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THE IMPORTANCE OF SERVICE CULTURE FOR INSTITUTIONAL WORK IN MEDICAL TOURISM: THE ROLE OF MEDICAL DOCTORS

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Abstract

Extant studies in service-dominant (SD) logic put emphasis on the need to develop mid-range theories to bridge the gap between theoretical abstraction and empirical findings. While institutions are integral to midrange-theoretical advancement, little is known about how organisations deal with it. Additionally, present research in medical tourism has been focusing on private hospitals leaving the role of medical doctors with less attention. In view of the gap, this article briefly states the institutional types that constrain value co-creation in Malaysian medical tourism. Subsequently, the institutional work for medical doctors as derived from the expectations of other stakeholders is given a thorough discussions. Thus, two direct observations were held and a total of 13 semi-structured interviews were conducted with private hospitals, medical doctors, government section, and medical tourism facilitators. Interpretive analysis was done with the assistance of ATLAS.ti. Hence, the study derived seven institutions and the specific institutional work describing how medical doctors can improve their communication and collaboration with service providers and health travellers. This paper contributes to bridging the gaps in the mid-range theory of institutions by focusing on communication and collaboration. Additionally, medical doctors could improve their service exchange with other stakeholders through the suggested institutional work provided. Considering their integral role in treating patients, this article is important for service providers in crafting their strategies to optimise their service offerings.

Keywords: institutional work; institutions; service-dominant (SD) logic; medical tourism; medical doctors

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Introduction

Institutional work pertains to the practices of individuals and organisations in building, sustaining or demolishing certain institutions within an ecosystem (Lawrence & Suddaby, 2006). *Institution* is a term to describe individual and collective behaviour of following things as the way they usually are (Scott, 2013). Meanwhile, *organisation* is a group of persons that are deliberated assembled to achieve specific goals (Etzioni, 1961, as cited in Otley & Berry, 1980). Institutional work has caught the attention of several scholars in management studies (Lawrence & Suddaby, 2006; Lawrence et al., 2010; Pengtao et al., 2018; Sajtos et al., 2018).

Extant literature has unveiled the relationship between institutionalisation and various aspects such as actor engagement (Pengtao et al., 2018), network strategising (Anna-Greta et al., 2017), service innovation, and resource integration (Koskela-Huotari et al., 2016). Instead of *successful* institutional change (Lawrence et al. 2010) institutional work emphasises on the day-to-day experience that creates, maintains or disrupts a specific institution.

Little is known about how organisations deal with institutions (Barile et al., 2016; Pop et al., 2018). In view of the gap, this paper briefly states a constraining institutional type with examples from medical doctors; illustrates the institutional work as derived from the expectations of stakeholders; and

recommends the most prominent work to facilitate value co-creations between the stakeholders. This paper contributes to bridging the gaps in the mid-range theory of institutions, thus assisting medical tourism stakeholders to crafting their future strategies. In response to scholars (e.g. Koskela-Huotari, 2018; Koskela-Huotari et al., 2016), this study is essential to define the role of medical doctors in creating, maintaining or disrupting the specific institutions in Malaysian medical tourism ecosystem.

Literature Review

Service Ecosystem

Service ecosystem is an environment that encourages actors to exchange their resources as they undergo shared institutional arrangements (Vargo & Lusch, 2017). As a result, such mutual exchange allows for values in the services to be co-created and coherent. Research on service ecosystem was conducted towards explaining innovation (Koskela-Huotari et al., 2016). Past studies have also applied S-D logic in several ecosystems such as primary sector which consists of agriculture, forestry, fishing, mining and quarrying (Nenonen et al., 2018), healthcare sectors (Pop et al., 2018; Sajtos et al., 2018) and tourism management (Cabiddu et al., 2013; FitzPatrick et al., 2013). In healthcare ecosystems, Pop et al. (2018) proposed nine types of institutions and its relevant institutional work to enable or constrain value co-creation. Hence, medical tourism is a relevant context to study service ecosystem due to the wide range of stakeholders that collaborate and exchange their services (Heung et al., 2011) and the current lack of knowledge on the service providers' perspectives (Tham, 2018).

