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The Mediating Role of Perceived Service Quality in the Effect of Patient Relationship Management Practices on Institutional Commitment

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Abstract: *This study, which was carried out with the aim of determining whether the perceived service quality played a mediating role in the effect of patient relationship management practices on institutional commitment for patients receiving services from health establishments and whether this differed according to the demographic characteristics of patients in terms of both outpatients and inpatients, was conducted on 824 outpatients and 850 inpatients in a training and research hospital of a university in Turkey. According to the results of the study, it was found out that the perceived service quality played a mediating role in the effect of patient relationship management practices on institutional commitment in both outpatients and inpatients, and the mediating role of the perceived service quality in the effect of patient relationship management practices on institutional commitment differed according to all the demographic characteristics (gender, marital status, age, educational status, and hospital preference) in outpatients and only the ages and hospital preferences of the patients in inpatients.*

Keywords: *Patient Relationship Management Practices, Patient Commitment, Perceived Service Quality*

I. Introduction

Healthcare services, which require urgency and cannot be delayed, are benefited from circumstantially and provided by specialists who have received the best education in the field, are an area in which patients cannot have a say authoritatively since they lack an adequate level of content knowledge and which is more abstract, directly related to human life, more intolerant to possible mistakes and expensive, requires the coordination of experts from different professions and does not allow for the establishment of the supply and demand balance (Ak, 1990:69-71; Tatar and Tatar, 1996:36-37; Karafakioğlu, 1998:111; Şimşek, 1999:21; Kavuncubaşı, 2000:52-56; Mucuk, 2001:162; Tengilimoğlu, 2001:32, 2005:5; Gel, 2004:192; Öztürk, 2007:13).

According to the 2017 data of the Turkish Statistical Institute (TSI), there are a total of 1518 establishments that provide health services in Turkey. Of these, 879 are under the Ministry of Health, 68 are affiliated to universities, and 571 are in the private sector. When the bed occupancy rates for the same year are reviewed, it is observed that the bed occupancy rate of hospitals of the Ministry of Health is 69%, the rate of private hospitals is 61.4%, and the rate of university hospitals is 73.4% **(**http://ohsad.org/wp-content/uploads/2018/12/28310saglik-istatistikleri-yilligi-2017pdf.pdf).

Considering these data, it is possible to say that university hospitals are preferred more by patients who want to receive health services, although the number of these hospitals is lower compared to the other areas of the sector.

University hospitals, which have experienced academic personnel, provide advanced and quality treatment services, make an effort for raising human sources which will direct the health policies in the future and are considered as the last address by society, beyond the 3rd step, were included in the scope of the study for these aspects.
When viewed in terms of marketing, a 36.2% increase in the number of establishments providing health services between 2002 and 2017 (http://ohsad.org/wp-content/uploads/2018/12/28310saglik-istatistikleri-yilligi-2017pdf.pdf) has increased the competition between establishments that provide services in this sector and

forced them to use modern marketing techniques in order to attract more patients. At this point, it is possible to satisfy patients, who come to the establishment for the first time, and to create commitment by ensuring the perception of the received service as quality and with the practices provided.

In the literature, it is possible to encounter many studies conducted on patient satisfaction, patient commitment, perceived service quality, patient relationship management practices, and the relationships between them. However, no studies that investigated whether the perceived service quality played a mediating role in the effect of patient relationship management practices on institutional commitment could be found in national and international literature. This study is significant since it is the first study investigating the mediating role of the perceived service quality between patient relationship management practices and patient commitment and it contained such a big sample (824 outpatients and 850 inpatients) in the field of health services.
Before the execution of the study, the ethics committee approval of the related university, permission of the Provincial Directorate of Health, and the verbal consent of the patients included in the study were obtained. The study was conducted between October and November 2019.

The obtained data were analyzed using SPSS 21.0, and the intervariable correlations were tested through the multiple regression analysis. The statistical significance level was accepted as $P<0.05$.

II. Conceptual Framework

Regarding the conceptual framework of the study, the patient relationship management practices, perceived service quality, and patient commitment were first addressed, and then the section of research analyses was presented.

2.1.Patient Relationship Management Practices

Different characteristics and expectations of customers are observed to develop over time. For example, it can be said that the Internet has been used extensively after the 1960s (Winer, 2001:89), obstacles in the market have been eliminated (Sviokla and Shapiro, 1993:21), the educational levels of customers have increased, and their expectations have changed. Since consumers have had more dominance in the market than producers, enterprises have been obliged to become customer-oriented and use modern marketing methods in order to both keep their available customers and attract new customers (Kotler, 1997:721; Çiçek, 2005:60-61). Customer relationship management (CRM) appears as a marketing method that enterprises need to apply at this point.

