm. Donovan et al. (2004) believes CO can produce internal benefits to the service employee such as motivational well being, the service employees' performance will then improve and as a result produce benefits for the firm.

4.5.1 Satisfaction

The majority of service employees enjoy serving customers, and further express high levels of job satisfaction, hence fitting the service setting well. Previous studies, such as that by

Homburg and Stock (2005), have found levels of job satisfaction will lead to higher levels of CO. This study aims to test whether the presence of CO can result in stakeholder satisfaction and therefore positive reputation. Donovan et al. (2004) argues that dispositional CO will lead to job satisfaction, not vice-versa. In other words, a customer orientated service worker will fit the service job and therefore will experience greater job satisfaction. If managers want satisfied employees they should hire workers that possess a customer-orientated personality. Satisfaction from customers has been shown to be a major outcome of staff that are highly customer orientated. According to Licata, Mowen, Harris and Brown (2003) customers overall satisfaction with a service is derived from the personal interaction component.

4.5.2 Organisational Commitment

Employee commitment to their job is important for customer retention, as customers usually build a relationship with the firm and remain loyal if they deal with the same employees (Hennig-Thurau, 2004). Donovan et al. (2004) suggest if the marketing concept is implemented through employees, the service worker will experience high levels of CO and will become more committed to the organisation. Donovan et al. (2004) also suggests that organisational commitment is an outcome of being customer orientated. However, researchers such as Kelly (1992) and Pettijohn, Pettijohn, and Taylor (2002) argue that it is an antecedent of CO.

Different jobs in an organisation require different amounts of contact time with customers. Consequently Donovan et al. (2004) propose that the positive influence of CO on commitment and satisfaction will be stronger for workers who spend more time in contact with customers and vice-versa. Job performance is also enhanced when employee behaviours go beyond specified job requirements, through promoting positive outcomes for an organisation i.e. OCB's (organisational citizenship behaviours).

4.5.3 Organisational Citizenship Behaviours (OCB's)

OCB's are defined as the non-compulsive, helpful, and constructive behaviours that are directed to the organisation or to its members. OCB's can positively influence a work environment. Altruistic OCB is important in this context and is defined as one employee helping another employee who has a work related problem, that is, customer orientated employees will be motivated to help fellow employees if it will satisfy the customer.

Altruistic behaviour can involve behaviours such as employees helping fellow workers with work related problems voluntarily (Donovan and Hocutt, 2002). Altruistic behaviour is particularly important for service firms in that customer contact employees can help train co-workers while on the job. As a service employee becomes more satisfied in their job, helpful behaviours will increase so it is therefore important for a company to treat its employees fairly (Donovan et al. 2004; Donovan and Hocutt, 2002).

4.6 Customer Orientated Attitudes and Behaviour

Both behaviours and attitudes are important in determining if CO remains in the organisation short-term or is embedded in the organisation long-term. If CO is related to reputation it is important to have a high level of CO present for the long-term success of the organisation. According to Bowen and Schneider (1985) the attitudes and behaviours of customer contact employees are important in a service organisation as they can influence the customer's perceptions of the service (Hartline and Ferrell, 1996). The service encounter is crucial in terms of how the service quality is perceived; therefore management must find ways to manage the attitudes of the customer contact employees.

The majority of research by Stock and Hoyer (2005) refers to the differences between customer orientated attitudes and behaviours, thus it is important to look at this area as other studies researching CO have tended to focus solely on behaviour. An employee who displays customer-orientated behaviour is not strongly committed; they just do it because it is part of the job and they must satisfy the consumer. Saxe and Weitz (1982) refer to customer-orientated behaviour as the ability of the salesperson to help their customers by engaging in behaviours that increase satisfaction. In contrast, customer-orientated attitude is defined by Stock and Hoyer (2005) as the amount of a salespersons affect for or against customers. Further CO compromises of issues such as affinity to be in contact with the customer and understanding the importance of CO for both the employee and the company's performance.

According to Stock and Hoyer (2005, p.538) other differences between behaviour and attitude are as follows; behaviours are not permanent over time (they change when situations change), attitudes are enduring traits and are a lot more stable than behaviours. Customer orientated attitudes are required to create consistent customer orientated behaviours. Companies should therefore focus on attitudes first as this will have a positive

influence and will result in a long-term customer orientated strategy. Behaviours do not tend to be consistent, but simply change in the short run. If a firm would like its employees to have consistent behaviour they firstly need to concentrate on attitude (Stock and Hoyer, 2005).

It is not only customer-orientated behaviours that are linked to customer satisfaction but also customer-oriented attitudes have a direct link. According to Stock and Hoyer's (2005) findings, customer-orientated attitudes drive customer-orientated behaviours and are also a direct antecedent of customer satisfaction. Reviewing attitudes in CO is important as behaviours can sometimes be superficial and attitudes are more stable in the long run. If the organisation is serious about improving employee behaviours and attitudes to be more customer-orientated they must start at the beginning.

There are seven key behaviours that strongly indicate a CO attitude (Drucker, 1994), managers should look out for these and encourage employees to work this way:

- Thinking and talking about clients a lot
- Continually assessing your customers perceptions
- Resolving priority issues in favour of the customer
- Giving in, compromising, adding value for the customer
- Making amends to customers for poor treatment
- Employing a 'whatever it takes' policy to satisfy special needs
- Redesigning processes and redeploying resources when they get in the way of service quality

When judging service quality, customers often rely on the behaviour of service employees. Therefore to be economically successful, service firms must ensure CO is an imperative factor throughout the organisation (Hennig-Thurau, 2004). Day (1994) points out that there is three characteristics of a customer orientated firm, firstly they place high priority on customer interests, they also generate and use information about customers and finally they create systems to act on such information (Paarlberg, 2007 p.202). Given the clear importance of CO in service organisations, it is therefore critical to review its antecedents', which are covered in the next section.

4.7 - Antecedents of Customer Orientation

According to Philips, Wee Tan and Julian (2006) many researchers have conceptualised CO as a set of behaviours rather than beliefs. Previous researchers have found that job satisfaction, role conflict, role ambiguity, psychological empowerment, organisational socialisation and commitment are the main antecedents of CO.

Role ambiguity is important in the literature on CO, as employees need a clear outline of their tasks in order to perform efficiently. According to Singh (1993) role ambiguity can greatly reduce job satisfaction and performance. An employees' decreased satisfaction can decrease how the customer perceives the service quality.

Self-efficacy is another important term referred to in the literature on service delivery. Self-efficacy is important in CO as the customers' perceptions of the service they receive will usually be based on the employees' performance and how efficiently they can perform their tasks (Hartline and Ferrell, 1996 p.54). Anderson (2006) articulates that self-efficacy is how an employee perceives their ability to perform a task. An employee's confidence in his or her ability to perform a task can influence their performance. Self-efficacy is critical in relation to customer outcomes in a service setting. Positive perceptions' of the service organisation will lead to outcomes such as satisfaction, positive word of mouth and future purchases.

Employees who are confident in their role and who possess the ability, willingness, and competence to solve customers' problems will have satisfied customers. Self-efficacy has a strong relationship with employee performance. According to Anderson (2006) those employees that possess this trait are more likely to create a favourable service encounter, as a result customers will be satisfied with the service they receive and portray confidence towards the organisation.

Hartline and Ferrell (1996) found that self-efficacy and job satisfaction increase customers perceived service quality. The advantages of an employee that is highly self efficacious include an employee who is confident in their ability, an employee who is proactive and persistent in problem solving, an employee who is able to handle difficulties and as a result perform better and improve service quality. Self-efficacy is particularly important in a healthcare organisation, as patients will feel safer knowing they have a clinician who is reliable and confident in what they are doing.

Empowerment is also discussed widely in the literature. Empowered employees may gain confidence in their abilities, but the downside is that they tend to become increasingly frustrated as they are expected to fulfil multiple roles in the organisation (Hartline and Ferrell, 1996). The advantage of this is that it may make the employee become more self-efficacious; however it can also lead to role ambiguity, reduced job satisfaction and adaptability.

In the previous sections, we have identified that CO is essential for the organisation to be successful; therefore managers see it is as necessary to identify and measure its presence in the firm.

4.8 - Measuring Customer Orientation

Customer orientated service personnel view the customer relationship from a long-term perspective and therefore concentrate on what is best for the customer rather than the prospect of an immediate sale, which would fulfil their own short-term interest (Dorsch, Swanson and Kelley, 1998). Service employees' work revolves around the customer; they hold strong product knowledge, can read customer needs, have a flexible personality and adapt to the customers desire. It is therefore important for managers to measure CO as they need to be aware of the level of CO that exists in their organisation and if it needs to be improved.

4.8.1 The Customer Service Relationship Model

CO of service workers is an important area in any service organisation. A model was created that offers managers of service firms an inexpensive way to build a true loyal customer base, it is entitled "the customer-service worker relationship" (Bove and Johnson, 2000). Managers should encourage the development of strong relationships between their workers and high-value customers by concentrating on what can build and maintain strong relationship strength (Bove and Johnson, 2000), as it is known that a strong relationship between a customer and a specific service employee can result in the customers commitment to the organisation. The model indicates that strong relationships between customers and service workers are a positive asset for a service firm as they help build a true loyal customer base. The relationship strength was measured using six antecedents; perceived customer benefits/rewards derived from the service worker, relationship age, the

intensity of contact between the service worker and the customer, the customers perceived risk in acquiring the service, the customers interpersonal orientation, and the service workers CO as perceived by the customer.

The customer-service worker relationship model is best suited where:

- The extent of customer contact is great
- The service is high in experience
- The customer has alternatives from which to choose
- There is freedom to change service providers with little or no relationship termination costs.

Furthermore, the model offers managers an inexpensive way to build a true loyal customer base. Having identified the antecedents of relationship strength; managers can encourage the development of strong relationships between their personnel and high value customers. The downside to using this model in with the public sector context is that public sector organisations customers' do not often have alternatives to choose from. Therefore, the model is not suited to this context; as a result an alternative measure will be examined.

4.8.2 Browns (2002) Measures of Customer Orientation

In order to measure CO, Brown et al. (2001) collected qualitative data from service managers, employees and customers. They developed potential measurement items from qualitative data and existing literature. From their research they found four dimensions of CO; need to pamper, need to read the customer, need for personal relationship and need to deliver. Employees who possess these internal needs will flourish in their employment position, they will tend to be highly customer orientated and as a result they will be satisfied in their customer contact position.

Brown et al. (2002) also employed a hierarchical model used by Mowen and Spears (1999) in which basic personality traits (Introversion, Emotional stability, Conscientiousness, Agreeability, Openness to experience and Need for activity) combine with a specific context for performance (i.e. the role of the service worker) to produce surface traits (i.e. consumer orientation) or enduring dispositions, inclinations or tendencies to behave within the context. An index score was created to represent each construct. Brown et al. (2002)

developed a measure for the activity personality trait on the basis of ideas by Buss (1988). Preliminary factors, reliability analysis and substantive review of items resulted in a 3-item measure of activity.

The CO surface trait was conceptualised as having a needs dimension and an enjoyment dimension. To measure the needs component, Brown et al. (2002) adopted a six-item likert scale from the measure developed by Saxe and Weitz (1982). In order to do this, they used the six items with the highest factor loadings on the CO dimension in their research (Table 4.1). The enjoyment component of CO was also measured using a likert-type scale. Participants were asked to describe the characteristics of high and low performing service employees. Responses indicated that customer orientated service employees take pleasure in several different aspects of meeting customer needs. The responses from this study guided the development of the items that were intended to tap the enjoyment dimension. Two universal items were used to assess overall service workers performance, these were 'overall quantity of work performed' and 'overall quality of work performed'. Each item was measured on seven-point scales bounded by 'among the worst in the company/among the best in the company'.

Table 4.1: Measuring Customer Orientation at an Employee Level

<u>Needs Dimension</u>	<u>Enjoyment Dimension</u>
I try to help patients achieve their goals	I find it easy to smile at each patient
I achieve my own goals by satisfying patients	I enjoy remembering my patients' names
I get patients to talk about their service needs with me	It comes naturally to have empathy for my patients
I take a problem solving approach with my patients	I enjoy responding quickly to patients needs
I keep the interests of the patients in mind	I get satisfaction from making my patients happy
I am able to answer patients questions correctly	I really enjoy taking care of patients

Source: Brown et al. (2002); items adapted from Saxe and Weitz (1982)

As well as measuring CO at an individual level, Brown (2007) also discussed the measurement of CO at an organisation level or 'store level'. This involved measuring the actions of managers to see if they were orientated towards meeting customer needs through policies, and procedures etc. (Table 4.2). The following measures were adapted from work by Narver and Slater (1990).

Table 4.2: Measuring Customer Orientation at an Organisational Level

Our Managers…..
• Constantly check to make sure hospital policies and procedures don't cause problems for patients
• Constantly make sure that employees are trying their best to satisfy patients
• Think of patients points of view when making big decisions
• Plan to keep our hospital ahead of competitors by understanding the needs of our patients
• Assess patient satisfaction regularly
• Pay close attention to our patients after treatment
• Really care about our patients, even after they have received their treatment etc.
• Have organised our hospital to the needs of our patients

Source: Based on Narver and Slater (1990)

The above information is mainly adopted from the commercial sector literature therefore it is important to review the literature available on CO in the public sector, as it is the focus of this current study.

4.9 - Customer Orientation in the Public Healthcare Sector

According to Corbin et al. (2001) managers in the public sector have been asked to adopt more of the philosophy of the private sector in the way their organisations deal with the public, including greater CO and branding. Rather than satisfying all of its stakeholders' (the function of a commercial organisation), the primary function of a public service organisation is to service its clients (Beltramini, 2001), accentuating the importance of CO in the public sector. CO can be assessed at two levels, that of the organisation (OCO) and that of the customer facing employee (ECO).

According to Jarrar and Schiuma (2007), public sector organisations' feel the need to increase their accountability and customer focus orientation in order to improve efficiency and performance; the reason for this being frontline staff have the majority of encounters with customers in a service organisation. All employees therefore need to understand the organisations' values, recognise their roles, and be committed to delivering the service brand (Heskett, 1987; de Chernatony and Horn, 2003). From a consumers' perspective, it is not the institution that is important to us but the individuals with whom stakeholders

engage with. The public sector should then be encouraged to give voice to the people who actually deliver their services and focus on their employees being highly customer orientated. CO in the public sector services is important as customers find it hard to evaluate a service in comparison to a product; therefore strong focus on intangible elements occurs.

The outcomes of a service are mainly intangible and according to Cinca, Molinero and Queiroz (2003) so too are the objectives. Cinca et al. (2003) state that public sector services objectives are relatively intangible, examples include: creating a secure environment, to raise the cultural level of the population and to impart justice. Intangibility is important in public sector organisations; public sector organisations' (PSO) have multiple objectives of non-financial nature, and hence have to make more intensive use of such intangibles such as human resources and knowledge (Cinca et al., 2003). Resources and final products of public sector organisations, such as services and information are intangible.

Better knowledge of a work environment that drives service quality and customer satisfaction is valuable to healthcare managers. According to Scotti, Harmon, Behson and Messina (2007) evidence is accumulating in relation to how customer orientated work climates can provide a superior service quality and customer/patient satisfaction, which in turn impacts the organisations reputation. Healthcare employees must be highly involved in the work environment if they want to deliver exceptional service quality, satisfied patients, and ultimately lead to loyal customers (Scotti et al., 2007). The simultaneous provision and receipt of healthcare in a high contact, face-to-face, professional-service context obscures the boundary between employees and patients. Patients must participate in the care delivery process and are often co-creators of their own service. Therefore, the perceptions of employees and customers regarding service quality are rooted in a common foundation. Scotti et al. (2007) found that high contact healthcare encounters are required to align employees' perceptions with the service experience they provide to patients and to translate this into patient satisfaction.

The service climate of a healthcare organisation is determined by the people that it hires (Licata et al., 2003; Scotti et al., 2007). After the process of recruitment and the selection of service employees are complete, staff should then be put through orientation programs. Once hired and acculturated, service providers must be empowered to address, and if

possible to resolve patient complaints on a real time basis, while being recognised and awarded for doing so. A willingness to listen to the customer is one of the defining features of a customer orientated work climate (Scotti et al., 2007).

The influence of CO may also be affected by an individuals' position within an organisation – whether the individual is a line or support staff and also by their own managers orientation towards customers. According to Jaworski and Kohli (1993) a managers' CO may signal the importance of customers to the organisation, serving as an important predictor of the successful implementation of customer-orientated strategies (Paarlberg, 2007). Customers' experience with employees and the CO of frontline service employees will influence the perceptions external stakeholders have of their experiences with a service organisation (Brown, Mowen, Donovan and Licata, 2002). Thus this study aims to explore the relationship, if any, between CO and brand perceptions via reputation.

4.10 – Conceptual Framework and Hypotheses Development

The below diagram (Figure 4.1) illustrates the hypothesised relationships based on the preceding review of the literature that this study expects to find.

Figure 4.1: Conceptual Framework
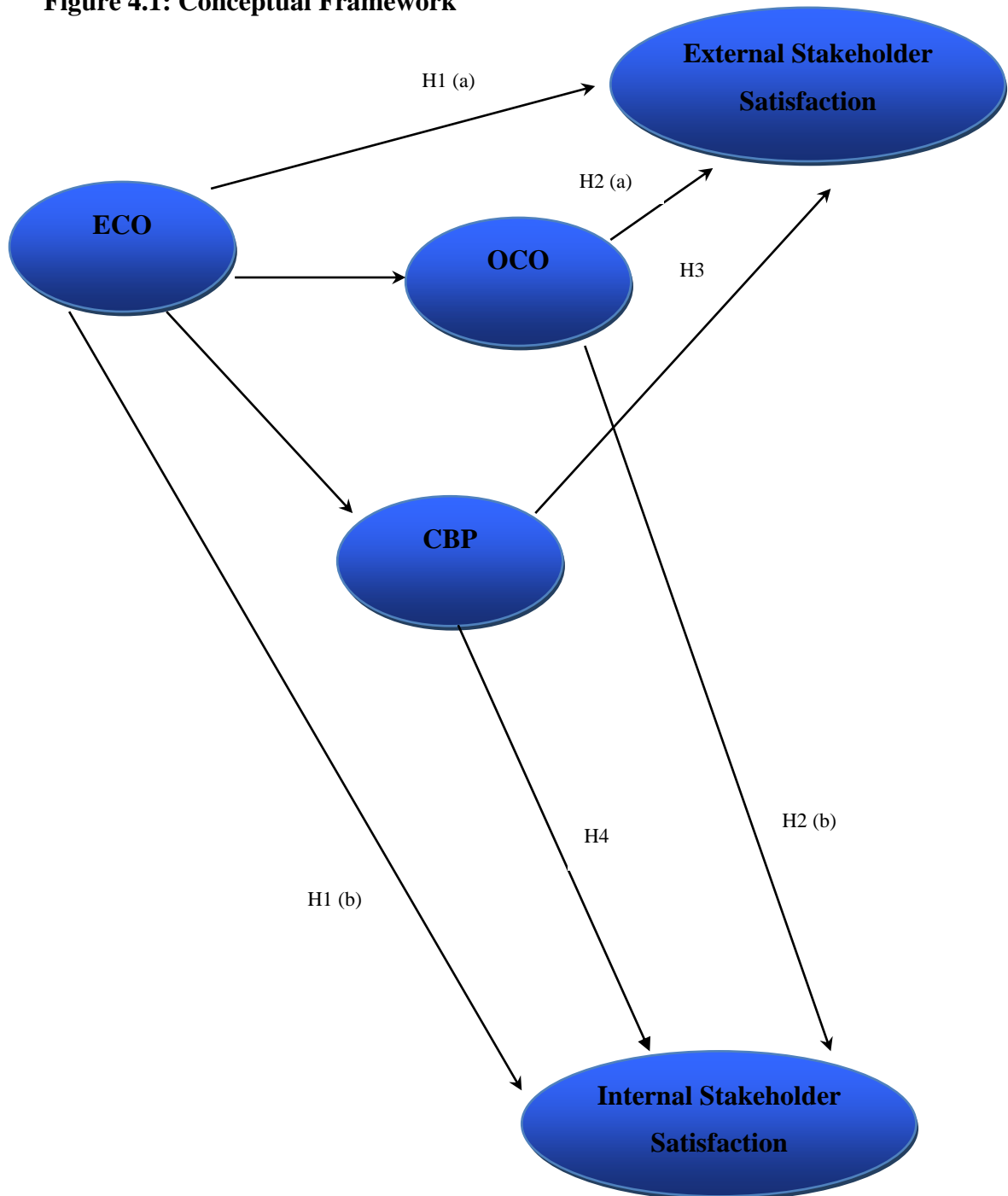
CO is defined as an individuals tendency or predisposition to meet customer needs in an on the job context (Brown et al., 2002). Work in the CO stream can be traced to a seminal article by Saxe and Weitz (1982), who found evidence for a two-dimensional view of selling orientation-customer orientation. Further research has investigated individual salesperson CO and has found a positive relationship between CO and customer satisfaction (Reynierse and Harker, 1992).

More recently, Brown et al. (2002) found that CO mediates the relationship between basic personality traits and service performance. Based on this work, results obtained across three studies in two different service industries reveal that CO positively influences employee job satisfaction. Therefore, prior work establishes the relationship between employee level CO and satisfaction among both employees and customers in the private sector. If the management of a publically owned organisation is akin to that in the private sector we should expect to find similar findings for publicly owned organisations. Hence, this study postulates the following hypothesis (Figure 4.2):

H1: *The higher the perceived Employee Customer Orientation (ECO) the higher the satisfaction of a public sector organisation's (a) employees and (b) customers will be. (Tested separately for both patient/visitor and employee datasets).*

Figure 4.2: Hypothesis One

| Customer Orientation | → | Satisfaction |
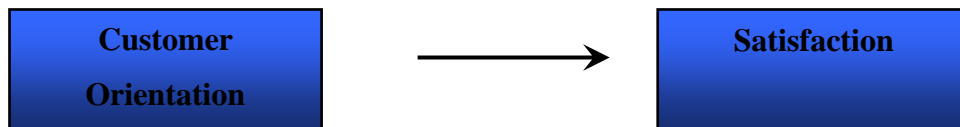
Based on Narver and Slater's' (1990) work, OCO refers to the degree to which the climate or culture of the organisation is conducive to meeting customer needs (Grizzle et al., 2008). OCO has been found to moderate the relationship between ECO and customer satisfaction, given that employees act as brand ambassadors (de Chernatony, 2006) or potentially as brand saboteurs (Wallace and de Chernatony, 2008), and their interaction with external stakeholders will shape the external view of the brand (Bettencourt, Gwinner and Meuter, 2001).

For employees, how customer oriented the organisation is perceived to be will influence how customer oriented they become, as employees will respond to the policies of their employer. This can also influence their satisfaction, as employees in a service environment should be more satisfied if they feel supported by their employer's attitude towards customers. Customers will be more satisfied if they perceive that the organisation is more

oriented towards them and their views of the policies of the organisation will influence their perceptions as to the orientation of its employees (Whelan et al., 2008). Thus OCO is expected to have a positive relationship with both ECO and satisfaction, placing OCO in a potentially moderating role between ECO and satisfaction and implying the following hypothesis (Figure 4.3):

H2*: The relationship between perceived employee customer orientation (ECO) and internal and external stakeholder satisfaction is mediated by the perceived level of organisational customer orientation (OCO) (Tested separately for both patient/visitor and employee datasets).*

Figure 4.3: Hypothesis Two
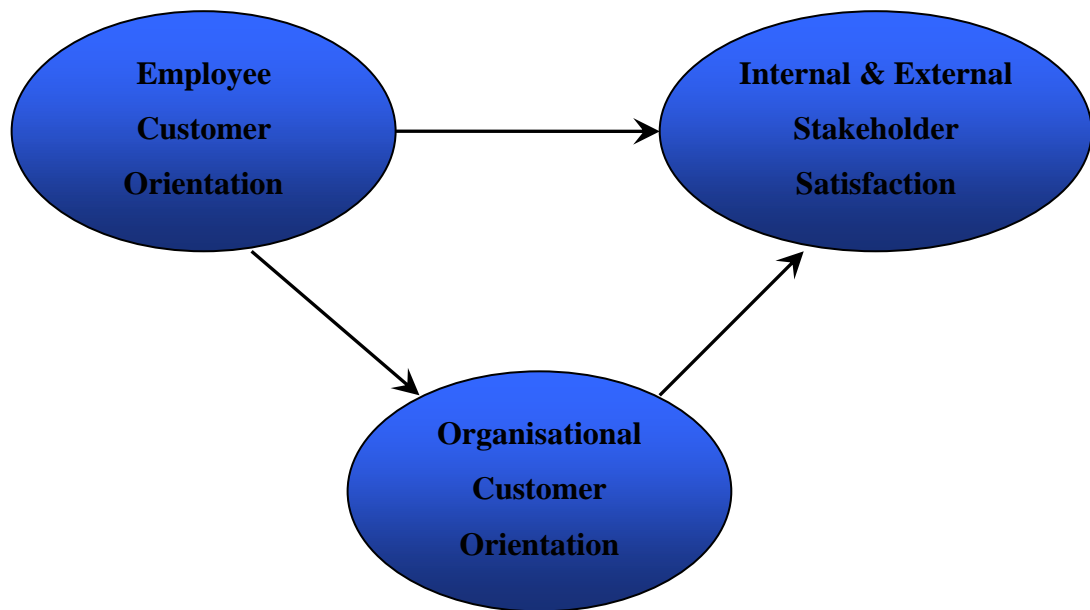
Prior work thus establishes that ECO leads to both employee satisfaction (Brown et al., 2002) and external stakeholder satisfaction (Reynierse and Harker, 1992). The reason for this relationship between CO and satisfaction is however unclear in the literature thus far, nor is it fully understood by marketing managers. As CO by its very nature can be expected to influence the customer experience, one can hypothesize that CO is positively linked to

brand image. Secondly, as brand image should be positively related to stakeholder satisfaction brand image is potentially a mediating variable between CO and satisfaction.

Five dimensions are included in this study to measure brand personality: agreeableness, competence, enterprise, machismo and ruthlessness. The more positive dimensions (agreeableness, competence and enterprise) appear the most likely to be correlated to CO, as evidence exists to expect such associations to be promoted by ECO and also to create satisfaction. Agreeableness is important for employees, because trust is significantly correlated with job satisfaction and organisational commitment (Pella, Schreisheim and Williams, 1999). According to Westbrook (1981) customers of service organisations value the helpfulness, friendliness, and fairness of treatment by frontline staff memebers. One component of competence, reliability, is one of the dimensions of service quality (Parasuraman, Zeithaml and Berry, 1985), and service failure is a source of customer dissatisfaction (McCollough, Berry and Yadav, 2000). The enterprise dimension includes items such as innovative and up to date. Customers in both the public and private sectors can be positively influenced by how enterprising a service organisation appears to be (Bellenger and Korgaonkar, 1980).

How both employees and customers view the corporate brand can then be expected to influence their satisfaction with the organisation. The more positive the associations a stakeholder makes with a corporate brand the more satisfaction they report with that brand. These associations are built through experience with the brand, and in a service context this means with employees, a process which will depend upon how customer-orientated those employees appear to be. Customer views may be particularly affected by their perception of ECO; hence the study postulates the following hypothesis (Figure 4.4);

H3*: Corporate brand personality (CBP) mediates the relationship between employee customer orientation (ECO), as perceived by customers, and customer satisfaction **.*

Figure 4.4: Hypothesis Three
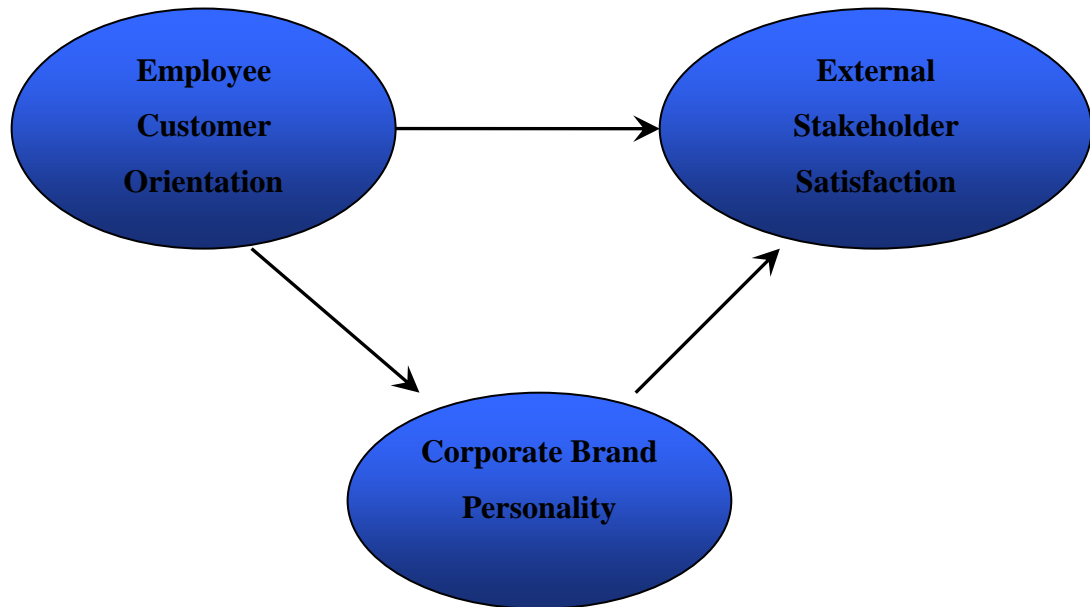
**The above hypothesis is tested separately for each corporate brand personality dimension i.e. agreeableness, competence, enterprise, machismo and ruthless.

Similarly, in the case of employees, their view of the corporate brand is a function of its culture and therefore the experiences they have at work (Hatch and Schultz, 1997). Further, it is thought that employee satisfaction will also depend on how customer orientated employees believe their colleagues to be. This study expects their level of CO to influence their image of the company and for that same imagery to affect their overall satisfaction (Davies et al., 2003). Hence, implying the following hypothesis (Figure 4.5):

H4: *Corporate brand personality (CBP) mediates the relationship between employee customer orientation (ECO), as perceived by employees, and employee satisfaction.***

Figure 4.5: Hypothesis Four
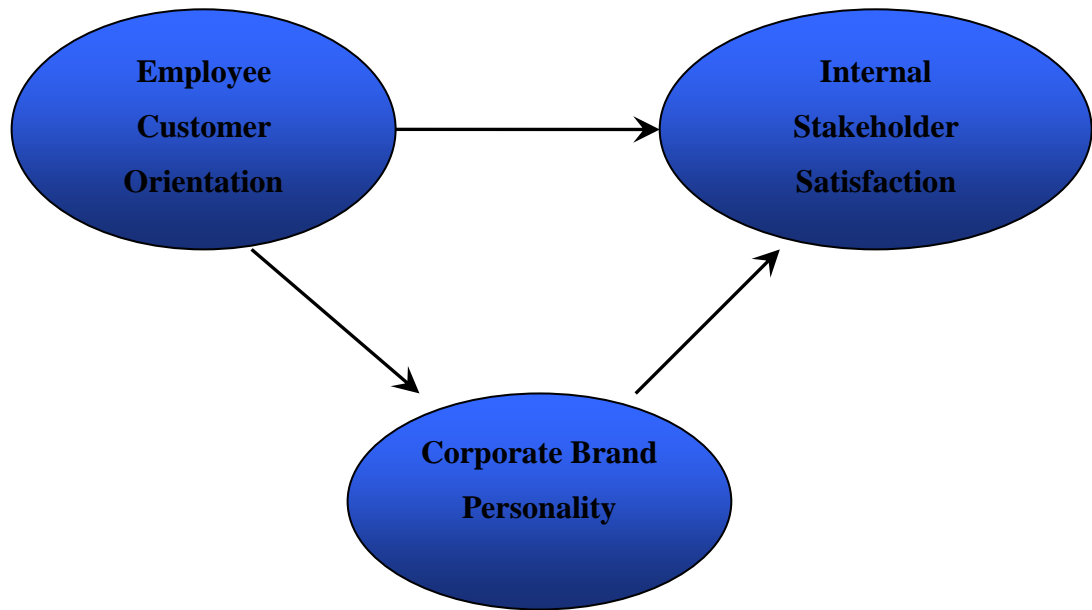
*__**The above hypothesis, similar to hypothesis three, is tested separately for each corporate brand personality dimension.__*

4.11 - Conclusion

The interactions between employees and external stakeholders are especially important in service organisations such as a hospital, as they are known to contribute to reputation. Thus, this chapter has reviewed the literature relating to CO relevant to the current study. The following chapter presents the methodological foundations for the study and the justification for same.

~ Chapter 5 ~

RESEARCH METODOLOGY

5.1 - Introduction

The purpose of this chapter is to critically assess the range of research methods available to researchers and to justify the research methods used for this current study. Firstly, the research question and objectives are outlined. Methodological foundations and the mixed methodology approach are then discussed. Secondary research methods are then outlined, followed by the primary research section, which discusses both the qualitative and quantitative methods used in this research study. The methods of data analysis used for both quantitative and qualitative methods are examined, followed by limitations of the study.

5.2 - Research Questions

The research questions are known to evolve directly from analysis of the research problem, which is to ascertain the factors that influence the reputation of a public sector organisation, in this context a hospital, and also to examine if CO, at both levels, impacts stakeholder satisfaction and as a result impacts the reputation of the organisation, this assumption arose from the qualitative findings. A lot of prior work on reputation has focused mainly on commercial organisations so it is therefore important to study reputation in the public sector as what drives the reputation of a private service sector organisation may differ from that of a public service sector organisation. It is evident from a review of the literature that no prior studies report investigating this issue, thus it is apparent that the area is under researched.

It is essential to consider both internal and external stakeholder groups when investigating an area such as reputation and not just the organisations external stakeholders. Davies et al. (2003) stated that customers are only one of the 'stakeholders' that a business needs to concern itself with and different stakeholders have different views of the organisation and what satisfies them may also differ, therefore the challenge of the stakeholder approach,

which is used in this study, is to reconcile the different views and different priorities of each group.

The empirical aim of this dissertation is to therefore try and answer the following research questions:

- What are the key drivers of positive hospital reputation and inhibitors in terms of negative perceptions of hospital reputation among the three main stakeholders of a public service organisation, explicitly clinical staff, non-clinical staff and service users?
- What are the main outcomes of hospital reputation among both clinical and non-clinical staff and service users?
- Does the level/presence of individual/organisational CO affect/contribute to the organisations' reputation?

Saunders, Lewis and Thornhill (2003) acknowledged that the statement of the research questions would, more often than not, be originated from the research objectives. The objectives for the current research study are outlined in the next section.

5.3 - Research Objectives

Research objectives are a vital start to the research process as they delineate the type of information that should be collected and provide a framework for the scope of the study (Zikmund, 1997 p.58).

In line with Malhotra's (1996) description *"research objectives can be defined as specific action-orientated statements of intent"* (p.120). Objectives explain the purpose of the research in measurable items and define standards of what the research should accomplish; outlining objectives also helps to ensure that the project will be manageable in size (Zikmund, 2000 p.93). The specific empirical research objectives of this study, which derive from the overall aims, are as follows:

- To provide a critical assessment of the breadth and depth of the pertinent literature relating to healthcare marketing, reputation management and CO;

- To identify what are the major influences on a hospital's reputation from the perspective of three stakeholder groups: clinical staff, non-clinical staff and service users;

- To identify the outcomes of a positive/negative reputation for a public sector organisation;

- To investigate how CO, at employee and organisational levels, affects the reputation of the hospital from both the internal and external stakeholders perspectives.

5.4 – Research Hypotheses

Hypotheses are usually generated from a theoretical perspective and evaluated through data the researcher collects. From the literature review, a theoretical framework is developed along with hypotheses to describe the relationships that this study aims to test and evaluate based on the primary research findings. According to McNeill and Chapman (2005, p.31) a hypothesis is '*an informed guess about what the researcher thinks may be happening, based on previous reading, research and observation. This hypothesis will be broken down into a number of indicators which can be operationalised i.e. turned into questions which collect evidence that may support or challenge the hypotheses*'.

A hypothesis is an empirically testable statement about a relationship involving two or more variables. An essential component of the scientific process is the formulation and evaluation of hypotheses. The primary importance of hypotheses is that they suggest variables that should be included in the research design (Malhotra, 1999). In seeking to learn more about the social world, social scientists ask many different kinds of questions about relationships between factors of social life. According to Black (1999) a hypothesis is an educated guess, an expectation, stemming from observations and either existing or new models or theories. Whatever the hypothesis, the aim is to test it in some way to see if it is supported or not.

Formulating a hypothesis is not an easy skill and one too often neglected by researchers who leap into a study without the adequately defined reason that every investigation needs. The whole design of a research study will be affected by a hypothesis, thus it is better to establish one early before too much intellectual effort is invested in a dead end. The process will highlight the need for clear operational definitions and sound definition of

concepts, as well as the need to clarify how variables will be identified and controlled. Hypotheses/expected outcomes usually refer to the expected relationships between variables, though not necessarily causal ones.

Once hypotheses have been stated they can still be changed as the study moves through the research process, however it should not be allowed to drift or change unintentionally. If a hypothesis is too general or vague, then it will be difficult to make decisions regarding constructs and operational definitions. On the other hand, too specific a hypothesis may imply relationships among trivial variables. A balance is essential between too great a specificity and vague generality that tries to encompass too many variables at once. The realisation of just how weak a hypothesis is may not become apparent until the researcher tries to devise operational definitions for the variables indicated (Black, 1999). The research hypotheses formulated for this study are outlined in section 4.10.

According to Bryman (2006) there is little doubt that research that involves the integration of quantitative and qualitative research has become increasingly common in recent years. This study employs a mixed methodology and the following section will discuss the reasons for using such an approach as well as its advantages.

5.5 - Mixed Methodological Approach

There are three approaches to research: quantitative, qualitative and mixed methods. A quantitative approach is one in which the researcher primarily uses post positivist claims for developing knowledge, employs strategies of inquiry such as surveys, and collects data on predetermined instruments that yield statistical data (Creswell, 2003 p.18). A qualitative approach is one in which the inquirer often makes knowledgeable claims based primarily on constructivist perspectives, advocacy perspectives or both. The researcher collects open ended, emerging data with the primary intent to develop themes from the data (Creswell, 2003 p.18). A mixed method approach is chosen in this research study to ensure the study collects data that is most relevant to accomplish the research aims and objectives.

A mixed method approach is one in which the researcher tends to base knowledge claims on pragmatic grounds (Creswell, 2003 p.18). Greene et al. (1989) defines mixed methods as *"an approach to investigating the social world that ideally involves more than one methodological tradition and thus more than one way of knowing, along with more than*

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one kind of technique for gathering, analysing, and representing human phenomena, all for the purpose of better understanding" (Cited in Johnson, Onwuegbuzie, and Turner, 2007 p.119). A mixed methodology employs strategies of inquiry that involve collecting data either simultaneously or sequentially to best understand research problems. The data collection also involves gathering both numeric information as well as text information so that the final database represents both quantitative and qualitative information.

Lee (1999) states that each method can offer valuable and useful research design to aid the understanding of a topic or subject. Lee (1999) also states the prime focus of a researcher should be to assess whether the most suitable method has been applied to a study, and not focus unnecessarily on whether qualitative or quantitative designs should be used. A key advantage of using such an approach is that a researcher does not have to choose one method to the total exclusion of the other but can combine both methodologies to aid in offsetting the particular weaknesses inherent in all available research (Easterby-Smith et al., 2001). According to Miles and Huberman (1994), the leading practical reason why qualitative and quantitative data might be linked is triangulation. Bryman (1988) states the term 'triangulation' usually means that there is more than one method of investigation used and hence more than one type of data produced. In the case of this study the focus groups produce rich data and an understanding of the area to be investigated, while the findings produced from conducting the surveys are more focused on linking causes and effects of reputation and discovering new understandings (Bryman, 2002) and statistical evidence to display this.

There are several advantages and justifications to combining both qualitative and quantitative techniques, the main one being triangulation (Bryman, 2006). Triangulation of data tends to occur when data is collected from more than one source and at different times thus increasing its reliability and assisting in reducing potential bias associated with a single method approach (Bryman, 1988). Triangulation is defined by Bryman (2004, p.454) as '*the results of an investigation employing a method associated with one research strategy are cross-checked against the results of using a method associated with the other research strategy*'. Amaratunga, Baldry, Sarshar and Newton (2002), state that the effectiveness of triangulation rests on the premise that the weaknesses in each single method will be compensated by the counter-balancing strengths of another. Triangulation is a useful business method as it '*obtains evidence from multiple sources to ensure that a*

biased view is not being obtained from one informant' (Remenyi, Williams, Mooney and Swartz, 1998 p.142). Using two research methods can enhance confidence in the findings as more than one research method is being used. Easterby-Smith et al. (2001) postulate that there can be downsides to adopting two methods of research, Remenyi et al. (1998) also argue that triangulation is often a time consuming and costly activity.