Service Culture

Service culture is defined as the presence of excellent service and delivers it to internal and external customers (Gronros, 2007, as cited in Hoang et al., 2010). Accordingly, Curtis and Upchurch (2008) outlined that internal customers consist of the employees whose satisfaction, emotion and morale are significant to the organisation.

On the other hand, external customers are the recipients of the service delivered. Thus, inculcating a service culture involves changing the mindset of employees from product-centric to service offerings (Kowalkowski et al., 2017). Moreover, it entails the participation of customers and key partners in co-creation throughout the service process (Aarikka-Stenroos & Jaakkola, 2012). As for medical tourism, service culture describes the hospitability that the hospitals and relevant stakeholders in the service chain offers.

Institutional Work

Vargo and Lusch (2017) emphasised that more research is needed on the midrange theoretical derivative under the rubric of *institutional work*. This is put forward due to the imminent role of institutional work in S-D logic as the work in creating, maintaining and disrupting institutions are deemed to be the central process for innovation in technology and markets (Vargo et al., 2015). Moreover, Lusch and Nambisan (2015) offered a broad view of service innovation in the digital age that includes service ecosystem and value co-creation

Koskela-Huotari et al. (2016) posited that institutional work permits actors to co-create value through three ways which are (a) including new actors; (b) redefining the roles of the involved actors; and (c) re-examine resources within service ecosystem (Koskela-Huotari et al., 2016). The authors posited that creating and disrupting the institutions are central for changes to happen. Further, Koskela-Huotari (2018) argued that all actors either disrupt or maintain markets in a fundamentally similar way by doing institutional work. She also suggested for future research revolving the role of actors, specifically their power and domination, in directing towards institutional stability.

In view of actors' roles, Wieland, et al. (2015) conjectured that actors do not only participate, but influence how value is created and evaluated in the future through institutional work. Taking the use of video content for entertainment (e.g. Netflix and YouTube) as an example, Wieland et al. (2015) posited that generic actors such as firms, customers, suppliers and other stakeholders created, maintained and disrupted institutions in fundamentally similar way through integrative, normalising and

representational practices. On the other hand Anna-Greta, et al. (2017) published a conceptual paper to gain enlightenment on how sense-making and interaction in relation to institutional work would increase strategising in business networks via role and position of multiple actors.

Scholars had suggested for more research on collective organisational confrontations of institutions. Nevertheless, there is also lack of studies that link institutional work and actors' roles with medical tourism ecosystem. Therefore, this study aims to bridge the gaps by integrating the stakeholders' work of creating, maintaining and disrupting the institutions in medical tourism industry.

Medical Tourism in Malaysia

Malaysia began participating in medical tourism during the 1997 Asian economic crisis. Due to the decreased purchasing power, local patients have shifted their treatment preferences to public healthcare, leaving the private hospitals with low occupancy rates. Yeoh, et al. (2013) described that the undesirable situation affected the healthcare sector since many local patients reverted to public hospitals. It resulted in private hospitals having poor utilisation rates in the clinics, wards and other facilities (Yeoh et al., 2013). In 2005, Malaysia Healthcare Travel Council (MHTC) was established by the Ministry of Health (MOH) Malaysia to promote the country's healthcare travel industry.

Limitations in the Number of Healthcare Travellers and Revenue Earned

Cham et al. (2016) delineated that 70% of the medical tourism activities in Malaysia occur in the northern state with majority of the medical travellers are from Indonesia. Specifically, International Medical Travel Journal (2018) posited that Penang, Kuala Lumpur, Selangor, Melaka and Sarawak are the top medical tourism contributing states.

Between 2011 and 2015, Malaysia received annual increase in health travellers from 643,000 to 859,000. These travellers brought in revenue between MYR527 million and MYR914 million respectively (Malaysia Healthcare Travel Council, 2020). Moreover, Malaysia received over 900,000 of health travellers in 2016 with revenue of MYR1.15 billion. In 2018, Malaysia earned MYR1.5 billion revenue from the 1.2 million health travellers (Malaysia Healthcare Travel Council, 2020). In 2019, Malaysia received 1.22 million health travellers equivalent to MYR1.7 billion revenue (Malaysia Healthcare Travel Council, 2020).