Customer relationship management is a managerial philosophy which creates customer databases via information technologies and relational marketing strategies, thus tries to produce goods or services beyond the expectation of customers, values customers, aims at establishing a long-term relationship with them and tries to turn this understanding into an organizational culture (Anton, 1996:9; Ryals and Payne, 2001:3; Burnett, 2001:253; Kotler, 2003:166; Odabaşı, 2010:3). Enterprises that adopt such an understanding convey the right message to the right customer by making use of databases and individual marketing efforts. Hence, the enterprise prevents several operational costs to be covered for gaining new customers. It maximizes the enterprise profit by producing goods or services beyond the expectation of customers and increasing customer satisfaction, commitment, and value. Moreover, it is ensured that potential customers are attracted to the enterprise, and a positive establishment image is formed through the word of mouth marketing of satisfied customers. Happy customers mean happy enterprise personnel. The motivation and organizational commitment of the personnel working under good conditions and with good salaries are high. Finally, thanks to the information technologies used by the enterprise for customer relationship management, the enterprise analyzes its current status and the market in a better way and can make right decisions on the development of new goods and services, distribution channels, and the market sections (Reicheld and Sasser, 1990:108; Griffin, 1995:11-13; Takala and Uusitalo, 1996:53; Peppers et al., 1999:151; Ballantyne, 2000:274-286; Newell, 2000:5-15; Brown, 2000:8; Sheth and Parvatiyar, 2000:545-546; Gronstedt, 2002:225; Tiwana, 2003:24; Kotler, 2005:88).

As can be seen above, the focal point of customer relationship management in terms of enterprises is customers. On the other hand, the focal point of patient relationship management practices in terms of health establishments is patients.

Because patients are not competent enough to evaluate the health services they receive, they pay more attention to the easy accessibility and physical environment of the hospital, completion of front office operations without any mistakes and in a short time, accuracy of the medical diagnoses, the attitudes of the health personnel towards themselves and their companions, cleanliness of the hospital, quality and delivery of the food and drinks, and the cost of the related service. At this point, patient relationship management practices come to the fore.

Patient relationship management practices are very important for enterprises producing health services considering the increase in the number of both public and private hospitals in Turkey.

Patient relationship management practices have advantages such as attracting more patients, providing patient-specific services by creating patient databases, reducing the costs by preventing unnecessary treatment and diagnoses, minimizing the patient complaints, creating satisfaction and commitment in the relationships of the patient with the hospital, increasing the preferability of the hospital if the patient needs any health services again, enabling the treated patients to recommend the hospital to potential patients, creating a positive image about the hospital and increasing the profitability and rates of capacity utilization (Varinli and Çakır, 2004:36; Özer and Çakıl, 2007:141; Tüzün and Devrani, 2008:14-15).

When the literature review is conducted, it is possible to find many studies suggesting that patient relationship management practices have an effect on patient satisfaction, patient commitment and perceived service quality, and this effect differsaccording to the demographic characteristics of patients (Özer and Çakıl, 2007:141; Geçkil et al., 2008:41-51; Büyükyörük et al., 2010:1-6; Emhan and Bez, 2010:241-247; Top et al., 2010:4; Zaim and Tarım, 2010:9; Tanrıverdi and Erdem, 2010:73-92; Arslan and Kelleci, 2011:1-8; Demir et al., 2011:68-76; Derin and Demirel, 2011:208-235; Arslan et al., 2012:717-724; Acharyulu, 2012:72-87; Atilla et al., 2012:23-37; Akkaya and Akkaya, 2012:62-68; Büber and Başer, 2012:265-274; Senic and Marinkovic, 2013:312-319; Topal et al., 2013:199-205; Atilla et al., 2013:101-119; Öztürk et al., 2015:25-36; Güllüpunar, 2016:895-925; Yıldızbaşı et al., 2016:293-302; Erdugan et al., 2017:165-177; Gökkaya et al., 2018:136-148; Abdulsalam and Khan, 2020:18-37).

In this study, patient relationship management practices were discussed within the framework of the variables defined by Acharyulu (2012:72-87). The variables discussed within this scope are as follows: *location and accessibility* (the access of the patient to the hospital and easiness of hospitalization procedures), *front office* (the duration between hospitalization procedures and the admission of the patient to the room, and adequate informing), *general comfort and convenience* (impression of the hospital with its general atmosphere), *medical comfort/convenience* (coordinated work of doctors and nurses, informing inpatients during the day, and the assurance of the hospital about patient care), *care provided by doctors* (whether visiting doctors inform the patient adequately about the treatment process, whether their medical and professional activities are satisfactory, and doctors' attitudes towards the patient), *care provided by nurses* (whether nursing services are specific to the patient, satisfactory and quick, and nurses' attitudes towards patients), *laboratories and diagnoses* (the period awaited for having various diagnostic tests, whether the assigned personnel give adequate information about this matter, and their attitudes towards the patient), *food and drinks* (Delivery of food services and the approach of dieticians in the hospital to patients), *cleaning work* (general cleanliness of the hospital and the attitudes of the cleaning personnel towards the patient), and *billing* (easiness and comprehensibility of the billing procedures, information given about the treatment costs).