A mixed methodology is chosen, as it is the most appropriate method for the range of research objectives. This study developed its objectives and research questions first, and then based the methodology around achieving these objectives. This approach is known in market research terms as the "paradigm perspective". A mixed methods approach is also employed as Green et al. (1989) state it was determined that such an approach would allow the results from one method to inform the other method (Creswell, 2003).

5.5.1 Criteria for choosing a strategy

Creswell (2003, p.211) developed four main decisions to be made when selecting the mixed methods strategy:

1. What is the implementation sequence of the quantitative and qualitative data collection in the proposed study?
2. What priority will be given to the quantitative and qualitative data collection and analysis?
3. At what stage in the research project will the quantitative and qualitative data and findings be integrated?
4. Will an overall theoretical perspective be used in the study?

1. Implementation

This study's mixed methodology is implemented sequentially rather than concurrently, meaning the researcher collected both the qualitative and quantitative data in phases (sequentially) rather than at the same time (concurrently). For this study, the qualitative data is collected first in order to explore the topic with participants and to scope the issues relevant to the topic, ensuring the development of an effective data collection instrument for use in phase two which expanded the data. Due to its quantitative nature, phase two is collected with a larger sample than initially used in phase one (Creswell, 2003).

2. Priority

The researcher must choose to give priority to either the qualitative or quantitative approach. The priority may be equal or it may be slightly skewed. The priority given to any research method depends on the interests of the researcher, the audience of the study and what the investigator seeks to emphasise in the study. Priority tends to occur in the mixed methods approach through whichever strategy is used first in the study (Creswell, 2003).

3. Integration

Integration may occur throughout several stages of the research process, integration means that the researcher 'mixes' the data (Creswell, 2003). Figure (5.1) illustrates the approach taken for this particular research study (Creswell, 2003). It is known as the sequential exploratory strategy, it is conducted in two phases. The initial stage is the qualitative data collection, followed by the second stage which is quantitative data collection. This two-phase approach makes it easy to implement, and it is straightforward to describe and report the results. It is useful to a researcher who wants to explore a phenomenon, but also to a researcher who wants to expand on the qualitative findings.

Figure 5.1: Sequential Exploratory Designs

QUAL → quan
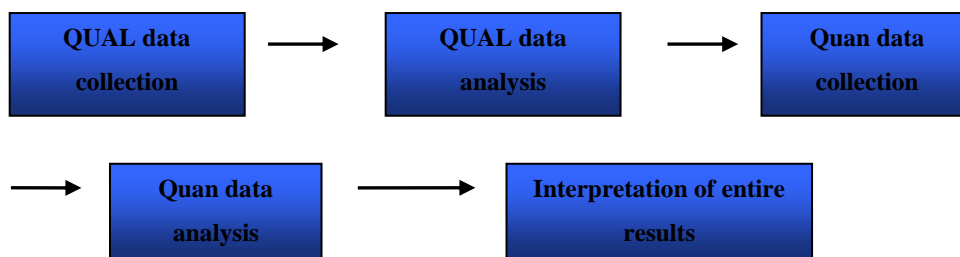
Source: Creswell (2003 p.213)

This research study conducts phase one as qualitative research and then phase two as quantitative research. This process is undertaken in order to begin the research study by unearthing issues and concepts in relation to hospital reputation with both the internal and external stakeholders. The basis for this is that previous research on hospital reputation, has solely focused on statistical data about medical care or the ability of the hospital to meet patients' perceptions, in order to conduct a larger scale study on the effect CO has on

organisational reputation it is firstly essential to understand the drivers and outcomes of hospital reputation.

Study two involves a follow up to study one and numerous sections of both the employee and patient surveys are based on the constructs emerging from study one, as well as measures for CO and the corporate brand. Study two includes measures of CO as both ECO and OCO are highlighted in Study 1 as very significant dimensions in relation to what drives the hospitals reputation. When questioned about the drivers and outcomes of reputation, both internal and external stakeholders, highlight for example the importance of the needs and enjoyment dimensions of CO to hospital reputation. From an internal and external stakeholder perspective, satisfying patient needs and ensuring they have an enjoyable experience is crucial to the organisations reputation. These qualitative findings are therefore further used to assist in illustrating and explaining the quantitative findings.

5.6 - Secondary Research

Before conducting primary research it is important to analyse and investigate the literature already available that relates to your research study. Secondary research has been defined by Malhotra (1996) as "*data collected for some purpose other than the problem at hand*" (p.117). It is information that has already been gathered by another person for another reason (Malhotra and Birks, 2000). Analysis of data helps the researcher in defining the market research problem and developing an approach.

Secondary data is easily accessible, quickly obtained, and less costly than primary data and may act as a background to primary data. This is particularly true when retrieving electronically stored data. However, there are also disadvantages in that it can be relatively broad in nature, may not be sufficient and data may be outdated and/or lacking in accuracy (Malhotra and Birks, 1999).

Secondary research is used at the beginning of this research study in the production of the literature review. The sources of secondary data used include academic literature, electronic databases and online articles relating to the research topic. The main electronic databases used in this study are ABI INFORM, Business Source Premier, Emerald Fulltext, and Science Direct.

5.7 - Secondary Research versus Primary Research

Secondary research is used to gain a better understanding and initial insight into the research topic. Secondary data may help in answering the research question but it is the job of primary research data to ascertain the specifics of the research question's and objectives. According to Malhotra and Birks (1999, p.42) primary data is *"data originated by the researcher specifically to address the research problem"*. The following sections outline the data collection process and methodology components of this research study.

5.8 - Primary Data Collection: Process and Methodology

This section seeks to discuss, in detail, the research process and methodology conducted during primary data collection. This research study uses both qualitative and quantitative measures to investigate the empirical objectives outlined in the previous sections. A number of issues are examined below including the research design, quantitative and qualitative research, the sample selection, the pilot study, administering the research instrument and data analysis.

5.8.1 Research Design

Kinnear and Taylor (1996) define research design as *"the basic plan that guides the data collection and analysis phases of the research project"* (p.135).

Domegan and Fleming (1999, p.54) describe the importance of the research design as 'the '*blueprint'* upon which the research is based'. Furthermore they define research design as '*the bridge between the research objectives and the methodology used to fulfil theses objectives'*.

According to Tull and Hawkins (1990, p.42) the research design requires the specification of procedures for collecting and analysing the data necessary to help identify or react to a problem or opportunity. Such procedures involve decisions on what information to generate, the data collection method, the measurement approach, the object to be measured, and the way in which the data is to be analysed, all of which are discussed throughout this chapter. The research process aids the researcher in deciding on the most appropriate method of research to be undertaken. A research process can be defined as "the basic plan that guides the data collection and analysis phase of the research process, it is a framework

that specifies the type of information to be collected, the sources of data and the data collection procedure and analysis" (Kinnear and Taylor, 1996, p. 64).

According to Green et al. (1988) a research design forms the framework of the entire research process; '*if it is a good design, it will ensure that the information obtained is relevant to the research problem and that it was collected by objective and economic procedures*' (Creswell and Tashakkori, 2007). Therefore, it is essential that the study select the research design most appropriate to investigating the research problem.

According to Tull and Hawkins (1994), there are three categories of research design known as exploratory, descriptive, and causal. This research study engages in all three designs using both qualitative and quantitative methods. Tull and Hawkins (1994, p.48) define exploratory research as '*an attempt to discover the general nature of the problem and the variables that relate to it*' while Malhotra and Birks (2000, pp. 75) define exploratory research as "*one type of research design that has, as its primary objective, the provision of insights into, and comprehension of the problem situation confronting the researcher*". Descriptive research is depicted by Tull and Hawkins (1994, p.49) as '*the accurate description of the variables in the problem model*' while Causal research is defined by Tull and Hawkins (1994) as '*an attempt to specify the nature of the functional relationship between two or more variables in the problem model*' (p.49).

Initially qualitative methods, in the form of focus groups, were conducted. The main results were subsequently used in the development of the quantitative survey questionnaires in the second phase of the research. The exploratory based qualitative insights initially found offer valuable insights to the variables worthy of consideration in the descriptive and causal aspects of the research design used in the second study, enabling the research problem to be more closely defined (Chisnall, 2001) and gaining an understanding of what was occurring at the hospital prior to a more comprehensive quantitative investigation (Sekaran, 2003). Exploratory research was thus followed by descriptive and causal research; designs which are used when the researcher has more knowledge of the area and can therefore develop specific questions to measure particular relationships and attributes (Chisnall, 2001), and understand the nature of the causal relationships between CO and stakeholder satisfaction (Tull and Hawkins, 1994). These were two critical insights that emerged from the initial qualitative depth analyses.

Malhotra and Birks (2000) suggest that exploratory research is the initial research that is used to provide an insight to a broader problem. For this research study specifically, the goal of the qualitative stage of the primary research is to gain a deeper understanding of the main drivers and outcomes of hospital reputation, so that these can be included in a follow up quantitative study and tested on a much larger scale. The key advantage of conducting the qualitative study is that it highlights a gap in the literature regarding the effect CO can have on the reputation of an organisation. The effect of CO on stakeholder perceptions of the brand/organisation is investigated in the quantitative stage of the study, as it is believed that the findings will contribute significantly to knowledge surrounding public sector reputation. The quantitative stage is descriptive in nature and will be useful to investigate if there is a relationship between individual and organisational CO and reputation, and if this relationship results in outcomes such as satisfaction, confidence, and affinity towards the organisation.

To summarise the three main types of research design, Domegan and Fleming (1999) provide a useful framework to compare and contrast the main characteristics of each design (Table 5.1).

Table 5.1: Choosing a Research Design

	Exploratory Research	**Descriptive Research**	**Causal Research**
Data Type	Qualitative	Qualitative Quantitative	Quantitative
Data	Literature Review Expert Survey Focus Groups In-depth Interviews Projective Techniques	Literature Review Expert Survey Surveys Observation Panels (Focus Groups)	Literature Review Expert Survey Experiments (Surveys) (Observation)
	Small	Small to Large	Large
Question Types	Probing Response Driven	Some probing Interviewer driven	No Probing
Hypothesis	Generates, develops	Tests and/or generates, develops	Tests
Reference: Domegan and Fleming (1999) 'Marketing Research in Ireland: Theory and Practice.			

Phase one of this research study involves conducting focus groups in order to unearth views surrounding the main drivers and outcomes of hospital reputation, one of the objectives of this study. Phase two, a follow up to phase one, involves administering a survey questionnaire to all three-stakeholder groups. The survey aims to further investigate the main findings from the qualitative study as well as investigating the presence of CO in the hospital at both an individual and organisational level and to identify if the presence of CO influenced patient and employee satisfaction, which is perceived will in turn affect the organisations overall reputation, a main objective of this research study which evolved from the qualitative study. Primary research methods that are relevant to the study of this dissertation will now be presented. The methods used are the most appropriate methodologies to reach the study objectives.

5.8.2 Primary Research

Malhotra (1996, p.41) defines primary data as '*being originated by a researcher for the specific purpose of addressing the problem at hand'*. Primary research is carried out when secondary research methods become exhaustive. Primary research is more difficult to gather, more expensive and more time consuming. This current research study is important, as there is lack of information on the drivers of reputation in relation to public sector service organisations, and there is also no conceptual or empirical evidence to date that has addressed the affect of CO on internal and external views of an organisation's reputation.

The empirical context is a public hospital in the Republic of Ireland. The health service in Ireland is a mixture of private and publicly funded organisations. This particular hospital obtains its funding from government sources and its employees work for the Health Service Executive (HSE).

Primary research can be quantitative or qualitative in nature. According to Blaxter, Hughes and Tight (2001), there is a basic differentiation between quantitative (numbers) and qualitative (words) data. Qualitative data is linked to the phenomenology school of thought and offers more detail about the subject under consideration, while quantitative data is linked to positivism and appears to provide hard data and numbers. Malhotra and Birks (1999) define qualitative research as *"a variety of methods that are flexible to enable respondents to reflect upon and express their views*, *it seeks to encapsulate the experiences and feelings of respondents in their own terms*" (p.158). Domegan and Fleming (1999)

define qualitative research '*as the collection of data which is open to interpretation, for instance on attitudes and opinions, and which might not be validated statistically'*.

Kinnear and Taylor (1996) define quantitative research as "*research that is designed to explain what is happening and the frequency of occurrence, it is normally conducted by asking a large sample of respondents a few simple questions in a brief time span*" (p. 147). Bryman (2004, p.19) defines quantitative research as '*a research strategy that emphasises quantification in the collection and analysis of data'*.

5.8.2.1 Phase One: Qualitative Research – Focus Groups

As discussed previously, the first stage of research conducted is exploratory in nature. One of the main aims of this study is to identify the main drivers and outcomes of hospital reputation. As can be seen from a review of the available literature, previous studies on hospital reputation have focused mainly on external stakeholder perspectives to the exclusion of internal stakeholder perspectives. This study aims to uncover the views and attitudes of both internal and external stakeholder's in relation to what drives hospital reputation and the outcomes of hospital reputation. As the aim is to uncover attitudes and opinions, it was determined from the start of this study, that an exploratory study would be necessary to accomplish this aim.

Malhotra and Birks (2000, p. 75) define exploratory research as "*one type of research design that has, as its primary objective, the provision of insights into, and comprehension of the problem situation confronting the researcher*". The term "exploratory research" has close connotations with a term known as "qualitative research". Malhotra and Birks (2000, p.156) define qualitative research as "… *an unstructured, primarily exploratory methodology based on small samples, intended to provide insight and understanding*". Creswell (1998, p.37) defines qualitative research by emphasising its characteristics and a holistic picture '*Qualitative research is an inquiry process of understanding based on distinct methodological traditions of inquiry that explore a social or human problem. The researcher builds a complex, holistic picture, analyses words, reports detailed views of informants, and conducts the study in a natural setting'*. According to Creswell (1998) qualitative research should be selected on the following basis:

1. The research question often starts with 'how' or 'what' rather than quantitative research, which asks 'why' and looks for relationships and associations.
2. The topic area needs to be explored.
3. A detailed view of the topic must be presented.
4. Individuals are studied in their natural setting.
5. The audience is receptive to qualitative research.
6. The researcher is an active learner who can tell the story from the participants view.

The type of qualitative research selected for this current study is focus groups, they are chosen as it is believed they will best answer the research questions, and explore, in-depth, the topic of reputation among both the internal and external stakeholder groups. A focus group is *"an interview conducted by a trained moderator among a small group of respondents in an unstructured and natural manner,"* (Malhotra and Birks, 2000 p.161). The qualitative stage of the research is employed first in order to explore the main drivers and outcomes of hospital reputation in order to create and set up the quantitative study. The main reason focus groups are chosen over any other qualitative method is due to the fact that focus groups are known to be more exciting and offer more simulation to the participants than a standard depth interview. This heightened interest and excitement affords the opportunity for meaningful comments to arise.

The aim of the focus groups is to gain a deeper understanding of the main drivers and outcomes of hospital reputation from the perspective of the three main stakeholder groups. Therefore, three focus groups are conducted, one with patients and services users, one with non-clinical staff and the final one with clinical staff, (see Table 5.2). The qualitative dimension of this research study is critical to identify possible avenues where potential improvements can be made for both internal and external stakeholder groups, in order to increase service user care, confidence and satisfaction and the overall reputation of our healthcare system.

The qualitative phase of this research study also identifies some of the main outcomes of hospital reputation; both the drivers and outcomes found in this exploratory study are used in the follow up survey instrument. The focus groups are an appropriate method to use in stage one as they provided rich data through detailed and frank discussions with both employees and patients. Findings from the focus groups provide a framework for the

survey instrument. The main objective of the survey developed from the focus group findings and aimed to investigate if the presence of CO in the organisation affects stakeholder satisfaction and further affects how stakeholders perceive the organisations reputation. Focus group respondents highlighted that dimensions of CO shape experiences with the brand for both patients and employees and experiences in turn shape the associations both make with the brand. Therefore, CO and brand associations are expected to be intertwined.

Table 5.2: The Composition of Each Focus Group

Focus Group	Breakdown of Participants
Patients/relatives/visitors group:	Patient Partnership Forum members x4 Other nominees x4 (surgical, medical, oncology and endocrine diabetics services)
Support Staff:	2 Portering 2 Housekeeping 2 Catering 2 Admin Staff 2 Maintenance 2 Care Assistants
Clinical Staff:	4 Nursing (staff nurse, senior staff nurse, nursing management student nurse) 4 Allied Health Professionals (1 physiotherapy, diabetics, 1 occupational therapy, and 1 technician) 4 Medical Doctors (1 intern, 1 NCHD, 1 registrar, and 1 consultant)

In order to aid the flow of the focus group session an instrument known as a *focus group discussion guide* was drawn up and utilised for all three groups (See appendix B).

5.8.2.2 Qualitative Sample Selection

A sample is a subset or some part of a larger population (Zikmund, 1997 p.444). Sampling is important, as without a sound sampling plan and a suitable sample size, the data will be collected from neither the proper respondents nor the appropriate number of them. The target population for the qualitative study was defined as the three key stakeholders of a

public hospital in the south of Ireland; patients/relatives/visitors, support staff and clinicians.

A non-probability sampling technique known as "judgemental sampling" was used to select study participants. Judgemental sampling is "a form of convenience sampling in which the population elements are purposely selected based on the judgement of the researcher" (Malhotra and Birks, 2000 p. 354). Malhotra and Birks (2000, p. 352) define non-probability sampling as "sampling techniques that do not use chance selection procedures but rather rely on the personal judgement of the researcher". The decision to adopt a non-probability sampling technique was influenced by several factors typical of a focus group, for example an exploratory research design, the need for a homogenous group of participants, and the non-statistical nature of the research design. The sample size was influenced by best practice guidelines for conducting focus groups. These guidelines specify that a focus group should consist of 6-12 homogenous participants (e.g. Malhotra and Birks, 2000).

5.8.2.3 Phase Two: Quantitative Research – Questionnaires

This type of research is also known as descriptive research. According to Creswell (1994) a quantitative study is '*an inquiry into a social or human problem, based on testing a theory composed of variables, measure with numbers, and analysed with statistical procedures, in order to determine whether the predictive generalisations of the theory hold true'*. A research questionnaire is a method of systematically gathering the primary information from a specified sample of the population for the purpose of understanding specific problems (Baker, 2002; Malhotra and Birks, 2000). The main advantage of surveys/questionnaires is that they are quick, inexpensive, and provide accurate means of assessing information about the phenomena (Zikmund, 1997). Baker (2003) states that surveys are the most widely used data collection technique. Furthermore, there are a number of advantages associated with surveys in that they are comprehensive, catering for all types of research methods and their design can be manipulated to suit different research problems, budgets and time constraints.

By using a questionnaire the author aimed to provide anonymity to the respondents in order to obtain a true opinion of the population. Self completion surveys, with the presence of the researcher was the chosen method of data collection for this research study as the author

believes that due to the complexity of the questions and measurement scales, a lower non-response error would be achieved if the questionnaire was administered in the presence of the researcher. Two separate surveys were designed, one for internal stakeholders (clinical and non-clinical staff) and one for external stakeholders (service users/relatives/visitors).

Both surveys contained the Davies et al. (2003; 2004) standardised and validated measure of reputation i.e. The Corporate Character Scale. By using this scale we measured items such as agreeableness, competency, enterprise, ruthless, machismo and informality (Table 3.2). Both surveys also contained Brown's (2002) measures of CO and included a separate measure for ECO and OCO. The individual measure of customer orientation (ECO) was derived from Brown's (2002) dimensions of CO; the needs dimension and the enjoyment dimension (Table 4.1).

 The measures used were edited slightly to make them specific to our study i.e. customers became patients. The items were inserted into the questionnaire in the format of a scale (1=strongly disagree, 5=strongly agree) employees were asked to rate themselves and patients/visitors were asked to rate employees. The aim of the measure in this study was to identify the level of CO in a public service organisation and whether or not this affects stakeholder perceptions of reputation and satisfaction.

In relation to the organisational measure of CO, this was known as store level CO and Brown based this on work by Narver and Slater (1990). These items were once again edited and entered into the questionnaire in a scale format. Both employees and patients were asked to rate the management of the organisation (OCO) on the items listed in Table 4.2.

The surveys also contained some of the main findings from our qualitative research. As focus groups have a small sample size and are not representative, it was decided to test these further by including them in the main survey instrument. This study also measured the key outcomes of hospital reputation, those being: satisfaction with the hospital, association with the hospital, affinity towards the hospital, and confidence in the hospital.

5.8.2.4 Quantitative Sample Selection

The researcher administered 700 surveys. The aim was to administer 250 surveys to each of the three stakeholder groups, however due to low staff morale in the H.S.E it was not

possible to administer all the surveys. A total of 450 staff were given hard copies of the questionnaire and 302 valid returns (without significant amounts of missing values) were obtained over the two weeks of the survey, an effective response rate of 74.6%. All employees were included in the sample frame and the interviewers visited the hospital during two separate weeks to ensure that the majority of employees had a similar chance of being approached.

Patients and their visitors were given a similar questionnaire. The response rate here was higher as respondents were contacted in person. A total of 250 potential respondents were approached and 200 questionnaires were obtained without significant amounts of missing values (80% response rate). The sample frame did not include all patients as the interviewers had to be sensitive to certain categories of patient in approaching them for interviews. Participants were instructed that the research was strictly confidential and the information would only be accessible by the researcher, they were also informed that no names were required and the data would only be stored for the required time period.

The convenience form of non-probability sampling was used to select respondents to participate in the quantitative study. Malhotra and Birks (1999, p.353) describe convenience sampling as a "*non-probability sampling technique that attempts to obtain a sample of convenient elements*". This was essential when interviewing employees as several of the employees the author approached had not got the time to participate in the study due to understaffing at their station etc.

When selecting patients there was an element of judgement sampling employed, the judgement of trained hospital staff was required in order to approach those patients in better health that would be capable of participating in the study. Malhotra and Birks (1999, p.354) define judgemental sampling as '*a form of convenience sampling in which the population elements are purposely selected based on the judgement of the researcher*'. This sample frame did not include all patients as the interviewers had to be sensitive to certain categories of patient in approaching them for interviews.

5.8.3 Pilot Testing

According to Chisnall (2001) well-organised piloting reveals possible misinterpretations owing to ignorance or misunderstanding of questions, and indicates differences in the frames of reference between the researchers and respondents. It is necessary to conduct a pilot study to determine if the proposed questionnaire is understandable and unambiguous to the intended respondents (Remenyi et al., 1998). Bryman (2004) agreed by stating that piloting seeks to ensure the survey questions work well and also that the tool as a whole functions well. The term pilot study is used in two diverse ways in social science research. It can denote 'trial runs', which are grounding for the main study and additionally to 'pre-test' a particular research tool (Von Teijlingen and Hundley, 2001).

For this current study, pilot testing was conducted before administering the surveys to assess the effectiveness of the questions and to identify any questions that could cause problems or that needed to be clarified. The survey questionnaire was tested with a sample from each stakeholder group (n=30). The questionnaires were self-completed by participants to try reduce interviewer bias. A number of adjustments were made:

- Firstly instead of waiting for staff to fill in the questionnaires, it was sometimes necessary to leave the questionnaires with them for a period of time as they were often too busy to complete the questionnaire immediately, in particular this was the case with clinical staff.

- There was also some confusion surrounding the meaning and the need for the corporate character scale, and some sections were left incomplete. As a result, when introducing the questionnaire to respondents its use and importance were explained at the initial stage, clarifying that some scales, which the respondent will encounter, had been extracted from academic literature in the corporate reputation and CO areas.

- The second question in the survey 'Please describe the words or phrases that come to mind when you think of hospital X was often misunderstood in the pilot study. Respondents thought it was part of the description for the following question, which immediately followed on the corporate character scale. A possible explanation for

this confusion is that there was little room between the question and the space for an answer; as a result it was left incomplete by several respondents. The visual flow of this aspect of the questionnaire could have been better and thus was improved upon for the main study.

5.8.4 Administering the Survey

The surveys were conducted over a period of two weeks, in a public hospital operating in the south of Ireland. Participants were randomly selected; patients were selected on the condition that they were well enough to take part and a member of medical staff judged this. When administering the surveys there was a possibility that errors may occur including non-response error, item non-response error and sampling error. The majority of people that were approached were willing to participate. However, as members of staff in the hospital were feeling stressed due to low staff morale and being understaffed, some surveys had to be left with respondents and collected at a later date. To try and avoid some of the above errors the study ensured confidentiality and surveyed the majority of respondents individually to prevent others influencing their response.

5.9 - Method of Data Analysis - Qualitative

Data analysis can be defined as a set of methods and techniques that can be used to obtain information and insights from the data; it is about the translation of data into information (Domegan and Fleming, 1999 p.25). The process in which one should follow for data analysis is provided below (Figure 5.2).

Figure 5.2: Data Analysis Process
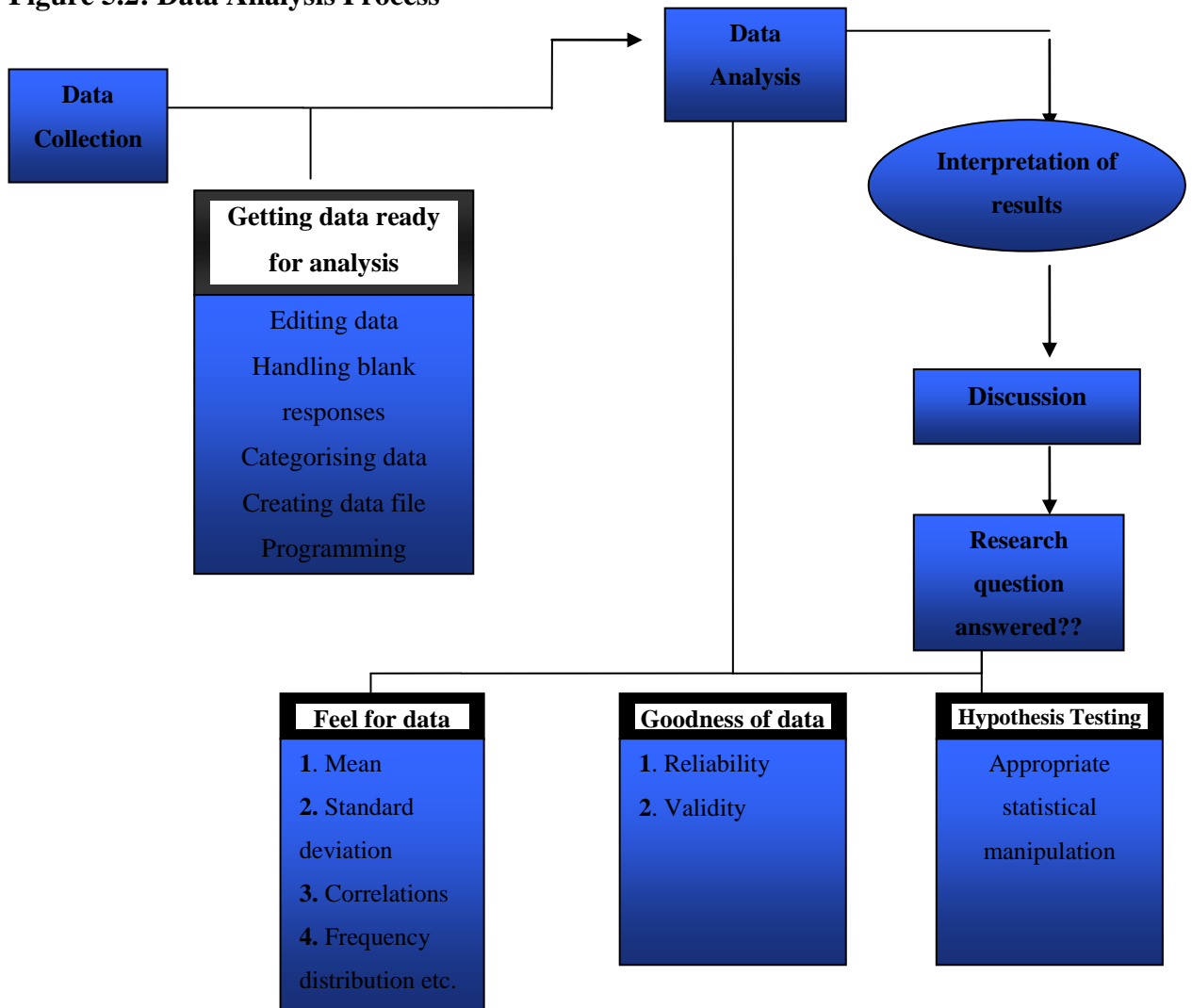
Source: Sekaran (2003)

Phase one – the qualitative study was analysed first, focus groups were analysed through the use of a software program know as Nvivo. According to Rabiee (2004, p.655) the main aim of a focus group is to understand, and explain, the meanings, beliefs and cultures that influence the feelings, attitudes and behaviours of individuals. Nvivo was chosen to analyse the qualitative results as one of the study's research objectives is to identify common influences and gaps in relation to the main drivers and outcomes of the hospitals reputation, Nvivo was the most appropriate method to accomplish this objective.

The focus group method was used in this study to provide a more in-depth exploration of issues. As previously discussed, three separate focus groups were conducted one with patients, one with clinical staff and another with non-clinical staff. This is in line with

Krueger (1994) who believes that rich data can only be generated if individuals in the group are prepared to engage fully in the discussion and, for this reason, advocates the use of homogenous groups. Participants were selected on the criteria that they would have something to say on the topic, have similar socio-characteristics and would be comfortable talking to the researcher and each other (Rabiee, 2004). Each focus group contained 6-12 participants, large enough to gain a variety of perspectives and small enough not to become disorderly or fragmented (Rabiee, 2004). Each focus group was tape-recorded on site and accompanied by a comprehensive set of notes, the researcher was then able to create a transcript corresponding to each discussion.

Qualitative research generates large amounts of data, a one hour interview could take 5-6 hours to transcribe thus the aim of data analysis is to reduce data. Using the qualitative data software package "Nvivo", the transcripts were analysed to identify key themes, which were edited and coded to produce the qualitative findings from phase one of the current study. Coding is one of the main steps in the data analysis process. The primary purpose of coding is to organise the data in a way that assists further analysis and interpretation (Catterall and MacLaran, 1997). They empower and speed up analysis.

Nvivo is designed to help manage and analyse data that is not easily reduced to numbers. Nvivo provided a means of electronically storing and organising the focus group transcripts, reducing the need for large quantities of paper. Nvivo also enabled the study to create a comprehensive research project on a computer. By storing the transcripts in this way, the researcher was able to avoid losing any transcripts as they were all stored in one precise location on the computer's memory; making it much easier to retrieve them whenever needed.

The researcher worked with the stored transcripts to attach ideas and find patterns among these ideas in order to formulate the findings. According to best practice, researchers usually generate some first concepts, ideas and categories and store them in Nvivo and then expand these initial ideas as they work through the transcript. This is precisely what was done for this research study. Firstly the transcribed documents were imported into Nvivo in their word format, following on from this ideas emerged when the researcher was reading through the transcript and these ideas are called "nodes". Nodes can be explored, organised and changed as many times as required. The nodes (ideas) were then attached to

different parts of the transcripts, a process known as "coding the data", making the transcript more meaningful to the researcher. Coding allows the researcher to make sense of large quantities of text and by doing so, to identify similarities and differences between various parts of the transcript. In essence, Nvivo creates a much more effective and efficient method of analysing qualitative data. Although the main source of data analysis is the recorded conversations derived from the interview; reflecting about the interview, the settings and capturing the non-verbal communication expressed by the participants add a valuable dimension to the construction and analysis of data (Rabiee, 2004 p.657). When analysing focus groups it is important to work both '*on*' and '*off*' screen. We work on-screen when we are dealing with transcript content, for example, in what ways can participants experiences with a particular topic be categorised. We work off-screen when we are dealing with the interaction aspects of focus groups (Catterall and Maclaren, 1997).

According to Thomas et al. (1995) one of the most distinct features of focus groups is its group dynamics, the data generated through the social interaction of a group is often deeper and richer than those obtained from one-to-one interviews (Rabiee, 2004 p. 656). Without a software package such as Nvivo, the qualitative data analysis process would prove to be a very tedious and unstructured process, increasing the chance of misinterpretations of the data, leading to misleading results. Bazeley and Richards (2000) give a structured account of the Nvivo process:

1. The first step involves the creation of a document; this may involve a list of the researcher's ideas or they may have created a document from transcribing focus groups that they previously conducted.

2. Ideas, concepts and categories are stored as nodes that can be explored, organised or changed. Data can be constantly edited, browsed, and reviewed. Nvivo also allows the researcher to rethink and revisit ideas.

3. Nvivo stores the imported documents and nodes. Observations and reflections are recorded and ideas captured in memos about the documents or annotations in them.

4. At this stage coding will become more systematic. New insights are stored in a nodes memos and links, and by reporting and modelling what has been found.

5. By using Nvivo a project rapidly grows complex bodies of data and ideas about it. The data now begins to find a shape; tress can be used for organising nodes and sets for organising either documents or nodes. At this stage we can use the integrated

search tool for asking questions of coding, text or attributes and pointing the search exactly where you want your question asked. Nvivo combines these options in a search tool that walks you into a search operation allowing you to specify the scope of the search and what you want to do with the result.

6. Theory begins to emerge at this stage. A web of ideas can be built from memos, text and nodes.

7. This stage is necessary to begin the management and strengthen of the projects nodes. Ideas need to be ordered in a more careful index system. Nodes are cut, copied and merged as the researcher gets a stronger feeling for what is going on.

8. At this stage the researcher should be comfortable with the process and focusing on moving faster. Searching usually becomes more intense and complex as the data builds up.

9. At the final stage the goal is to seek and explore relationships and associations, finding patterns and most importantly returning to the data, for detailed understanding, insight, surprise and arrival.

5.10 - Method of Data Analysis – Quantitative

During the analysis stage several interrelated procedures are performed to summarise and rearrange the data. In assessing methods for data collection during planning phase, it is beneficial to consider what data analysis procedures will be used. For phase two of this study, once questionnaires are distributed, spreadsheets on the SPSS program are developed in order to prepare for the data collection and analysis phase. A separate spreadsheet is developed for both employees and external stakeholders. Every variable is allocated a tab and codes are created for all the possible responses. Four key steps are required to analyse quantitative data when using a software package such as SPSS. These include editing, coding, tabulation and summarisation (Domegan and Fleming, 1999).

- Editing

According to Zikmund (1997, p.64) editing is the process of checking and adjusting the data for omissions, legibility, and consistency and readying then for coding and storage. Once questionnaires are received back from the field they are examined to identify any incomplete or unanswered questions. Any unusable surveys are put aside and the fully completed surveys are separated into either employees or patients and assigned a

number. According to Aaker, Kumar and Day (1998) problems to be identified can include some of the following; interviewer error, ambiguity, inconsistencies, lack of cooperation, and ineligible respondent.

- Data Coding

Coding refers to the process of allocating a numerical value to all response categories, for example, Yes=1, No=2 etc. this is done to speed up tabulation (Burns and Bush, 2000). Assigning codes to all possible responses also allows for easier transfer of data to the SPSS database. Coding the closed-ended questions is very straightforward but open-ended questions are a lot more tedious and time consuming. Usually a lengthy list of possible responses is generated and then each response is placed into of the list of items. Often the assignment of a response involves a judgement decision if the response does not match a list item exactly (Aaker et al., 1998).

- Tabulation

This is an essential step in the data analysis process and it involves the physical counting of the number of responses that correspond to each response category (Burns and Bush, 2000). According to Zikmund (1997) it is the arrangement of statistical data in a row and column format that exhibits the count of responses or observations for each category assigned to a variable. Tabulating the data makes it easier for the researcher to revive meaning and allows for greater significance to be achieved from the data. According to Aaker et al. (1998, p.444) the primary use of tabulation is in determining the empirical distribution of the variable in question and also calculating the descriptive statistics, particularly the mean or percentages.

- Summarisation

Eventually, the researcher must develop some conclusions from the data analysis and present results. The presentation, whether written or oral, can be critical to the ultimate ability of the researcher to influence decisions (Aaker et al., 1998). Once conclusions have been reached from the analysis of data, the results will be presented in both tabular and chart form to facilitate interpretation (Domegan and Fleming, 1999).

5.10.1 Treatment of Missing Values

In order to increase accuracy and consistency, the data obtained must be screened and edited before the analysis stage. Any unsatisfactory responses or unanswered questions will be assigned a missing value. A consistent set of rules is developed for both databases. If a respondent does, not answer a question or part of a question, then a value of 800 is entered, if the question is not applicable for the respondent then a value of 900 is assigned.

A missing value analysis is conducted in SPSS, for both the patient and employee databases, in order to identify missing data and their potential patterns (Hair et al., 1998). Within the employees' database, 147 respondents did not answer the question *'Please describe the words or phrases that come to mind when you think of X hospital'*, the analysis showed this was 48.7% of respondents which is very high, the reason allocated to this low level of response is the layout of the question, some respondents felt the question was a description for the following question on the hospitals characteristics, this problem had been identified in the pilot test and it was rectified prior to the main administration. Another reason for the low response rate could be that the rest of the questions are scale items and only involved a tick, as a result employees, due to lack of time etc., decided not to answer this question. The majority of the remaining questions have a very high response rate with only one or two missing responses.

In relation to the patients' database, again the words or phrases question has a low response rate with 45 missing responses, 22.5% of respondents; however this is not too low compared to the employee responses. A second question with a low response rate for the patients was 'the purpose of the visit'; this question had 93 missing responses, 46.5% of respondents. The reason for such a high non-response rate was that several patients/visitors might not have been comfortable writing their medical history on a survey despite the confidentiality they were promised. The following section critically evaluates the techniques used to analyse the data obtained from the surveys.

5.11 - Initial Data Analysis Techniques

Data obtained from the survey instrument is computed and analysed, for both stakeholder groups, using a number of statistical techniques in SPSS. Initially preliminary analysis is conducted in order to examine stakeholder views in relation to ECO and OCO, as well as

their views on the corporate character of the organisation. A tool known as a radar (spider) diagram was produced in excel, the purpose of such a diagram is to display the comparative values of multiple variables in a data set. For this research study, spider diagrams are created to chart the difference between stakeholder views of the corporate character of the hospital.

Reliability and validity estimates are then computed to test the reliability of the scales used in the survey instrument, followed by descriptive statistics such as means and standard deviations. The main section of the data analysis highlights key drivers of the model outcomes by use of significant correlations and hierarchical regression. Each hypothesis with a mediating relationship is tested by the Sobel test. This test requires the conduction of regression analysis, as values such as the raw regression coefficient and the standard error for the regression coefficient are required.

5.11.1 Descriptive Statistics

According to Aaker et al. (1998, p. 446) descriptive statistics are statistics normally associated with a frequency distribution that helps summarize the information presented in the frequency table. These include measures of central tendency (mean, median and mode), measures of dispersion (range, standard deviation and coefficient of variation), and measures of shape (skewness and kurtosis). For the purpose of this research study means and standard deviations are calculated. According to Bryman and Cramer (2005) 'the arithmetic mean, often symbolised by x is by far the most commonly used method of gauging central tendency. It is easy to understand and interpret, which heightens its appeal. Standard deviation is the most commonly used method of summarising dispersion. Following descriptive statistics, reliability and validity tests are conducted.

Reliability and validity are crucial criteria in the evaluation of variables, especially if the research study involves a form of survey work (Chisnall, 2001). Gill and Johnson (1997) indicate that the strength of survey research lies in its validity and reliability. Questionnaires are highly structured, enabling quantitative analysis to take place; they can be replicated, and therefore are viewed as a reliable data collection. The two terms reliability and validity are often used interchangeable; however they refer to different aspects of the qualities of variables and each does have their own specific meaning (Tull

and Hawkins, 1990; Hardy and Bryman, 2004). For the purpose of this research study, reliability and validity analysis is conducted on all scale items used.