Nevertheless, figures on health travellers' arrival and the revenue earned do not reflect the entire performance of medical tourism. This is due to the differences in recording the actual medical travellers' arrivals which may only occur at the specific private hospitals. Thus it results in varying figures and recording format (Crooks et al., 2017). As shown in Table 1, medical expenditure takes up a relatively small percentage of foreign tourists' expenditure in Malaysia between 2017 and 2019 in comparison with other expenses.

In 2019, the largest pool of expenditure by foreign tourists is on shopping (33.6%), followed by accommodation (24.0%), food and beverages (13.3%), and local transportation (7.6%). As for medical expenditure, not only it contributed a small amount of percentage (3.4%), but the figures are also diminishing as compared to 2017 (3.7%). This signifies the need for the present study to explore the role of medical doctors in offering high-value medical treatments to health travellers. Moreover, the number of health travellers combined the inflow of health travellers and medical travellers. It hinders the analysis on actual medical travellers' arrival and revenue earned to the country. Therefore, the present study is in line with Crooks et al. (2017) suggestion that focus should be made on the medical and non-medical spending of travellers (Crooks et al., 2017).

Table 1. Components of Foreign Tourist Expenditure in Malaysia between 2017 and 2019

Expenditure components							Growth	
ITEMS	2017		2018		2019		2017/ 2018	2017/ 2018
	(%)	MYR ('MIL)	(%)	MYR ('MIL)	(%)	MYR ('MIL)	(%)	(%)
Shopping	32.7	26,868.00	33.4	28,101.20	33.6	28,944.20	4.6	0.2
Accommodation	25.6	21,034.20	25.7	21,622.70	24.0	20,674.40	2.8	-1.7
Food & Beverages	13.3	10,927.90	13.4	11,274.10	13.3	11,457.10	3.2	-0.1
Local Transportation	5.8	4,765.60	6.1	5,132.20	7.6	6,546.9	7.7	1.5
Organised Tour	4.9	4,026.10	4.4	3,701.90	6.3	5,427.0	-8.1	1.9
International Airfares by Local Carriers	4.1	3,368.80	4.5	3,786.10	4.9	4,221.0	12.4	0.4
Entertainment	3.9	3,204.40	3.6	3,028.90	3.4	2,928.90	-5.5	-0.2
Medical	3.7	3,040.10	3.4	2,860.60	3.4	2,928.90	-5.9	0.0
Domestic Airfares	3.2	2,629.30	3	2,524.10	2.6	2,239.7	-4	-0.4
Fuel	0.7	575.2	0.7	588.9	0.3	258.40	2.4	-0.4
Sports	0.3	246.5	0.3	252.4	0.2	172.30	2.4	-0.1
Others	1.8	1,479.00	1.5	1,262.00	0.4	344.60	-14.7	-1.1

Source: Malaysia Tourism Key Performance Indicators 2019 (Tourism Malaysia, 2020)

Methodology

Sampling

The list of private hospitals that fall under the sample of the study is obtained from MHTC website. There were 74 private hospital members during the time of data collection. Nevertheless, MHTC does not provide the list for medical tourism facilitators. Hence, the researchers obtained MTF1 and MTF2 from a conference coded as C01. The relatively small size of medical tourism facilitator and medical doctors are in resemblance with Tham (2018).

Data Collection Process

Through non-contrived study setting, a cross-sectional single case study was conducted in reference to Yin (2017). Data collection began with a preliminary group interview, followed by with *Phase 1: Direct Observations* and *Phase 2: Semi-structured Interviews*. Direct observations were aimed at; (a) obtaining primary information on the current challenges and strategies in medical tourism and private healthcar; and (b) refining the scope of the interview questions. Semi-structured interviews were aimed at obtaining emerging worldview of the participant and new ideas relating to the topic being asked (Merriam & Tisdell, 2015). Moreover, interviews offer targeted and insightful explanation on the case study topics (Yin, 2017).