2.2.Perceived Service Quality

Services are the economic activities that provide consumers with formal, spatial, temporal, and psychological benefits without creating a possession utility, cannot be held with hands but are consumed where they are produced (Kuriloff et al., 1993:247; Uyguç,1998:8; Karahan, 2000:90; Mucuk, 2001:319).

Quality is the conformity of a good or service, which has been bought or will be bought, to the characteristics expected by a customer, or its status of being good or bad (Parasuraman et al., 1985:41; Demirkaya, 2002:170; Sözer et al., 2002:46).

Perceived service quality refers to whether a customer is happy or unhappy about a service after comparing his/her expectations before buying that service to his/her experiences after buying it. If the service that has been bought fulfills the customer expectations or has a performance beyond the expectations, the customer will be satisfied with the service and positively evaluate the quality of the service. However, the

customer will be unsatisfied and negatively evaluate the service quality if the service that has been bought is below his/her expectations (Uyguç, 1998:27; Zeithaml and Bitner, 2000:27; Bülbül et al., 2008:182).

The different characteristics of services compared to goods (Inability to be stocked/Instability-Inability to be homogeneous-Heterogeneity-Simultaneity of Production and Consumption-Untouchableness/Inability to be held with hands) and the variability of the service quality perceptions according to the customer needs and expectations make the service quality measurement difficult compared to goods (Parasuraman et al., 1985:42-43; Kotler and Armstrong, 2018:245).

Although there are many models for service measurement (critical incident management, data envelopment analysis, service barometer, perceived total quality model), the most widely used scales are the SERVQUAL and SERVPERF service quality scales (Saat, 1999:107; Eleren et al., 2007:75-88).

The SERVQUAL scale consists of two separate surveys, each consisting of five dimensions and twenty-two items, to measure the difference between customer expectations and perceptions (Parasuraman et al., 1988:12-40). The SERVPERF scale, on the other hand, measures only the service performance perceived by customers, excluding the section of expectations in SERVQUAL (Cronin and Taylor, 1992:55-68).

The dimensions used in the SERVQUAL or SERVPERF scales are given in Table 1 below.

Table 1.Dimensions of the SERVQUAL/SERVPERF Scale

DIMENSIONS	SUGGESTIONS	DEFINITIONS
Tangibles	1-4	Physical facilities, equipment used for rendering the service, and physical appearance of the personnel
Reliability	5-9	Accurate completion of the service with consistent performance at the first time and fulfillment of the promises by the enterprise
Responsiveness	10-13	Employees' desires for service delivery and helpfulness
Assurance	14-17	Employees' adequate level of knowledge and equipment, politeness and reassurance, rendering risk-free and safe services
Empathy	18-22	Understanding customer needs and dealing with them personally

Source: Parasuraman, A., Zeithaml, V. A. and Berry, L. L. "SERVQUAL: A Multiple-Item Scale for Measuring Consumer Perceptions of Service Quality," Journal of Retailing, 64(1), 1988, 23.

The difference of health services from other services obligates a different approach to the perceived service quality of patients. It is observed that many studies trying to put forward the quality dimensions have been conducted in this field (Parasuraman, 1985:41-50; Parasuraman, 1988:12-40; Reidenbach and Sandifer Smallwood, 1990:47-55; Panchapakesan et al., 2009:157-191; Karassavidou et al., 2009:34-46; Yogesh and Satyanarayana, 2016:300-323; Taqdees et al., 2017:1195-1214).

However, some researchers have also conducted studies proving that the SERVPERF scale yields better results and suggesting this scale to be used (Cronin and Taylor, 1992: 55-68; Boulding et al., 1993:7-27; Gotlieb et al., 1994:875-885; Brady et al., 2002:17-31). In this study, the SERVPERF scale was used for the measurement of the perceived service quality of patients.

2.3.Patient Commitment

In the marketing literature, customer loyalty is a psychological status indicating that a customer has positive feelings about an enterprise, its goods or services without hesitation, continues buying the same or cross goods or services from the enterprise and sincerely praises the enterprise or its goods and services to the people around even though the customer has the right to choose and rival companies make tempting efforts (Dick and Basu, 1994:102; Zeithaml et al., 1996:31-46; Kandampully, 1998:435; Hennig-Thurau et al., 2002:235; Uncles et al., 2003:296; Kim and Yoon, 2004:762; Oliver, 2015:126).