5.11.2 Reliability

The term reliability is used to refer to the degree of variable error in a measurement. Zikmund (1997) states reliability is '*the degree to which measures are free from random error and therefore yield consistent results*'. According to Aaker et al. (1998) it is the random error component of a measurement instrument. According to Tull and Hawkins (1990) there are four approaches to assessing reliability; firstly test-retest reliability, which involves applying the same measure to the same objects a second time, secondly alternative-forms reliability which involves measuring the same objects by two instruments that are designed to be as alike as possible, followed by internal-comparison reliability which involves comparing the responses among the various items on a multiple item index designed to measure a homogeneous concept and finally scorer reliability which involves comparing the scores assigned the same qualitative material by two or more judges. Essentially reliability is concerned with the consistency, accuracy and predictability of specific research findings (Chisnall, 2001). The most widely accepted statistic measuring internal consistency reliability is Cronbach's (1951) Alpha co-efficient. Hatcher (1994) defined reliability coefficient as "the percent of variance in an observed variable that is accounted for by true scores on the underlying construct". To be considered acceptable Cronbach's alpha should be 0.7 or higher.

5.11.3 Validity

Validity and reliability are similar as they are both concerned with error. However reliability is concerned with variable error whilst validity is concerned with systematic error (Tull and Hawkins, 1990). According to Aaker et al. (1998, p.766) validity is the ability of a measurement instrument to measure what it is suppose to, if it does not there will be problems. Validity refers to the extent to which the measurement scale is representing a construct free from error and results in the same findings being noted across different trials (Hair et al., 1998). According to Chisnall (2001, p.38) the three types of validity are face, internal and external validity. Face validity refers to the results form a specific survey that appears generally plausible in the lack of supporting evidence. Internal validity refers to the measures related to a specific survey rather than to the generalisability

of the findings. External validity refers to the degree to which specific research results could be generalisable to other, dissimilar, research situations.

There are three main ways of estimating validity, namely content, criterion-related and construct validity (Tull and Hawkins, 1990).

5.11.3.1 Content Validity

According to Carmines and Zeller (1979), content validity is the extent to which an empirical measurement reflects a specific domain of content (Whelan, 2004). Content validity involves assessing the representativeness or the sampling adequacy of the items contained in the measuring instrument.

5.11.3.2 Criterion-related validity

Criterion related validity assesses a scale in terms of a criterion in terms of which people are known to differ (Hardy and Bryman, 2004). It involves assessing the extent to which the obtained score may be used to estimate an individuals present standing with respect to some other variable (Aaker et al., 1998). Criterion related validation can take two forms concurrent validation and predictive validation. Testing for concurrent validity relates a variable to a contemporaneous criterion, whereas testing for predictive validity relates a variable to a future criterion (Hardy and Bryman, 2004).

5.11.3.3 Construct Validity

Construct validation involves understanding the meaning of the obtained measurements. It refers to the degree to which inferences can be made legitimately from the operationalisations in your study to the theoretical constructs on which those operationalisations were based. Construct validity involves generalisation from your program or measures to the concept of your program or measures (Trochim, 2006).

According to Chisnall (2001) for a research method to be valid, it must be reliable, but a research method may be reliable but not necessarily valid, therefore reliability is a necessary but not sufficient condition for validity.

5.11.4 Factor Analysis

Factor analysis allows us to spread the distribution by examining each variable of each scale separately rather than as one. It allows the researcher to simplify complex data by finding the minimum number of dimensions that can be used to describe them, it also allows the researcher to identify the items which do not fit the summary variables and which should be discarded (Sapsford and Jupp, 1996).

When conducting factor analysis (FA) for this study, principal component analysis is used (PCA). FA and PCA are statistical techniques applied to a single set of variables when the researcher is interested in discovering which variables in the set form coherent subsets that are relatively independent of one another. (Tabachnick and Fidell, 2001). According to Smith (2002) PCA is a way of identifying patterns in data, and expressing the data in such a way as to highlight their similarities and differences. A main advantage of PCA is that once you have found these patterns in the data, you can compress the data i.e. reduce the number of dimensions, without much loss of information (Smith, 2002) i.e. single variables in this study were computed into ECO, OCO, Agreeableness, Competence, Enterprise, Machismo, Ruthless and Satisfaction.

When factor analysis has been run the most important output for a researcher to examine is the component matrix, if only one component is extracted the result is good, however if more than one factor is extracted, rotation of the variables is required. Rotation maximises the loading of each variable on one of the extracted factors whilst minimising the loading on all other factors. Rotation works through changing the absolute values of the variables whilst keeping their differential values constant (Field, 2005a). Varimax rotation developed by Kaiser (1958) is used for this study. Varimax rotation is a common method and is used in this study mainly to reduce the amount of correlation among the factors and thus impose orthogonal rotation.

5.12 – Statistical Hypotheses Testing

The quantitative research i.e. surveys, were analysed using the Statistical Package for the Social Sciences (SPSS) software package. The first step of analysis conducted is descriptive statistics. Descriptive statistics are conducted by selecting and analyzing variables, a number of statistics can be calculated here including the mean and standard

deviation, which are the most frequently used, followed by the minimum and maximum as well as variance and range. Descriptive statistics are used initially to provide information about the entire distribution. Regardless of what approaches are selected to address the research questions, the first step will always be to learn about the distributional properties of ones data (Hardy and Bryman, 2004).

Following the descriptive statistics analysis phase, preliminary analysis is conducted and involves obtaining the means of the corporate character dimensions, ECO and OCO. The corporate character means are presented using spider diagrams, which are created in Excel. Two radar (spider) diagrams are produced for this study: a patient diagram displaying the means of the corporate character dimensions, and an employee diagram displaying the means of the corporate character dimensions. The means for the stakeholder perceptions in relation to ECO and OCO are presented by use of tables.

Following on from this more advanced data analysis is conducted using bivariate correlations and multiple regressions through SPSS. During the main stage of analysis correlations are conducted prior to regression analysis. Two types of measure can be distinguished: measures of linear correlation using interval variables and measures of rank correlations using ordinal variables (Bryman and Cramer, 2005). If a high value on one variable is associated with a high value on another, they are said to be positively correlated. If a high value is associated with a low value on another variable, they are said to be negatively correlated. In order to interpret the results displayed from regression and correlation analysis, a number of statistics provided by SPSS must be understood (Whelan, 2004).

The index used to indicate the strength of the association between two variables is *Pearson's correlation coefficient.* Pearson's is the most widely used form of correlation coefficient. The measure indicates how closely the linear association is by taking values from -1 to +1, a value of -1 or +1 would indicate an association, a value of 0 means there is absolutely no association (Hair et al., 2003). Linear correlation means that the measures for the pair of variables being investigated together form a straight line when plotted on a graph. In order for our results to be significant they must produce a value at a one-tailed or two-tailed level of significance. One or two tailed levels of significance can be 95% or 99%. The reason for using one or two tails, depend on the hypothesis formulated (i.e.

greater, lower, or different from a point of comparison). In other words, a one-tailed test is used when we predict the direction of the difference in advance (e.g. one mean will be larger than the other). With that assumption, the probability of incorrectly rejecting the null is only calculated from one tail of the distribution. In standard testing, as is the case for the hypotheses presented in the current study, the probability is calculated from both tails.

R is the correlation coefficient (equal to the Pearson correlation) between the observed value of a dependant variable and the predicted value on the regression model (Whelan, 2004). A correlation of $r = 0.8$ would indicate a strong association (Sapsford and Jupp, 1996). *R square* is the percentage of the variation in the dependant variable that is explained by the independent variable(s) (Bryman and Cramer, 2005). *Beta* is the standardised regression coefficient for an independent variable within a multiple regression to allow for direct comparison as to their relative explanatory power of the dependant variable (Hair et al., 1998).

According to Baker (1991, p.230) correlation analysis only measures the existence and overall strength of a relationship between two variables, whilst regression analysis determines the nature of the statistical dependence between a dependant variable and at least one independent variable (p.232). Although regression analysis does not permit any causality between variables to be made, it is an ideal approach to test the causation that derived from theory and is expressed in hypotheses (Hair et al., 2003).

Following on from conducting correlations, regression analysis is undertaken. Regression analysis is a technique used for modelling and analysis of numerical data consisting of values of a dependant variable (DV) and of one or more independent variables. According to Hair et al. significance is displayed in regression when a value is less than 0.05. Regression can be used for prediction, inference, hypotheses testing and modelling of causal relationships (Berk, 2004). The idea of regression is to summarise the relationship between two variables by producing a line that fits the data closely, this line is known as *the line of best fit* (Bryman and Cramer, 2005).

Regression analysis is chosen in this study as it determines whether a relationship exists between some of the dimensions of the corporate character scale, other than merely identifying an association and the strength of association between the dimensions for the

service brand (Whelan, 2004). Regression is a powerful tool used for summarising the nature of the relationship between variables and for making predictions of likely values of the dependant variable (Bryman and Cramer, 2005). Within SPSS there are quite a large range of statistical options related to regression. Two of the most common types of regression are linear and ordinal. For the purpose of this study, regression analysis is conducted through a mediation test known as the Sobel test.

5.12.1 The Sobel Test

This tests mediation and the indirect effect. Mediation analysis is conducted in order to indirectly assess the effect of a proposed cause on some outcome through a proposed mediator (Preacher and Hayes, 2004). The Sobel test was introduced in 1982, it is the most commonly reported test of the indirect effect. The purpose of the Sobel test is to test whether a mediator carries the influence of an IV to a DV. There are three types of the Sobel test, one that adds the third denominator term (Aroian, 1944/47), one that subtracts it (Goodman, 1960) and one that does not include it at all. It is recommended to use the Aroian version of the Sobel test, the Sobel test is also known to work best with larger sample sizes and is known to become less conservative as the sample size becomes smaller (Preacher and Leonardelli, 2006), which is suitable for this specific study. The Sobel test was the chosen method of mediation as it is a traditional method of testing the significance of mediating effects. The Sobel test is also used because it is so widely applied and cited which offers credibility to the method (Bontis, Booker and Serenko, 2007). A search on the ISI Web of Science citation database (February, 2009) indicates that Baron and Kenny's paper has been cited over 11,500 times that adds credibility to this method. The process of conducting the Sobel test begins with factor analysis, this is required to evaluate the factor structure of the group of items the researcher develops to order to assess each of the constructs in the study's theoretical model. The next step is to test three conditions, through correlation analysis, to determine whether mediation has occurred, the following are the conditions:

1. The IV predicts the DV
2. The IV predicts the mediator
3. The mediator predicts the DV (Baron and Kenny, 1989).

If all three steps are met then there is said to be complete mediation. Partial mediation may also occur when the path from X to Y is reduced in absolute size but is still different from zero when the mediator is controlled. In order to conduct the Sobel test, the next step requires the study to compute the raw regression coefficient and the standard error for this regression coefficient for the association between the IV and the mediator, and the association between the mediator and the DV. This can be conducted through regression analysis in SPSS. The first analysis is between the mediator and the IV, the second analysis is between the dependant variable and the independent and mediating variable, these two stages of analysis produced the four values needed to calculate the Sobel test. To complete the Sobel test it is necessary to go online and enter the required values into the calculator and results will produce a Sobel test statistic and also p values that will highlight the significance of the mediating relationship. For this study, the calculator is used on two different websites to ensure the results are reliable; website 1 was www.danielsoper.com/statcalc/calc31 and website 2 is www.people.ku.edu/~preacher/Sobel/Sobel.htm. The second website produces the Sobel test statistic for the three types, those being; the Sobel test, the Aroian test and the Goodman test. If the observed p value falls below 0.05, there is evidence of mediation and vice versa. If the calculator produces a p value of 0 but all or some of the conditions have been met it should be written as p<0.001 to display a complete or partial mediation. Further, previous work states that for results to be significant they must include a zero i.e. 0.0824, otherwise the hypothesis is rejected (Taylor, MacKinnon and Tein, 2008).

Hypotheses 2, 3 and 4 all involve relationships with a mediated variable. Each relationship has three variables: the independent variable, the dependant variable and the mediating variable. The mediating variable is known as the intervening or process variable. According to Preacher and Leonardelli (2006) a variable may be considered a mediator to the extent to which it carries the influence of a given independent variable to a given dependent variable. Mediation can be said to occur when (1) the IV significantly affects the mediator, (2) the IV significantly affects the DV in the absence of the mediator, (3) the mediator has a significant unique effect on the DV, and (4) the effect of the IV on the DV shrinks upon the addition of the mediator to the model (Pierce, 2003). One major reason for testing mediation is trying to understand the mechanism through which the initial variable affects the outcome (Kenny, 2008).

5.13 - Measures Used in the Research Instrument: Reputation

The personification metaphor used to measure reputation/branding in this study, has been used in works on branding since the 1970's. According to Davies et al. (2003) one of the earliest authors to develop the idea was King (1973) who insisted the main difference between two brands lay in the personalities projected by each brand.

In order to measure brand personality, a standardised measure of reputation developed by Davies et al. (2003; 2004) is selected, namely The Corporate Character Scale. By using this scale this study measures items such as agreeableness, competency, enterprise, ruthless, and machismo (Table 3.2). The main objective of including this scale is to test the relationship between CO, satisfaction and reputation. Hypotheses 3 and 4 test this relationship within both patient/visitor and employee databases. These hypotheses are developed from findings that emerged from the qualitative study; respondents highlight the importance of CO in driving the reputation of the hospital.

Agreeableness is one of the main dimensions of the scale, which includes measurement items such as warmth, empathy and integrity. These items are made up of many constructs, one being trust which is essential to measure as it is held to influence employees and customers. Customers of service organizations value the helpfulness, friendliness, and fairness of treatment by frontline staff members (Westbrook, 1981). Agreeableness is also important for employees, because trust is significantly correlated with job satisfaction and organizational commitment (Pillai, Schreisheim and Williams, 1999). Competence is also perceived as one of the scales main dimensions and has three facets, conscientiousness, drive and technocracy. It was thought that the competence dimension could be important in creating satisfaction for both employees and customers, because organisational effectiveness is a major signal a company gives to the market (Brown and Dacin, 1997). Enterprise is also seen as a main dimension and is made up of three facets, those being modernity, adventure and boldness. Customers in both the public and private sectors can be positively influenced by how enterprising a service organization appears to be (Bellenger and Korgaonkar, 1980).

The survey measures these items by asking respondents to imagine that the organisation 'came to life' as a human being and to rate its personality based on the list of traits

provided. A scale was created to measure the traits; it is a seven point likert-type scale, ranging from strongly agree to strongly disagree (appendix C).

5.13.1 Customer Orientation

ECO defined as 'an employee's tendency or predisposition to meet customer needs in an on-the-job context' was measured using a scale taken from Brown et al. (2002); it was adapted to this context by replacing 'customer' with 'patient'. The scale is two dimensional, measuring both the needs and enjoyment dimension. The needs dimension is assessed with six items (e.g. Staff at X take a problem solving approach with their patients); the enjoyment dimension is also measured with six items (e.g. Staff at X find it easy to smile at each patient. Each item is measured by the use of a 5 point likert scale ranging from strongly disagree to strongly agree (Table 4.1). OCO is also measured and the 8 item scale used in this study is obtained from work by Narver and Slater (1990) and once again is adapted to correspond with the context (e.g. Managers at X constantly make sure that employees are trying their best to satisfy patients) see Table 4.2.

5.13.2 Satisfaction

Oliver (1997) defined satisfaction as the difference between what we expect and what we receive (Davies et al., 2003 p.177). The measurement of patient satisfaction is often used by healthcare professionals in order to increase their services (Spicer, 2002). It is important to obtain the views of patients for the process of monitoring and improving services in order to maintain and increase their satisfaction with the hospital; if customers are not satisfied a business/organisation will not survive (Davies et al., 2003). According to Sitzia and Wood (1997) hospital managers must ensure the highest level of patient satisfaction not only to maintain their patient base but also to expand it. As well as measuring patient satisfaction in this context, employee satisfaction is just as important. In order for employees to possess positive traits such as CO they must be satisfied in the workplace, employee satisfaction can be notified by patients and affect patient's overall experience at the hospital. Employee satisfaction is also important for an organisation to ensure they maintain high levels of staff retention. It is therefore essential for employees to have positive experiences at work so that they can be passed on when frontline employees are dealing with the external stakeholders i.e. patients/visitors/relatives.

In this context, satisfaction is defined as the stakeholder's overall satisfaction with the corporate entity (Davies et al., 2006), rather than satisfaction with a particular treatment or as job satisfaction. For employees, two of the three scale items for measuring satisfaction are taken from Davies et al. (2004) and one from the literature on hospital marketing that emphasises the outcome of "confidence" in satisfaction (Linder-Pelz, 1982). For patients and visitors, the three-item scale for measuring satisfaction was taken from Davies et al. (2004).

5.14 - Limitations

Limitations can occur at all stages of the research process. All methods of research have limitations attached to them.

5.14.1 Qualitative Limitations

The first limitation identified from conducting focus groups is that the sample size is small and not representative. To overcome this, the findings from the qualitative phase of the research study are tested further with a larger sample size, as they are included in the survey questionnaires.

Another limitation is group dynamic i.e. peer pressure. If one highly opinionated participant makes a compelling or emotional argument, others in the group may have a hard time expressing contradictory opinions. To attempt to limit this reluctance, researchers try to keep the demographic composition of groups as homogenous as possible. For example, this study conducted three separate focus groups to facilitate keeping patients, support staff and clinicians in their individual groups.

5.14.2 Quantitative Limitations

Interview and observation bias: To overcome this limitation the study refrained from prompting the respondents whilst they were completing the questionnaire. It is also important to keep a certain distance from the respondent to allow for confidentiality and to give the respondent adequate time to complete the questionnaire.

Non-response is also known to cause problems whilst administering surveys in a hospital (Binshan and Kelly, 1995). So as to avoid this from happening hospital staff assisted the

researcher in administering the surveys as recommended by Binshan and Kelly (1995). This was helpful in obtaining a higher response rate as those patients well enough to participate were approached and furthermore, hospital staff were aware of staff rotation, this helped the researcher to avoid repeatedly approaching the same staff.

Due to low staff morale in the HSE, some staff were unwilling to participate in the study. To try to overcome this limitation the researcher emphasised the importance and the usefulness of the findings from this study and its benefits for both the H.S.E and their hospital specifically. Another limitation is the lack of understanding towards the corporate character scale instrument; an essential part of the questionnaire. This was noticed at the pilot testing stage; to prevent respondents from skipping this section the administrator explained its importance and clearly amended the section instructions.

Another limitation is that the section measuring OCO was not fully understood by patients. Patients were unaware of management activities throughout the organisation. However, this is not a major problem as once the staff answered this section it can be measured. Respondents were simply asked to answer the questionnaire to the best of their ability.

5.15 - Conclusion

The methodology chapter provides an overview of the key stages involved in the research process for this study. The aim of the chapter was to justify the selected research approaches based on the research question and objectives. Subsequently, this chapter highlights how the primary research was designed, conducted and analysed. Subsequently, methodological foundations were explored and justification of the primary data collection process was outlined. Finally, an overview of the types of analysis performed on both sets of data was presented. The findings are discussed in the next chapter and compared/contrasted to those in the literature review.

~ Chapter 6 ~

DATA ANALYSIS: QUALITATIVE FINDINGS

6.1 - Introduction

The purpose of this chapter is to present the findings from the qualitative primary research undertaken for the first phase of this study. This chapter includes the results of three qualitative group discussions (N=32): one with patients/visitors, another with support staff and one with medical staff. The findings are structured in accordance with the drivers and outcomes of positive/negative reputation for the hospital. Results from the patient/visitor focus group will firstly be outlined, followed by support and clinical staff findings.

6.2 - Qualitative Findings – Patients/Visitors

The first focus group was conducted with patients/visitors of the hospital. The main findings for the drivers of positive hospital reputation will be outlined first, followed by the drivers of a negative reputation. To reveal patients/visitors main perceptions' regarding what drives the hospitals reputation, respondents were asked the following questions: 'What do you feel effects how the hospital is seen in terms of its reputation?' 'What factors do you feel would lead you to talk positively/negatively about X?' 'What influences your decisions to attend X?'

6.2.1 Drivers of Positive Hospital Reputation
6.2.1.1 Management Competence
It was declared that in order to have a good hospital, you must have good management. The respondents believed that hospital management are constantly improving: -

"I think that any good hospital has to be run by good management, and if you haven't good management you haven't a good hospital, it's all down to management as far as I'm concerned and I think hospital X is very good so far, and it's getting better, everyday it's getting better…"

6.2.1.2 Staff Relations

Respondents felt that in order to have a positive reputation, you need good management-staff relations. Respondents highlighted the importance of management communicating with staff in order to ensure that they are working to satisfy patient needs. They also felt that staff interaction is a very important factor contributing to their overall well being as a patient in the hospital, and it was argued that this is especially important in the public service sector. Respondents felt that staff at all levels should be approachable including senior management, and that patients should not feel intimidated: -

"I think approachability is very important, being able to communicate and not be afraid to communicate and not be intimidated..."

In order to be satisfied with a hospital, respondents' felt feeling secure was of utmost importance. The hospital staff, nurses in particular, were described as caring and friendly. The group participants confirmed that the hospital's nurses definitely meet this very important physiological and psychological human need: -

"A feeling of relief, I was brought in a couple times by ambulance, the great feeling of relief when you are brought in and you have experienced nurses, it's the nurses, the nurses are very kind, the feeling of relief like when you come in and they take over..."

Furthermore, respondents stated they know when attending the hospital that they will be cared for, receive a friendly service, and be safe. They are contented in the knowledge that they are in the hands of experienced people. All respondents reported to having good interpersonal experiences at the hospital and as a result, always spread good word of mouth about it.

Moreover, it was stated that good experiences at the hospital lead to patient confidence. A caring and personal touch is provided at the hospital, respondents stated that '*you are not just a number here*' staff remember your name and small things like this lead to a positive perception towards the hospital: -

"...I didn't feel scared coming in here. I was so safe coming in here because I knew I would be cared for and get help. I knew the nurses were so good and caring. That unit

down there, they are special, they really are fantastic…absolutely fantastic…I have never been in that unit but I would say anytime I've been in the hospital I've always been well cared for… beautiful people, really they were absolutely fantastic {in ICU} and yet they didn't leave every Tom, Dick and Harry in to see me, you know, they were careful…I have been to Z and they are so impersonal…it's being safe and I think that matters when you are vulnerable and sick…In this hospital, I think when you're sick you always feel safe the minute you get inside the hospital's doors".

6.2.1.3 Hospital Cleanliness and Hygiene

In general, it was agreed that there is a good level of cleanliness and hygiene in the hospital and that this was a driver of positive reputation. The respondents felt very strongly about the importance of having a clean and healthy hospital environment, and there appeared to be universal agreement amongst respondents that staff at the hospital are devoted to this purpose. It was mentioned that the housekeeping staff at the hospital are an extremely dedicated and committed team: -

"…I found the cleanliness of the place top class and they do a very good job, hospital X is very dedicated and the staff are very good…"

"…the cleanliness is very good compared to other hospitals, hospital X is very comfortable and we are very lucky to have it here…"

6.2.2 Drivers of Negative Hospital Reputation

The next section will cover the main findings from the patient/visitor focus groups surrounding their perceptions with regard to the main drivers of negative hospital reputation.

6.2.2.1 Media Influence

The first issue raised was the media. Respondents felt that during a previous strike, the media strongly criticised the hospital, doing its level best to degrade the hospital's reputation in the eyes of its key stakeholders (both internal and external): -

"The media's behaviour was disgraceful when the strike was on and hospital X got attacked…"

Patients felt that the behaviour of the media towards public sector organisations is disgraceful and demeaning, and they said that they would rarely allow what the media says to affect their opinion of the hospital. When asked about what advice they would give to the General Manager of hospital X in relation to reputation management, participants believed that the hospital should "*tell the media absolutely nothing*" as the leakage of information would be detrimental to the hospital's reputation. Respondents went on to state that a media frenzy would be both the greatest cause and result of a negative reputation for the hospital, thus, supporting the reason why the participants thought that the media should not be told anything: -

"...to let the media know as little as possible. Just tell them nothing..."

"...I feel if there was something negative, that if the media in the present time would get hold of something like that, it would be detrimental to the hospital's reputation..."

Thus, the respondents strongly felt that the major factor affecting the reputation of the hospital is the media. Respondents stated that the media tends to focus on negative points, ignoring the more positive stories that emerge about the hospital: -

"Yes, if it's a good reputation you don't hear about it..."

As a result of the media portraying the hospital in a negative light, patients believed that many services have been downgraded by the H.S.E., and patients are consequently being transported to hospital Y: -

"The reason that was downgraded was because of the media as well. I remember the media, I suppose it would be about eight or nine years ago now, the media splashed all over the papers that people had to get bones rebroken, that they were badly set in this hospital and they had to go to Y to get them rebroken".

6.2.2.2 Staff Shortages
Besides the media driving a negative reputation for the hospital, a second factor perceived by respondents related to the shortage of staff in the hospital, especially in the nurses' department. It appears that patients believe understaffing does not allow for patients needs'

to be looked after properly. Respondents felt that due to a scarcity of nurses, there is not enough time to explain medical matters to patients, and that patients are left uninformed as a result: -

"The doctors and the nurses are always in a hurry, when the doctor is in the ward they are always running around. I find it more so here than anywhere else; the nurses are always running around when they are on the wards, because of the simple reason that there aren't enough of them…"

The respondents progressed to state that the hospital staff tend to be overworked, and as a result they sometimes do not perform to the best of their ability. It was felt that this may lead to both patient and staff dissatisfaction, creating negative impressions of the hospital and sadly, leading to a negative reputation being formed for the hospital. Respondents shared the view that dissatisfied staff may talk negatively about the hospital to the public: -

"...people who are in a job and who hate their job are going to run it down to hell, and if you like your job you are actually going to praise it and that's going to have an impact on the reputation of the hospital…"

6.2.2.3 Patient-Doctor Communication

Communication was believed to be a major driver of a negative reputation for Hospital X. Overall respondents felt that communication in the hospital was quite poor. Respondents pointed out that this is specifically in relation to medical teams in the hospital. It was believed that more explanation is needed from the medical team to the patients and relatives. Several times during the discussion, respondents cited experiences when they did not understand the doctor or vice-versa; the doctor found it difficult to communicate through the English language. All respondents were in agreement that both culture and language barriers make communication a difficult challenge at the hospital: -

"...not understanding the doctors or the medical people, particularly doctors who don't have English as their first language… communication, and language are the problems, you know, doctors, particularly junior doctors who are new, their English may be good but it can also be a culture thing, communication is actually more a culture than a language problem…"

The argument was also made that "*nurses end up having to translate on behalf of the doctors*", leading to reduced patient satisfaction and confidence. From a patient perspective, it was stated that there is also a lack of communication between doctors in this hospital and other hospitals (Intra-hospital communication). Lengthy waiting periods for test results and in A&E were also mentioned as being drivers of a negative reputation. The lack of intra-hospital communication was believed to be the main reason for these long waiting periods. One patient had been waiting over a week for test results "of a simple biopsy" that had been conducted in hospital Z: -

"I am a week and a half waiting for test results to come back from Z at the moment from one simple biopsy and it is not good…it's not a very efficient system…"

In the eyes of the patients, "the systems are faulty". Doctors and consultants in the hospital do not exert maximum effort to communicate with other hospital doctors to request test results: -

"The doctor here should be in contact with the doctor in Z, it's his job to find out what's wrong with me rather than Z telling them what's wrong with me. You know, so I think that is an issue here, you know, the waiting, the waiting and waiting here, you are taking up a bed on somebody else who might need it more".

"At the moment I'm taking up a bed for the last two weeks, I wasn't let home, they wouldn't let me home, you know, I am fit enough to walk around, but yet I wasn't let home because of the waiting for the biopsy results. Somebody else that needed a bed could have had a bed for the period of time they wanted to be in here. I'm here waiting, hanging around waiting, taking up a bed just for the simple reason that a doctor here will not ring Z, but instead he is waiting for a doctor in Z to ring him with my test results".

According to respondents, there is also a lack of communication in the hospital's A&E department. An example provided by the patients was that if a doctor is called away to an emergency, nobody informs the patients of how long they will be waiting for his/her return:-

"...the doctor could have to go away because an emergency came in, he/she could be gone for maybe an hour or an hour and a half, I think the nurse should come out and maybe explain that to the patients in A&E and then it is up to the patients if they want to continue to wait or else go home and return later..."

Respondents were also annoyed with the fact that they may have to spend 3-4 hours waiting in A&E only to be transferred to hospital Y at the end of the evening after a long wait: -

"What's affecting its reputation is when you come into casualty with a child who has cut themselves badly or has a broken leg and their in pain. You have to sit there for 3-4 hours to see a doctor, and then you are sent to hospital Y at the end of the evening".

Respondents conveyed that reducing waiting lists, both in A&E and for operations, should be the first priority for the hospital's management if they want to improve its reputation. The respondents argued that it is very difficult for patients "who are experiencing any sort of pain", or who are "forced to endure lengthy waiting periods prior to an operation". It was admitted by the participants that although waiting times affect the reputation of the whole health sector, it still reflects badly on the reputation of individual hospitals: -

"...now I know that is a HSE problem rather than a specific problem for this hospital, but it still reflects badly on this hospital the same as on any other hospital, and it's not good for patients..."

6.2.2.4 Hospital Facilities

Turning to the issue of hospital facilities, respondents were annoyed over a lack of patient specific facilities, such as televisions. It was firmly believed that the hospital tends to waste scarce resources. To illustrate this, one patient mentioned that there are televisions in private rooms, when 90% of those occupying such rooms are very ill patients, or very elderly, and do not want or need a television. In contrast, those patients who are fit and able to get out of bed and walk around the hospital do not have a television facility: -

"The only television facility available to patients is down in the waiting rooms where it is cold and drafty, so this is not a suitable option".

Respondents were also annoyed about the lack of dining facilities for them and compared it to hospital Y. They felt their hospital was situated in a big enough area for them to have adequate services and patient facilities of their own. Another facility that patients felt needed to be improved was the transport service for patients. They highlighted the importance of having a comfortable journey and a good experience. They felt that the minibus was "*uncomfortable*", the driver was "*rude*" and it was "*by no means fit for patients*": -

"*I don't agree with the transport system we have either…for sick people going on a long journey…the transport, the minibus is very, very uncomfortable for patients, chairs are very uncomfortable, your knees are jammed up behind the backs of the seats… not fit for any ill patient…*"

Furthermore, it was stated that there is a lack of counselling services in the hospital for recovering alcoholics etc. One patient felt that there was very little communication between counsellors and patients in the hospital. A patient argued, "*Alcoholism is a sickness and it needs to be treated as such*".

Another respondent agreed with this and added that: -

"*There should be even a day ward here in the hospital for people like that to get counselling if they need it for addictions*".

Respondents also felt that there is a problem with parking facilities at the hospital. Respondents suggested that parking should be monitored to a greater extent as cars are always illegally parked. The smoking area is also a factor creating a negative reputation for the hospital. Respondents stated that the smoking area at the front entrance of the hospital "*is always dirty*" and should be away from the front of the hospital: -

"*…my partner came home from England a few days ago to see me and we went out to the front to have a cigarette and it was a disgrace, my partner said to me how could the hospital leave a smoking area in that state over the weekend? The bins were full all around*

the front, the whole place was stinking with ashes, and some people say that it is the patients who are going out there smoking but 90% of this is coming from the visitors…"

6.2.3 Outcomes of Positive Hospital Reputation

The question posed for this section of the discussion was as follows 'If hospital X had a positive reputation, what do you think the results would be for you? And Why?'

One definite outcome of positive reputation mentioned by the respondents was that people would have confidence and faith in the hospital, they would feel secure and know they would be looked after, thus people would not be afraid to attend or visit the hospital: -

"I think people wouldn't be afraid to visit it; there is a knock on effect there".

In addition, respondents recognised that the hospital would be in a better position to receive funding from the government, and hopefully have its facilities upgraded as a result of having a positive reputation.

However, this point was challenged by some members of the focus group, who mentioned that when the hospital has a positive reputation the outcomes may not work in the same direction as when the hospital has a negative reputation: -

"I'm not sure that that quite works the other way, it works on the downgrading but it doesn't necessarily work on the upgrading though, and it's political. It depends on what politicians are there, what politicians are in the area and what power they have".

Finally, respondents argued that a positive reputation is rarely heard about in Ireland, pointing out that it is an Irish trait to criticise and focus on negative points without a valid reason: -

"I feel very often that when something has a good reputation it does not get the credit for what it has, that people are inclined to pick out the little negative bits, and I mean, which of us is perfect? That it doesn't get the credit that we are entitled to".

"It's an Irish trait, we love to criticise things".

6.2.4 Outcomes of Negative Hospital Reputation

The following question was put to respondents 'If hospital X had a negative reputation, what do you think the results would be for you? And Why?' Following on from this question they were asked if they would 'recommend hospital X to a friend?'

Firstly, respondents were of the opinion that if the hospital had a negative reputation less people would potentially use the service as they would lose confidence and trust in the hospital and its services.

Respondents were also of the opinion that poor performance would lead to a reduction in hospital revenue and the downgrading of facilities' by the HSE.

Furthermore, respondents shared the belief that a media frenzy would be an outcome of negative hospital reputation, in evidently being a ground for everyone to air their own stories and personal grievances.

6.2.5. Summary of External Stakeholder Focus Group

To summarise the above findings from the patient/visitor focus group, a brief outline of the key findings will be offered. The main drivers of a positive hospital reputation appear to be management competence, hygiene and cleanliness and, most importantly, staff relations. The interpersonal relationship between employees and patients was perceived as being the main driver of a positive reputation. In terms of drivers of negative hospital reputation from an external perspective, the following areas were discussed: the media, staff shortages, communication and hospital facilities. The main outcomes resulting from a positive reputation were an increase in satisfaction and confidence with both the hospital and the healthcare system, and an increasing in funding for the hospital. In terms of outcomes of negative reputation, confidence and trust levels would diminish, along with the downgrading of facilities and a media outbreak.

6.3 - Qualitative Findings – Support Staff

The same questions were put to the non-clinical staff as were put to the patients/visitors regarding the main drivers/outcomes of positive reputation and the main drivers/outcomes of a negative reputation at the hospital. There was one small change in the discussion in

that, patients were asked what factors would lead them to attend the hospital, whilst employees were asked what factors influence them to work at the hospital.

6.3.1 Drivers of Positive Hospital Reputation

In summation, the contributors of a positive reputation for hospital X from the support staff perspective were believed to be the quality of staff interactions and relations, hospital improvements, location and ease of access, and patients' reactions to their experiences with the hospital.

6.3.1.1 Staff Relations

From the point of view of the support staff, staff interaction and employee relations in the workplace are a major concern when it comes to how they evaluate the hospital. Respondents felt that as an employee, having a healthy interpersonal relationship with co-workers is a definite plus, and provides help in *"getting through the working day"*. They highlighted the importance of being happy in the workplace, as they believed that if those at the frontline are unsatisfied in the workplace, this negativity might pass to patients. Basically, the support staff conveyed the notion that there is a positive relationship between the employees themselves. They feel that the working environment (at their level) is collective, and because of this, they stated that they enjoy coming into work everyday: -

"There is a good work environment and positive interactions between us".

"It is important to get on with those you work with and not to dread meeting them when you come into work. You are depending upon other people".

"Good Teamwork –we get on well with everyone and work together as a team".

Employees spoke highly regarding the relationship between themselves but appeared concerned and disappointed when it came to their relationship with management. Staff would like to see an improvement in the communication and relationship between employees and top management. They felt that this would improve the service delivery, as management would become more aware of patient needs and manage the hospital based on these needs.

6.3.1.2 Hospital Improvements

There have been many improvements at the hospital that the staff felt drive the hospital's reputation in a positive direction. Waiting times have been reduced, hygiene has been improved and as a result, the status of the hospital has improved. Respondents explained that they believe an improved status generates a considerable amount of conversation, and good remarks towards the hospital i.e. positive word of mouth amongst the public: -

"The status of the hospital has improved, and this generates a considerable amount of conversation".

6.3.1.3 Hospital Location

The location of the hospital was said to be a positive factor in terms of driving positive reputation from the support staff perspective. Support staff said that they appreciated the hospital's open and country setting; making it easy for them to access compared to most hospitals in Ireland: -

"…If you lived in Z it would be a nightmare to try and get to a hospital compared to here. It's in the open here…"

6.3.1.4 Patients Reactions and Experiences

Respondents were of the opinion that the hospital provides positive interpersonal experiences and interactions between staff and patients. Support staff believed that those in contact with patients (frontline employees) should make their experience enjoyable by being friendly and smiling at their patient: -

"Being friendly and smiling won't cost you anything. If you are not that kind of person then you are in the wrong job".

Respondents felt that the patients themselves would contribute to a positive reputation for the hospital through positive word-of-mouth: -

"The patients' and visitors' experiences affect the reputation when they go out and talk to people. However, it may only take one person to spread bad news".

According to the support staff, "the patients always seem to be happy with their experience and are always thankful". Respondents felt that providing a good service and having satisfied patients will lead to positive word of mouth and hence, positively impact the hospitals reputation: -

"They {patients} always seem to be happy with their experience and are always thankful. If this is the case they will leave and spread good word of mouth".

6.3.2 Drivers of Negative Hospital Reputation

To summarise, the support staff cited the following as being the main drivers of negative reputation: the media, politicians, staff and staff interactions, waiting lists and A&E, hospital layout, communication, training, management, and visitors.

6.3.2.1 The Media

It was also mentioned by support staff that a major driver of negative reputation is the media. Respondents stated that what you hear from the media is on average 75% negative. They feel that it is the negative stories that sell: -

"It is all-negative that you hear, "75% negative" anyway. It is the bad stories that sell. That's what the media likes".

6.3.2.2. Politicians

Support staff believed that politicians could also have a negative impact on the hospital's reputation. Respondents conveyed the point that should politicians be in an opposition party to the government, they will highlight any poor performance at the hospital. The hospital being portrayed in a negative way will lead to further downgrading of hospital facilities, impacting poorly on the overall reputation of the hospital. Support staff felt that the hospital then becomes portrayed as being second best to hospitals of similar size in Ireland: -

"Depending on if they are in Government or out, if they are in government the hospital is a great hospital, if they are in opposition to the government it's a dive and it should be done up "

6.3.2.3. Staff Relations

Respondents also felt that many of their co-workers should be more welcoming to patients/visitors who attend the hospital; this again emphasises the importance of frontline employees to the hospitals reputation. Respondents believed that being unfriendly and not smiling can give patients bad experiences and as a result, this may impact negatively on the hospital's reputation through the spread of negative word-of-mouth created by negative experiences with the hospital's staff: -

"Some staff themselves should be more welcoming. Being friendly and smiling won't cost you anything; if you are not that kind of person then you are in the wrong job".

Problems were also cited in relation to management-staff relations. It was felt that management do not engage enough with staff. This can lead to angry staff as they feel management, by not communicating with staff, do not fully know the needs of a patient. Therefore, hospital policy and guidelines are not created around real patient needs but rather what the management thinks best. Support staff felt that reputation, from their perspective, would improve if management formed a better relationship with staff: -

"Management should listen to what employees have to say about patient care, and how the hospital is run"

6.3.2.4. Waiting Lists and A&E

Waiting lists and the A&E department were other factors that support staff saw as contributors to a negative reputation. Respondents agreed that the A&E department is consistently talked about in a negative way, which rubs off onto the rest of the hospital's reputation. In addition, it was indicated by group participants that the hospital is: -

"Too small for the area and this results in people being transferred to other hospitals, leading to patient dissatisfaction"

"There is always negative talk about this and it's generally way too small".

6.3.2.5. Hospital Layout

Respondents also voiced concerns in relation to the layout of the hospital building. The hospital building is very impractical from the point of view of the support staff members. For example, the catering staff felt that they are forced to walk a long way around the hospital due to a badly planned new kitchen. Staff said that the hospital is designed without actually taking them into consideration, even though they are the ones using the building the most

"Security doors were put in three years ago, designed in a way that the security doors have to be left open now the whole time…"

"The staff work here but still get no say. For example, a new nurse's station was built facing a wall; and also it is a long walk to the canteen and new kitchen. People that use the facilities don't get a say in their design. Nurses may be unsatisfied and this may pass to patients".

"Planning etc. should be shown to all staff members... Sometimes they are but we are not told, all staff should get emails informing us that plans etc. are up and can be viewed if we wish".

The above issues create negative perceptions towards the hospital from the viewpoint of support staff.

6.3.2.6. Communication

Respondents perceived the ability of foreign clinicians to communicate with patients to be an issue for the hospital. Although foreign doctors/members of staff were praised for being well-educated and hardworking individuals, respondents continued to feel that there is a communication problem as a result of the growing population of foreign doctors working within the hospital. The foreign doctors, who often have poor English, find it a challenge to communicate with patients, and this seems to be a particular problem as regards elderly patients: -

"Older patients don't understand them. There is a large population of non-national staff and there is bad communication".