The researchers then participated in two direct observations named as Conference 1 (C01) and Workshop 1 (W01) which took place in September and October 2018 respectively. Field notes were taken on the current issues in medical tourism and private hospital. Semi-structured interviews were held between December 2018 and April 2019. Later, 13 semi-structured interviews were held with seven private hospitals (PH1-PH7), Government Section (GS), medical tourism facilitator 1 (MTF1), medical tourism facilitator 2 (MTF2) and three medical doctors (D1, D2, D3) respectively. This information is summarised in Table 2 below.

Table 2. Summary of Research Participants and the Assigned Codes

Phase 1: Direct observations		
Conference 1 (C01) Workshop 1 (W01)		
Phase 2: Semi-structured interviews		
Participants	Number of organisations/ individuals	Codes
Government Section	1	GS
Private hospitals	7	PH1, PH2, PH3, PH4, PH5, PH6, PH7
Medical tourism facilitators	2	Medical Tourism Facilitator 1 (MTF1) Medical Tourism Facilitator 2 (MTF2)
Medical practitioners	2	Doctor 2 (D2), Doctor 3 (D3)
Medical academic	1	Doctor 1 (D1)

(a) **Private hospitals**

The seven private hospitals are located in Kuala Lumpur (PH1, PH4), Selangor (PH3, PH5), Melaka (PH2), Penang (PH6), and Johor (PH7). The criteria of choosing private hospitals are that they must be a member of MHTC and have experiences in serving medical travellers. While most of the organisation were derived from the researchers' encounter at C01 and W01 (PH1, PH2, PH4, PH5), the remaining hospitals were snowballed throughout the data collection (PH3, PH6, PH7). This condition justifies the variety of states involved in the study. Interview participants range from the Chief Executive Officer (CEO), marketing director, group chairman, operation manager, and marketing executive in the respective hospital. Each interview was held for around one hour. Participants were asked to provide their signature indicating their voluntary participation.

(b) **Government Section (GS)**

On the other hand, Government Section (GS) is responsible in surveillance for private healthcare practices in Malaysia. A representative from GS was interviewed at their office located at the Federal Government Administrative Centre, Putrajaya, Malaysia. GS was approached due to their imminent role as unveiled during the direct observation at W01. The aim of this interview was to enquire their expectations on private hospitals and medical doctors in private healthcare.

(c) **Medical Tourism Facilitators**

Medical tourism facilitators consist of MTF1 and MTF2. The former is based in Jakarta bringing Indonesian medical travellers to Malaysia. Meanwhile, the latter caters for medical travellers upon arrival and departure at airports. However, the location of MTF2 is enclosed in the study. Due to geographical barriers, an online interview was conducted with MTF1 and the session was held via WhatsApp video call. A semi-structured interview was conducted with a representative of MTF2 at one of the international airports.

(d) **Medical Doctors**

D1 is an academician in a public university in Malaysia teaching dentistry and pharmacy students. A perspective of an academician was sought after due to the frequent mention of *service culture* by private hospitals thus indicating the possible role of tertiary education centres to overcome the concern. Only a single interview was conducted with medical academic as findings on *service culture* from D1 has resonated to the existing information obtained from private hospitals. Meanwhile, D2 is a physician doing sub-speciality in cardiology and has been a medical doctor for over 13 years. On the other hand, D3 is a consultant cardiologist who has been practicing for over 20 years with 13 years of experience in cardiology.

The criteria for selecting the practicing medical doctors are that D2 and D3 practice at two different private hospitals in Malaysia that are listed as MHTC members. Further, both of them have experiences in treating medical travellers. The study decided to discontinue collecting data from medical doctors

because the responses provided on their *motivations to participate in medical tourism* as well as *the role of stakeholder groups in developing the medical tourism industry* have reached similarities to the responses obtained from private hospitals.

Data Analysis

Analysis on ATLAS.ti version 8 was done by firstly assigning codes and grouping the similar codes together which then built several themes. To build validity of the findings, *member validation* was conducted by emailing the participants with a summary of the interview findings to obtain their feedbacks. Majority of the participants reverted by saying that they do not have any more comments about the findings while other participants replied with minor amendments. *Method triangulation* occurred between *Direct Observations* and *Semi-structured Interviews*. Data is presented through cross-tabulation data analysis (see Table 3).

Findings and Discussion

Institution disrupting the development of medical tourism

The term *service culture* was mentioned by all private hospitals, three doctors and MTF1. Service culture is defined as the presence of excellent service and delivers it to internal and external customers (Gronros, 2007, as cited in Hoang et al., 2010). As for medical tourism, service culture describes the hospitability that the hospitals and relevant stakeholders in the service chain offers. PH1 expressed that Malaysians are losing the hospitable culture to serve tourists. PH1 used the term *Sciences* and *Arts* to illustrate the state of Malaysian *medical* and *non-medical* service respectively.

> *"Our 'Sciences' are excellent, but we are hindered by the 'Arts' of our services. This happens due to the diminishing service culture of greeting and welcoming in our society. It's a long work to do, but we need to emphasise on this matter." (PH1, Line 2:34)*

Non-medical aspect includes the hospitability at hospital premises. Malaysia lacks the *service culture* in catering for medical travellers' needs. The service offerings are claimed not delivered from the heart but only driven by monetary purposes.

> *"To tell you the truth, our services are lousy. In order sustain or grow we need to depend on culture. The servicing culture that we have is very poor." (PH2, Line 1:62)*

> *"But here in Malaysia...we do not have that customer service culture. It's non-consistent in here because we only greet patients for work and not from within. We are only doing this for work and money..." (PH1, Line 2:10)*

The Role of Medical Doctors

The theme *role of medical doctors* emerged in the data analysis. The cross-tabulation analysis in Table 3 signifies that PH3, PH5 and three doctors emphasised on the importance of medical practitioners in maintaining their relationship with patients as well as participating in marketing activities. The present study has inducted that doctors' participation in medical tourism is voluntary. They are given the options to decide if they want to participate in treating medical travellers.

PH5 will usually detail the commitments needed and let the doctors choose if they wish to partake in medical tourism activities. Not all doctors are keen to take part in medical tourism owing to the high number of existing patients and workload. Thus PH3 and PH5 described that they will only channel the medical travellers to the doctors who agreed to embark on medical tourism.

> *"Even for the health talk, not all doctors are keen, you know! So we channel the patients to the doctors who can cater for health tourism." (PH3, Line 6:142)*

> *"But, I always say, if there is a doctor who feels he cannot spend enough time with the patient, we will ask him to tell us 'I don't want foreign patients'. So we will send foreign patients only to the doctors who are willing." (PH5, Line 7:147)*

Table 3. Role of Medical Doctors in Developing Medical Tourism

Theme: Role of medical doctos in developing medical tourism																		
Barrier	**Codes on the role of medical doctor**	**PI**	**Phase 1: Direct Observation**		**Phase 2: Semi-structured Interviews**													
		MHTC	W01	C01	PH1	PH2	PH3	PH4	PH5	PH6	PH7	D1	D2	D3	GS	MCL	MTF1
Poor service culture	Enhance relationships with patients											✓	✓	✓			
	Doctors' readiness criteria						✓		✓				✓				✓
	Participate in marketing activities						✓		✓		✓		✓	✓			

Private hospitals are stringent in ensuring that doctors meet the relevant criteria of serving medical travellers. Hence, this study derives the doctors' readiness criteria to participate in medical tourism. These criteria portray the role of medical doctors to develop the medical tourism industry which are (a) prior treatments; (b) during treatments; and (c) post treatments.

Prior treatments

At prior treatments, doctors are expected to communicate with patients via phone or video call if patients wish to do so. This effort helps medical travellers to develop trust to the doctors and hospitals. Apart from that, it helps medical travellers to obtain the desired information about the treatments thus making informed decisions in their health trip. Moreover, doctors should involve in marketing activities such as health talks, exhibition and consultation to communicate and bridge the patients to hospitals.

"So it is very important that the doctors work in the form of publications, in form of promotional activities so that people know about the doctor." (D2, Line 11:91)

D2 explained that by having the doctors to convey the health talks, it escalates medical travellers' trust towards the services that are offered to them. Instead of fearing that the services are a form of scam, patients are confident to travel abroad and seek treatment in the specific hospital.