It was advised that these doctors should be fluent English speakers prior to being hired by any hospital; this is crucial for transferring medical information to a patient. The staff recommended that the management team should organise English classes for those members of staff who are challenged by the English language: -

"There should be English classes for the foreign workers. Younger people are managing ok, but older people can't deal with them and find communication difficult. A patient said to me this morning she was given instructions by a doctor and only got the last 2 words. We find we have to translate sometimes. I have nothing against them they are well-educated people. However, they are employed to deal with the general public, so they should be able to communicate. They should have working knowledge of English before they get a job here".

It was generally felt that the failure to communicate fluently with patients can lead to negative public opinion/word of mouth, and will ultimately lead to reputational damage in the long term.

6.3.2.7. Training

Training was another concern articulated by the support staff. Respondents mentioned that induction days for new members of staff are virtually unheard of in the hospital. Respondents stated that they have experienced little training development attempts on the part of the hospital's management; and some even cited their job interview turned into their first day at work. It was mutually agreed upon by support staff that should training programmes, and managerial attitudes towards training be modified, the hospital's reputation will benefit immensely as a result of being able to provide a top class service to the patient: -

"Nobody is dedicated to training, and regardless of the type of work, people need to be trained before they start. Inductions are needed. You don't get proper training; you're just left on your own. It's an ongoing problem here".

"Train staff from day one – This will improve the reputation; you will have a top-class service".

6.3.2.8 Management

Support staff suggested that they believed the hospital management would drive a negative reputation. As previously mentioned under staff relations, management tend not to ask for the staff's opinions when it is a matter of design and planning: -

"We are asked our opinion here today but when its work related we never are"

"No-one gets a say with anything here. The building looks lovely but it's not practical".

Another issue respondents had with management is that there are *"too many chiefs"* and management is *"top heavy"*. Respondents felt that there are far too many layers of management and nobody knows whom exactly they are supposed to be directing comments and concerns to. Respondents aired the opinion that management, if they want to improve the hospital's reputation, need to start listening to the needs and wants of their staff. That is the key to reputation management as far as these members of staff were concerned. According to the support staff, service delivery will not be improved or reputation will not be enhanced, unless the management team starts communicating better and listening. It was believed that management must adapt and become more approachable and open-minded to employees' concerns and suggestions, after all they are the ones that deal with the patient on a personal level. It was advised that management should base policies and procedures on what they hear from employees.

Management has the tendency to "*remain behind closed doors*" and almost "*work in silence*". Respondents believed that management must begin to communicate better with employees in order to gather a sense of what is going on around them, and cease being oblivious to the current situation. Further, it was voiced that management needs to integrate with the employees more than what they are doing, and inform staff of what is happening, and advise them of any changes in the pipeline. Moreover, respondents highlighted the importance of management-staff relations for the efficient running of the organisation and they also stated the importance of communicating policies and procedures to the reputation of the organisation. Overall, the support staff stated that management must improve communication with staff if it is to begin a reputation management strategy: -

"Staff should be listened to at all levels. Management should listen to what is said at these focus groups. If they keep doing their own thing, things wont be improved. Management should integrate and mix with the staff, there is a suggestion box but people aren't always aware of where it is and if it's ever looked at. Management should be more approachable, even for one hour a month they should make themselves available for example in the canteen. They should talk to all departments and find out what's going on and not stay behind closed doors; or even have a representative that would go back and fill her in".

In addition, management was criticised for setting themselves too many unrealistic goals: -

"Have fewer goals and implement them rather than a big list of long-term plans, timetables, and goals. There is always room for improvement in terms of the reputation".

6.3.2.9. Visitors
A further factor that irritated support staff was that visitors can be so demanding, sometimes even more so than the patients themselves: -

"The demands of visitors, they demand as much as patients".

Furthermore, it was stated that visitors tend not to comply with the hospital's visiting times, again stressing the importance of rules and procedures.

6.3.3 Outcomes of Positive Hospital Reputation
Once again the same questions that were put to patients/visitors for this section were also applied to the non-clinical staff regarding their opinion of the results for the hospital if it possessed a positive or negative reputation.

Overall, respondents believed that in the event of a positive reputation, the following would be the outcomes for the hospital: proud to be associated with the hospital, staff would like telling people where they work, feeling of being associated with a winner and a success story, expansion of the hospital and its facilities, positive perceptions being formed by the public of the hospital resulting in a high level of support for the hospital, and staff would take pride in their place of work. Respondents stated that they could also see the community holding enhanced perceptions of the hospital: -

"Good perceptions of the hospital, the community are passionate about the hospital and raise a lot of money for it. Collections are always supported".

Respondents confirmed that a positive reputation for the hospital "would drive them to do everything in their power" to prevent the hospital from gaining a negative reputation. They would also take pride in their place of work: -

"Audits are coming out on hygiene etc., you don't want to be at the bottom. We take pride in our place of work and wouldn't like to hear bad things being said".

6.3.4 Outcomes of Negative Hospital Reputation

Should the hospital have a negative reputation, respondents felt they would be ashamed to say they work there, opt to change jobs and they would not want to be associated with it. Respondents agreed that any association with the hospital would be denied should it have a negative reputation in the eyes of the wider community: -

"If the hospital did have bad press, I wouldn't want to be associated with it".

The participants indicated that they would also feel personally responsible for the hospital's negative reputation, and as a result their job performance may be affected: -

"I would not want to be associated with it – you would think you are part of the bad reputation. You would feel responsible and it may affect your job performance".

Further, respondents believed that as the hospital is a place where patients often spend their final days, it would not be nice for those patients if the hospital had a positive reputation: -

"Vulnerable clients are here, some may not have long to live and you don't want the place to have a bad reputation, you would feel bad".

6.3.5 Summary of Support Staff Focus Groups

From the perspective of internal support employees, the main drivers of a positive hospital reputation appear to be employee benefits, hospital improvements, working environment,

staff relations and word of mouth through patients. Word of mouth is of particular importance; it reinforces the need for high quality care and positive interactions between frontline employees and external stakeholders. In terms of drivers of negative hospital reputation, the media was again discussed, along with politicians, staff shortages, communication, staff training, hospital layout and waiting lists. The main outcomes resulting from a positive reputation were; upgrading of facilities and association with the hospital, while the outcomes of a negative reputation were staff opting to change jobs, dissociation with the hospital and poor job performance.

6.4 - Qualitative Findings – Clinical Staff

Once again, to reveal the main positive/negative drivers of the hospitals reputation the same questions were put to clinical staff respondents as were to patients/visitors and non-clinical staff. Respondents were asked what factors they felt would affect the hospital possessing a positive or negative reputation, what factors would lead them to talk positively or negatively about the hospital, and what factors influence them to work at the hospital (Appendix B).

6.4.1 Drivers of Positive Hospital Reputation

Overall, the drivers of positive hospital reputation, from the perspective of clinicians included: a good work environment with plenty of support structures in place, respect and interaction with co-workers, and work related benefits such as family friendly hours.

6.4.1.1 Hospital Working Environment

Clinicians expressed that a lot of hospital work environments are similar in terms of what employees do professionally. Overall, respondents felt that there is certain factors that make them feel positive about their workplace, which extends beyond the professional aspect of their work as a clinician. The clinicians referred to the social aspects of the working environment, such as a nice canteen facility where they can sit down and chat with colleagues, and "not be a doctor". The key thing mentioned here was that they desired social interaction with their colleagues; and the hospital support structures need to allow this to happen. Clinicians said that this is what shapes their impressions of the hospital. Respondents felt that those support structures are "what make one's day nice", and that is why these staff members said they like to work at the hospital: -

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"It's social, good social interaction, there is support and then you can do your work nice as well".

6.4.1.2 Staff Relations

Respondents felt the respect they get from co-workers leads them to feel positively about the hospital. They stated, "It is the way that you are treated by other members of staff and your employers". Furthermore, respondents stated that if you are treated well by you co-workers then you will prefer going to work: -

"The respect you get from your co-workers, the way you are treated by your employers and other members of staff. For example, if they treat you well and respect you, you will prefer going to work than if you are not treated well".

Another factor mentioned by the group related to teamwork; clinicians said that they appreciate a well-staffed team that allows their heavy workload to be covered from every angle, and that then allows them to do their work properly: -

"Like I said earlier, for me personally it's, what is important to me is the team work that you are going to work with, a well staffed team that is covering the workload so you can enjoy your work and do your work properly; I like when I have patients that are divided into a small enough groups so you can care for them properly and devote proper time. It's not nice when, I don't like a situation where you're sort of spreading; spread your butter so thin that you are sort of only doing a little bit here and there".

Clinical staff highlighted the importance of caring for the patient and meeting their needs. If they can do this properly their perceptions of the hospital will improve. Respondents felt that they have a sense of responsibility to the patient: -

"I like when I have patients that are divided into small enough groups so you can care for them properly and devote proper time"

"Providing a proper fashion, in a timely fashion to patients, is where you get your reputation and it's very simple. Ok maybe I'm being a bit simplistic but that's at least how it should be done".

6.4.1.3. Employee Benefits

According to clinical staff, there are several work benefits that leads them to think positively about the hospital, and thus leading to a good overall reputation. Firstly, respondents stated that they are grateful that the hospital is sociable, has good dining room facilities, and family friendly hours. They also said that they appreciate its easily accessible location, and the fact that they are in a secure job: -

"... There are many positives in the non-work side of things, a good place of recreation, and a good canteen where doctors can sit and talk and have tea or, with the nurses or whoever, with everybody, just all the different departments. If you have places where you're not just a doctor, where you can interact properly that's a good thing for the staff. So I would say a well staffed, organised team and you're your sort of structures around that, your nice canteen, your nice doctors' rooms or nurses' rooms or whatever you want to call them. These are your support structure".

"The hours are family friendly hours so you are able take flexi-time and parental leave; you know that's important to me".

6.4.2 Drivers of Negative Hospital Reputation

From a clinician perspective, the main drivers of negative hospital reputation related to: poor public opinion and the media, a lack of both human and physical resources, poor communication and a lack of transparency, management, and an absence of employee contracts leading to increased feelings of job insecurity.

6.4.2.1. Media Influence and Public Opinion

It was widely agreed upon that the media poses a significant threat to the hospital, often giving it a negative reputation. It was mentioned that there is one local newspaper in particular that is actively hostile towards the hospital and constantly attacks it: -

"The press gives it a negative reputation; one local paper in particular is actively hostile towards the hospital and absolutely slates it".

6.4.2.2 Hospital Resources

The understaffing, and the impact this has on patients, would drive respondents to talk negatively about the hospital. Respondents stated that the hospital is currently under staffed, and the patient is the last thing management thinks about. Respondents revealed that the hospital's management often wouldn't find replacement staff to cover leave and holidays. Furthermore, it was stated that if they are going on leave, the management's answer is "cancel clinics". Respondents highlighted the importance of patient needs to them and stressed that it should also be management priority. Some staff felt very strongly about this issue and felt that management would prefer the hospital to be quite, and cost less to run, rather than look after the sick and elderly. This should not be the situation in a public organisation: -

"If the hospital is understaffed we are put under more pressure and as individuals we are not acknowledged, this really drives me down".

Other members of the group stated that they felt that the patient is being forgotten about; business plans and cost analysis are taking over the ultimate objective of satisfying customer needs. Respondents stated that a public service does not have the ultimate objective of making a profit, rather it is there to serve the community and it is important that management are aware of this; -

"It is very sad when the day has come when a hospitals management and the HSE forgets about the patient, the single most important reason for the very existence of the HSE and public hospitals in the first place"

"I believe that the only business plan that will ever drive the hospitals reputation will be only by satisfying patients. Now, that is the ultimate plan and not some profit making business plan designed to only cater for profitable patients and ignoring many other patients in the country. The only way to help the hospitals reputation is by satisfying patients..."

In certain areas of the hospital, respondents felt the hospital remains behind other equivalent hospitals in terms of what staffing they have: -

"I'm afraid, whatever parameter you want to look at we are in the lower end in terms of resources, be that human resources or physical resources we are in the lower end, all the time, consistently".

Respondents expressed the view that the hospital's management is becoming overly concerned with the profits and costs associated with delivering a health service to the end user – the patients. Respondents conveyed the importance of having policies and procedures based around the patient: -

"These frail and elderly patients do not fit into a business plan, because as far as the hospital is concerned, and the H.S.E. is concerned, these types of patients do not make a profit for the hospital".

It was believed that in comparison to other hospitals in the region, the hospital tends to compare badly when it is a matter of having enough resources. It was expressed that there is a lack of ability to develop as a hospital, due to the lack of resources. Respondents further stated that the hospital, due to its poor reputation for research and development, is not being upgraded by Mary Harney and the H.S.E. It was stated that they could actually see the need for a service development and the hospital has willing people to do it, but respondents said that there is not sufficient resources in place to actually enable it. Staff felt frustrated as a direct result: -

"You know, it's not being upgraded, where you actually see the need for a service development and you have willing people to do it but you don't have the resources in place to actually enable it".

It was pointed out that the hospital is poorer in terms of resources when compared to equivalent hospitals. According to clinicians, the hospital is disadvantaged in both physical and human resources. For example, it was pointed out that there was not sufficient cover in place to accommodate staff leave and absence: -

"I think that right across the board the hospital is poorer in terms of resources. I mean this is not a sort of subjective rant, whatever objective parameter you want to look at, the hospital is disadvantaged…"

Respondents felt that they are being penalised by management for being efficient, and that was cited as being the most frustrating thing about working in the health service in general, but in this hospital in particular: -

"We are penalised for this, you know, we are being penalised for being efficient and that is the most frustrating thing about working in the health service in general, but in this hospital in particular".

6.4.2.3 Communication

Communication between staff and management was described as appalling and a major driver of negative reputation*: -*

"It's nothing short of appalling, it is discourteous and it's rude. I would have no hesitation in saying that and all of my colleagues would feel the same".

It was stated that there is communication sent from management down through the hospital; however, the staff feel that they don't always get the real story: -

"There is communication downwards but we don't always get the real… That's why I said sometimes it is a mysterious person when we were describing it as a person, sometimes it's mysterious and you are trying to figure it out and you can't quite figure it out and then when you figure it out in your head it may not necessarily be right".

Respondents deemed that one tends to find out what is happening in the hospital in their local newspaper rather than finding it out directly from management. It was stated that the management team does not really come down and talk to the staff. Hence, it was thought that further communication is needed between the management and the staff: -

"You find out things in your local newspapers about what's happening in your hospital".

In terms of communication, it was noted that transparency would go a long way; if a request goes up to management, it must be seen to go up, it must be seen to be registered, and then what is being done must be seen to come back down to the staff. Respondents agreed that if they can see that a request or a concern has been acknowledged, then if the General Manager may be having difficulties in doing something about it, the staff can then appreciate the difficulty: -

"From the point of view of communication, I think transparency would go a long way, in terms of like a request goes up it must be seen to go up, it must be seen to be registered, and then what's been done must be seen to come back down, so that if that's visible then if she may be having difficulties to do something we have to see that to understand her difficulty, so a greater transparency in communication would go a long way".

Respondents conveyed the notion that for them, one of the greatest faults with the hospital relates to the way the hospital is run: -

"I think one of the great criticisms of the way a hospital is run as well is that everything gets managed in silence, and as professionals we all kind of work in our own little silo like nursing, medics, dieticians or whatever, but the General Management function is really supposed to kind of pull us all together…"

6.4.2.4 Hospital Management

Previously, hospital management has been mentioned as a contributor to negative perceptions towards the hospital. The hospital's management was described as *"rude", "stupid", "ignorant"* and their style was called *"management by ignoring".* It was stated that there are *"far too many layers of management"* in the hospital and *"nobody knows whether they are coming or going".* There was also the belief that management is failing to engage on a personal level with the hospital's employees, and further there is the perception of an uncoordinated management team.

6.4.2.5 Employee Contracts and Future Direction

Another issue leading to the clinicians' poor perception of the hospital was the absence of employee contracts. This was causing them to question their future at the hospital, and initiating a certain feeling of insecurity about the future: -

"Your future in the hospital… I came to the hospital; I don't know if it is across all domains, I just qualified this year and there are no contracts, you are not guaranteed work every year. You may not have work some weeks, like if somebody doesn't go on annual leave like, you mightn't have work that week, you know, and that's ok when your are maybe 21 or 22 like, but if this was to go on until maybe when you are 27 or 28 I would need to know that I would have work next week or that I will have work after Christmas…So am, I could end up in a restaurant after being in college for four years you know".

6.4.3 Outcomes of Positive Hospital Reputation

Finally, the same questions were applied to clinical staff as were to the rest of the respondents. Another small difference existed in the questions put to patients and staff; patients were the asked would they recommend the hospital to a friend, whilst staff were asked if they were pleased to be associated with the hospital.

When asked about the outcomes of positive reputation, respondents felt they would be proud to work at the hospital, committed to their job, motivated to work, enjoy work and pleased to be associated with the hospital. Many things could be a lot better they felt, but overall they were mostly pleased to be associated with the hospital: -

"You'd be proud to work here"
"Committed to your job"
"Motivated"
"You wouldn't mind coming to work; you would enjoy your work"
"Pleased to be associated with the hospital if it had a positive reputation"

6.4.4. Outcomes of Negative Hospital Reputation

When asked about the outcomes of negative reputation, responses resembled those provided by the support staff. One outcome of negative reputation was believed to be a complete act of disassociation with the hospital: -
"We would not be telling people that we work here, disassociation with the hospital definitely. We would just do our bit and go home".

Respondents also felt it would reflect on them personally, especially if this negative reputation was portrayed in the media: -

"*Yeah it would be personal to me, you would feel it personally*".

That said respondents felt that a negative reputation would not necessarily reduce the number of patients attending the hospital. The reason for this was attributed to people not having a huge choice when it comes to public hospitals: -

"Patients simply do not have any choice whether or not to attend the hospital as it is the only acute hospital in the region": -

"*Could I just add to that, if we were a supermarket or if we were a restaurant, and if we got the slating's we did, we'd probably go out of business. However, because we are a healthcare institution, we are the only acute hospital in the region, people have no choice, and they have to keep coming here. Public patients have to come in here, so whether we have a bad reputation or not, people don't have any choice in coming here. Private patients do, maybe they can go elsewhere. This is the only acute hospital in the area, so if you are involved in a RTA ten miles out the road, you are not going to be brought to hospital Y just because you are a little bit dubious about hospital X. If you had another public hospital here and they had a bad reputation then patients might prefer to come here, then you would have competition. Personally, I don't think it's a major factor because the majority of people in this area don't have any choice, they have to come here*".

6.4.5 Summary of Clinical Staff Focus Groups

The key drivers of hospital reputation were discussed. The main drivers of a positive hospital reputation, from a clinical staff perspective, appear to be the following; employee benefits, hospital location, working environment, staff relations and job security. In terms of drivers of negative hospital reputation, communication was again discussed, along with understaffing. Understaffing was a major problem for clinical staff, due to the reality that the patient does not get enough time devoted to their needs. Clinical staff reinforced that patient needs is their number one priority. They want them to be cared for properly and they also want to have enough time to interact with the patient and ensure they have a positive experience at the hospital. Subsequently, the outcomes of hospital reputation were examined. The main outcomes resulting from a positive reputation were association with

the hospital, increased motivation toward their job and more commitment to the hospital. In terms of the outcomes of negative reputation, clinical staff said they would simply want to be disassociated with the hospital, as they would feel they are to blame for the negative reputation.

6.4.6 Comparing Findings across the Focus Groups

Some issues arose consistently throughout all three focus groups. All respondents agreed that the patient had to be centre stage in terms of both the departments in the hospital and from a managerial priority perspective. Communication was seen as lacking transparency; requests and concerns regarding issues affecting patients are often submitted to management without any feedback, for example. From a resource perspective, internal stakeholders are becoming increasingly frustrated at the hospital due to their perceived lack of staff and resources to devote sufficient care and attention to patients. From an external perspective, patients felt that staff are overworked due to a scarcity of human resources, thus there is a lack of sufficient time available to care for patients and satisfy their needs. The impact that these issues have on both internal and external stakeholder satisfaction was an important concern and discussions around satisfaction emerged from all three focus groups. Satisfaction was seen as mainly internal and external stakeholders positive experiences with the hospital, with a special focus on increasing satisfaction in relation to the service provided to external stakeholders.

6.5 – Conclusion

The above qualitative findings closely mirror an allied theoretical concept in the marketing literature, CO, or "a predisposition to meet customer needs in an on the job context" (Brown et al., 2002). In the qualitative study, the patient and their interactions with staff at all levels of the hospital, was the critical concern, especially in terms of how such experiences at the hospital and interactions with staff promote satisfaction and enhanced reputation. Furthermore, the relationships between this important construct and how it affects internal and external stakeholder views of an organisation, and how such views can promote satisfaction has not been previously investigated in any

published work. On this basis therefore, the second phase to the empirical work examines these relationships using a large-scale quantitative study.

~ Chapter 7 ~

DATA ANALYSIS: QUANTITATIVE FINDINGS

7.1 – Introduction

The purpose of this chapter is to present the findings from the second phase of the primary research undertaken for this study. In order to obtain the subsequent findings, this study administered two survey types, one with patients/visitors, and another with all levels of staff working within the hospital. A breakdown of the responses from the quantitative research collection will firstly be presented, followed by preliminary findings aided by the use of spider diagrams. Subsequently, initial quantitative data analysis is outlined i.e. descriptive statistics by use of means and standard deviations. Finally, the findings related to hypotheses testing of this study are presented.

7.2 - Breakdown of Sample Profiles

For the first stage of this research study, the qualitative research, there were 32 participants in the three focus groups. The breakdown being 8 patients, 12 support staff and 12 clinical staff. For the follow up stage, the quantitative study, 650 surveys were distributed with a total of 502 fully completed and useable surveys, a total response rate of 77.2%.

7.2.1 Breakdown of Sample Profiles – Employees (Quantitative)

Several frequencies were calculated in SPSS in order to identify the characteristics of respondents within this study. Analysis of the employee database displayed a high percentage of female employees in the sample, 87.7% of employee respondents were female whilst only 12.3% were males (Figure 7.1). Figures are in line with those stated by management at Hospital X, which exemplify that the larger percentage of employees is indeed female.

Figure 7.1: Gender of Employee Respondents
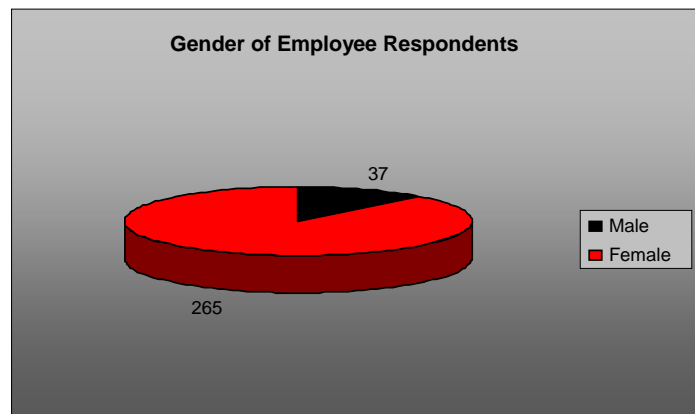
Analysis was also run to highlight the age category the majority of employees fell under. It was found that 33.4% of staff were in the age group of 35-44, followed by 29.5% in the 25-34 age category. The ensuing analysis was on the length of service to the hospital, 25.8% of staff were working at the hospital between 1-5 years followed by 24.5% working their 5-10 years. Respondents were also asked their occupation at the hospital; results are in line with hospital records, the majority of respondents were nurses (41.1%) followed by administration and clerical officers (20.5%).

7.2.2 Breakdown of Sample Profiles – Patients/Visitors (Quantitative)

Analysis of patient/visitor respondents displayed the following characteristics; 38.5% of respondents were male and 61.5% of respondents' female. In terms of the age of respondents, analysis illustrates 25% of respondents were in the age group of 25-34, followed by 17.5% being 45-54 and 14.5% being 55-64. The aim was to obtain responses from 50% patients and 50% visitors/relative, by running a frequency analysis it was highlighted that the target was met, 22% of respondents were inpatients, 29% were outpatients and 49% were visitors/relatives.

Figure 7.2: Patient Respondent Types
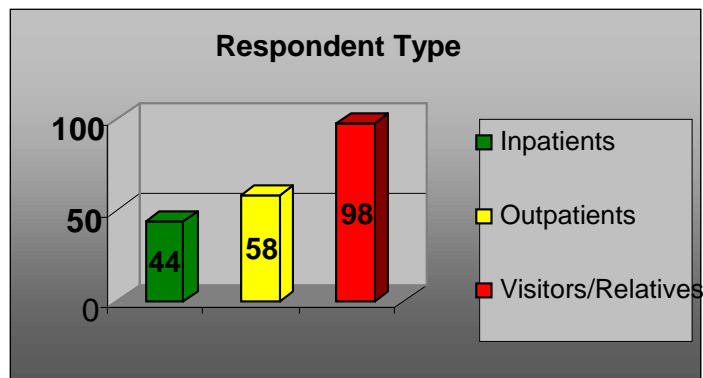
Respondent Type

Respondents were also asked the number of times they attended the hospital in the last three years (Figure 7.3); 35.5% of respondents attended the hospital once or twice in the past three years (35.5%), followed by three or four times (21%). The top three reasons for attending hospital X as an inpatient were maternity (15%), personal accident (5.5%) and chest problems (5%).

Figure 7.3: Patient attendances in the past 3 years at hospital X

Patient Attendance
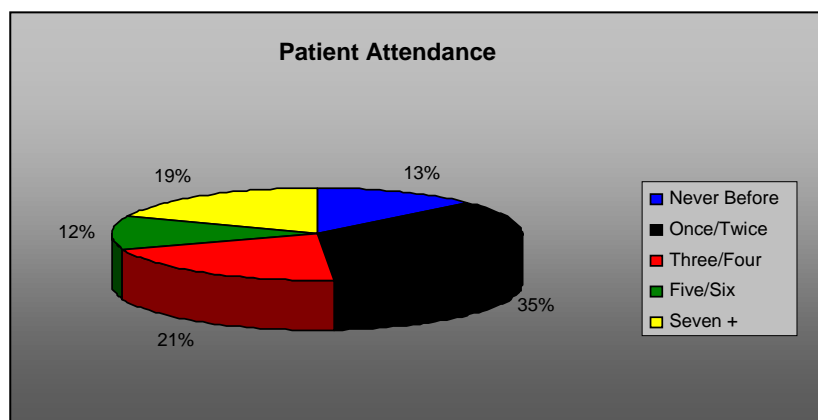
Respondents were also asked if they had been an inpatient in the past, 62.5% answered 'yes' and 37.5% had not previously been an inpatient at the hospital. Respondents that replied 'yes' were asked the purpose of their visit; 15% of respondents attended for maternity, followed by 5.5% for a personal accident, followed by 5% for chest problems.

7.3 - Descriptive Statistics

As discussed in the methodology chapter, the most common forms of descriptive statistics are the mean and standard deviation. The mean is conducted to exhibit an average score; the standard deviation is conducted to measure dispersion. Dispersion highlights the amount of variation shown by a distribution; the deviation reflects the degree to which the values in a distribution differ from the arithmetic mean (Bryman and Cramer, 2005). Before analysis is conducted, the reliability of the scales used must be tested and results are presented. Subsequently, descriptive statistics for the patient/visitor database will be outlined, followed by the employee database.

7.3.1 Reliability of the Corporate Character Scale and Customer Orientation Scales

Before commencing the preliminary analysis, the reliability of the scale items is tested. According to Davies et al. (2003), reliability is concerned with how coherent a scale is. A perfectly coherent scale will have a Cronbach's alpha score of 1, however an acceptable score is 0.7 or above. The main dimensions of the Corporate Character Scale, consisting of a total of 40 items, produced a Cronbach's alpha score of 0.895. In addition, to ensure the reliability of the scale, the reliability coefficient of each dimension was calculated. Each dimension was greater than the recommended score of 0.7 as follows: agreeableness (0.961), competence (0.909), enterprise (0.941), machismo (0.872) and ruthless (0.955). In order to measure ECO, Brown et al's (2002) measures of the need and enjoyment dimensions are assessed. These scales were originally developed for customers and are therefore slightly altered for the context of the public healthcare sector. As a result the wording in the scales is slightly changed from 'customers' to 'patients'. To ensure the scale still remains reliable, reliability analysis is conducted through SPSS. For the individual measure of customer orientation (ECO) there was a slight difference in the Cronbach's alpha score produced from the employee database to that produced from the patient/visitor database. This may be due to the difference in wording in the surveys, for example employees were asked to rate 'I find it easy to smile at patients', whereas patients/visitors were asked to rate 'Staff find it easy to smile at patients'. Considering the employee database, ECO produced a Cronbach's alpha score of 0.893. Considering the patient database, ECO produced a slightly higher Cronbach's alpha score of 0.928. Both tests produced a score above the required level of 0.7. The OCO scale produced a score of 0.918

from both databases, demonstrating the scale to be reliable as it is also above the required level of 0.7.

7.3.2 Corporate Character Dimensions – Patients/Visitors

This section will focus on the main questions and scales in the survey instrument (summary of findings Table 7.1). The first and one of the most important sections within the survey is the scales for the CBP dimensions, each dimension is made up of a number of traits but for the simplicity of analysis the traits are computed into one variable. Each variable was measured using a seven point likert scale, ranging from strongly disagree=1 to strongly agree=7. The scales rated patients/visitors views on the corporate personality of the organisation i.e. the human traits they perceive the organisation to have. Competence had the greatest mean at a score of 5.25, with a standard deviation of 1.16, followed by agreeable with a mean of 5.18 and a standard deviation of 1.23, enterprise had a mean of 3.83 and a standard deviation of 1.45, machismo was next with a mean of 3.33 and a standard deviation of 1.43, ruthless had the lowest mean of 2.72 and a standard deviation of 1.55. Competence had the lowest standard deviation which illustrates most responses were close to the mean value, on the other hand ruthless had the largest standard deviation illustrating that the responses were furthest from the mean.

Figure 7.4: Corporate Character Dimensions – Means
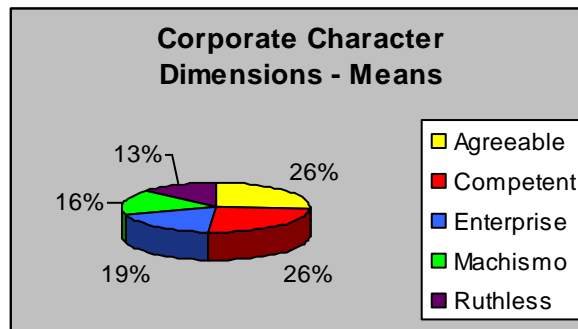
Figure 7.5: Corporate Character Dimensions – Standard Deviations
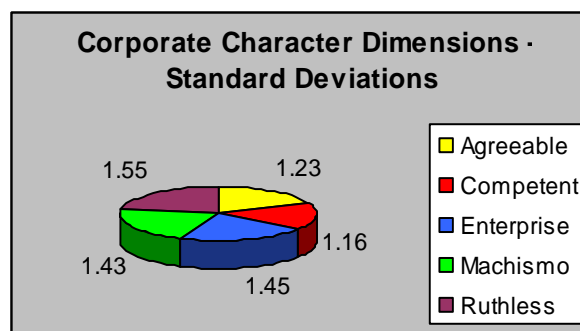
7.3.3 Satisfaction – Patients/Visitors

Satisfaction was also computed into one overall variable, it was made up of four questions: I would recommend X to a friend or colleague, I am pleased to be associated with X, I feel an affinity with X and a rating of the respondents overall satisfaction. All items were on a 5-point likert scale, 1 being the negative and 5 being the positive. The overall mean for satisfaction was fairly positive at 3.68 and a low standard deviation of 0.879.

7.3.4 Customer Orientation – Patients/Visitors

ECO was rated more highly than OCO. Both were also measured on a 5-point likert scale. The mean for ECO was 3.91, the mean for OCO being 3.35, standard deviations being 0.699 and 0.791 respectively.

Table 7.1: Means and Standard Deviations: Patients/Visitors

Measure	N	Mean	Standard Deviation
CBP – Agreeable	200	5.18	1.23
CBP – Competence	200	5.25	1.16
CBP – Enterprise	200	3.83	1.45
CBP – Machismo	200	2.72	1.55
CBP – Ruthless	200	3.33	1.43
Satisfaction	196	3.68	0.88
ECO	193	3.91	0.70
OCO	193	3.35	0.79

7.3.5 Corporate Character Dimensions – Employees

A summary of the findings from the subsequent sections is displayed in Table 7.2. Once again the first and one of the most important sections within the employee survey is the scales for the CBP dimensions, the layout is the same as that in the patient's survey; each dimension is made up of a number of traits but for the simplicity of analysis the traits are computed into one variable. Each variable was measured using a seven point likert scale, ranging from strongly disagree=1 to strongly agree=7. The scales rated employee's views on the corporate personality of the organisation i.e. the human traits they perceive the organisation to have. Competence again had the greatest mean at a score of 4.73, with a standard deviation of 1.15, agreeable was next with a mean of 4.54 and a standard

deviation of 1.28, machismo had a mean of 3.90 and a standard deviation of 7.78 which was extremely high and showed a large variance in answers, ruthless was next with a mean of 3.58 and a standard deviation of 1.52, enterprise had the lowest mean of 3.51 and a standard deviation of 1.20. Competence, once again had the lowest standard deviation, which illustrates most responses, were close to the mean value, on the other hand machismo had the largest standard deviation illustrating that the responses were furthest from the mean.

Figure 7.6: Corporate Character Dimensions – Means
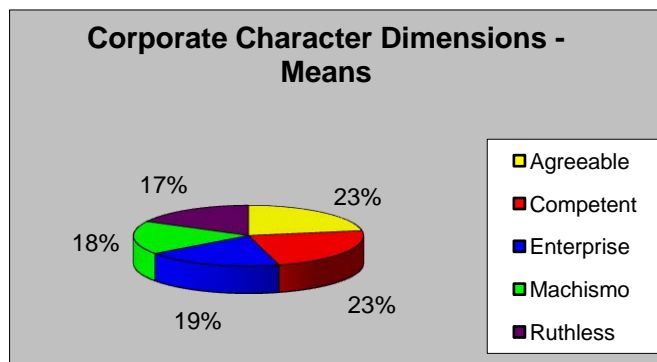
Figure 7.7: Corporate Character Dimensions – Standard Deviations
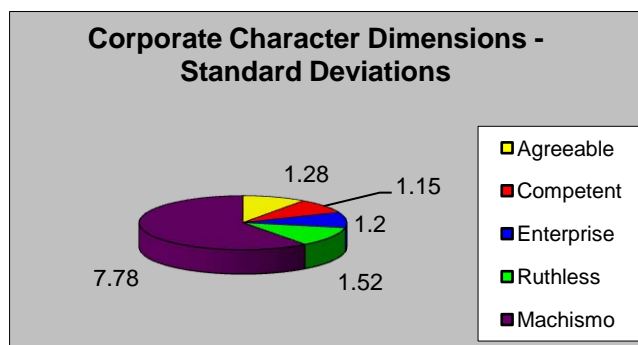
7.3.6 Satisfaction - Employees

Satisfaction was also computed into one overall variable, it was made up of four questions: I feel that I am associated with a winner at X, I would recommend X to a friend or colleague as a good employer or hospital, I feel an affinity with X and a rating of the respondents overall satisfaction. All items were on a 5-point likert scale, 1 being the negative and 5 being the positive. The overall mean for satisfaction was fairly positive at 3.45 and a standard deviation of 1, which was relatively high.

7.3.7 Customer Orientation - Employees

ECO was rated much more highly by employees than OCO. Both were also measured on a 5-point likert scale. The mean for ECO was 4.45, the mean for OCO being 3.42, standard deviations being quite dispersed at 4.20 and 5.76 respectively, showing quite a variance in respondents answers.

Table 7.2: Means and Standard Deviations: Employees

Measure	N	Mean	Standard Deviation
CBP – Agreeable	302	4.54	1.28
CBP – Competence	302	4.73	1.15
CBP – Enterprise	302	3.51	1.20
CBP – Machismo	302	3.58	7.78
CBP – Ruthless	302	3.70	1.52
Satisfaction	300	3.45	3.45
ECO	302	4.46	4.46
OCO	302	3.42	3.43

7.3.8 Factor Analysis

As previously mentioned, factor analysis was conducted to allow the researcher to examine each variable of each scale separately rather than as one. It allows the researcher to simplify complex data by finding the minimum number of dimensions that can be used to describe them, it also allows the researcher to identify the items which do not fit the summary variables and which should be discarded (Sapsford and Jupp, 1996).

The measures for ECO, OCO and the corporate personality scale were all recognised measures adapted from theory; therefore the researcher hoped that no variables would have to be discarded. Results from conducting factor analysis in the patient/visitor database demonstrate communalities after extraction above 0.5 as recommended by Field (2005, b) for the following variables; agreeableness, competence, enterprise, machismo, ruthless, OCO and satisfaction. A communality score of 0.5 suggests that 50% of the variance associated with the question is common or shared variance. For the ECO dimension, communality was slightly below 0.5 at .471 and two components were extracted, these results were demonstrated from the component matrix output table (Table 7.3). As a result,

varimax rotation was conducted; items were then loaded onto the second component, as the values were higher.

Table 7.3: Component Transformation Matrix – ECO (patients/visitors)

Component	1	2
1	.766	.643
2	-.643	.766

Factor analysis results from the employee database demonstrate communalities above 0.5 (Field, 2005b) for all variables (Table 7.4). For ECO and machismo the component matrix identified two components were extracted (Table 7.5). As a result varimax rotation was run, items from both variables loaded onto the second component.

Table 7.4: Component Transformation Matrix – ECO (employees)

Component	1	2
1	.726	.688
2	-.688	.726

Table 7.5: Component Transformation Matrix – Machismo (employees)

Component	1	2
1	.735	.678
2	-.678	.735

7.4 - Preliminary Quantitative Data Analysis

The dimensions of corporate character held by the hospital from the perspectives of both patients and employees will be presented by use of radar (spider) diagrams. Davies et al. (2003) state these diagrams are the most effective way of displaying such findings. Preliminary analysis will also be conducted to highlight the level of both (ECO) and (OCO) present in the hospital from the viewpoint of both patients and employees

7.4.1 The Corporate Character Scale

In order to display these findings the researcher, through SPSS, computed an average mean for each dimension, each item of each dimension is presented individually in the databases. However, one code was created for each dimension consisting of all the items relating to that dimension i.e. instead of measuring cheerful, pleasant etc. individually, all items were grouped together as one i.e. agreeableness.

In terms of the corporate character scale and employee responses (Figure 7.8), the mean of each corporate brand dimension (CBP) was computed. Competence (4.73) was found to be the strongest dimension, followed by agreeableness (4.54), machismo (3.89), ruthlessness (3.58) and finally enterprise (3.51). The mean was calculated by running descriptive statistics. Results outline that internal stakeholders view the organisation as being highly competent and agreeable, slightly machismo and ruthless and least of all enterprising.

Figure 7.8 - Perceptions of Corporate Character – Employees
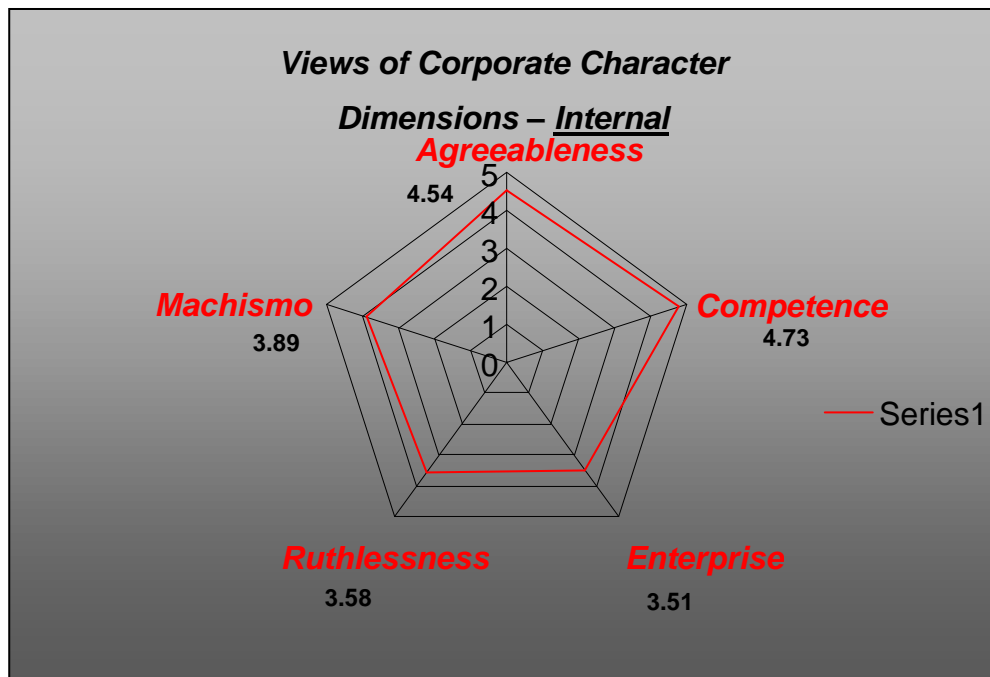
In terms of the patients (Figure 7.9), competence was also found to be the strongest dimension with a mean of (5.25), followed by agreeableness (5.18), enterprise (3.83), machismo (3.32) and ruthlessness (2.72). Results display that external stakeholders viewed the organisation as being highly competent and agreeable, only slightly enterprising and machismo and least of all ruthless, slightly similar results to that of employees.