"The way it is promoted must be in a way that people can trust that this place, it is not like scamming. So that is why I think our approach is good. When the patients have seen that the doctor is talking, they can trust us." (D2, Line 11:47)

During treatments

During the treatment period, doctors are expected to make their time to see and treat patients at any point in time. This step is important as it would resonate to the medical travellers' expectations on non-medical services as described.

"Secondly, when the patient comes, whatever time it is, you must make yourself available to see the patient."(PH5, Line 7:148)

PH5 described that doctors should spend ample time with patients to explain about the procedures and risk. Moreover, doctors should allocate appointments to discuss about the test results so patients could comprehend on their current state of health.

"...talking to a doctor who is good, who will explain clearly. Not a doctor who is rushing to see the next patient. Spend time with him, answer all his questions, and do all the check up...Maybe you have to come back on second day. Sit and discuss, 'These are the results. You are quite okay except for this small problem. This is what you should be doing and like this, like this...' That is what they want." (PH5, Line 7:87)

At the absence of a translator, language barrier between medical practitioners and patients are imminent. Thus, doctors' tolerance in treating non-English speaking patients is highly appreciated.

"When patient does come here, we have to realise the patient come all over from another country and we must be a bit more patient especially because when there is a language barrier and we cannot understand or they cannot understand us." (D2, Line 11:82)

Post-treatments

During post-treatments, doctors are required to produce a Health Summary report that explains about patients' conditions, medication, and follow-ups that they should undergo. The report should be handed over and explained to them prior to discharge.

"Thirdly, when the patient goes back, you must write a medical report."(PH5, Line 7:148)

Additionally, should patients experience complications in their home country or that their GP wishes to discuss with this particular doctor, the doctor is expected to make themselves available and cater to their concern. This step extends the after-care services that the hospital offers to medical travellers aside from the Health Summary reports.

Institutional Work of Medical Doctors in Malaysian Medical Tourism

Institutionalisation delineates the roles and positions based on the expectations imposed on them (Jansson, 2007). Hence, **Error! Not a valid bookmark self-reference.** encapsulates the contribution of this study towards the development of institutional work for medical doctors. Concerns on non-medical services are addressed with the role of medical doctors in serving patients at before, during and post treatments. The effort is hoped to *disrupt* the poor service culture towards health travellers.

Table 4. Medical Doctors' Readiness Criteria to Participate in Medical Tourism

Stages	Institutional Work	Key Patterns	Collective Institutional Work
Prior treatments	Communicate with patients via phone or video call	Disrupt poor service culture	Regular dialogues between medical doctors and other stakeholders
	Participate in marketing activities such as health talks, exhibition and consultation		
During treatments	Make time to see and treat patients at any point in time.		
	Tolerance towards non-English speaking patients		
Post treatments	Produce a Health Summary report to guide patients on their medication and follow-up schedule		
	Available to cater the concerns addressed by patients.		

For collaborations to be effective, actors need to undertake specific institutional work (Sajtos et al., 2018). Hence, the work should also be aligned with regular dialogues between stakeholders. The sessions are important to strengthen communication between medical doctors and other stakeholders. This study also reciprocate to the call for more focus towards the *midrange theoretical abstraction* to link SD-Logic with practice; medical tourism (Vargo & Lusch, 2017). The midrange level of abstraction includes communication and engagement. Through empirical research, the present study produces findings on the communication between stakeholders in Malaysian medical tourism.

Conclusion

This study emphasises the essential role of medical doctors in developing medical tourism at before, during, and after treatments. Contribution is apparent through the delineation of readiness criteria in serving medical travellers. Moreover, this article reciprocates to the call for more empirical evidence of institutional work with examples drawn from medical tourism. Nevertheless, this study is bound to several limitations. First, the cross-sectional approach that hinders the researchers from understanding a trend of institutional work over a longer period. Second, the role of other stakeholders in response to the needs of medical doctors. These concerns open the door for future research to conduct longitudinal studies on the described institutional work. As for the poor service culture, prospective studies could explore the morale of medical and non-medical staff at private hospitals which could provide avenues for private hospitals to cater the issue. Additionally, research could also be conducted on measuring the

relationship between doctors' readiness criteria and institutional work in medical tourism.

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