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Figure 7.9 - Perceptions of Corporate Character – Patients/Visitors
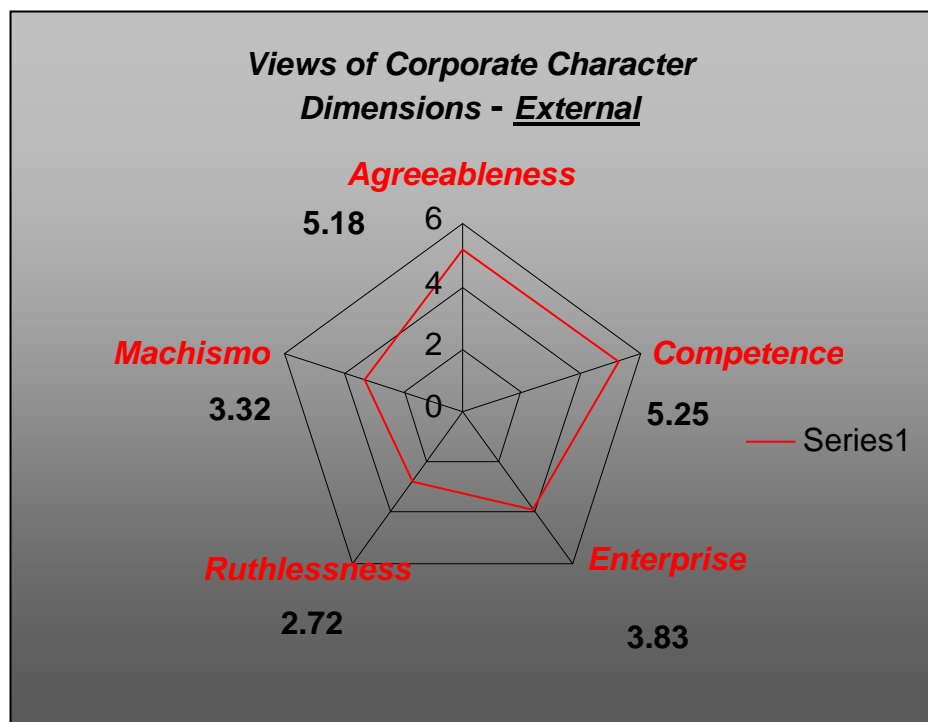
7.4.2 Customer Orientation and Satisfaction

A preliminary analysis of CO was also conducted. Through SPSS, an overall mean for ECO and OCO was computed from the viewpoint of both stakeholder groups. From an employee's perspective, employees were perceived to be more customer orientated than management and the firm. Results found ECO (Table 7.6) displaying a mean of 4.46 and OCO displaying a lower mean of 3.43.

Table 7.6 - Employee Perceptions of Customer Orientation

Level of Customer Orientation	Mean
Employee	4.46*
Organisational	3.43

In terms of external stakeholders views of CO results were similar. Patients perceived employees as being more customer orientated than the organisation/management. In the patient/visitor database ECO (Table 7.7) displayed a mean of 3.91, followed by OCO with a mean of 3.35.

Table 7.7 - Patient Perceptions of Customer Orientation

Level of Customer Orientation	Mean
Employee	3.91*
Organisational	3.35

7.5 - Testing of the Study Hypotheses

The main purpose of this empirical study is to test the hypotheses outlined in Chapters Four and Five. The following are the four main hypotheses developed for this study:

- The higher the perceived ECO, the higher the satisfaction for organisations internal and external stakeholders will be.

- The relationship between perceived ECO and internal and external stakeholder satisfaction is mediated by OCO.

- Corporate brand personality (CBP) mediates the relationship between ECO as perceived by customers, and customer satisfaction.

- Corporate brand personality (CBP) mediates the relationship between ECO as perceived by employees, and employee satisfaction.

Correlation and regression analysis was conducted in order to measure the relationships between variables. Hypothesis one was measured using the Pearson correlation co-efficient, this simply measures the linear association between two metric variables (Hair et al., 1998), in this case the two variables were ECO and satisfaction. ECO consists of the measurement items from Brown et al. (2002). Satisfaction is made up of the following items; I am proud to be associated with X, I would recommend X to a friend or colleague, I feel an affinity with X and My overall satisfaction with X. For all four hypotheses a separate analysis was conducted for internal and external stakeholders.

7.5.1 Hypotheses One (patients/visitors): *The higher the perceived employee customer orientation (ECO), the higher the satisfaction for an organisation's internal and external stakeholders will be*

Analysis began on the patient/visitor views on ECO and satisfaction, correlation analysis was used to determine if there was a link between ECO and patient satisfaction. Results indicate a significant link between the two variables (Table 7.8). The Pearson correlation coefficient indicates a strong and statistically significant relationship (p<0.01). Pearson's correlation coefficient produced a value of 0.593**. There is also a 0.01 value present at the two-tailed level of significance, indicating a 99% confidence level in the result. The link suggests that a high level of ECO increases the probability of high patient satisfaction from the perspective of patients/visitors; thus, H1 is strongly supported for external stakeholders of hospital X.

Table 7.8: Hypotheses One – Patient/Visitors

		ECO	Satisfaction
Employee Customer Orientation	Pearson Correlation	1	.593(**)
	Sig. (2-tailed)		.000
	N	193	191
Satisfaction	Pearson Correlation	.593(**)	1
	Sig. (2-tailed)	.000	
	N	191	196

** Correlation is significant at the 0.01 level (2-tailed).

7.5.2 Hypotheses One (Employees):

The next step was to run the same analysis but this time for the employees of the hospital. The relationship between ECO and employee satisfaction was not as strong as it was for patients and the results produced by SPSS were not significant (Table 7.9). A Pearson correlation value of (p<0.01) was produced; however it was not significant (0.061). This result indicates that employees do not see the level of CO they possess having a link to or affecting their level of satisfaction, thus hypothesis one is not supported for internal stakeholders.

Table 7.9: Hypotheses One – Employees

		ECO	Satisfaction
Employee Customer Orientation	Pearson Correlation	1	.061
	Sig. (2-tailed)	196	.296
	N	302	300
Satisfaction	Pearson Correlation	.061	1
	Sig. (2-tailed)	.296	
	N	300	300

7.6 The Sobel Test

For hypotheses 2, 3 and 4, the study will present results using a method of mediation known as the Sobel test (discussed in section 5.13.1). The study will firstly present the method and outcome of the Sobel test for each hypothesis, finally a table will be presented to highlight each individual hypothesis and whether the hypothesis is supported or not.

7.6.1 Hypotheses Two (A) – Patient Database

H2: *The relationship between perceived ECO and internal and external stakeholder satisfaction is mediated by OCO*
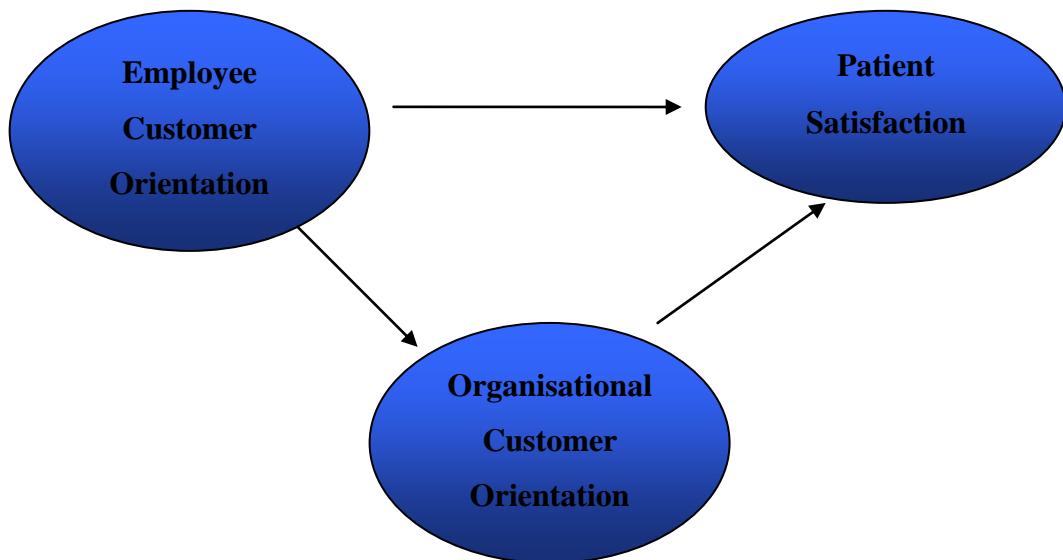
In order to ensure the three above conditions are met, the correlation coefficients for the three relationships must be obtained (Table 7.10). Correlations were conducted between the three variables ECO, OCO and patient satisfaction. The normalised variables were used

here. They appear to be more accurate as variables were normalised through factor analysis. Strongly significant relationships were displayed between the three variables:

Table 7.10: Correlations: ECO/OCO/Satisfaction

		COMPUTE Employee CO	COMPUTE Organisational CO	COMPUTE Satisfaction
COMPUTE ECO	Pearson Correlation	1	.436(**)	.593(**)
	Sig. (2-tailed)		.000	.000
	N	193	188	191
COMPUTE OCO	Pearson Correlation	.436(**)	1	.424(**)
	Sig. (2-tailed)	.000		.000
	N	188	193	190
COMPUTE Satisfaction	Pearson Correlation	.593(**)	.424(**)	1
	Sig. (2-tailed)	.000	.000	
	N	191	190	196

** Correlation is significant at the 0.01 level (2-tailed).

The relationship between ECO and OCO, ECO and patient satisfaction, as well as the relationship between OCO and patient satisfaction are all strongly significant at a two-tailed level of significance, a 99% confidence level. The links between each of the three variables is significant; therefore these results indicate that at the bivariate level, each of the conditions necessary to test for the possible role of a mediator has been met.

The next step was to find the values needed to run the Sobel test; it was necessary to compute the raw regression coefficient and the standard error for this regression coefficient for the association between the IV and the mediator, and the association between the mediator and the DV. Through regression analysis, four values are produced that are required for the Sobel test calculator (Table 7.11, 7.12); A, SEa, B and SEb;

A: The regression weight (regression coefficient) for the relationship between the independent variable and the mediator.
SEa: The standard error of the relationship between the independent variable and the mediator

B: The regression weight (regression coefficient) for the relationship between the mediator variable and the dependent variable

SEb: The standard error of the relationship between the mediator variable and the dependent variable.

The first test for hypotheses two (a) was to use the OCO dimension as the dependant variable, and to use ECO as the independent variable to obtain the raw regression coefficient and the standard error for this regression coefficient. This produced a value of **A=0.5** and a **SEa value of 0.076**.

Table 7.11: Regression Analysis: OCO/ECO

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta	B	Std. Error
1	(Constant)	1.405	.300		4.690	.000
	COMPUTE ECO	**.498**	**.075**	.436	6.609	.000

A Dependent Variable: COMPUTE Organisational CO

The next regression test was to use patient satisfaction as the dependant variable, and for the independent variable ECO remained, with the addition of the OCO dimension. The values produced were **B=0.229** and a **SEb value of 0.071**. From conducting linear regression analysis, the following are the results:

Table 7.12: Regression Analysis: Patient Satisfaction/ECO/OCO

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta	B	Std. Error
1	(Constant)	.467	.307		1.519	.130
	COMPUTE ECO	.627	.081	.498	7.712	.000
	COMPUTE OCO	**.229**	**.071**	.208	3.213	.002

A Dependent Variable: COMPUTE Satisfaction

All values were entered into the Sobel test calculator and produced the following results;

Sobel test statistic: 2.89

Probability one tailed: 0.001890

Probability two tailed: 0.003779

Results report that there is a strong significant relationship between ECO and OCO as well as a strong significant relationship between patient satisfaction and ECO and OCO at both one tailed and two tailed levels of significance. Results conclude that there are positive relationships overall as the sobel tests statistic is greater than +/- 1.96. Hence, ECO is a predictor of OCO and both ECO and OCO are predictors of patient satisfaction. Mediation is found to occur given all three conditions are met as above.

7.6.2 Hypotheses Two (B) – Employee Database

H2:   *The relationship between perceived ECO and internal and external stakeholder satisfaction is mediated by OCO*
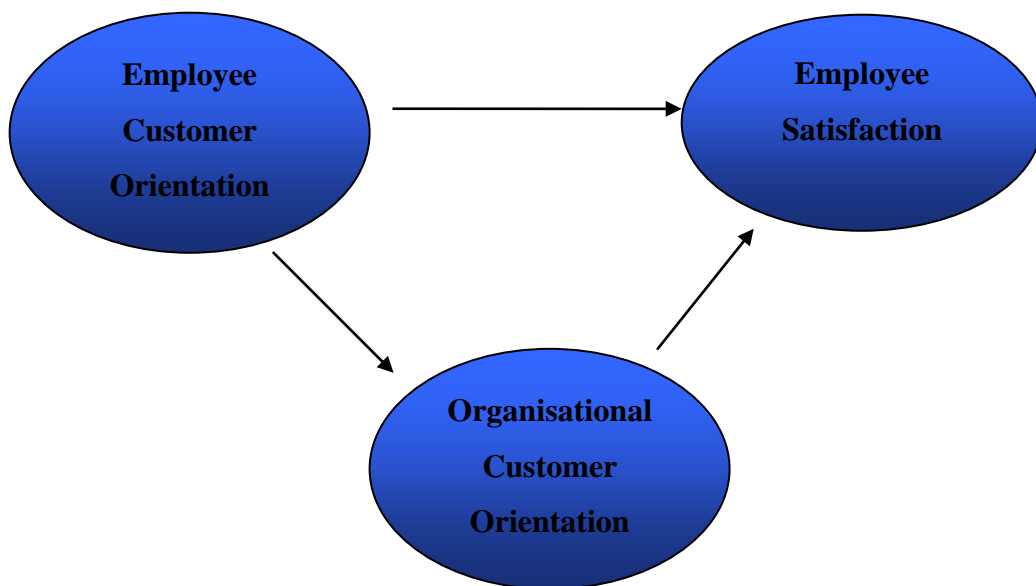
For the employee's, the same process as previously used for the patients/visitors was conducted, using the normalised scores. Correlations were conducted between the three variables; ECO, OCO and employee satisfaction (Table 7.13).

Table 7.13: Correlations: ECO/OCO/Employee Satisfaction

		COMPUTE ECO	COMPUTE OCO	COMPUTE Satisfaction
COMPUTE ECO	Pearson Correlation	1	.119*	.061
	Sig. (2-tailed)		.039	.296
	N	302	299	300
COMPUTE OCO	Pearson Correlation	.119*	1	.549**
	Sig. (2-tailed)	.039		.000
	N	299	301	299
COMPUTE Satisfaction	Pearson Correlation	.061	.549**	1
	Sig. (2-tailed)	.296	.000	
	N	300	299	302

** Correlation is significant at the 0.01 level (2-tailed)

*Correlation is significant at the 0.05 level (1-tailed).

The relationships between ECO and OCO appears strongly significant, results appear to be significant at a one tailed level of significance, therefore at a 95% confidence level. Results are also strongly significant between OCO and satisfaction at a value of 0.549**, this is at a two tailed level of significant, and therefore results are at a 99% confidence level.

The relationship between ECO and employee satisfaction was not strongly significant. Overall significant relationships exist, the next step was then to find the values needed to run the Sobel test, it was necessary to compute the raw regression coefficient and the standard error for this regression coefficient for the association between the IV and the mediator, and the association between the mediator and the DV. The first test for hypotheses two (b) was to use the OCO dimension as the dependant variable, and to use the independent variable as ECO. This produced a value of **A= -0.008** and a **SEa value of 0.079** (Table 7.14).

Table 7.14: Regression Analysis: ECO/OCO

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta	B	Std. Error
1	(Constant)	3.461	.485		7.140	.000
	COMPUTE ECO	**-.008**	**.079**	-.006	-.101	.919

A Dependent Variable: COMPUTE Organisational CO

The next test was to use employee satisfaction as the dependant variable, and for the independent variable ECO remained, with the addition of the OCO dimension to again find the raw regression coefficient and the standard error for the regression coefficient. The values produced were **B=0.016** and a **SEb value of 0.010** (Table 7.15).

Table 7.15: Regression Analysis: Employee Satisfaction/ECO/OCO

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta	B	Std. Error
1	(Constant)	2.916	.458		6.370	.000
	COMPUTE ECO	.113	.107	.061	1.055	.292
	COMPUTE OCO	**.016**	**.010**	.089	1.546	.123

A Dependent Variable: COMPUTE Satisfaction

From conducting linear regression analysis, the following are the results from the Sobel test calculator;

Sobel test statistic: **-0.101064**

Probability one tailed: **0.054**

Probability two tailed: **1.08**

Regression results report that OCO is not a strong predictor of ECO and that ECO and OCO are not strong predictors of employee satisfaction. However, correlations displayed some relationship exists between ECO and OCO and OCO and employee satisfaction. Further, from conducting the sobel test analysis the probability result at a one tailed level of significance is only slightly above the required level of (>0.05), however at a two tailed level of significance results are not strong enough to be reported. Moreover, the sobel test

statistic does not meet the required level of +/-1.96. Therefore, there can only be partial mediation for this relationship as not all three conditions were met.

7.6.3 Hypotheses Three – Patient/Visitor database

H3: *Corporate brand personality (CBP) mediates the relationship between employee customer orientation (ECO) as perceived by customers, and customer satisfaction.*
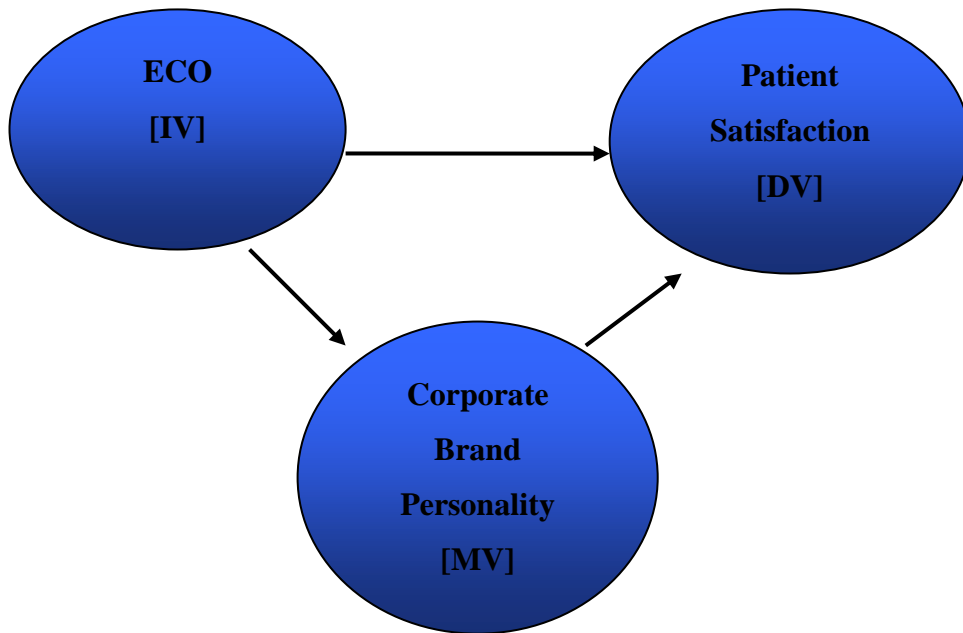
7.6.3.1 Agreeableness

Correlation analysis was conducted first using normalised scores. Correlation analysis displayed strongly significant relationships between the three variables ECO; patient satisfaction and the CBP dimension-agreeableness (Table 7.16).

Table 7.16: Correlations: Patient Satisfaction/Agreeableness/ECO

		COMPUTE Satisfaction	COMPUTE Agreeableness	COMPUTE Employee CO
COMPUTE Satisfaction	Pearson Correlation	1	.610(**)	.593(**)
	Sig. (2-tailed)		.000	.000
	N	196	196	191
COMPUTE Agreeableness	Pearson Correlation	.610(**)	1	.473(**)
	Sig. (2-tailed)	.000		.000
	N	196	200	193
COMPUTE Employee CO	Pearson Correlation	.593(**)	.473(**)	1
	Sig. (2-tailed)	.000	.000	
	N	191	193	193

** Correlation is significant at the 0.01 level (2-tailed).

Again the links between each of the three variables are strongly significant at a two tailed level of significance; therefore there is a 99% confidence level in the result. Correlation analysis reports that there is a link between ECO and agreeableness, ECO and satisfaction, as well as a link between agreeableness and satisfaction. These results indicate that at the bivariate level, each of the conditions necessary to test for the possible role of a mediator has been met.

The next step was to find the values needed to run the Sobel test, it was necessary to again compute the raw regression coefficient and the standard error for this regression coefficient for the association between the IV and the mediator, and the association between the mediator and the DV. The first test for hypotheses three was to use the agreeableness dimension of the corporate character scale as the dependant variable, and to use the independent variable as ECO. This produced a value of **A=0.844** and a **SEa value of 0.114** (Table 7.17).

Table 7.17: Regression Analysis: Agreeableness/ECO

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta	B	Std. Error
1	(Constant)	1.884	.452		4.172	.000
	COMPUTE Employee CO	**.844**	**.114**	.473	7.423	.000

A Dependent Variable: COMPUTE Agreeableness

The next test was to use patient satisfaction as the dependant variable, and for the independent variable ECO remained, with the addition of the agreeableness dimension. The values produced were **B=0.302** and a **SEb value of 0.042** (Table 7.18).

Table 7.18: Regression Analysis: Patient Satisfaction/ECO/Agreeableness

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta	B	Std. Error
1	(Constant)	.177	.273		.650	.517
	COMPUTE Employee CO	.496	.075	.392	6.648	.000
	COMPUTE Agreeableness	**.302**	**.042**	.425	7.200	.000

A Dependent Variable: COMPUTE Satisfaction

From conducting linear regression analysis, the following are the results from the Sobel test calculator;

Sobel test statistic: **5.15**
Probability one tailed: **0.000**
Probability two tailed: **0.000**

Regression and correlation results highlight that there is a strongly significant relationship between ECO and the CBP dimension agreeableness. Strongly significant relationships also exist between ECO and satisfaction, as well as agreeableness and satisfaction. The Sobel test found that the presence of agreeable traits is a mediator of the relationship between ECO and patient satisfaction as $p < .001$, which shows mediation. Also the sobel test

statistic is greater than the required level of +/-1.96. Complete mediation occurs as all three conditions were met.

7.6.3.2 Competence

Correlation analysis was conducted using normalised scores. Results displayed strongly significant relationships between the three variables; ECO, patient satisfaction and the CBP dimension-competence (Table 7.19).

Table 7.19: Correlations: ECO/Patient Satisfaction/Competence

		COMPUTE Employee CO	COMPUTE Satisfaction	COMPUTE Competency
COMPUTE Employee CO	Pearson Correlation	1	.589**	.589**
	Sig. (2-tailed)		.000	.000
	N	193	191	192
COMPUTE Satisfaction	Pearson Correlation	.589**	1	.681**
	Sig. (2-tailed)	.000		.000
	N	191	196	195
COMPUTE Competency	Pearson Correlation	.589**	.681**	1
	Sig. (2-tailed)	.000	.000	
	N	192	195	199

** Correlation is significant at 0.01 level (2-tailed).

Again the links between each of the three variables is strongly significant at a two tailed level of significance; therefore there is a 99% confidence level in the result. Hence, linear relationships exist between ECO and patient satisfaction, competence and patient satisfaction and also ECO and competence. These results indicate that at the bivariate level, each of the conditions necessary to test for the possible role of a mediator has been met.

The next step was to find the values needed to run the Sobel test, it was necessary to again compute the raw regression coefficient and the standard error for this regression coefficient for the association between the IV and the mediator, and the association between the mediator and the DV. The first test for hypotheses three was to use the competence dimension of the corporate character scale as the dependant variable, and to use the

independent variable as ECO. This produced a value of **A=0.992** and a **SEa value of 0.099** (Table 7.20).

Table 7.20: Regression Analysis: Competence/ECO

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta	B	Std. Error
1	(Constant)	1.364	.392		3.476	.001
	COMPUTE Employee CO	**.992**	**.099**	.588	10.047	.000

A Dependent Variable: COMPUTE Competency

The next test was to use patient satisfaction as the dependant variable, and for the independent variable ECO remained, with the addition of the competence dimension. The values produced were **B=0.380** and a **SEb value of 0.047** (Table 7.21).

Table 7.21: Regression Analysis: Patient Satisfaction/ECO/Competence

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta	B	Std. Error
1	(Constant)	.226	.262		.863	.389
	COMPUTE Employee CO	.374	.079	.295	4.724	.000
	COMPUTE Competence	**0.380**	**.047**	.506	8.097	.000

A Dependent Variable: COMPUTE Satisfaction

From conducting linear regression analysis, the following are the results from the Sobel test calculator;

Sobel test statistic: **6.29**

Probability one tailed: **0.000**

Probability two tailed: **0.000**

Regression results and Sobel test results again indicate strong relationships between ECO and competence, as well as significantly strong relationships between competence and employee satisfaction and ECO and employee satisfaction. The sobel test statistic is also

above the level of significance at 6.29. Complete mediation occurs as all three conditions were met.

7.6.3.3 Enterprise

Correlation analysis was conducted first using normalised scores. Results displayed strongly significant relationships between the three variables ECO; patient satisfaction and the CBP dimension-enterprise (Table 7.22).

Table 7.22: Correlations: ECO/Patient Satisfaction/Enterprise

		COMPUTE Employee CO	COMPUTE Satisfaction	COMPUTE Enterprise
COMPUTE Employee CO	Pearson Correlation	1	.593(**)	.391(**)
	Sig. (2-tailed)		.000	.000
	N	193	191	193
COMPUTE Satisfaction	Pearson Correlation	.593(**)	1	.535(**)
	Sig. (2-tailed)	.000		.000
	N	191	196	196
COMPUTE Enterprise	Pearson Correlation	.391(**)	.535(**)	1
	Sig. (2-tailed)	.000	.000	
	N	193	196	200

** Correlation is significant at the 0.01 level (2-tailed).

Again the links between each of the three variables is strongly significant at a two tailed level of significance; therefore there is a 99% confidence level in the result. These results indicate that at the bivariate level, each of the conditions necessary to test for the possible role of a mediator has been met.

The next step was to find the values needed to run the Sobel test, it was necessary to again compute the raw regression coefficient and the standard error for this regression coefficient for the association between the IV and the mediator, and the association between the mediator and the DV. The first test for hypotheses three was to use the enterprise dimension of the corporate character scale as the dependant variable, and to use the independent variable as ECO. This produced a value of **A=0.322** and a **SEa value of 0.036** (Table 7.23).

Table 7.23: Regression Analysis: Enterprise/ECO

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta	B	Std. Error
1	(Constant)	2.455	.149		16.442	.000
	COMPUTE Enterprise	**.322**	**.036**	.535	8.813	.000

A Dependent Variable: COMPUTE Satisfaction

The next test was to use patient satisfaction as the dependant variable, and for the independent variable ECO remained, with the addition of the enterprise dimension to again find the raw regression coefficient and the standard error for the regression coefficient. The values produced were **B=0.221** and a **SEb value of 0.035** (Table 7.24).

Table 7.24: Regression Analysis: Patient Satisfaction/ECO/Enterprise

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta	B	Std. Error
1	(Constant)	.606	.269		2.249	.026
	COMPUTE Employee CO	.570	.073	.451	7.768	.000
	COMPUTE Enterprise	**.221**	**.035**	.364	6.275	.000

A Dependent Variable: COMPUTE Satisfaction

From conducting linear regression analysis, the following are the results from the Sobel test calculator;

**Sobel test statistic**:   **5.15**

Probability one tailed: **0.000**

Probability two tailed: **0.000**

Results again display a significant relationship between the three variables with a probability level of $p<0.001$ at both a one and two tailed level of significance. The sobel test statistic is also above the required level of +/-1.96. Hence, the presence of enterprising

traits will increase the relationship between ECO and patient satisfaction. Complete mediation occurs for this relationship as all three conditions are satisfied.

7.6.3.4 Machismo

Correlation analysis was conducted first using normalised scores. Results displayed strongly significant relationships between the three variables; ECO, patient satisfaction and the CBP dimension-machismo (Table 7.25).

Table 7.25: Correlations: ECO/Patient Satisfaction/Machismo

		COMPUTE Employee CO	COMPUTE Satisfaction	COMPUTE Machismo
COMPUTE Employee CO	Pearson Correlation	1	.589**	.172*
	Sig. (2-tailed)		.000	.017
	N	193	191	193
COMPUTE Satisfaction	Pearson Correlation	.589**	1	-.019
	Sig. (2-tailed)	.000		.792
	N	191	196	196
COMPUTE Machismo	Pearson Correlation	.172*	-.019	1
	Sig. (2-tailed)	.017	.792	
	N	193	196	200

** Correlation is significant at the 0.01 level (2-tailed).
*Correlation is significant at the 0.05 level (1-tailed).

The relationship between ECO and patient satisfaction is strongly significant (0.589**) at a 99% confidence level, the relationship between ECO and the CBP dimension-machismo is also significant (0.172*) at a slightly lower confidence level of 95%, however the relationship between machismo and patient satisfaction is negative and quite low at a value of p -0.019, this result displays a negative relationship between the two variables. Hence, machismo will decrease patient satisfaction.

The next step was to find the values needed to run the Sobel test, it was necessary to again compute the raw regression coefficient and the standard error for this regression coefficient for the association between the IV and the mediator, and the association between the mediator and the DV. The first test for hypotheses three was to use the machismo

dimension of the corporate character scale as the dependant variable, and to use the independent variable as ECO. This produced a value of **A=0.374** and a **SEa value of 0.146** (Table 7.26).

Table 7.26: Regression Analysis: ECO/Machismo

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta	B	Std. Error
1	(Constant)	1.854	.582		3.187	.002
	COMPUTE Employee CO	**.374**	**.146**	.182	2.557	.011

A Dependent Variable: COMPUTE Machismo

The next test was to use patient satisfaction as the dependant variable, and for the independent variable ECO remained, with the addition of the machismo dimension. The values produced were **B= -0.063** and a **SEb value of 0.037** (Table 7.27).

Table 7.27: Regression Analysis: Patient satisfaction/ECO/Machismo

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta	B	Std. Error
1	(Constant)	.864	.301		2.876	.004
	COMPUTE ECO	.774	.075	.612	10.313	.000
	COMPUTE Machismo	**-.063**	**.037**	-.101	-1.710	.089

A Dependent Variable: COMPUTE Satisfaction

From conducting linear regression analysis, the following are the results from the Sobel test calculator;

Sobel test statistic: **-1.41**

Probability one tailed: **0.922**

Probability two tailed: **1.84**

The Sobel test statistic was negative and did not meet the required level of greater than +/-1.96. The probability levels were also high; therefore no strong relationship exists between ECO and the CBP-machismo or between the dependant variable employee satisfaction and

the dimension machismo. The presence of machismo, similar to correlation results, will decrease the relationship between ECO and patient satisfaction as results highlight negative values. A mediating relationship does not occur at this point, as all three conditions are not met, specifically step 1 shows correlations are not completely significant, as one link is negative.

7.6.3.5 Ruthless

Correlation analysis was conducted first using normalised scores. Normalised scores were created through factor analysis. Correlation analysis displays strongly significant relationships between the three variables ECO, patient satisfaction and the CBP dimension-ruthless (Table 7.28).

Table 7.28: Correlations: ECO/Patient Satisfaction/Ruthless

		COMPUTE Employee CO	COMPUTE Satisfaction	COMPUTE Ruthless
COMPUTE Employee CO	Pearson Correlation	1	.589**	-.116
	Sig. (2-tailed)		.000	.109
	N	193	191	191
COMPUTE Satisfaction	Pearson Correlation	.589**	1	-.272**
	Sig. (2-tailed)	.000		.000
	N	191	196	194
COMPUTE Ruthless	Pearson Correlation	-.116	-.272**	1
	Sig. (2-tailed)	.109	.000	
	N	191	194	198

** Correlation is significant at the 0.01 level (2-tailed).

Again the links between two of the three variables is strongly significant at a two tailed level of significance however one of these results is negative, there is a 99% confidence level in the result. A positive significant relationship exists between ECO and satisfaction, a negative significant relationship exist between satisfaction and ruthlessness showing that the CBP has no effect on satisfaction, and a negative relationship exits between ECO and the ruthless dimension, however this does not appear significant.

The next step was to find the values needed to run the Sobel test, once again it was necessary to again compute the raw regression coefficient and the standard error for this regression coefficient for the association between the IV and the mediator, and the association between the mediator and the DV. The first test for hypotheses three was to use the ruthless dimension of the corporate character scale as the dependant variable, and to use the independent variable as ECO. This produced a value of **A=-0.253** and a **SEa value of 0.158** (Table 7.29).

Table 7.29: Regression Analysis: ECO/Ruthless

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta	B	Std. Error
1	(Constant)	3.692	.627		5.890	.000
	COMPUTE Employee CO	**-.253**	**.158**	-.115	-1.604	.110

A **Dependent Variable: COMPUTE Ruthless**

The next test was to use patient satisfaction as the dependant variable, and for the independent variable ECO remained, with the addition of the ruthless dimension. This test was conducted to find the raw regression coefficient and the standard error for this regression coefficient. The values produced were **B= -0.121** and a **SEb** value of **0.033** (Table 7.30).

Table 7.30: Regression Analysis: Patient Satisfaction/ECO/Ruthless

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta	B	Std. Error
1	(Constant)	1.192	.310		3.846	.000
	COMPUTE Employee CO	.720	.072	.569	9.967	.000
	COMPUTE Ruthless	**-.121**	**.033**	-.208	-3.649	.000

A **Dependent Variable: COMPUTE Satisfaction**

From conducting linear regression analysis, the following are the results from the Sobel test calculator;

Sobel test statistic: 1.47

Probability one tailed: 0.07129

Probability two tailed: 0.142257

Again the relationship here appears insignificant at both a one and two tailed level of significance as p values are significantly higher than 0.05. The Sobel test statistic does not meet the required level of greater than +/-1.96 and the probability levels are insignificant, therefore it can be said ruthlessness has no mediating relationship on the relationship between ECO and patient satisfaction. A mediating relationship does not occur here as some correlations have been found to have a negative relationship, therefore not satisfying the three conditions.

7.6.4   Hypotheses 4 – Employee Database

H4: *Corporate brand personality (CBP) mediates the relationship between employee customer orientation (ECO), as perceived by employees, and employee satisfaction.*
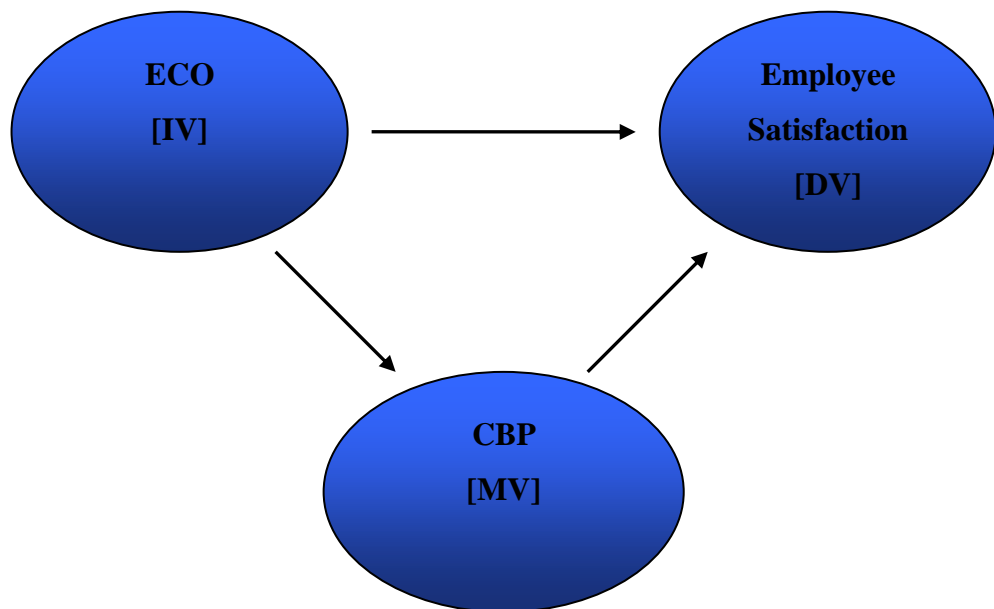
7.6.4.1 Agreeableness

The same process and variables are used as was for hypothesis three, this time analysis is conducted on the employee database. Correlation analysis was conducted between the three

variables ECO, employee satisfaction and the CBP-agreeableness. Normalised scores were again used for correlation analysis, to produce a more accurate score (Table 7.31).

Table 7.31: Correlations: Employee Satisfaction/ECO/Agreeableness

		COMPUTE Satisfaction	COMPUTE EmployeeCO	COMPUTE Agreeableness
COMPUTE Satisfaction	Pearson Correlation	1	.061	.656(**)
	Sig. (2-tailed)		.296	.000
	N	302	300	297
COMPUTE Employee CO	Pearson Correlation	.061	1	.0211**
	Sig. (2-tailed)	.296		000
	N	299	300	297
COMPUTE Agreeableness	Pearson Correlation	.656(**)	.0211**	1
	Sig. (2-tailed)	.000	.000	
	N	297	297	299

** Correlation is significant at the 0.01 level (2-tailed).

Results show there is two significant links between the three variables at a two tailed level of significance and that is between employee satisfaction and agreeableness (meaning they are satisfied to work in an organisation that possesses traits under the agreeableness dimension) and ECO and agreeableness (an organisation high in ECO is known to be agreeable). From an employees perspective there is no significant relationship between ECO and employee satisfaction.

The next step was to find the values needed to run the Sobel test, it was necessary to compute the raw regression coefficient and the standard error for this regression coefficient for the association between the IV and the mediator, and the association between the mediator and the DV. The first test for hypotheses four was to use the agreeableness dimension of the corporate character scale as the dependant variable, and to use the independent variable as ECO. This produced a value of **A=0.017** and a **SEa value of 0.018** (Table 7.32).

Table 7.32: Regression Analysis: ECO/Agreeableness

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta	B	Std. Error
1	(Constant)	4.466	.107		41.608	.000
	COMPUTE Employee CO	**.017**	**.018**	.055	.958	.339

A Dependent Variable: COMPUTE Agreeableness

The next test was to use employee satisfaction as the dependant variable, and for the independent variable ECO remained, with the addition of the agreeableness dimension. The raw regression coefficient and the standard error for this regression coefficient were again found. The values produced were **B=0.437** and a **SEb value of 0.039** (Table 7.33).

Table 7.33: Regression Analysis: Employee Satisfaction/Agreeableness/ECO

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta	B	Std. Error
1	(Constant)	1.889	.398		4.752	.000
	COMPUTE Employee CO	-.100	.093	-.054	-1.079	.281
	COMPUTE Agreeableness	**.437**	**.039**	.552	11.075	.000

A Dependent Variable: COMPUTE Satisfaction

From conducting linear regression analysis the values were entered into the Sobel test calculator and the following results were produced;

Sobel Test: **0.941**

Probability one tailed: **0.17**

Probability two tailed: **0.35**

Results indicate that there is a strong significant relationship between agreeableness and satisfaction displayed from regression analysis. Correlations also display a significant relationship between agreeableness and employee satisfaction and between agreeableness and ECO. When the appropriate values are entered into the Sobel test calculator, probability levels of $p < 0.001$ occur suggesting that agreeable traits representing the

organisation mediate the relationship between ECO and employee satisfaction. However, it can be said that this relationship is not completely mediated as not all three conditions were met as correlations and regression found no significant relationship between ECO and employee satisfaction. Further, the sobel test statistic is also not above the significance level of +/-1.96**.**

7.6.4.2 Competence

Correlation analysis was conducted between the three variables ECO, employee satisfaction and the CBP-agreeableness. Normalised scores were again used for correlation analysis, to produce a more accurate score (Table 7.34).

Table 7.34: Correlations: ECO/Employee Satisfaction/Competence

		COMPUTE Employee CO	COMPUTE Satisfaction	COMPUTE Competence
COMPUTE Employee CO	Pearson Correlation	1	0.061	**0.219****
	Sig. (2-tailed)		0.296	0.000
	N	302	300	298
COMPUTE Satisfaction	Pearson Correlation	0.061	1	**0.596****
	Sig. (2-tailed)	0.296		.000
	N	300	302	298
COMPUTE Competence	Pearson Correlation	**0.219****	**0.596****	1
	Sig. (2-tailed)	.000	.000	
	N	298	298	300

** Correlation is significant at the 0.01 level (2-tailed).

Results show there is two significant links between the three variables and that is between employee satisfaction and competence (meaning they are satisfied to work in an organisation that possesses traits under the competent dimension) and ECO and competence (an organisation high in ECO is known to be competent). From an employees perspective there is no significant relationship between ECO and employee satisfaction.

The next step was to find the values needed to run the Sobel test, it was necessary to compute the raw regression coefficient and the standard error for this regression coefficient

for the association between the IV and the mediator, and the association between the mediator and the DV. The regression test for hypothesis four was to use the competent dimension of the corporate character scale as the dependant variable, and to use the independent variable as ECO. This produced a value of **A=0.038** and a **SEa value of 0.016** (Table 7.35).

Table 7.35: Regression Analysis: ECO/Competence

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta	B	Std. Error
1	(Constant)	4.560	.096		47.565	.000
	COMPUTE Employee CO	**.038**	**.016**	.140	2.447	.015

A Dependent Variable: COMPUTE Competence

The next test was to use employee satisfaction as the dependant variable, and for the independent variable ECO remained, with the addition of the agreeableness dimension. The values produced were **B=0.445** and a **SEb value of 0.046** (Table 7.36).

Table 7.36: Regression Analysis: Employee Satisfaction/ECO/Competence

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta	B	Std. Error
1	(Constant)	1.691	.420		4.030	.000
	COMPUTE Employee CO	-.081	.096	-.044	-.848	.397
	COMPUTE Competence	**.445**	**.046**	.503	9.771	.000

A Dependent Variable: COMPUTE Satisfaction

The raw regression coefficient and the standard error of this regression coefficient were entered into the Sobel test calculator, producing the following results;

Sobel Test: **2.31**

Probability one tailed: **0.0105**

Probability two tailed: **0.0211**

Results indicate strongly significant relationships between the CBP dimension – competence, ECO and employee satisfaction at both one and two tailed levels of significance. Probability levels of p<0.001 indicate that a competent organisation can mediate the relation between ECO and employee satisfaction, supporting the hypothesis. Further, the sobel test statistic is above the significance level of +/-1.96.

7.6.4.3 Enterprise

Correlation analysis was conducted between the three variables ECO, employee satisfaction and the CBP-enterprise. Normalised scores were again used for correlation analysis, to produce a more accurate score (Table 7.37).

Table 7.37: Correlations: ECO/Employee Satisfaction/Enterprise

		COMPUTE Employee CO	COMPUTE Satisfaction	COMPUTE Enterprising
COMPUTE Employee CO	Pearson Correlation	1	0.061	.113
	Sig. (2-tailed)		.296	.051
	N	300	300	200
COMPUTE Satisfaction	Pearson Correlation	.061	1	.503**
	Sig. (2-tailed)	.296		.000
	N	300	302	300
COMPUTE Enterprising	Pearson Correlation	.113	.503**	1
	Sig. (2-tailed)	.051	.000	
	N	300	300	302

** Correlation is significant at the 0.01 level (2-tailed).

Results show there is one significant link between the three variables and that is between employee satisfaction and enterprise (meaning they are satisfied to work in an organisation that possesses traits under the enterprise dimension). From an employees perspective there is no significant relationship between ECO and employee satisfaction and ECO and enterprise.

The next step was to find the values needed to run the Sobel test, it was again necessary to compute the raw regression coefficient and the standard error for this regression coefficient for the association between the IV and the mediator, and the association between the mediator and the DV. The regression test for hypothesis four was to use the enterprise

dimension of the corporate character scale as the dependant variable, and to use the independent variable as ECO. This produced a value of **A=0.011** and a **SEa value of 0.016** (Table 7.38).

Table 7.38: Regression Analysis: ECO/Enterprise

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta	B	Std. Error
1	(Constant)	3.466	.101		34.380	.000
	COMPUTE ECO	**.011**	**.016**	.037	.643	.521

A Dependent Variable: COMPUTE Enterprising

The next test was to use employee satisfaction as the dependant variable, and for the independent variable ECO remained, with the addition of the enterprise dimension. The values produced were **B=0.350** and a **SEb value of 0.045** (Table 7.39).

Table 7.39: Regression Analysis: ECO/Enterprise/Employee Satisfaction

Model		Unstandardized Coefficients		Standardized Coefficients	T	Sig.
		B	Std. Error	Beta	B	Std. Error
1	(Constant)	2.084	.432		4.824	.000
	COMPUTE ECO	.032	.099	.017	.328	.743
	COMPUTE Enterprising	**.350**	**.045**	.416	7.841	.000

A Dependent Variable: COMPUTE Satisfaction

The values obtained from conducting regression analysis were entered into the Sobel test calculator and the following results were produced;

Sobel statistic: **0.68**

Probability one tailed: **0.247**

Probability two tailed: **0.493**

Once again results indicate strong relationships at the two levels of significance. Probability levels of $p<0.001$ highlight the relationship between ECO and employee satisfaction as mediated by the enterprising organisation, therefore supporting the

hypothesis. However, the hypothesis is only partially supported as not all three conditions are satisfied and the sobel test statistic is not greater than the required level of +/-1.96, only one correlation appears significant, that being between the enterprise variable and employee satisfaction.

7.7.4.4 Machismo

Correlation analysis was conducted between the three variables ECO, employee satisfaction and the CBP-machismo. Normalised scores were again used for correlation analysis, to produce a more accurate score (Table 7.40).

Table 7.40: Correlations: ECO/Employee Satisfaction/Machismo

		COMPUTE Employee CO	COMPUTE Satisfaction	COMPUTE Machismo
COMPUTE Employee CO	Pearson Correlation	1	.061	-.026
	Sig. (2-tailed)		.296	.654
	N	302	300	299
COMPUTE Satisfaction	Pearson Correlation	.061	1	.081
	Sig. (2-tailed)	.296		.165
	N	300	302	299
COMPUTE Machismo	Pearson Correlation	-.026	.081	1
	Sig. (2-tailed)	.654	.165	
	N	299	299	301

The output produced above indicates that there are no significant relationships at a one or two tailed level of significance. A negative relationship exists between machismo and ECO. The next step was to find the values needed to run the Sobel test, it was again necessary to compute the raw regression coefficient and the standard error for this regression coefficient for the association between the IV and the mediator, and the association between the mediator and the DV. The regression test for hypothesis four was to use the machismo dimension of the corporate character scale as the dependant variable, and to use the independent variable as ECO. This produced a value of **A=0.002** and a **SEa value of 0.107** (Table 7.41).

Table 7.41: Regression Analysis: ECO/Machismo

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta	B	Std. Error
1	(Constant)	3.888	.654		5.942	.000
	COMPUTE Employee CO	**.002**	**.107**	.001	.017	.986

A Dependent Variable: COMPUTE Machismo

The next test was conducted to again produce the raw regression coefficient and the standard error for this regression coefficient. The following variables were used; employee satisfaction as the dependant variable and for the independent variable ECO remained, with the addition of the machismo dimension for this section of the analysis. The values produced were **B=0.013** and a **SEb value of 0.007** (Table 7.42).

Table 7.42: Regression Analysis: ECO/Machismo/Employee Satisfaction

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta	B	Std. Error
1	(Constant)	2.923	.457		6.400	.000
	COMPUTE ECO	.112	.107	.060	1.047	.296
	COMPUTE Machismo	**.013**	**.007**	.100	1.728	.085

A Dependent Variable: COMPUTE Satisfaction

From conducting the above analysis, values were entered into the Sobel test calculator and the following results were produced;

Sobel statistic   **0.019**

Probability one tailed: **0.493**

Probability two tailed: **0.985**

Results display that both ECO and machismo have an impact on the dependant variable employee satisfaction. However, correlation analysis highlights this relationship as being negative. P values of <0.001 supporting the mediating relationship, however this relationship is only partially supported as correlation analyses are not significant, the sobel

test statistic is not greater than +/-1.96, and the regression results between ECO and machismo and ECO and employee satisfaction.

7.6.4.5 Ruthless

Correlation analysis was conducted between the three variables ECO, employee satisfaction and the CBP-ruthless. Normalised scores were again used for correlation analysis, to produce a more accurate score (Table 7.43).

Table 7.43: Correlations: ECO/Employee Satisfaction/Ruthless

		COMPUTE Employee CO	COMPUTE Satisfaction	COMPUTE Ruthless
COMPUTE ECO	Pearson Correlation	1	.061	-.095
	Sig. (2-tailed)		.296	.101
	N	302	300	300
COMPUTE Satisfaction	Pearson Correlation	.061	1	**-.461****
	Sig. (2-tailed)	.296		.000
	N	300	302	300
COMPUTE Ruthless	Pearson Correlation	-0.095	**-.461****	1
	Sig. (2-tailed)	.938	.000	
	N	299	299	301

** Correlation is significant at the 0.01 level (2-tailed).

Results show there is one significant link between the three variables and that is a negative relationship between employee satisfaction and ruthless, the link is strong as it is at a two tailed level of significance. This results states that the dimension ruthless has no effect on employee satisfaction. From an employees perspective there is no significant relationship between ECO and employee satisfaction and ECO and ruthless.

The next step was to find the values needed to run the Sobel test, it was again necessary to compute the raw regression coefficient and the standard error for this regression coefficient. The regression test for hypothesis four was to use the ruthless dimension of the corporate character scale as the dependant variable, and to use the independent variable as ECO. This produced a value of **A=0.002** and a **SEa value of 0.021** (Table 7.44).

Table 7.44: Regression Analysis: ECO/Ruthless

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta	B	Std. Error
1	(Constant)	3.574	.128		27.965	.000
	COMPUTE ECO	**.002**	**.021**	.005	.078	.938

A Dependent Variable: COMPUTE Ruthless

The next test was to use employee satisfaction as the dependant variable, and for the independent variable ECO remained, with the addition of the ruthless dimension for this section of the analysis. This analysis produced the raw regression coefficient and the standard error for this regression coefficient. The values produced were **B= -2.32** and a **SEb value of 0.036** (Table 7.45).

Table 7.45: Regression Analysis: Employee Satisfaction/ECO/Ruthless

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta	B	Std. Error
1	(Constant)	4.031	.460		8.759	.000
	COMPUTE Employee CO	.059	.101	.032	.582	.561
	COMPUTE Ruthless	**-.232**	**.036**	-.349	-6.405	.000

A Dependent Variable: COMPUTE Satisfaction

The above analysis produced values that were entered into the Sobel test calculator and the following results were produced;

Sobel statistic:	**-0.95**
Probability one tailed:	**0.538**
Probability two tailed:	**1.08**

Results for the ruthless dimension were rather insignificant. When conducting correlations a negative link was found between ECO and ruthless, after conducting regression analysis and the Sobel test, results show that the relationship between ECO and satisfaction and ruthless and satisfaction are also insignificant as the high probability levels above illustrate. The sobel test statistics is also negative and does meet the significance level of 1.96. If the

ruthless dimension is to have an effect on the relationship between ECO and employee satisfaction it is said that this relationship will have a certain negative effect.

7.7 - Summary of Hypotheses Testing

For the benefit of the reader and to summarise the above results, the following table (7.46) presents a summary of the overall results for each hypothesis. Each hypothesis is stated and whether it is supported or not is outlined.

Table 7.46: Summary of the Hypotheses

Hypotheses	Result	
H1: The higher the perceived ECO the higher the satisfaction for an organisations internal and external stakeholders will be	**Patients/Visitors**	**Supported**
	Employees	Not Supported
H2: The relationship between perceived ECO and internal and external stakeholder satisfaction is mediated by OCO	**Patients/Visitors**	Supported
	Employees	Partially Supported
H3: Corporate Brand Personality (CBP) mediates the relationship between ECO as perceived by external stakeholders and satisfaction	**Agreeable**	Supported
	Competence	Supported
	Enterprise	Supported
	Machismo	Not Supported
	Ruthless	Not Supported
H4: CBP mediates the relationship between ECO as perceived by internal stakeholders and employee satisfaction	**Agreeable**	Partially Supported
	Competence	Supported
	Enterprise	Partially Supported
	Machismo	Partially Supported
	Ruthless	Not Supported

7.8 - Conclusion

A comprehensive overview of the data analysis procedures and empirical findings were presented in this chapter. Descriptive statistics were outlined first, followed by a preliminary analysis presented with the use of radar (spider) diagrams. Subsequently, each

hypothesis was presented under the mediation method used – the Sobel statistic test, along with a brief interpretation of the results. Finally, a summary of each hypothesis was presented. These findings provide a foundation for the discussion that will take place in the next chapter when the findings from this section are critically compared and contrasted to findings in previous published literature.

~ Chapter 8 ~

DISCUSSION AND CONCLUSION

8.1 – Introduction

The aim of this chapter is to discuss the results of the research findings in light of prior published studies previously explored in the literature review section, in order to highlight common issues or discrepancies, and in doing so articulating the contributions of the current work to both the literature and managerial practice. The discussion of the research findings commences with a summary of the qualitative findings. Subsequently, the expected and unexpected findings from the qualitative study will be highlighted. The subsequent stage will examine the descriptive research findings, as well as the correlation and regression findings across the four quantitative research hypotheses. Finally, a summary of the research findings is presented outlining the major contributions of this research study, as well as the implications for management and recommendations for future research avenues.

8.2 – Summary of Focus Group Findings

The following tables (8.1, 8.2, and 8.3) present a summary of the main drivers and outcomes of hospital reputation revealed through the qualitative focus group discussions. A separate table is outlined for each of the three stakeholder groups.

Table 8.1: Drivers/Outcomes of Hospital Reputation - Patients/Visitors

	Positive	**Negative**
Drivers	*Management Competence *Hygiene and Cleanliness *Interpersonal relationships and experiences	*The Media *Staff Shortages – Patients needs not always satisfied as a result *Communication (language and Culture) *Patient-Doctor Communication *Hospital Facilities
Outcomes	*Increase in satisfaction with the hospital *More Confidence in the Healthcare System *Increase in Funding	*Loss of confidence and trust in the hospital *Downgrading of Facilities *Media Frenzy

Table 8.2: Drivers/Outcomes of Hospital Reputation - Support Staff

	Positive	Negative
Drivers	*Employee Benefits *Hospital Improvements – Patient needs can be better cared for *Working Environment *Staff Relations (employee-employee) *Positive patient interpersonal experiences and interactions	*Politicians & the Media *Staff Relations – All staff should be welcoming and friendly to patients *Communication (language and culture) *Communication (management-staff) – Policies and procedures are not always created with the patient in mind *Lack of Staff Training – Management should provide training to ensure employees can best satisfy patient needs *Hospital Layout *Waiting Lists
Outcomes	*Facilities Upgraded *Proud to be Associated with the Hospital	*Opt to Change Jobs *Disassociation with the Hospital *Poor Job Performance

Table 8.3: Drivers/Outcomes of Hospital Reputation - Medical Staff

	Positive	Negative
Drivers	*Employee Benefits *Hospital Location *Working Environment – If employees work as a team, patient will be better cared for *Staff Relations (employee-employee) *Job Security *Hospital Resources – Patients needs should be priority	*Staff Shortages *Communication (management-staff) – As a result of management not fully interacting with employees, the hospital is not fully organised to suit patients needs
Outcomes	*More Committed to the Hospital *More Motivated to Work *Proud to be Associated with the Hospital	*Disassociation with the Hospital

8.3 – Expected/Unexpected Qualitative Findings

The following section will outline the expected and unexpected findings based on the knowledge acquired from previous published findings available throughout the reviewed literature.

8.3.1 Expected Findings – Drivers

An expected driver of positive reputation was ***patients' perceptions of staff*** within the healthcare sector. Patients found staff very welcoming and friendly at hospital X and found the interpersonal relationship between staff and patients to be a strong contributor of a positive reputation. This is supported by Licata, Mowen, Harris and Brown (2003) who state that customers overall satisfaction with a service is derived from the personal interaction component. Further, this finding is consistent with Darby and Daniel (1999 p.278) who suggest that frontline personnel are normally the key to clients perceptions' of the delivery of high quality services because they have a major influence in forming expectations and controlling customer experiences. Moreover, Brown et al. (2002) state that how customer orientated frontline employees are will influence the perceptions external stakeholders have of their experiences with an organisation. Patients stated that a friendly face would make them feel at ease and relaxed from the start, resulting in a more enjoyable experience at the hospital. Several respondents reported having positive experiences at hospital X and as a result they have increased satisfaction with the hospital.

Understaffing was a further expected driver of negative reputation, perceived to result in longer waiting times which are a problem in the Irish healthcare sector. Patients felt the nursing staff in particular were overworked '*there aren't enough nurses to go around the hospital and that's the truth'.* When asked to describe the hospital, based on human characteristics (the personification metaphor), respondents described the hospital as resembling an overworked person. Clinicians also felt angry about the staff shortages, they were of the opinion that management were more concerned about '*keeping costs low'* and stated that clinics have to close if clinicians are gone on holidays because management won't get staff to replace them. These findings concur with Newman, Maylor and Chansarkar (2002) who found that there is both a short and long term shortage of nursing staff to provide sufficient care and treatment in healthcare services. Understaffing can cause a major problem in a service organisation as the needs of the service recipient i.e. the patient, are not looked after properly. A poor service will ultimately lead to poor perceptions of the organisation and furthermore, a negative reputation. Clinicians stated that patients are not cared for properly (their needs are not fully satisfied) and not enough time is devoted to them as a result of under staffing.

Schlegelmilch, Carman and Moore (1992) highlighted the importance attached by the patient to his/her personal relationship with the clinician, clinicians need to emphasis the non-technical side in their interaction with patients' in order to keep current patients loyal and to attract new ones. An external respondent emphasised the importance of the personal touch '*it's personal at hospital X; they remember your name, you not just a number here*'. Internal respondents also highlighted the importance of the non-technical side. Support staff stated '*being friendly and smiling won't cost you anything; if you are not that kind of person then you are in the wrong job*'. Clinical staff cited the importance of devoting enough time to patients and caring for them properly; if they had the right amount of staff it would enable them to deliver a better service. If the hospital is understaffed, then it does not allow for employees to fully employ customer orientated tasks. Thus, according to Brown (2002) if CO is not present, customer needs will not be fully satisfied. Press (2003) also found that patients like the way staff interact with them, inform them and treat them. This requires continuous training, therefore the healthcare industry should place emphasises on instructing staff in communication skills in order to instil a better client orientation (Schlegelmilch et al., 1992). In hospital X, training was found to be a driver of negative reputation as the training provided is either very poor and scarce or non-existent for some employees. This will be discussed in the next section – unexpected drivers.

Considering the importance of employees to patient perceptions' of the organisation, management must emphasise the importance of CO to all staff that are in contact with patients. Further, management must create policies and procedures throughout the organisation that will contribute to positive patient experiences at the hospital. This reinforces the importance of OCO to satisfying patient needs, OCO is the degree to which the climate or culture of the organisation is conducive to meeting customer needs (Grizzle et al., 2008). It is important for management to outline that dealing with patient needs and requests (the needs dimension) is not the only part of their job, but they must also satisfy the patient by interacting with them in a positive manner (the enjoyment dimension), this is akin to findings by Brown (2002). It is also important for management, if they want employees to adopt CO practices, to display that satisfying patients' need is on the top of their agenda. Lovelock and Weinberg (1990) stated that governments require organisations to become more responsive to the 'customer' and his/her needs, in other words to become more customer orientated, rather than to increase the number of customers. Despite this,

clinical employee respondents in this study reported that 'cost analysis' appears more essential to management than the patient.

Another expected finding was *facilities* as a driver of hospital reputation; whether positive or negative it was expected to arise as an influencing factor. This finding is supported by Boscarino (1988) who suggested that the clients of a hospital will rate it based on its facilities. Further, facilities was an expected finding, as literature by Miller and May (2006) states that although the reputation of a hospital is based on health related issues, patients also make judgements and base their choices on subjective assessments of the hospital environment, parking facilities, hygiene and cleanliness and also the facilities available for visitors. Further, Dey et al. (2006) states that it is important for any healthcare organisation to make the required facilities available as if the organisation performs to the required standards, it will assist in satisfying both healthcare personnel and patients. This study did expect to find negative perceptions with regards the hospital hygiene, as according to hospital management, previous public reports rated the hospital quite low in this area. However findings were quite different, patients and staff alike praised the cleanliness of the hospital and the dedicated staff. According to hospital management the explanation for this misjudgement seemed to be the result of politics.

The *media* was seen to be a major driver of negative reputation by all three stakeholder groups. Previous literature discusses the media as an influencing factor of commercial reputation therefore this study also expected it to affect public sector reputation. Analogous with the findings of this study, Davies et al. (2004) state that any negative information that the media obtains will result in media exposure to its customers being detriment to the organisations success and reputation. In order to avoid the media having any negative influence on the organisations reputation, Ritchie et al. (1999) stated the importance of a strong brand as it will create goodwill and protect the organisation from the media and vagaries of public opinion. This reinforces the importance of conducting reputation/branding research in the public sector.

Waiting times was another expected driver of negative reputation; it is one of the most talked about issues regarding the healthcare service in Ireland. Despite many developments in organisation and technology, this study believes that patients still have to experience unacceptable levels of waiting, these waiting experiences create negative perceptions and

have been shown to affect the consumers overall satisfaction and their evaluation of the service encounter. The research findings of this study are in accordance with previous research by Barlow (2002), who found that patients overall perceptions of the hospital service is clouded by the initial unnecessary and ill informed wait the patient has to endure. Further, the federal express stated "waiting is frustrating, demoralising, agonising, annoying, time consuming and incredibly expensive" (Barlow, 2002). Patients from this study stated that *'if they were more informed of the waiting length or approached more with regards the hold up it would take away some of the negative feelings'*.

8.3.2 Unexpected Findings - Drivers

Management appeared to be a major issue within Hospital X. This finding was unexpected as it is essential for a healthcare organisation to be run efficiently and to have excellence in management. Clinicians stated management as being a problem within the hospital; as they believed keeping costs low is more important for management than the hospitals patients. The findings of this study concur with previous theorists in that OCO must be present to ensure patient satisfaction (Rust et al., 1996). Management should have 'meeting patient needs' as their main concern. In order to do this, they must organise the hospital to meet patient needs and consider the patient when making big decisions (Narver and Slater, 1990). OCO is central in a public hospital, as according to (Beltramini, 2001) the primary function of a public service organisation is to service its clients. Respondents further felt that management do not devote enough time and effort to understanding and listening to the staff, they felt this should be an important role of a manager as their staff are the ones who engage with the organisations key stakeholders i.e. patients. The importance of management was reiterated throughout a review of the literature, for example Anderson (2006) stated that it is essential for a firms' management to understand that frontline workers and customers need to be at the centre of management concern. Moreover, Davies and Chun (2007) found that firms tend to focus on what consumers think, to the exclusion of what employees' think, they advised that the management of an organisation must involve its staff and interact with both internal and external stakeholders in order to drive reputation.

Employees felt angry towards management not been concerned enough about patients needs "*I honestly feel that patients are actually forgotten about most of the time; it seems that business plans and cost analysis are taking over the objective of satisfying customers'*

needs". Paarlberg (2004) offers an explanation for this difference between what employees and management see as important; the study focused on government organisations and found that the management of an organisation have different perceptions of who the organisations customers are compared to its employees. To employees, customers are service users and to management there may be several people to consider, for example an important customer may be a funding agency. Corresponding with this current study, Newman et al. (2002) found that poor management exists in healthcare organisations and this leads to poor communications. Respondents from their study cited similar opinions to the respondents in this study regarding issues such as *'management are not seen'*, and *'complaints are not heard or followed through'*. It is believed that these concerns need to be overcome to avoid damaging the hospitals reputation.

Considering the literature and the findings, if staff are not happy in the workplace it may come across to patients in the service delivery. According to Davies and Chun (2006) it is important for staff to have a positive view of the organisation, they state that if customer-facing employees share a positive view of the organisation with customers, then a positive interaction between them is more likely to occur. From focus groups discussions, it is evident that staff had a lot of anger towards the hospital management. Support staff felt that they are never informed by management and there are *'too many chiefs'*. They were also of the opinion that the key to a positive reputation is for management to start listening to staff. Clinical staff perceived management as *'rude'*. They also suggested that management failing to engage with staff on a personal level was a definite driver of negative reputation. Employees believe that management conduct demotivates them, and creates negative feelings; which are passed to patients, and result in external stakeholders perceiving the organisation pessimistically. Similar findings were found by Schlesinger and Heskett (1991) who suggest that if a service sector employee is frustrated with the work environment, the frustration does not only influence the employee's performance, it can directly impact on a customers perception of the organisation (Anderson, 2006).

Contrary to the above employee findings, patients perceive management as being a driver of positive reputation and not negative reputation. Overall external stakeholders viewed the hospital as positive and put this down to how the organisation is run by its management. They believed that managements' behaviour influences employee behaviour. As a result of patients having little contact with management, it was unexpected to find patients

describing management as a driver of positive hospital reputation. Given the discrepancies identified within this public sector organisation between internal and external stakeholder views, it was therefore important to assess both views in the quantitative phase also, as recommended by many studies in the reputation management literature (Chun and Davies, 2006; Davies et al., 2003)

Both support staff and clinicians complained about the level of **staff training** and employee development available at the hospital. This was an unexpected finding, as when dealing with customers it is essential that frontline staff are trained adequately to fulfil their job role, deal with the customer and ensure customer satisfaction is at a high level. Support staff stated there is a lack of inductions before you even start a job, training is an ongoing problem as people are, according to one respondent, '*just left on their own from day one'*. Within the healthcare industry, technology is constantly improving and advancing, in order to keep up with this, high quality inductions and continuous training are expected by staff. A high level of staff training is also required to ensure public confidence exists towards the health sector.

Further, training was an unexpected driver of negative reputation as Farnfield (1999) reveals that a well designed induction and training programme helps create greater staff commitment, which is an important component for a strong service brand. Moreover, Cleaver (1999) suggests that successful service brands depend on good internal communication programmes and Camp (1996) also found that training is needed to support greater consistency in delivering the service experience (de Chernatony and Segal-Horn, 2003). According to Bitner (1990), a lack of training in the organisation can be disastrous for its reputation, as the customer perceives the service organisation based on their service encounter with the employee. de Chernatony and Segal-Horn (2003, p.1096) state that despite the importance of having a strong brand, frontline employees are often not trained to understand customers and do not have the discretion to ensure effective responses, this research study found that this is occurring in public service organisations even though employees are demanding more training be provided. As a result of inefficient training, service users may become concerned about issues such as how competent the staff member really is in performing their job responsibilities. Service users' satisfaction and confidence may also suffer as a consequence, leading to negative word of mouth and consequently reputation defects.

Communication was also found to be a major issue in the organisation, driving a negative reputation in the eyes of the hospitals three key stakeholders. Previous literature emphasises the importance of communication within the service organisation, therefore the study did not expect to find it as a driver of negative reputation. de Chernatony and Segal-Horn (2003, p.1099) state communication is important for any service organisation '*communication is essential in any service organisation as there are far more points of contact between service brands and stakeholders compared to a product brand*'. Furthermore de Chernatony and Segal-Horn (2003) state that it is necessary for a service organisation to devote more attention to a coherent communication strategy both internally and externally. The major issues surrounding communication at hospital X were the lack of communication between employees and management and the lack of communication between foreign doctors and patients. McKinlay (1972) state that the amount and form of information patients' receive is one aspect about which they express most dissatisfaction. Therefore, in agreement with McKinlay (1972), communication and information are perceived as drivers of negative reputation; communication is connected to information as the information doctors are trying to communicate to patients does not always reach them as patients sometimes find the medical staff hard to understand. Additionally, a strong link exists between communication, information and training as the literature suggests that in order for the employees to understand their role as brand ambassadors of the organisation, management should communicate information about the service vision to the staff and furthermore, enhance this through training (de Chernatony and Segal-Horn, 2003). If hospital management continues with a lack of communication between themselves and employees and secondly, does not provide the desired training, then their actions will be damaging to the hospital's reputation. The next section will discuss the possible outcomes of positive/negative hospital reputation.

8.3.3 Outcomes of Positive Reputation

It was decided to structure this section into positive and negative outcomes rather than expected and unexpected findings. The majority of outcomes mentioned by respondents were expected, therefore, the following discussion displays evidence of how the current study mainly concurs with previous studies in the literature.

A major outcome of positive reputation for both patients/employees' was **satisfaction**. Satisfaction is essential for any service organisation. Organisations' should constantly be working towards improving customer satisfaction. Hall (2008) states '*improving patient satisfaction increases loyalty to the firm*' (p. 79), therefore increasing customer retention. Likewise, this study discussed customer retention; patients stated revisiting the hospital would be an outcome of positive reputation. Literature suggests that researchers and practitioners have a keen interest in understanding what drives customer satisfaction, this study found that customer satisfaction is both a driver and outcome of organisation reputation. In that, a satisfied patient will drive a positive reputation through word of mouth communication and further, awareness of a positive hospital reputation will result in increased service user satisfaction. As well as patient satisfaction, a positive reputation will lead to employee satisfaction, as respondents stated they would feel it is a reward for their hard work and devotion to the hospital. According to Currivan (1999), employee satisfaction refers to the degree to which an employee has positive emotions towards the organisation, not towards the specific job role (Davies and Chun, 2002).

This study found that the external perspective on satisfaction is somewhat different to the internal perspective; patients base their satisfaction on their personal experiences with the hospital whereas support staff get satisfaction from job security and clinical staff get satisfaction from personal fulfilment i.e. saving life's'. Chun and Davies (2006) also found that job security leads to satisfaction, especially in a competent organisation, this study found competency is the second highest dimension correlated to employee satisfaction. The findings from this study provide evidence of a circle-like relationship between satisfaction and reputation, in that satisfaction drives a positive reputation and a positive reputation results in outcomes such as employee/patient satisfaction.

Other employee findings that appear to be outcomes of a positive reputation include **motivation**, **commitment** and **association with the hospital**. Support staff stated that they would be proud to be associated with the hospital and feel that they are associated with a winner when the hospital holds a positive reputation. Support staff also felt that if the hospital had a positive brand/reputation it would motivate them to work harder to maintain that brand/reputation. Clinical staff felt that they would be satisfied with their workplace, pleased to be associated with it, motivated and more committed to their job if it had a positive reputation. Employees felt that they would be contributors to the reputation as they

are part of the organisation. Da Camara (2007: 2008) found similar findings to this, in that people feel proud to belong to an organisation that is believed to have socially valued characteristics such as a public service, Da Camara (2007: 2008) also stated that reputation has been identified as a key factor for potential applicants seeking to work at a particular organisation (p.17). According to Hall (2008), improving employee satisfaction increases employee engagement, which increases staff retention and decreases turnover costs (p.79). Reputation is therefore crucial for recruiting and attracting employees in the public sector.

A further outcome of a positive reputation is patient *confidence and trust*; the two terms are often used interchangeably. Confidence and trust were expected findings in this study as the context is healthcare; these are two important dimensions for this sector. It was hoped to expose confidence as a key outcome of reputation, as it will further exemplify to public sector organisations, specifically those involved in healthcare that maintaining a positive reputation will result in an increase in service user confidence. The more confidence we have in a hospital and the service it delivers as a patient, the more likely we are to recover (Health Service Executive Transformation Programme, 2007-2010). The more positive an image an external stakeholder holds, the more likely they are to select one hospital over another, if they have a choice (Shahian et al., 2000) and the more confident they will feel entering the same hospital that their treatment will be successful.

The qualitative work illustrated this point whereby external stakeholders stated that, in order to be satisfied with a hospital, patients' should feel safe and well cared for. The patients in this study felt that the medical staff at the hospital meet this important physiological and psychological human need '*A feeling of relief… I was brought in a couple of times by ambulance, the great feeling of relief when you are brought in when you have experienced nurses and doctors'*. Da Camara (2007: 2008) found that public authorities are becoming aware of the need to manage public confidence, which is essential, as it will determine patient attendance. Patients in this study felt that they would have confidence and faith in the hospital and would not be afraid to attend it if it had a positive reputation. This finding is similar to work by Davies et al. (2003) who suggest that a service organisation with a positive reputation will lead to stakeholders having confidence in the service they receive.

Furthermore, Davies et al. (2004) found trust to be an element of superior reputation from the perspective of external stakeholders. Entwistle and Quick (2006) highlight the importance of trust relationships in healthcare contexts. Trust appears to be linked to both media and word of mouth, as Entwistle and Quick (2006) state that before a customer lays their trust in a healthcare provider, they will firstly seek information about them, and this information may come from what they see in the media or what they hear people say. From an external perspective trust appears to be strongly valued in relation to reputation, similarly Da Camara (2007: 2008) found that the role of trust in improving stakeholder relationships and achieving performance is becoming more valued in public organisations.

Trust and confidence are essential components for maintaining long-term relationships. A strong reputation increases confidence, and customer retention (Schwaiger, 2004). Furthermore, Hall (2008) discusses the importance of confidence and trust, he states that they lead to a better understanding of opportunities to improve the patient experience and build loyalty. Kim et al. (2008) suggest that to have a successful healthcare organisation, marketing efforts must be focused on building a high level of trust. Brands are essential for intangible products, as brands offer some measure of assurance that the provider of the good or service will deliver consistently on its promises, and is therefore worthy of trust. This helps to overcome barriers of uncertainty that might otherwise prevent people from becoming customers (Ritchie et al., 1999). In order to keep the brand successful, trust must be a standard that hospitals and employees offer their patients.

Macintosh (2007) found further outcomes of a successful service organization; satisfaction, positive *word of mouth* and loyalty to the brand/organisation. Word of mouth (WOM) is particularly important in service organizations, as consumers are more likely to depend on the communication of others rather than marketing based communication (Macintosh, 2007). As well as being a driver of reputation, this study found that word of mouth is also an outcome of reputation. Both patients and support staff stated that word of mouth results from patients' experiences at the hospital, patient satisfaction is therefore necessary to promote positive word of mouth.

Staff can also spread word of mouth; their experiences at the hospital in terms of job satisfaction and treatment by other staff members can result in positive/negative WOM. Weigelt and Camerere (1988) suggest that a good reputation leads to existing customers

providing positive word of mouth, when asked about the outcomes of positive reputation in this current study, it was mentioned by all three stakeholders. Support staff stated '*patients always seem to be happy with their experience and are always thankful*, *they leave and spread good word of mouth*'. Clinical staff stated that *'word-of-mouth tends to impact peoples' impressions and shape their perceptions of public and private hospitals; this then shapes the hospital's overall reputation'.*

The ability to **attract good staff and maintain customer loyalty** is an outcome of positive reputation found in this study and is akin to findings by Markham (1972) as cited in Chun (2007). Findings from this study are also in agreement with Hall (2008) who suggests that patient loyalty can be an outcome of positive reputation. Furthermore, Hall (2008) states that in order to stay ahead, one must have a positive reputation throughout the community and have loyal patients, as well as influencing consumer choice a positive reputation will result in where physicians send their patients and also whether current employees would recommend the hospital for employment. Employees in this study were asked if they would recommend the hospital as a place of employment (Figure 7.1), 62.2% strongly agreed/agreed with the statement 'I would recommend hospital X as a good employer'.

Figure 8.1: Employees rating of recommending the hospital as an employer
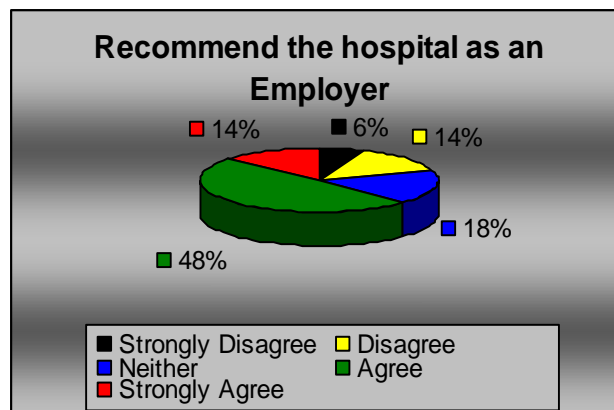
From discussing the outcomes of reputation in this study, it can be noted that internal and external stakeholder perceptions are interlinked, this is in line with findings by Hatch and Schultz (1997), and Fombrun (1996). Results display that the three groups of respondents have similar views and according to Davies et al. (2004), if both the internal and external groups share similar positive views then a positive interaction between them is likely to occur.

8.3.4 Outcomes of Negative Reputation

The outcomes found in this study of negative hospital reputation are subsequently both compared and contrasted to those outlined in previous published work.

According to Hibbard et al. (2005) if a hospitals reputation is affected it may experience market share decline via consumer choice. The findings of this study are in agreement with Hibbard et al. (2005). Patients stated that even though there is only one hospital in their community, if it had a disastrous reputation it would be possible for them to attend another hospital, as a result the hospital would see a reduction in service users. According to Power (2005) patients now have more choice in the healthcare provider they choose. However, clinicians contradict this patient view, they are of the opinion that even if the hospital has a negative reputation, it would see a reduction in the number of service users, especially public patients, as patients would simply have no choice but to attend the hospital. I the case of healthcare, choice will always fall down to the importance or urgency of the visit to the hospital. In the case of hospital X, some attendees are in between the X and Y areas so realistically this study believes that they could make a choice. In line with findings by Hibbard et al. (2005), patients of Hospital X still choose to attend, as they perceive it as having a positive reputation.

Hibbard et al. (2005) also found that a declining hospital reputation may pose several other challenges, one being difficulty in recruiting and retaining staff. The findings of this study also concur with this as both support and clinical staff stated if the hospital had a negative reputation they would disassociate themselves from it. Support staff stated that they would opt to change jobs and be ashamed to say they worked at the hospital. Clinical staff said they would not tell people where they work, similar to findings by Hall (2008), disassociated themselves from the hospital and feel personally responsible for its negative reputation. Schwartz (2000) state that disassociation with the organisation you work for is a sign that the company is in deep trouble. Kmetovicz (n.d.) states that it is hard work for an organisation to get the best employees and in order to attract them it needs a sound reputation, this view corresponds with the findings as respondents believe if the organisation had a negative reputation it would find it difficult to retain and attract new staff.

As well as trust being an outcome of positive reputation it can also be an outcome of negative reputation, as patient trust levels may diminish. Patients were of the opinion that bad experiences can reduce their perceptions of the organisation and further reduce their trust in the organisation. Research conducted by Satir (2006) illustrates trust to be one of the major determinants to affect customers' perceptions of organisation reputation. Much of the findings by Satir (2006) found similar drivers of reputation to those found in this study however Satir (2006) focused on the private sector. This study therefore offers new knowledge to public sector theory.

As previously mentioned, an outcome of positive reputation is positive word of mouth; an outcome of negative reputation can also be word of mouth and public opinion. Patients stated they would tell people if they were unhappy with the service and support staff believed that patients would talk about their experiences at the hospital especially if it is a negative one. It is important that patient's needs are met so that their experiences will be positive and the organisation will avoid negative public perceptions. Hall (2008) found that for every patient that complains, 20 unsatisfied patients do not, of those 20 unsatisfied patients who do not complain, 90 percent won't return. Thus, it is important for the organisation to resolve any issues' patients may have before they leave in order to prevent negative word of mouth. Respondents felt that if the firm had a negative reputation they would talk about it and it would diminish even more. In agreement with this, Rob and Fishman (2005) state that word of mouth effects reputation as consumers tell other consumers and members of the public about their experience and as a result the firm declines.

Another outcome of negative reputation was found to be 'media frenzy'. The three main stakeholder groups highlighted a media frenzy as being an outcome of a negative hospital reputation. Respondents felt that if the media were to get hold of any negative information in relation to the hospital, then they would expose it through local and national media. Findings by Davies et al. (2004) support the findings of this study; they also found any negative information that the media gets hold of will result in media exposure to its customers, being detriment to the organisations success and reputation. If the organisation acquires a negative reputation, respondents felt that the media will report this and slate the organisation as they only report bad press '*70% of the media is bad news*'. Findings from this study further concur with those by Dean (2004) who states that the media has a

preference for reporting bad press and it has a tendency to be weighted more than positive information. Advice by Caruana (1997) states that it is important to use media efficiently and consistently, to explain 'what's' and 'whys' about each activity properly, therefore decreasing the chance of the media reporting false stories.

Another major finding of this study was the downgrading of facilities due to negative reputation. Downgrading of facilities' was an unexpected finding as previous research on drivers of reputation mainly focused on the private sector and government funding would not have been an issue in such a context. This finding therefore contributes to public sector theory. Respondents felt that the hospital would not be in a position to receive government funding if it had a bad reputation. According to the HSE transformation programme (2007-2010), Irish public healthcare organisations are only given increased funding if they meet certain needs through an accreditation process, therefore the reputation the hospital possesses is crucial to its future success. According to Balabanis et al. (1997), a consensus exists today that non-profit organisations are characterised by an increasing demand for their services, a reduction in the traditional governmental financial support, and a growing number of participants competing fiercely to raise funds (Shoham et al., 2006). This proves how important it is for hospitals to display good performance through reputation in order provide a high-quality service to its customers.

An additional outcome of negative hospital reputation, from the perspective of internal stakeholders was '*feeling responsible*'. Staff stated that they would feel personally responsible for the organisations reputation. The reason for such an outcome can be attributed to the fact that hospital X is a service organisation and both clinical and support staff provide services to the patient. Consequently, it is believed that if these services are unsatisfactory then the frontline staff will feel responsible. The study further postulates that the reputation of an organisation is the responsibility of all its internal stakeholders not just those in contact with the external stakeholder. Such a finding is not evident through a critical review of available literature; therefore this study contributes further to public sector theory.

In conclusion, several outcomes of reputation were mentioned by patients and employees in the focus group discussions. However different opinions exist in relation to the outcomes. This is in line with previous research by Davies and Chun (2002) who state gaps do exist

between internal and external stakeholders as a result of stakeholders having different experiences with the organisation. A good example here would be concerning management; patients and employees have different dealings with management and therefore different perceptions. Theory further suggests that management should aim to align these perspectives, and as a result patients and employees will be more satisfied. Satisfaction was the key outcome in the quantitative study which aimed to assess the impact of both ECO and OCO on internal and external stakeholder perceptions of the hospital's corporate character, and the subsequent effect on stakeholder satisfaction. A summary of the survey findings are first presented.

8.4 – Summary of Survey Findings

The first major finding was highlighted in the descriptive statistics section. The three stakeholder groups' views of the organisation were assessed by use of the corporate character scale (Davies et al., 2001). All previous studies reveal agreeableness to be the strongest dimension but in the case of this study, in the public sector, competence appears to be the strongest dimension in the eyes of all three groups i.e. the organisation was viewed as being reliable, secure and hardworking. The subsequent finding concerned satisfaction levels, results appear to be slightly stronger with the external stakeholder group; patients/visitors had a mean satisfaction score of 3.68, whilst employees had a score of 3.45. In terms of stakeholder perspectives of CO, both groups rated CO higher at an individual level than CO at an organisational level; patients rated both levels fairly close (3.91, 3.35 respectively) whilst there was a larger gap from the employee perspective (4.45, 3.42 respectively). The relevance of CO to an organisation such as a hospital goes beyond the idea of assuring taxpayers that the public is getting value for money. The more confidence we have in a hospital and the service it delivers as a patient, the more likely we are to recover (Health Service Executive Transformation programme, 2007-2010).

Following on from the preliminary analysis, the researcher began analysis for the hypotheses. Hypothesis one firstly tested the relationship between individual level CO and patient satisfaction. Results found that there is a strongly significant relationship between both components suggesting the higher the level of CO held by employees the more satisfied patients will be. The same analysis was then run for employees. This study again tested the relationship between individual level CO and employee satisfaction. The results

were insignificant; therefore the study found that the perceived level of CO possessed by employees does not have an impact on their satisfaction levels.

Hypotheses two, three and four analysis was conducted by using a measure of mediation. From testing the mediation relationships of H2, H3 and H4, the sobel statistical test reveals quite positive results. The results found will be discussed, and compared in relation to the findings of previous theorists.

8.4.1 The Sobel Statistical Test

Beginning with hypothesis two - the first mediating relationship, correlations were conducted to establish if there is a relationship between the variables. Correlation results exposed that there is significant relationships between ECO, OCO and patient satisfaction. Probability levels were calculated through the Sobel test calculator, results were significant at one and two tailed levels, thus supporting the hypothesis. Therefore, this study states that the relationship between ECO and external stakeholder satisfaction is mediated by OCO.

The same tests were calculated but this time for employees. Correlations concur with previous preliminary analysis in that ECO does not have a significant relationship with employee satisfaction. At a 95% confidence level there is a relationship between ECO and OCO. At a 99% confidence level there is a relationship between OCO and employee satisfaction, suggesting the presence of CO at an organisational level affects employee satisfaction. The sobel test produces a probability level of just over 0.5 at a 95% confidence level. For H2 (b) the mediating relationship is only partially supported, as not all three conditions stated by Baron and Kenny (1989) were satisfied.

Hypothesis three is based on external stakeholders. Analysis begins with the *agreeableness* dimension. Correlations display significant relationships between all three variables; patient satisfaction, ECO and agreeableness. Through regression analysis, results reveal that hypothesis three is fully supported at both a one and two tailed level of significance. Results suggest that there is a relationship between ECO and the CBP dimension agreeableness, as well as relationships between ECO and patient satisfaction and agreeableness and patient satisfaction, therefore the presence of ECO will impact patients/visitors views of the corporate brand and further their satisfaction with the organisation. In addition to regression results displaying relationships, the probability

levels produced from the sobel test, at both a one and two tailed level of significance, show a mediating relationship as values p<0.01.

The next stage was to examine the hypothesis with regards the *competence* dimension. Correlations were again strongly significant between all three variables. The hypothesis was again supported at both levels of significance, illustrating ECO will increase the likelihood of external stakeholders viewing the organisation as competent and hence, increasing their satisfaction with the firm.

Correlations between *enterprise*, ECO and patient satisfaction were also found to be significant. Regression analysis again supports the hypothesis, which illustrates that the presence of ECO creates perceptions of enterprising traits towards the organisation and thus increases patient satisfaction.

The next stage was to test the *machismo* dimension. Correlations again display significant relationships between ECO and patient satisfaction at a two-tailed level of significance and between machismo and ECO at a one tailed level of significance. A negative relationship exists between machismo and satisfaction but it was not strongly significant. Regression analysis displays that hypothesis three is not supported when machismo is tested. The sobel test also reports probability levels above the required value. There is no relationship reported through regression between machismo and satisfaction or between machismo and ECO. There is a strong relationship, as previously reported in this study, by ECO and patient satisfaction. Thus, the presence of ECO does not make external stakeholders perceive the organisations' brand as machismo and therefore does not affect external satisfaction.

The final analysis on hypothesis three was using the *ruthless* dimension. Correlations again displayed a significant relationship between ECO and external stakeholder satisfaction, a significant negative relationship between ruthlessness and patient satisfaction and a negative relationship between ECO and ruthlessness. Regression supported the correlation results in that there is no relationship reported between ECO and the ruthless dimension, ECO and patient satisfaction again came out as strongly significant, likewise the ruthless dimension displayed a value of 0 but the beta and b values were negative. Overall calculations from the sobel test were negative and probability values over 0.05 therefore

the hypothesis is not supported, also all three conditions recommended by Baron and Kenny (1989) were not met.

Hypothesis four is similar to hypothesis three but this time analysis is conducted on the employee database. Correlations concur with previous correlations and descriptive statistics in that ECO and employee satisfaction do not correlate. However, strong significant correlations were found between *agreeableness* and ECO and agreeableness and employee satisfaction. Regression analysis highlights a relationship between agreeableness and satisfaction but does not show any significant values between ECO and agreeableness and agreeableness and satisfaction. Despite this when the regression coefficients' and the standard error for the regression coefficients' are entered into the sobel test calculator, probability levels of p<0.001 are the outcomes, suggesting a partial mediating relationship exists.

Competence was the next dimension tested. Correlations again show no relationship between ECO and satisfaction, but relationships do appear between ECO and competence and competence and satisfaction. Regression also shows there is a relationship between competence and employee satisfaction and between ECO and competence, p values of <0.001 are also reported from entering values into the sobel test calculator therefore supporting the hypothesis.

Enterprise was the next dimension that was analysed. There is a strong correlation between enterprise and satisfaction but not between enterprise and ECO. Regression results are in accordance with the correlation results of this study. Hypothesis four is only partially supported for the enterprise dimension as only one of the three conditions was satisfied.

Once again correlations reveal that there is a negative relationship between *machismo* and ECO and no relationship between ECO and employee satisfaction and machismo and employee satisfaction. Regression also displays some insignificant relationships therefore this hypothesis is only partially supported, as the required conditions are not met.

Correlation analysis of hypothesis four revealed there is a negative relationship between ECO and the *ruthless* dimension and a significant negative relationship between ruthless and satisfaction. High probability levels and negative regression results show that this

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dimension is not supported i.e. the presence of ECO does not lead employees to perceive the organisation as ruthless and further does not relate to their satisfaction.

8.5 – Expected/Unexpected Quantitative Findings

8.5.1 - H1: The higher the perceived employee customer orientation (ECO), the higher the satisfaction for an organisation's internal and external stakeholders will be

To summarise the results of hypothesis one the study found, in a public sector context, hypothesis one to be supported for external stakeholders (0.593**) and to be rejected for internal stakeholders (0.061). The following section will discuss both internal and external findings in conjunction with previous literature review findings.

High levels of ECO enhance service users' views of the organisation's brand through positive interactions with the brands employees and results in greater overall satisfaction among internal and external stakeholders (Rust et al., 1996 p. 391). The effect CO, at both an individual and organisational level, has on an organisation's main stakeholders and its reputation is a major contribution of this research study.

8.5.1.1 Internal stakeholders

CO in public sector services is important as customers find it hard to evaluate a service in comparison to a product; therefore strong focus on intangible elements occurs. CO at an individual level can be viewed as the practice of the marketing concept at the level of the individual salesperson and the customer (Saxe and Weitz, 1982), in this specific case a staff member and patient. Furthermore, it refers to the degree to which frontline staff, practice the marketing concept by trying to help their customers make purchase decisions that will satisfy customer needs.

Donovan and Licata (2002) conducted three studies in two different service industries in the private sector. Their results revealed that CO has a positive influence on employee satisfaction in a service context, and employees working in a service environment can be expected to be more satisfied the more customer orientated they are themselves.

Furthermore, (Brown et al., 2002; Donovan et al., 2004) found that employees with high levels of CO will be more satisfied with their jobs than employees who possess smaller levels of CO. The findings of this study show no significant relationship between CO and employee satisfaction in a public sector service setting. When correlations were conducted it was evident that no strongly significant customer orientated traits correlated to internal satisfaction. There was a consistently negative relationship between the enjoyment component of ECO and employee satisfaction. Making patients happy or responding quickly to their requests was not found to correlate to employee satisfaction. Employees viewed the needs dimension as having priority over the enjoyment dimension, which is understandable in a healthcare setting. This finding contrasts with the patients desire for more than just medical expertise, as it is evident from patient responses that nurses who are '*supportive and kind*' are highly regarded and valued, and a comfortable enjoyable experience can create positive external perspectives towards the organisation brand.

Despite ECO not having a significant relationship to employee satisfaction, results illustrate that employees at the hospital view themselves as being highly customer orientated as they rated themselves highly on questions such as '*I try to help patients achieve their goals*', '*I get patients to talk about their needs with me*', '*I keep the best interest of the patient in mind*' and '*I am able to answer a patients questions correctly*'. The above questions show strong signs of CO at an individual level as employees are helping customers to make decisions and trying to satisfy their needs. Recruiting the right employee is an important task for managers of a service organisation especially if they are frontline employees, they must possess traits that will allow them to be customer orientated (Licata et al., 2003).

Donovan et al. (2004) and Sergeant and Frenkel (2000) found in their studies that how customer orientated customer contact employees are, depends on the individual employees satisfaction with their job and how committed they are to the service organisation. This study argues this point as findings show no significant correlation between ECO and their commitment to their job, and no significant relationship between ECO and employees overall satisfaction, therefore the level of ECO is not influenced by their commitment to their job nor does being customer orientated contribute to the employees overall job satisfaction in this context – a public sector hospital.

Results, as previously mentioned, are quite high regarding the presence of ECO. From both a patient and employee perspective, staff at the hospital are viewed positively with regards to interpersonal relations and interactions with patients. Employees were also rated highly in terms of resolving patient complaints. Scotti et al. (2007) stated that resolving patient complaints and adopting a willingness to learn are two defining features of a customer orientated work climate. Paarlberg (2007) states that the degree to which an employee's work affects the health and well being of other people encourages a person to believe that his work is worthwhile or important, this study validates this finding: - "*Looking after patients is extremely satisfying, it makes it all worthwhile when you see the difference you make, it is the biggest motivator to work*".

As CO does not affect employee satisfaction in this context, it is important to reveal what does. Scotti et al. (2007) found that healthcare workers that are highly involved in their work environment leads to exceptional service quality, satisfied patients, and ultimately to loyal customers. Results from this study found that the work environment is a predictor of satisfaction for employees. There is a highly significant relationship (0.469**) between a positive work environment and employee satisfaction. The work environment was also mentioned in the qualitative stage of this study, employees felt that having a good work environment would lead to positive perceptions towards the organisation. Scotti et al. (2007) also suggest that organisations that provide enabling work environments will have employees who can devote their efforts to meeting the needs and expectations of customers (ECO), thereby improving service quality and ultimately having satisfied patients. Scotti et al. (2007) also stated that Newman et al. (2001) found that nurse's perceptions of their ability to serve patients have been conceptually linked to their work conditions.

Employee satisfaction is also important for an organisation to investigate to ensure they maintain high levels of staff retention. Staff retention is necessary as patients can become loyal to one employee and may leave the service organisation when the employee does. Hospital X has high staff retention; most employees are working at the organisation over five years. In the case of a public sector institution, such as a hospital, not attending the organisation when a certain employee leaves may not be possible as the patient may have little choice with regards the hospital they attend.

The next section will discuss the same hypothesis, but will focus on the patient/visitor findings.

8.5.1.2 External Stakeholders

According to Anderson et al. (1994) it is important to uncover if CO affects customer satisfaction, as customer satisfaction is important in any organisation. Further, customer satisfaction is known to be an antecedent of increased market share, profitability, positive word of mouth and customer retention (Anderson, Pearo and Widener, 2008 p. 365). This study found that there is a positive relationship between CO and customer satisfaction, this is in line with previous published findings (Reynierse and Harker, 1992; Darby and Daniel, 1999; Scotti et al., 2007).

Patients viewed staff positively and rated them as being highly customer orientated in this study. Bove and Johnson (2000) suggest that strong customer relationships between the firm's employees and its customers will lead to true customer loyalty and customer retention. They also suggest that if managers want to retain customers they need to retain staff as in the service organisation the customer usually develops a relationship with one particular service worker. Hospital X has high staff retention, which enables relationship development. Saxe and Weitz (1982) suggest that the customer orientated service personnel view the customer relationship from a long term perspective and therefore concentrate on what is best for the customer rather than fulfilling their own needs, this study is in agreement with this as customers rated staff as being strongly driven towards keeping the best interest of the patient in mind.

The external view of the organisation is determined in part by the interaction between customers and employees. In a service business, such as a hospital, this can be expected to shape the external view, as the customers of a service business will judge it by their perceptions of that interaction. According to Licata et al. (2003), customers overall satisfaction with a service is derived from the personal interaction component, satisfied customers are an outcome of highly customer-orientated staff. There seems to be general agreement from marketing theorists that customer orientated employees are likely to deliver a high quality service, resulting in satisfied customers (Reynierse and Harker, 1992; Sergeant and Frenkel, 2000). The findings of this study are akin to this as employees at

hospital X are highly customer orientated and ECO strongly correlates to patient satisfaction at a 99% confidence level.

Patients agreed with all the statements in the survey regarding individual level CO, which suggests that not only do employees view themselves as being customer orientated but the patients also perceive the staff as being customer orientated, illustrating that employees are working towards satisfying the patients needs. The qualitative findings further illustrate the importance of satisfying patient needs for employees, as several respondents stated that they have a responsibility to patients and looking after their needs *"I like when I have patients that are divided into a small enough groups so you can care for them properly and devote proper time"*. According to previous theorists (Hennig-Thurau, 2004; Hartline et al., 2000) customer contact employees are the representatives of a service firm. Customers often base their impressions of the firm on the service they receive from those customer contact employees, in this study findings show that patients have a high view towards the employees of the organisation and therefore are satisfied with the organisation as a whole. Results show that employees are very dedicated to their role and to their patients; this is shown by the results from the CO scale in the survey. Employees rated themselves highly when asked about responding to patient requests, getting satisfaction from making patients happy, enjoying taking care of patients and achieving their own goals by satisfying patients.

Bitner (1990) found that customers are more satisfied with the service encounter when employees possess the ability, willingness, and competence to solve their problems, this study found similar findings when asking patients about how customer orientated they perceived staff to be, patients strongly agreed with the statement '*Staff at hospital X are able to answer patients' questions correctly'*. High levels of employee CO enhance service users views of the organisation's brand through positive interactions with the brands employee and result in greater overall satisfaction among internal and externals stakeholders (Rust et al., 1996, p. 391). Similarly Scotti et al. (2007) state that patients' perceptions of a service are a strong antecedent of their overall satisfaction and that this has been widely researched and accepted in the services marketing literature. Investigating the effect of CO on external stakeholder satisfaction is essential to any sector or organisation as the customer, if satisfied, will remain committed to the organisation and impact its reputation by word of mouth. Correspondingly, Press (2003) found that staff sensitivity to

patient needs, how well staff work together and service recovery are three important aspects towards creating patient satisfaction. These aspects display signs of CO and result in satisfaction, satisfaction then appears to lead to positive perceptions towards the organisation and overall a positive reputation.

Bryant, Kent, Lindenberger and Schreiher (1998) suggest factors that affect client satisfaction. Socio-emotional factors deals with communication and interpersonal skills of the provider, system factors refer to technical or physical aspects of the service such as waiting times, moderating factors include socio-demographic variables and finally family and friends are viewed as influencing factors. This current study found similar findings for factors that affect patient satisfaction, these being culture and communication, care, hygiene and waiting lists and word of mouth.

8.5.2 Main Discussion – H2

H2: The relationship between perceived ECO and internal and external stakeholder satisfaction is mediated by OCO

Kennedy et al. (2002) state that the true concept of marketing can only be achieved when CO is considered to be a working philosophy for all of a firms' members. This reinforces the need to study CO at both the individual and organisational level. A defining feature of CO at an organisational level is managers adopting strategies that will benefit the patient and empower frontline staff to satisfy the patient; managers must measure progress as well as recognising that changing their work environment takes time and dedicated effort (Scotti et al., 2007). This study supports this theory as overall the scale for OCO was viewed as positive by both patients and employees, suggesting that management are considering the patients point of view, organising the hospital to suit patient needs and constantly checking to make sure policies and procedures do not cause problems for patients. Despite employees rating management activities positively, their views in the focus groups were quite negative. This study finds that employees view management positively in terms of setting policies and procedures but when it comes to really caring about patients needs, management appear to be lacking on the interpersonal level with patients. This view is in agreement with quantitative findings that demonstrate employees' rate managers high on policies and procedures but low on caring about patients and paying close attention to

patients. The following sections will discuss H2, in relation to internal and external stakeholders, in more detail.

8.5.2.1 External Stakeholders

Customers/Patients will be more satisfied if they perceive the organisation as being more orientated towards them, further it appears their views of OCO will influence their views as to the orientation of employees. Thus this study expected OCO to be a mediator between ECO and patient satisfaction, empirical findings supported this hypothesis. For external stakeholders, OCO has a strong and positive influence over the presence of ECO and this impacts their satisfaction with the hospital. One respondent in the focus group referred to the importance of the relationship between management and employees: -

"I think that any good hospital has to be run by good management, and if you haven't got good management then you haven't got good staff or a good hospital; it's all down to management as far as I'm concerned"

Hartline et al. (2000, p.36) suggest that managers of a service organisation can encourage frontline staff to carry out customer orientated strategies, the dissemination of customer orientated strategies is vital for managers' as they rely on customer contact employees to implement the strategies and ensure customer satisfaction. From findings within H1a and H2a, it is evident that both levels of CO impact external stakeholder satisfaction, if a hospital is highly customer orientated, the service users i.e. patients will be satisfied and therefore being customer orientated will have a positive impact on the organisations reputation.

Previous literature states that a business is market orientated when its entire culture is committed to the continuous creation of customer value, such an organisation culture will guide employees on how to provide excellent customer service and hence satisfied customers (Slater and Narver, 1994; Bellou, 2007). This is akin to the findings of this current hypothesis in that management's level of CO will drive employees to possess CO and therefore result in satisfied external customers; this was displayed through sobel test probability levels. This finding corresponds with previous literature that perceives OCO as a driver of ECO, resulting in satisfied customers (Brown, 2007; Stock and Hoyer, 2005; Brady and Cronin, 2001; Kohli and Jaworski, 1990). However, previous studies have been

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mainly conducted in the private sector, by focusing on the public sector this study offers new knowledge to public sector theory, particularly the healthcare sector.

Brady and Cronin (2001) suggest customer orientated firms will outperform competitors by anticipating the developing needs of consumers and responding with goods and services to which superior value and greater satisfaction are consistently attributed. OCO allows firms to acquire and assimilate the information necessary to design and execute strategies that result in more favourable outcomes. OCO focuses on the concept of 'market orientation' that fundamentally establishes tenets of organisational behaviour with respect to a firm's customers and competitors (Stock and Hoyer, 2005 p. 536). A firm that is customer orientated will outperform its competitors by developing/learning the needs of its customers and responding with goods/services of superior value, which will lead to high levels of satisfaction. Favourable consumer outcomes, such as satisfaction, occur when firms acquire information necessary to design and execute appropriate strategies (Brady and Cronin, 2001). Kohli and Jaworski (1990) argue that organisations that are market orientated, i.e. those that track and respond to customer needs and preferences, can better satisfy customers and hence perform at higher levels. The findings of this study concur with this as they highlight a significant relationship between OCO and patient satisfaction.

In relation to the public sector, market orientation is also known as public service orientation, it involves getting close to the citizen to satisfy his/her needs. Cowell (1989) mentioned adopting such an approach will provide public service organisations with the instruments required to reduce criticism from interest groups or the media, as the knowledge surrounding public needs will help them be organised for better satisfying public needs (Cervera, Mollá and Sánchez, 1999). Day (1994) suggest that there are three characteristics of a customer orientated organisation; placing a high priority on customer interests, generating and using information about customers, and creating systems to act on such information (Paarlberg, 2007). This study found that the patients have a slightly more positive view towards hospital management and OCO, compared to employees; this is again reiterated through the qualitative research.

Results from this study found that the level of CO held by managers' i.e. (OCO) influences ECO and patient satisfaction. This is somewhat similar to findings by Scotti et al. (2007) who found that customer satisfaction is linked to managers who create a positive enabling

environment for employees to deliver high-quality customer service. This suggests that managers who perceive CO as being important and encourage its existence in the organisation will increase the level of patient satisfaction. This current study examines the public sector and even though public organisations have been encouraged to become customer centered organisations, concerns exist about the application of such market orientation to the management of government organisations (Paarlberg, 2007). According to Paarlberg (2007) for an organisation to be successful they must have the ability to continuously collect information about customer needs and wants and to use this information to create value for customers and improve performance. In the public sector, concern exists around CO diluting the relationship citizens have to the government, and creating passive, as opposed to participatory, roles for citizens. The co-production of government services, such as the provision of healthcare, makes government employees highly dependent upon the participation of the customer in the process and the exchange of knowledge in such interactions. Interactions with customers provide information to the employees not only about the desires and preferences of the clients, but also about the employees own performance.

8.5.2.2 Internal Stakeholders

As we move toward an economy of increasing service organisations, frontline workers and customers need to be at the top of management concern (Anderson, 2006). In this study employees do not see themselves or patients at the top of management concern. This is quite an important issue for management, as if employees are dissatisfied it may come across to service recipients (Chun and Davies, 2006). The empirical findings of this study, similar to Kennedy et al. (2002), found that OCO has a significant relationship to employee satisfaction. OCO correlates significantly to ECO, but ECO does not have a significant relationship to satisfaction. Through regression analysis and the sobel test calculator probability levels only partial support the hypothesis that OCO mediates the relationship between ECO and satisfaction.

In this study, OCO appears to be a mediator of ECO and hence satisfaction, and while the sobel test supports H2 for external stakeholders, it lends only partially support for internal stakeholders. This is in line with previous studies conducted in the private sector (Scotti et al., 2007; Kohli and Jaworski, 1990); the findings from their studies suggest that OCO drives ECO and satisfaction. OCO was found to significantly correlate to employee

satisfaction at a two tailed level of significance. This is in line with findings by Ruekert (1992) who proposes and verifies that there is a significant positive correlation between the level of MO and employee satisfaction. In variance to these findings, Galer (2000) tested the relationship between market orientation and employee satisfaction and found that they were not positively correlated.

According to Galer (2000, p. 16) '*market orientation requires the involvement of both employees and managers, an organisation that is market orientated focuses on continuously collecting information about its customers needs and its competitors capabilities, sharing this information across all departments i.e. down to employees, and using this information to create customer value and therefore customer satisfaction'.* In terms of market orientation in a public sector hospital, Raju et al. (1995) suggest that at the organisation level in order to develop a market orientation, hospitals have to be effective in four areas: gathering and using information, improving customer satisfaction and reducing complaints, researching and responding to customer needs, and responding to competitors' actions. At the individual level, hospital managers must ensure staff execute the previous areas effectively in order to perform successfully.

Furthermore, Galer (2000) discusses the importance of CO from a management perspective and how much of their efforts are focused on ensuring employees are committed to satisfying the customer. Taking this into consideration, that researcher feels identifying the level of CO within the organisation, at both management and employee levels, and the effects it will have on the organisations reputation is imperative in contributing to public sector theory. Davies et al. (2004) state that what managers do inside the firm can affect how the employee treats the customer, and as a result how the customer perceives the service provider. However in the case of hospital X, staff views of management contrast with those of customers, some suggesting that the behaviour of senior management towards employees differed from how employees were expected to behave towards patients.

Service firms must disseminate their CO values and beliefs in a way that inspires customer contact employees to be customer focused (Kelley, 1992 cited in Hartline et al., 2000). Findings from this study concur with this theory as employees stated they would value management demonstrating that CO is important to them. If management are not focused on CO, employees of the hospital feel frustrated, this frustration and anger does not only

influence the employees' performance but also directly influences the customers' perception of the brand/organisation reputation (Anderson, 2006). In order for managers to demonstrate that CO is important to them, they must recruit the right staff to carry this out and provide high standards of training for staff, results show that the level of staff training at the hospital is currently quite low and may become a bigger issue if not rectified.

As previously mentioned, employees rated OCO at hospital X slightly less than patients/visitors. From focus group findings this seems to stem from the fact that employees are quite angry towards management and feel that they do not care about the patient but more about the financial running of the hospital. In contrast, patients view management in a positive light as they see them as the people at the top, who run the organisation as a whole and therefore are responsible for the overall organisational operations by encouraging performance and motivating employees.

For employees, correlation analysis displays that ECO is not a predictor of satisfaction, however OCO is a predictor of employee satisfaction. This could be due to the reality that employees want management to be more integrated in the organisation and to care more about meeting patient needs than keeping costs low, if this happens it will result in more satisfied employees, employees demonstrate strong opinions towards this in the focus group discussions. Kohli and Jaworski (1990) suggest that a market orientated firm will motivate its employees to become more customer orientated, more committed to the company and their job, and more satisfied with their job, suggesting that OCO is a mediator of the relationship between ECO and employee satisfaction. Our findings partially support this hypothesis in the context of the public sector. Despite correlations showing a one tailed level of significance between OCO and ECO, regression analysis displays negative values when testing the relationship between the two variables.

Despite the presence of OCO impacting employee satisfaction, this study offers a reason for the hypothesis not being fully supported; that being the insignificant effect highlighted between ECO and employee satisfaction. If ECO does not affect satisfaction, then it appears the relationship between ECO and OCO will not. It is imperative for the management-employee relationships to improve at hospital X in order to improve employee satisfaction within the hospital.

In conclusion, an organisation that displays the presence of both ECO and OCO will reap many benefits. Jaworski and Kohli (1993) state that for possessing greater knowledge of the customer, and dealing with their needs and preferences, the organisation is rewarded by the customers' evaluation of the received services i.e. its perception of the brand. Despite the influence of management towards employees' behaviour in dealing with customers, the employees of a service organisation will have their own views of how to interact with a customer and this will be shaped by their perceptions of the corporate brand. This leads to the discussion of hypotheses three and four.

8.5.3 Main Discussion – H3

H3: **Corporate brand personality (CBP) mediates the relationship between employee customer orientation (ECO) as perceived by <u>external</u> stakeholder's satisfaction****[1].

Previous research by Davies et al. (2002) was conducted in private sector service organisations and findings illustrate that the perceptions of corporate personality can drive employee satisfaction, this study contributes to this area by firstly examining the public sector and secondly researching if the presence of ECO influences external stakeholder perceptions of the brand and furthermore external stakeholder satisfaction. As CO by its very nature can be expected to influence the customer experience, one can hypothesize that ECO is positively linked to brand image. Secondly, as brand image should be positively related to stakeholder satisfaction, brand image is potentially a mediating variable between ECO and satisfaction. In order to acquire stakeholder perceptions of the corporate brand, this study adopted the personification metaphor (brand as a person), whereby brands are imbued with human characteristics (Davies et al., 2003; 2004). This study assumes, from the information obtained throughout the research study, that the level of CO displayed by employees will influence patient/visitor perceptions of the organisation and therefore affecting their overall satisfaction levels.

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[1] **The above hypothesis was tested separately for each CBP dimension i.e. agreeableness, competence, enterprise, machismo and ruthless.

According to Keller (1998) brand personality is one of the ways of measuring the associations we make with a brand and the image we embrace of that brand. As brand image should be positively correlated to stakeholder satisfaction, brand image is potentially a mediating variable between CO and satisfaction. How the external stakeholders (patients) are treated by the internal stakeholders (employees) i.e. how customer orientated they perceive them to be, will influence their overall perception of the corporate brand (Chun and Davies, 2006). More specifically, how customer orientated the external stakeholders perceive the organisation to be, the stronger their view of the corporate brand will be.

The five dimensions measured in this study were agreeableness, competence, enterprise, machismo/informality, and ruthless, it was felt that they were the most appropriate terms for describing a hospital. As previously discussed the chic dimension was left out for this context. Agreeableness, competence and enterprise were found to most commonly correlate with employee and customer satisfaction (Davies et al., 2003), similar to what was found in this current study. Correlation analysis displayed strong significant relationships (two-tailed) between ECO and patient satisfaction, the *agreeableness* dimension and patient satisfaction, as well as between ECO and agreeableness. By testing mediation through use of the sobel test method it was found that all three of the above dimensions were supported in terms of H3 and the expected terms machismo and ruthless were rejected. Thus, the relationship between perceived ECO and external stakeholder satisfaction is mediated by associations with the corporate brand. Not surprisingly, the stronger the brand imagery, the more satisfaction reported, a finding very much in line with previous work in the commercial sector (Chun and Davies, 2006).

All previous known research has found agreeableness to be the strongest dimension correlated to stakeholder satisfaction. However, in the context of the public sector in particular the public healthcare sector, competence appears to be the strongest dimension correlated to patient satisfaction. In contrast, one of the studies conducted by Davies et al. (2002, p.165) found the competence dimension to not correlate highly with satisfaction. This offers strong, valuable knowledge to public sector theory, with particular emphasise on the healthcare sector. External stakeholders of hospital X perceive the organisation as being highly reliable, secure, hardworking, ambitious etc.

It is believed that competence was rated most highly for the hospital as it describes an organisation that is reliable, a factor that is very important for healthcare organisations. Furthermore, it describes an organisation that is accurate in its work, careful in what it does, meticulous even. Davies et al. (2002) states that a competent organisation is one in which employees pride themselves on hard work and long hours, such as professional organisations, consultancies, doctors' etc. Technocracy is another facet of the competent dimension; it describes an organisation that is up to date, and highly organised, these characteristics are important for an organisation such as a hospital to possess, as they must be up to date on the latest equipment, pharmaceuticals etc. Darby and Daniel (1999) describe a hospital as a technical, high intimacy, long-term service. Furthermore, they state the importance of technical dimensions in a hospital and the importance of communication in relation to this. As found by Gronroos (1984), the 'technical dimensions' are often misunderstood by clients. Therefore such a facet can contribute to how the external stakeholder perceives the organisation.

Following on from competence, agreeableness was the next highest scoring dimension. A main facet of the agreeable dimension is trust, trust is important to customer satisfaction. Trust is particularly important in the healthcare sector, along with confidence it was seen as a major outcome of a positive reputation in the qualitative study. Customers of an agreeable organisation tend to value the helpfulness, friendliness, and fairness of treatment by frontline staff members (Westbrook, 1981). Such characteristics were used in the qualitative study to describe the frontline staff at hospital X, interpersonal relations between staff and patients were reported -

"Caring, friendly nursing staff"

"It's the nurses, the nurses are very kind"

The enterprise dimension followed including such items as 'innovative' and 'up to date'. This reveals that customers in the public sector, as well as the private sector can be positively influenced by how enterprising an organisation appears to be. It is important in the healthcare sector to ensure patient satisfaction, and that the services provided are up to date. It implies that the organisations knowledge is current and their solutions to problems are forward looking. Results display that patients perceive the organisation as enterprising and it has links to satisfaction suggesting that they have an enjoyable, memorable experience. This links to the enjoyment dimension of CO; patients perceive the service

delivery as positive if they have an enjoyable experience and a personal service i.e. their names are remember and they are not just a number.

Correlation analysis found both machismo and ruthless to have a negative effect on satisfaction, suggesting that the more machismo (masculine, tough, rugged) and ruthless (arrogant, aggressive, selfish) an organisation appears to be the less impact it will have on external stakeholder satisfaction. According to Davies et al. (2003) the machismo dimension reflects a company that is tough with both its staff and with its customer. Such a characteristic is not associated with the healthcare industry, as it is a sensitivity industry that looks after people and being 'tough' is not part of the service provided. Furthermore, machismo may have been rated low due to the fact that it is associated with the stereotype maleness and hospital X has predominantly female staff.

The findings of this study regarding the ruthless dimension are in line with those by Davies et al. (2003), whose findings identified ruthless as a negatively valenced dimension. The negative values suggest that patients will be dissatisfied by ruthlessness. Customers of an organisation, in particular a service organisation, do not want to deal with a selfish, aggressive and arrogant service provider. Davies et al. (2003) state that a ruthless organisation deals with its customer in an impersonal way, findings from this study highlight that hospital X provides a personal, friendly service.

Considering the above results, this study found that ECO is linked to competence and from there to patient satisfaction; competence thus mediates the relationship between ECO and external stakeholder satisfaction. Likewise, but with slightly lower results, agreeableness and enterprise are linked to ECO and from there to patient satisfaction. H3 is therefore supported for the above three dimensions of corporate brand personality, thus these dimensions mediate the relationship between perceived employee CO and external stakeholder satisfaction. The external view of the corporate brand is determined, in part, by the interaction between customers and employees. This is expected to shape the external view, as customers of a service business will judge it by their perceptions of that interaction, hence determining their satisfaction. Employees of a service organisation will have their own views of how to interact with a customer and this will be shaped by their perceptions of the corporate brand, leading to the discussion of H4.

8.5.4 Main Discussion – H4

H4: Corporate brand personality (CBP) mediates the relationship between employee customer orientation (ECO) and <u>internal</u> stakeholder satisfaction (ISS).**[2]

Similar to H3, in the case of employees, their view of the corporate brand is a function of its culture and therefore the experiences they have at work (Hatch and Schultz, 1997). The corporate brand influences employees' experiences in the workplace and thus their level of satisfaction. This research study proposes that ECO is linked to employee satisfaction by associations with the corporate brand. This study is questioning the affect of ECO on the perceptions of the corporate brand and whether or not this will affect employee satisfaction levels. The corporate personality scale (2003; 2004) was once again used to measure the reputation and internal stakeholder perceptions of the organisation, as the way in which the company is perceived is crucial in determining its success (Brown, 1998), most studies that have used the corporate personality scale have been in the commercial sector, for the purpose of this study, it has been applied it to the public sector. For the internal stakeholders, this study expected to find similar findings to that for the external stakeholders, as this would display little gaps in their perceptions of the organisation. Public sector organisations should strive to maintain a solid reputation, for this reason, what drives stakeholder perceptions of the organisation should be investigated.

Correlation analysis for H4 found significant relationships between the dimensions *agreeableness* and satisfaction and also agreeableness and ECO. As previously mentioned there is no significant relationship between ECO and employee satisfaction. In relation to the *competence* dimension, correlations highlighted significant relationships between competence and ECO and also competence and satisfaction. The findings between the dimensions and ECO stipulates that working in an environment where those around you find it easy to smile at patients, where you and your colleagues take pleasure from making

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[2] **The above hypothesis was tested separately for each CBP dimension i.e. agreeableness, competence, enterprise, machismo and ruthless.

patients happy, promotes positive associations with the corporate brand. Correlation analysis for enterprise highlighted a significant relationship between enterprise and satisfaction but an insignificant relationship between ECO and enterprise. Conflicting findings were discussed in a study by Chun and Davies (2006) who found enterprise to have no significant impact on employee satisfaction. For the machismo dimension there were no significant relationships, and a negative result was produced between ECO and machismo. Correlation analysis for the ruthless dimension displayed a significant negative relationship between ruthless and satisfaction, in line with findings by Davies et al. (2003) in that ruthless causes dissatisfaction. A negative value was also produced between ruthless and ECO.

In terms of the findings for the sobel test method, H4 was supported for the competence dimension (p<0.001). Therefore, in agreement with (Rust et al., 1996) high levels of ECO enhance service user views of the organisations' brand through positive interactions with the brands employees' and result in greater overall satisfactions among both internal and external stakeholders. Findings highlight that the stronger the brand imagery, the more satisfaction was reported by respondents, a finding very much in line with previous work in the private sector (Chun and Davies, 2006). The sobel test method of testing mediation only partially supported H4 for the, agreeable, enterprise and machismo dimensions and rejected the hypothesis when considering the ruthless dimension.

Results are similar for both employees and patients, in terms of how they perceive the organisation and what brand associations' link to their satisfaction. As previously mentioned, all prior known studies have found agreeableness to be the strongest dimension (Davies et al., 2004). As previously mentioned in this study patient satisfaction was found to be most strongly correlated to competence, however employee satisfaction is akin to previous findings in that it is most strongly correlated to agreeableness. Competence follows, being the second dimension strongly correlated to employee satisfaction. Davies et al. (2002) also found agreeableness and competence to be the strongest dimensions related to satisfaction.

Agreeableness describes an organisation as being socially responsible, being a corporate citizen helps build an intangible asset that is reputation, and in turn a good reputation will attract and retain both employees and customers (Davies et al., 2003). A socially

responsible organisation is one that is concerned about society as a whole and aims to provide to the community, the high scoring of this dimension may be attributed to the context of the study i.e. a public sector service. Previous research suggests that organisations should recruit employees based on how they want be perceived e.g. if they want to be perceived as agreeable, they should employ people displaying such characteristics (Davies et al., 2003). According to (Hogan, Hogan and Busch, 1984; Hurley, 1998) employees who possess the agreeable human personality trait will feel an empathy with their customers and have a desire to respond to their needs and problems, such employees will derive personal satisfaction from helping others. Considering this, the study can infer that when examining a public service organisation, the same theory can be applied. However in this case, the relationship is not as strong as previous studies have found as it appears to be only partially supported. The reason for this may be attributed to the dimension consisting of traits' such as 'supportive' and 'honest'. It appears from the qualitative findings that several issues arise between employees and management in terms of support, communicate, and issues being discussed behind closed doors; resulting in staff feeling uninformed and perceiving management as dishonest.

The competent dimension describes the organisation as being conscientious, technocracy and having drive. A competent organisation contains employees who are serious about their work. From the qualitative responses of this study it was clearly evident that the clinical staff are very serious about their work. A competent organisation is one where the employees are ambitious and achievement orientated, they want to be seen as winning. Winning is important in healthcare as how the organisation performs can result in what funding they receive (HSE Transformation Programme, 2007-2010). The moves/decisions made by a component organisation are often seen by the media as being bold, audacious even, this again reflects findings in the qualitative study whereby internal stakeholders stated that the media only report bad press, exaggerate and even 'slate' Hospital X. In order to improve basic competencies, Davies et al. (2003) recommended using training as the best strategy. Training was seen as a problem within hospital X, employees felt it was lacking and even non-existent in some cases. A competent organisation is one that is reliable and secure, traits that were highlighted as important to employees in the qualitative studies. Hence, hypothesis four was supported for the competence dimension in that CO results in the hospital brand being perceived as competent by employees, thus resulting in greater employee satisfaction.

Enterprise was also seen as a factor to affect satisfaction; respondents' perceive the organisation as being modern, adventurous and bold. Organisations that want to be perceived as enterprising should hire younger staff rather than older looking frontline workers; however this raises equality at work issues and may result in damaging the reputation (Davies et al., 2004). An enterprise organisation is one that is innovative and up to date. Constant change can be a source of personal stress for employees of enterprising organisations (Cooper and Payne, 1988), and change has been found to have a negative effect on employee satisfaction in the services sector (Broadbridge, Swanson and Taylor, 2000), a possible reason why the hypothesis was not fully supported. An enterprise organisation is one that is exciting, young and modern; if the hospital possesses such traits employees will tend to be satisfied. Many of the traits that describe an enterprise organisation are not attributable to a healthcare organisation e.g. bold, hence the hypothesis was only partially supported.

A machismo organisation is one that is masculine, tough and rugged, characteristics that neither employees nor customers would want to perceive as being associated with the organisation. A machismo organisation is said to be tough with both its employees and customers, in a healthcare context, it was rated quite low and does not affect stakeholder satisfaction due to the nature of a healthcare organisation and the patients it deals with. A hospital requires staff to deal with customers by showing empathy, sensitivity and helpfulness and not to be 'tough'. The study further postulates that the organisation was not perceived as being masculine or male as the workforce was predominantly female, as demographic statistics display. Other traits associated with machismo/informality include; casual, simple and easy going. Again not characteristics of a hospital or how employees would like the hospital to be perceived, hence this hypothesis was only partially supported.

Similar to findings by Davies et al. (2002) ruthlessness is a dimension that was found to be negatively valenced; it correlates negatively with stakeholder satisfaction. An organisation that is dominant and egotistic will negatively affect employee and customer satisfaction. This could be due to the reality that customer orientated employees, want to be empowered to make some of their own decisions when dealing with the customer and not to constantly follow orders and decisions from management at the top. The fact that ruthlessness was not

rated positively is a good result, a ruthless organisation is inward looking and controlling, and according to Davies et al. (2004) it provides staff with little opportunity to use their own initiative, further postulating that a ruthless organisation is the opposite to a customer orientated organisation as it does not allow staff to make their own decisions and help resolve patient complaints etc.

According to the empirical findings of this study, competence is the only dimension expected to be positively influenced by ECO. Competence contains items such as hardworking and reliable, associations that might be expected to be promoted by CO, while being seen as incompetent would imply an inability to meet customer needs. CO involves being responsive to changes in customer needs (Narver and Slater, 1990). Agreeableness, enterprise and machismo were partially supported for this hypothesis. The dimension ruthless produced a negative result, rejecting the hypothesis. Thus, CO does not result in the brand being perceived as ruthless nor does the dimension mediate the relationship between ECO and employee satisfaction.

Having discussed the main findings in relation to previous known studies, the contributions made to theory will now be discussed.

8.6 – Contributions to the Literature

The current study builds upon previous work within a reputation management perspective in the commercial sector and applies this to hospital management. The first significant contribution is that there appear to be different drivers and outcomes of public sector reputation from those previously found in mainstream commercial literature among internal and external stakeholders in the context of a public sector brand. The commercial sector has tended to focus mainly on service quality as a driver of organisational reputation (Andaleeb, 2001). Other key drivers of a private sector organisation that emerged from a review of the literature were found to be good financial performance, limiting environmental damage, leadership in the industry and being a good employer, quite different from the drivers this study found for the organisation studied in this work. The main drivers found to influence this organisation's reputation however were perceived CO, management and communication, the media and public opinion and; resources and facilities.

Secondly, Brown et al. (2002) found that ECO has a significant impact on their levels of satisfaction. However in this study, it was found that perceived ECO does not have an overall significant impact on employee satisfaction. The measure of ECO used has two components; the needs dimension and the enjoyment dimension. Overall the findings suggest that ECO does not affect employee satisfaction, however when the items were examined individually it was found that the needs dimension had more of an impact on employee satisfaction than the enjoyment dimension. This is an important finding in the healthcare sector, as meeting patient needs is perceived as being more important by internal stakeholders in a healthcare organisation than the customer feeling enjoyment from the service experience. This is also consistent with focus groups findings, which suggest that clinical employees appeared dedicated to the needs of the patient and found this more crucial than smiling at the patient and getting enjoyment from making the patient happy. This is clearly contradictory of the views of external stakeholders who felt perceived ECO did have an impact on their resulting satisfaction levels. Despite this, to ensure maximum patient/employee satisfaction both dimensions should be regarded as important by internal stakeholders, consistent with the alignment of internal and external stakeholder views posited by Hatch and Schultz (2001).

Third, no prior studies have examined the effects that CO at organisational and individual levels has on organisational reputation and satisfaction. A significant contribution of this study therefore was testing the mediating relationships between ECO, OCO, reputation and stakeholder satisfaction. This study hypothesised that the relationship between ECO and stakeholder satisfaction would be mediated by the presence of OCO. Results support this hypothesis for internal and external stakeholder satisfaction. This contributes to literature as it suggests that the presence and importance of CO at the managerial level will mediate the relationship between individual level CO and patient satisfaction. Therefore the presence of CO at a management level is crucial to the satisfaction of employees as they will acknowledge its importance and continue to work towards satisfying customer needs and undertaking the responsibility to respond to customer requests. In order to increase employee satisfaction, management must fully embrace the CO concept. Patient views of OCO have a strong and positive influence over their views of ECO and their satisfaction with the hospital; this was evident from the qualitative findings as well as the quantitative findings. In order to increase external stakeholder satisfaction, this finding suggests that

CO must be present at the managerial level to increase stakeholder views of ECO and result in satisfaction.

Finally, the scale used to measure the reputation of the hospital, the Corporate Character Scale (Davies et al., 2003; 2004), is well established in studies of commercial sector organisations. The character dimensions with the strongest results for both patients and employees were competence, agreeableness and enterprise. Through a review of the literature, it is evident that the majority of previous studies that used this scale in the private sector context found agreeableness to be the strongest factor driving organisational reputation. A significant contribution of this research is that both employees and patients viewed competence, rather than agreeableness, to be the strongest influence on stakeholder satisfaction. This is in parallel with the findings regarding CO. Results demonstrate that being perceived as secure, reliable and hardworking (the competent organisation) and focusing on the needs dimension of CO results in greater levels of stakeholder satisfaction. In comparison, being perceived as a cheerful, and pleasant (agreeable organisation) and focusing on the enjoyment dimension of CO, results in slightly less levels of stakeholder satisfaction.

8.7 – Managerial Implications

It is hoped that by conducting this research study the findings will assist managers in creating, developing and implementing strategies designed to manage the reputation of a public service brand. Public sector organisations must uphold a positive reputation; satisfy customers through a customer orientated organisation and work to create positive brand images of their organisation. Marketing and market research is often overlooked and misunderstood by public sector managers. If overlooked it can have consequences for such organisations, as marketing can help in the management of relationships with external stakeholders. One concept central to marketing is CO, its relevance in an organisation such as a hospital goes beyond the idea of assuring tax payers that the public is getting value for money, the more confidence and satisfaction we have with a hospital and the service it delivers to a patient, the more likely patients are to recover (Health Service Executive Transformation Programme, 2007-2010).

CO is of very considerable importance to managers of any service organisation, the more customer orientated we perceive an organisation to be, the more satisfied we are. In addition, if we believe the management of the hospital to be customer orientated, then we are likely to believe that the employees are customer orientated and therefore we will also be satisfied. Considering the focus group responses from the qualitative study of this research, management at hospital X are not fully embracing CO, the findings from the quantitative study emphasise the potential to promote greater CO and by doing so build positive associations with the corporate brand.

As well as satisfying customers, it is important for an organisation to have satisfied employees, management by creating an objective to be customer orientated and informing employees of this, will increase their satisfaction (Davies et al., 2003). Similarly to avoid employee dissatisfaction, management should avoid any activity that would lead to the hospital being perceived as ruthless as findings indicate that this dimension does not mediate the relationship between ECO and internal/external stakeholder satisfaction. If management aim to reach high levels of CO throughout their firm they must include employees in their practices, adopt facilitative management styles, and decentralised decision making. Another recommendation reoccurring throughout the literature is for management to focus on recruitment, by recruiting and selecting applicants that fit the organisation and providing effective inductions. Budgets should allocate funding to measures that deal with the recruitment of new employees for boundary spanning positions and the training of new and existing service employees (Hennig-Thurau, 2004 p. 472). Managers should also keep in mind when recruiting frontline service workers, the image of the organisation they want to present to potential employees and to the labour market to attract the best and most suitable applicants. For example, there would be little point in attracting a person with ruthless characteristics if you want your organisation to retain its competent or agreeable image.

Hartline et al. (2000) state that in order for management to have a customer orientated firm, they must reduce rigid rules and foster an environment where employees are given responsibility and are not always watched. A highly structured environment will suppress the ability of employees to adapt and respond quickly to patient needs. They found that a manager-employee initiated control is more effective at disseminating CO than manager or employee controls in isolation. If employees are given a level of control to deal with

patients, it is the frontline staff that deal with patient complaints and questions, and according to Galer (2000) this level of control will lead to employee satisfaction. Without satisfied employees, the organisation will be at a distinct advantage.

An additional important recommendation for marketers to consider is that the enjoyment dimension of ECO was rated lower than the needs dimension by employees. Managers must try to convince those who actually interface with patients that both aspects of ECO are relevant. Some options that were used in the commercial sector include the provision of training to promote smiling at customers, or the recruitment of those with personalities more orientated towards pleasing customers. In an article by Lings (2004) it was discussed that the manor in which employees deal with customers influences customers' overall perceptions towards the service organisation. As a result, it is imperative that managers effectively influence how customer facing employees deliver the service. In order to do this, it is recommended that organisations' adopt suitable internal programs that complement external marketing programs aimed at customers (Hartline and Ferrell, 1996; Gummensson, 1994; Greenley and Foxall, 1996; 1998; Berman et al., 1999). Resistance from front line service employees to the articulation of marketing concepts has resulted in a widespread failure to translate organisational commitment into reality in the public sector (Laing and McKee, 2001). It is recommended that managers in the public sector adopt a cognitively based approach to CO development, including those in healthcare and education, where employees might need evidence that being more customer oriented makes their efforts within their professional role more effective (Whelan et al., 2008).

According to Brown et al. (2002) links have been found in the commercial sector between CO and organisational outcomes at both an individual level (Saxe and Weitz, 1982) and an organisational level (Narver and Slater, 1990). The same effects should be observable in the public sector, a context where the same commercial pressures are likely to be absent. According to the Health Service Executive Transformation Programme (2007-2010), organisations such as hospitals are given increased funding if they meet certain standards through an accreditation process. Poor performance can therefore result in reduced revenue, and downgrading of facilitates as mentioned by focus group respondents, as a result public sector managers can find themselves dealing with similar pressures to their commercial counterparts.

Another implication that can be drawn from this study offers knowledge to public sector managers surrounding the concept and importance of branding. The more positive view we hold as an external stakeholder, the more likely we are to select one hospital over another if we have choice (Shahian et al., 2000) and once again the more confident we will feel entering the same hospital that our treatment will be successful. Managing both ECO and employee satisfaction appears to be better achieved by managing the corporate brand. Management should also be aware that some differences exist between employee and patient perceptions; management should try to reduce/close these gaps. For example, the qualitative study found differing opinions on what drives the hospitals reputation and what should be done to improve this. Managers must keep this in mind as too many gaps between the stakeholders' perceptions can have negative impacts on the organisations reputation. A number of models of corporate branding see the customer and employee perspectives as being inter-linked or even interdependent (Hatch and Schultz, 1997; Fombrun, 1996; Davies and Miles, 1998). Such alignment emphasises matching external brand image to internal views and values (de Chernatony, 1999; Hatch and Schultz, 2001). If customer-facing employees share a positive view of the organisation with customers, then a positive interaction between them is more likely to occur (Chun and Davies, 2006).

8.8 – Limitations

Although this study furthers our understanding of the importance of CO in the organisation and how it can impact organisation reputation and stakeholder satisfaction, it is not without limitations:

- Firstly the empirical research offers knowledge to the public sector but the research was only conducted in one public sector organisation, a hospital. Therefore, to further validate the results, additional research in diverse organisations is recommended.
- Related to this, although the sample size was adequate for the empirical research study, a more diverse sample including perhaps employees and patients of another hospital, would have allowed for stronger generalisability.
- Consistent with the work of Brown et al. (2002), who also collected qualitative data from service managers in addition to survey data, an in-depth interview with the management of the hospital would have added valuable insight to issues surrounding OCO in terms of exploring the customer orientated practices that they

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are involved in. This however was not possible given the time constraints for this programme of research, but is considered a fruitful avenue for further research.

- A final limitation the study was encountered when administrating the surveys throughout the hospital. At times staff morale was low and this caused some difficulty for the researcher as some respondents were unwilling to participate due to their anger with both the hospital management and the Health Services Executive.

8.9 – Suggestions for Future Research

The significant links from ECO to satisfaction, but mediated by mainly competence and agreeableness, imply that the relationship between ECO and satisfactions is indirect and via brand imagery. This is a significant finding from this work and one that should be tested in the private sector and in further studies in different contexts within the public sector.

Secondly, as discussed previously the study recommends further qualitative research to include management in the research study in order to establish their views on CO at the organisation level. OCO involves the actions of managers and therefore their views are important when investigating the mediating effect OCO can have on ECO and the reputation of the organisation. Management and employees should have similar views regarding the organisation. If however they have differing views, the result could be their true character being exposed in the media and could be detriment of its overall reputation and success. To avoid this from happening, this research study recommends further studies to be conducted in order to incorporate management views into the findings and reveal the true presence and importance of OCO in a public sector organisation. As there have been no previous published studies conducted on the relationship between ECO, corporate brand personality and stakeholder satisfaction, the researcher believes further replication of such a study would make the results more reliable and would contribute to a deeper understanding and appreciation of CO, reputation and corporate brand associations.

Thirdly, the research findings on CO and employee satisfaction were quite surprising as many previous theorists who examined CO and employee satisfaction in the commercial sector found that there was a link. This raises the possibility that CO has a somewhat differing meaning in the context of public sector organisations. Further work is

recommended to explore the possibility that CO, as defined in the commercial sector, is not completely suited to the public sector or at least needs to be rethought (Whelan et al., 2008). Furthermore, corporate brand image is clearly relevant to the public sector, more so in promoting external stakeholder satisfaction than the study expected. Aspects of brand image are also promoted by ECO, but how brand image is formed in the public sector when there has been little or no conscious attempt to do so, is also worthy of additional research.

8.10 - Conclusion

This chapter critically discussed the research findings in respect to those views held within the literature, surrounding the areas of market orientation, ECO, satisfaction, reputation and the corporate brand personality dimensions. The study provides an interpretation of theory and findings in relation to the qualitative study, preliminary quantitative findings and the four hypothesises developed for the quantitative study. Following on from the discussion, this chapter outlined the managerial implications from the findings of this study, the limitations of the research study and finally suggestions for future research in this area. By conducting this research study, the empirical findings were valuable in that they add significance to previous public sector/healthcare literature.

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Corporate Brand Personality Dimensions

Agreeable: (*1=Strongly Disagree, 7=Strongly Agree*)

Cheerful	Pleasant	Open
Straightforward	Concerned	Reassuring
Supportive	Agreeable	Honest
Sincere	Trustworthy	Socially Responsible

Competent: (*1=Strongly Disagree, 7=Strongly Agree*)

Reliable	Secure	Hardworking
Ambitious	Leading	Achievement Orientated
Corporate		

Enterprise: (*1=Strongly Disagree, 7=Strongly Agree*)

Cool	Trendy	Young
Imaginative	Up to date	Exciting
Innovative	Extrovert	Daring

Machismo/
Informality: (*1=Strongly Disagree, 7=Strongly Agree*)

Casual	Simple	Easy-going
Masculine	Tough	Rugged

Ruthless: (*1=Strongly Disagree, 7=Strongly Agree*)

Arrogant	Aggressive	Selfish
Inward-looking	Authoritarian	Controlling

Employee Customer Orientation (ECO)

Needs Dimension: I try to help patients achieve their goals

I achieve my own goals by satisfying patients

I get patients to talk about their service needs with me

I take a problem solving approach with my patients

I keep the interests of the patients in mind

I am able to answer patients' questions correctly

Enjoyment Dimension: I find it easy to smile at each patient

I enjoy remembering my patients' names

It comes naturally to have empathy for my patients

I enjoy responding quickly to patients needs

I get satisfaction from making my patients happy

I really enjoy taking care of patients

Organisational Customer Orientation (OCO)

Managers at Hospital X:

- Constantly check to make sure hospital policies and procedures don't cause problems for patients
- Constantly make sure that employees are trying their best to satisfy patients
- Think of patients points of view when making big decisions
- Plan to keep our hospital ahead of competitors by understanding the needs of our patients
- Assess patient satisfaction regularly
- Pay close attention to our patients after treatment
- Really care about our patients, even after they have received their treatment etc.
- Have organised our hospital to the needs of our patients

Satisfaction

Employees: *(1=Strongly Disagree, 5=Strongly Agree)*
                         I feel that I am associated with a winner at Hospital X
                         I would recommend Hospital X to a friend or colleague as a good
                         employer or hospital
                         I feel an affinity with Hospital X
                         (1=Very Dissatisfied, 5=Very Satisfied)
                         Please rate your overall satisfaction with Hospital X

Patients/   *(1=Strongly Disagree, 5=Strongly Agree)*
Visitors: I am pleased to be associated with Hospital X
                         I would recommend Hospital X to a friend or colleague
                         I feel an affinity with Hospital X
                         (1=Very Dissatisfied, 5=Very Satisfied)
                         Please rate your overall satisfaction with Hospital X

Appendix B: Focus group discussion guide

'An Explanation of the Procedure Followed By the Researchers for Conducting the Three Focus Groups'

Hospital X Focus Groups

The focus groups were governed by a set agenda (allowing the facilitator a reasonable degree of scope to probe participants or delve further into interesting/unexpected comments). The agenda included the following:

- ➢ Welcome participants
- ➢ Review the agenda for the meeting
- ➢ Review the goal of the meeting
- ➢ Review the ground rules
- ➢ Introductions
- ➢ Questions and answers
- ➢ Wrap up the meeting

Beginning the Focus Group Discussion

An open environment was developed in order to ensure the success of the focus group discussion. To obtain this type of environment, Kruger (2002) recommended the following pattern for introducing the focus group:

(1) Welcome, (2) Overview of the topic, (3) Ground rules and (4) First question. The following was the introduction which we used for our own focus groups:

1. Introduction

Welcomed the participants, introduced ourselves, and asked the participants their names.

"Good morning/afternoon and welcome to today's focus group session. Thank you for taking the time to join me to talk about the reputation of Hospital X. My name is…. I am from Waterford Institute of Technology and I am conducting a research masters on healthcare reputation in order to increase service user confidence, care and satisfaction in our overall healthcare system. I am conducting focus groups with

patients/relatives/employees about their perceptions of the hospital's reputation. The management of the hospital are also very interested in the findings want to know what you like about the hospital, what you don't like about the hospital, and how the hospital's reputation might be improved".

The researcher then explained why these particular participants were selected for the focus group: "You were invited to participate in this morning's/this afternoon's session because you have attended/are attending Hospital X as a patient/you work in Hospital X, so you're familiar with what the hospital does".

The researcher then established some ground rules. I said the following to the group: "There are no wrong answers but rather differing points of view. Please feel free to share your point of view even if it differs from what others have said. Keep in mind that we're just as interested in negative comments as positive comments, and at times the negative comments are the most useful".

Having established the ground rules, the researcher then provided a brief explanation of the recording device as follows:

"You've probably noticed the tape recorder here in front of us. I am tape recording the session because I don't want to miss any of your comments. People often say very useful things in these discussions and we can't write fast enough to get them all down. We will be on a first name basis this morning/this afternoon, and no name will be used in the reports. You may be assured of complete confidentiality. The reports will go back to the senior management at Hospital X to help them plan future programs for the hospital's development and ongoing progress".

The focus group participants were informed of how long their participation was required:
"The focus group will not take any longer than 1.5-2 hours".

The next stage was to introduce and Ice Breaker – This involved a small activity or a discussion on a topical area. The aim of this was to get people talking and overcome any initial nervousness. As a means of "breaking the ice" amongst the participants,

name tags were also provided for the participants to display on their jackets to help everybody to get to know each other better, so when the actual discussion did begin, participants could refer to each other on a first name basis. This was a good mechanism to make the focus group discussion more informal and friendlier towards participants. The researcher did as recommended by best practice, which states that the seating be arranged in a circular manner whereby the facilitator can move freely inside the circle. This is a good method of ensuring even participation from all participants. By having a circle, the facilitator will be in a better position to draw out quieter participants in the group. Participants sat around a circular table in order to facilitate a fluent flow of discussion.

Section 1: Introduction

The facilitator said: "Well, let's begin. We've provided name tags for you to display on your jackets which I am going to distribute now before we begin. The name tags will help us remember each other's names. Now that we all have our name tags displayed, let's find out some more about each other by going around the table. For instance, tell everyone your name and where you live".

**For the staff focus group the following was also be included: "Tell us your name, your speciality or subspecialty, hospital affiliation, number of years in practice, number of years working at Hospital X and perhaps a brief description of their patient population".

Section 2: Data Collection

The introduction was followed by a brief write-down exercise before the main part of the discussion began:

 "Please write down the words or phrases that come to mind when you think about Hospital X".

Section 3: Warm-Up Discussion

Going around the table, the researcher got each of the participants to read aloud their words/phrases and jot them down on a flip chart. A list of all the words/phrases mentioned was then accumulated on the flip chart, and this initiated a discussion in terms of asking participants to comment on the list.

Before delving into the asking participants the main questions of the focus group, an activity was introduced at this stage to enable participants' to form a certain frame of mind when discussing Hospital X

Activity: The facilitator asked participants the following question:

"If Hospital X came to life as a person, how would you describe it in terms of the kind of person he/she would be?"

The researcher got participants to jot down their responses and then going around the circle, asked each participant to read aloud their responses. The researcher wrote up the answers on a flip chart and compiled a list, then spent a few minutes discussing the answers with the group, asking for them to comment, elaborate, etc.

-Then-

The researcher began asking participants the following questions:

Main Questions – Drivers of reputation

1. As a patient/visitor/employee/member of staff (used for the clinical staff), what do you feel effects how the hospital is seen in terms of its reputation?

2. As a patient/visitor/employee/member of staff, what factors do you feel <u>would</u> lead you to talk positively about Hospital X? Why?

3. As a patient/visitor/employee/member of staff, what factors do you feel <u>would</u> lead you to talk negatively about Hospital X? Why?

4. Tell me about a positive experience you have had with Hospital X?

5. Tell me about a disappointing experience you have had with Hospital X?

6. Who or what influences your decision to attend/work in Hospital X?

7. When you attend/visit/work in Hospital X, what do you look for? Take a piece of paper and jot down three things that are important to you when you attend/visit/work Hospital X?

8. Let's list these on a flip chart. If you had to pick only <u>one</u> factor that was the <u>most important to you,</u> what would it be? You can pick something that you mentioned or something that was said by others.

9. Thinking about the past, have you ever changed your choice of hospital to attend? What brought about this change?

Outcomes of reputation

10. If Hospital X had a negative reputation, what do you think the results would be for you? Why?

11. If Hospital X had a positive reputation, what do you think the results would be for you? Why?

12. PATIENT → Based on your perceptions of the hospital, would you recommend Hospital X to a friend or colleague (ASK INDIVIDUALLY AROUND THE TABLE). STAFF → Are you pleased to be associated with Hospital X? Why?

Section 5: Advice to the General Manager

Following the main part of the discussion, the researcher then said the following to the participants: "the group is almost over but there is one final input that would be helpful to complete the process. Assume a scenario whereby the General Manager comes into this room and asks for 30 seconds of your advice about the topic that was discussed that the General Manager can use to plan the direction of her effort in terms of reputation management over the next few days. Please write down the advice you would give to the General Manager". Once the write-down exercise was completed, we asked each participant to read aloud what he/she had written down as reputation management advice to the General Manager.

Section 6: Summarise

Following this last exercise, the facilitator summarised what had been heard throughout the entire discussion and questioned participants about their agreement or disagreement with the discussion summary:

"Based on what we have heard here today… (Summarise the main points of the discussion)

Ask does everybody agree with this?" or ask "Is this an adequate summary?"

The researcher then reviewed the overall purpose of the study and then asked participants "Have we missed anything or is there anything further anybody would like to add before we conclude?"

If participants had no further comments or questions, they were thanked for their kind participation and the meeting was then adjourned.

Appendix C: Patient and Visitor Questionnaire

ANONYMOUS AND CONFIDENTIAL

INSTRUCTIONS:

1. Please **CIRCLE** the most appropriate answer.
2. Please answer **ALL questions** to the best of your ability, otherwise responses **cannot** be used.
3. The survey should take **no longer than TEN minutes** to complete.

Demographics

Are you male or female? Male / Female	What is your nationality? _____
Which age group are you in? 16-24 55-64 25-34 65-74 35-44 75-84 45-54 85 +	**How many times have you attended Hospital X in the last three years?** Never before Five or Six Times Once or Twice Seven times or more Three or Four times

Have you ever been an in-patient at Hospital X? Yes/No If 'Yes', what was the purpose of your visit?

_____

_____

PLEASE write out the words or phrases that first come to mind when you think of Hospital X.

_____

_____

PLEASE rate how strongly you disagree (1) or agree (7) with the following statement: "If Hospital X came to life as a PERSON, he/she would be...

	Strongly Disagree	Disagree		Neither	Agree		Strongly Agree
1. Cheerful	1	2	3	4	5	6	7
2. Pleasant	1	2	3	4	5	6	7
3. Open	1	2	3	4	5	6	7
4. Straightforward	1	2	3	4	5	6	7
5. Concerned	1	2	3	4	5	6	7

6. Reassuring	1	2	3	4	5	6	7
7. Supportive	1	2	3	4	5	6	7
8. Agreeable	1	2	3	4	5	6	7
9. Honest	1	2	3	4	5	6	7
10.Sincere	1	2	3	4	5	6	7
11.Trustworthy	1	2	3	4	5	6	7
12.Socially Responsible	1	2	3	4	5	6	7

PLEASE rate how strongly you <u>disagree (1) or agree (5)</u> with each of the following statements

	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
1. Staff at Hospital X find it <u>easy to smile</u> at each patient.	1	2	3	4	5
2. Staff at Hospital X <u>enjoy remembering</u> a patient's name.	1	2	3	4	5
3. It comes naturally to staff at Hospital X to have <u>empathy</u> for their patients.	1	2	3	4	5
4. Staff at Hospital X <u>enjoy responding quickly</u> to their patients' requests.	1	2	3	4	5
5. Staff at Hospital X get <u>satisfaction</u> from making their patients happy.	1	2	3	4	5
6. Staff at Hospital X <u>really enjoy taking care</u> of their patients.	1	2	3	4	5
7. Staff at Hospital X try to <u>help patients achieve their goals</u>.	1	2	3	4	5
8. Staff at Hospital X <u>achieve their own</u> goals by <u>satisfying patients</u>.	1	2	3	4	5
9. Staff at Hospital X get <u>patients to talk</u> about their <u>service needs</u> with them.	1	2	3	4	5
10. Staff at Hospital X take a <u>problem solving approach</u> with their patients.	1	2	3	4	5
11. Staff at Hospital X keep the <u>best interest of their patient</u> in mind.	1	2	3	4	5
12. Staff at Hospital X are <u>able to answer a patient's questions correctly</u>.	1	2	3	4	5

Please rate how strongly you <u>disagree (1) or agree (5)</u> with each of the following statements "Managers at Hospital X...

	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
1. Constantly check to make sure hospital <u>policies and procedures</u> don't cause problems for patients.	1	2	3	4	5
2. Constantly make sure that <u>employees</u> are trying their best to <u>satisfy patients.</u>	1	2	3	4	5
3. Think of <u>patients' point of view</u> when making big decisions	1	2	3	4	5
4. Plan to keep our hospital <u>ahead of competitors</u> by understanding the needs of our patients.	1	2	3	4	5
5. Assess <u>patient satisfaction</u> regularly.	1	2	3	4	5
6. Pay <u>close attention</u> to patients after treatment	1	2	3	4	5
7. Really <u>care about patients</u>, even after they have received their treatment etc.	1	2	3	4	5
8. Have <u>organised</u> our hospital to the needs of its patients.	1	2	3	4	5

PLEASE rate how strongly you <u>disagree (1) or agree (7)</u> with the following statement: "If Hospital X <u>came to life as a PERSON</u>, he/she would be..."

	Strongly Disagree	Disagree		Neither	Agree		Strongly Agree
1. Reliable	1	2	3	4	5	6	7
2. Secure	1	2	3	4	5	6	7
3. Hardworking	1	2	3	4	5	6	7
4. Ambitious	1	2	3	4	5	6	7
5. Achievement oriented	1	2	3	4	5	6	7
6. Leading	1	2	3	4	5	6	7
7. Corporate	1	2	3	4	5	6	7

	Strongly Disagree	Disagree		Neither	Agree		Strongly Agree
8. Cool	1	2	3	4	5	6	7
9. Trendy	1	2	3	4	5	6	7
10. Young	1	2	3	4	5	6	7
11. Imaginative	1	2	3	4	5	6	7
12. Up-to-date	1	2	3	4	5	6	7
13. Exciting	1	2	3	4	5	6	7
14. Innovative	1	2	3	4	5	6	7
15. Extrovert	1	2	3	4	5	6	7
16. Daring	1	2	3	4	5	6	7

PLEASE rate how strongly you <u>disagree (1) or agree (5)</u> with each of the following statements

	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
1. I have a <u>lot of confidence</u> in Hospital X	1	2	3	4	5
2. I <u>talk about</u> Hospital X in a <u>positive</u> way.	1	2	3	4	5
3. I would <u>recommend</u> Hospital X to a friend or colleague.	1	2	3	4	5
4. I am <u>pleased to be associated</u> with Hospital X	1	2	3	4	5
5. I <u>feel an affinity</u> with Hospital X	1	2	3	4	5
6. I would be <u>willing to forgive</u> Hospital X if they treated me badly.	1	2	3	4	5
7. I would <u>not believe any story in the media</u> that put Hospital X in a bad light.	1	2	3	4	5
8. I think that Hospital X should receive <u>more money</u> from the government to have its <u>facilities improved</u>.	1	2	3	4	5
9. There are <u>high standards of hygiene and cleanliness</u> at Hospital X	1	2	3	4	5
10. The <u>media</u> have a major influence on the reputation of Hospital X	1	2	3	4	5
11. I feel that both <u>culture and language barriers</u> make <u>communication</u> a difficult challenge at Hospital X	1	2	3	4	5

	Very Dissatisfied				Very Satisfied
12. Please rate your <u>overall satisfaction</u> with Hospital X	1	2	3	4	5

	A Negative Reputation				A Positive Reputation
13. What sort of <u>reputation</u> do you think Hospital X has with the public?	1	2	3	4	5

	Very Unfavorable						Very favor-able
14. What is your <u>opinion of</u> Hospital X	1	2	3	4	5	6	7

	Dislike very much					Like very much	
15. Please rate how you <u>feel</u> about Hospital X	1	2	3	4	5	6	7

PLEASE rate how strongly you <u>disagree (1) or agree (7)</u> with the following statement: "If Hospital X <u>came to life as a PERSON</u>, he/she would be…"

	Strongly Disagree	Disagree		Neither	Agree		Strongly Agree
1. Arrogant	1	2	3	4	5	6	7
2. Aggressive	1	2	3	4	5	6	7
3. Selfish	1	2	3	4	5	6	7
4. Inward-looking	1	2	3	4	5	6	7
5. Authoritarian	1	2	3	4	5	6	7
6. Controlling	1	2	3	4	5	6	7

	Strongly Disagree	Disagree		Neither	Agree		Strongly Agree
7. Casual	1	2	3	4	5	6	7
8. Simple	1	2	3	4	5	6	7
9. Easy-going	1	2	3	4	5	6	7
10. Masculine	1	2	3	4	5	6	7
11. Tough	1	2	3	4	5	6	7
12. Rugged	1	2	3	4	5	6	7

Please check that you have answered every line.

Thank you for completing this questionnaire.

Appendix D: Employee Questionnaire

ANONYMOUS AND CONFIDENTIAL

INSTRUCTIONS:
1. Please **CIRCLE** the most appropriate answer
2. Please answer **ALL questions** to the best of your ability, otherwise responses **cannot** be used.
3. The survey should take **no longer than TEN minutes** to complete.

Demographics

Are you male or female? Male / Female	What is your nationality? _____
Which age group are you in? 16-24 55-64 25-34 65-74 35-44 75-84 45-54 85 +	**What is your occupation?** _____
Length of time working at Hospital X?	

0-1 year	1-5 years	5-10 years
10-15 years	15-20 years	20 + years

PLEASE write out the <u>words or phrases</u> that first come to mind when you think of Hospital X.

_____

_____

PLEASE rate how strongly you <u>disagree (1) or agree (7)</u> with the following statement: "If Hospital X <u>came to life as a PERSON</u>, he/she would be…"

	Strongly Disagree	Disagree		Neither	Agree		Strongly Agree
1. Cheerful	1	2	3	4	5	6	7
2. Pleasant	1	2	3	4	5	6	7
3.Open	1	2	3	4	5	6	7
4.Straightforward	1	2	3	4	5	6	7
5. Concerned	1	2	3	4	5	6	7
6.Reassuring	1	2	3	4	5	6	7
7.Supportive	1	2	3	4	5	6	7
8.Agreeable	1	2	3	4	5	6	7
9.Honest	1	2	3	4	5	6	7
10.Sincere	1	2	3	4	5	6	7
11.Trustworthy	1	2	3	4	5	6	7
12.Socially Responsible	1	2	3	4	5	6	7

PLEASE rate how strongly you <u>disagree (1) or agree (5)</u> with each of the following statements

	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
1. I find it easy to <u>smile</u> at each patient.	1	2	3	4	5
2. It comes naturally to me to have <u>empathy</u> for patients.	1	2	3	4	5
3. I enjoy <u>responding</u> quickly to patients' requests.	1	2	3	4	5
4. I get <u>satisfaction</u> from making patients happy.	1	2	3	4	5
5. I really <u>enjoy taking care</u> of patients.	1	2	3	4	5
6. I try to <u>help patients</u> achieve their goals.	1	2	3	4	5
7. I <u>achieve my own goals</u> by satisfying patients.	1	2	3	4	5
8. I get patients to <u>talk about their needs</u> with me.	1	2	3	4	5
9. I take a <u>problem solving approach</u> with patients.	1	2	3	4	5
10. I keep the <u>best interest of the patient</u> in mind.	1	2	3	4	5
11. I am able to answer a patient's questions<u> correctly</u>.	1	2	3	4	5

Please rate how strongly you <u>disagree (1) or agree (5)</u> with each of the following statements "Our managers...

	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
1. Constantly check to make sure hospital <u>policies and procedures</u> don't cause problems for patients.	1	2	3	4	5
2. Constantly make sure that <u>employees</u> are trying their best to <u>satisfy patients.</u>	1	2	3	4	5
3. Think of <u>patients' point of view</u> when making big decisions.	1	2	3	4	5

4. Plan to keep our hospital **ahead of competitors** by understanding the needs of our patients.	1	2	3	4	5
5. Assess **patient satisfaction** regularly.	1	2	3	4	5
6. Pay close attention to our patients **after** treatment.	1	2	3	4	5

7. **Really care** about patients, even after they have received their treatment etc.	1	2	3	4	5
8. Have organised our hospital to the **needs of our patients**.	1	2	3	4	5

PLEASE rate how strongly you <u>disagree (1) or agree (7)</u> with the following statement: "If Hospital X <u>came to life as a PERSON</u>, he/she would be…"

	Strongly Disagree	Disagree		Neither	Agree		Strongly Agree
1. Reliable	1	2	3	4	5	6	7
2. Secure	1	2	3	4	5	6	7
3. Hardworking	1	2	3	4	5	6	7
4. Ambitious	1	2	3	4	5	6	7
5. Achievement oriented	1	2	3	4	5	6	7
6. Leading	1	2	3	4	5	6	7
7. Corporate	1	2	3	4	5	6	7

	Strongly Disagree	Disagree		Neither	Agree		Strongly Agree
8. Cool	1	2	3	4	5	6	7
9. Trendy	1	2	3	4	5	6	7
10. Young	1	2	3	4	5	6	7
11. Imaginative	1	2	3	4	5	6	7
12. Up-to-date	1	2	3	4	5	6	7
13. Exciting	1	2	3	4	5	6	7
14. Innovative	1	2	3	4	5	6	7
15. Extrovert	1	2	3	4	5	6	7
16. Daring	1	2	3	4	5	6	7

PLEASE rate how strongly you disagree (1) or agree (5) with each of the following statements

	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
1. I am proud to tell people where I work.	1	2	3	4	5
2. I feel that I am associated with a winner at Hospital X.	1	2	3	4	5
3. I am committed to my job.	1	2	3	4	5
4. I am motivated to work to the best of my ability.	1	2	3	4	5
5. I feel personally responsible when Hospital X receives negative press.	1	2	3	4	5
6. I would not like to be associated with Hospital X if it had a bad reputation, especially in the media.	1	2	3	4	5
7. For me, ease of access, compared to most hospitals in Ireland is important at Hospital X	1	2	3	4	5
8. I feel that working at Hospital X creates job security for my future.	1	2	3	4	5

PLEASE rate how strongly you disagree (1) or agree (7) with the following statement: "If Hospital X came to life as a PERSON, he/she would be…"

	Strongly Disagree	Disagree		Neither	Agree		Strongly Agree
1. Arrogant	1	2	3	4	5	6	7
2. Aggressive	1	2	3	4	5	6	7
3. Selfish	1	2	3	4	5	6	7
4. Inward-looking	1	2	3	4	5	6	7
5. Authoritarian	1	2	3	4	5	6	7
6. Controlling	1	2	3	4	5	6	7

	Strongly Disagree	Disagree		Neither	Agree		Strongly Agree
7. Casual	1	2	3	4	5	6	7
8. Simple	1	2	3	4	5	6	7
9. Easy-going	1	2	3	4	5	6	7
10. Masculine	1	2	3	4	5	6	7
11. Tough	1	2	3	4	5	6	7
12. Rugged	1	2	3	4	5	6	7

PLEASE Rate Your Overall Impressions of Hospital X

	Strongly Disagree	Disagree	Neither	Agree	Strongly Agree
1. I would recommend W.G.H. to a friend or colleague as a good employer or hospital.	1	2	3	4	5
2. I feel an affinity with W.G.H.	1	2	3	4	5
3. I would be willing to forgive W.G.H. if they treated me badly.	1	2	3	4	5
4. I would not believe any story in the media that put W.G.H. in a bad light.	1	2	3	4	5

	Very Dissatisfied				Very Satisfied
5. Please indicate your overall satisfaction with W.G.H.	1	2	3	4	5

	Very Favorable					Very Unfavorable	
6. What is your overall opinion of W.G.H.	1	2	3	4	5	6	7

	Very Weak				Very Strong
7. I feel staff facilities at Hospital X are	1	2	3	4	5

	Very Negative				Very Positive
8. I feel patient experiences generally are	1	2	3	4	5

	Very Poor				Very Good
9. Hygiene and cleanliness at the hospital is	1	2	3	4	5

	Very Negative				Very Positive
10. The working environment at Hospital X is	1	2	3	4	5

	Very Negative				Very Positive
11. The effect of the <u>media commentary</u> is	1	2	3	4	5

	Very Inadequate				Very Adequate
12. <u>Parking facilities</u> at Hospital X are	1	2	3	4	5

	Very Impractical				Very Practical
13. The <u>layout</u> of the hospital building is	1	2	3	4	5

	Very Ineffective				Very Effective
14. <u>Clinicians' communication</u> with patients is	1	2	3	4	5

	Very Inadequate				Very Adequate
15. <u>Staff Training</u> at Hospital X is	1	2	3	4	5

Please check that you have answered every line.

Thank you for completing this questionnaire.