When it comes to health establishments, it is observed that the concept of patient commitment is used rather than the concept of customer commitment. Patient commitment may result from compulsory cases; for example, the patient may think his treatment will remain incomplete if he leaves the hospital where he has received services, or there may be no alternative health establishments in the patient's environment (behavioral commitment). The patient may also feel grateful towards the hospital and suggest it to people in his environment

after buying the health service (attitudinal commitment) (Oyman, 2002:171; Çatı and Koçoğlu, 2008:169; Derin and Demirel, 2011:216).

The creation of patient commitment has many advantages in terms of health establishments. When it is primarily thought, in the light of the studies, that the costs to cover for gaining new patients are 5-7 times higher than keeping old patients and patients remain under the significant effect of the advisory groups when buying health services, the decrease in the costs of finding new patients, the increase in earnings from loyal patients, rising market share, positive corporate image, etc. can be mentioned as the first advantages of patient commitment (Derin and Demirel, 2011:215; Şahin et al., 2013:236; Hoşgör et al., 2017:443-444).

In addition to the advantages provided to health establishments, patient commitment also has significant advantages for patients. The treatment period which gets shorter and easier thanks to the trust-based communication established between patients and their doctors and knowing the patient expectations enable the treatment process to be overcome without stress, and the patient makes a decision on the hospital preference in a shorter time if there is a need for receiving another health service, which are only a few of those advantages (Şahin et al., 2013:54).

The above-mentioned advantages of patient commitment in terms of health establishments and patients attract the attention of both implementers and marketing academicians. However, the creation of patient commitment is quite a difficult matter. The dynamics specific to health services complicate this situation more substantially.

Considering the studies conducted, quality care services beyond patient expectations, technical competency of the health establishment, coordinated work of the health personnel, respected patients' rights, communication with the patient and patient's relatives, long-term relationship between the patient and the doctor, complaint management, system of access to appointments and other services, post-treatment service programs, service cost, corporate reputation, and trust in the establishment, etc. have been found to affect patient commitment (Kandampully and Hu, 2007:435-443; Tanrıverdi and Erdem, 2010:73-92; Rundle-Thiele and Russell-Bennett, 2010:195-214; Derin and Demirel, 2011:215; Şahin et al., 2013:54). The common point of all these studies is to measure the effect of patient relationship management practices offered by health establishments on patient commitment.

III. Research Methodology

In this section, the purpose and significance, model, population and sample, method and limitations, and hypotheses of the study are discussed.

3.1.Purpose and Significance of the Study

The purpose of the study is to determine whether the perceived service quality plays a mediating role in the effect of patient relationship management practices on institutional commitment for patients receiving services from health establishments and whether it differs according to the demographic characteristics of patients in terms of both outpatients and inpatients.

When the relevant literature is reviewed, it is observed that the correlations between patient relationship management practices and patient satisfaction, between perceived service quality and patient satisfaction or commitment were rather examined via the simple regression analysis and the mediating role between the variables was not checked. The study is significant theoretically and practically for filling the gap in this matter in national and international literature.

3.2. Conceptual Model of the Study

The conceptual model of the study is presented in Figure 1, and the sources from which the scales used with respect to this model were taken are shown below.

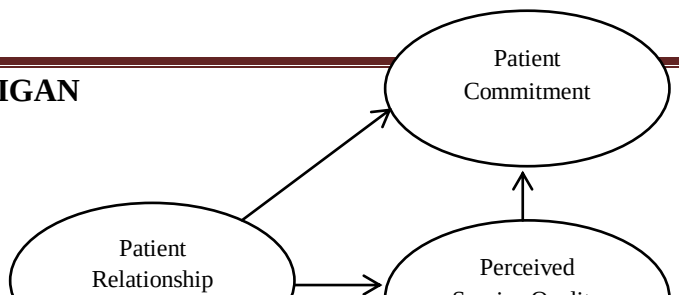

Figure 1:Research Model

Patient Relationship Management Practices: Acharyulu, G. (2012)

Patient Commitment: Chaudhuri, A. and Holbrook, M. B. (2001); Matzler, K., Grabner-Krauter, S. and Bidmon S. (2008)

Perceived Service Quality: Parasuraman, A., Zeithaml, V. A. and Berry, L.L. (1990)

3.3.Population and Sample of the Study

The population of the study consists of outpatients and inpatients at the hospital. Therefore, separately for both groups, the sample size was calculated as follows (Yükselen, 2017:67):

$$n = p * q * (Z / e)^2$$

p = Rate of those satisfied with patient relationship management practices (0.50)

q = (1 - p)

Z = normal value at the 95% confidence level (±1.96)

e= Tolerance level (±0.05)

When the p-value was unknown in the population with two options, the value of 0.50, which gave the maximum variance, was used, and the sample size was calculated as follows:

$$n = 0.50 * 0.50 * (1.96 / 0.05)^2 = 384$$

Sample units were defined via the convenience sampling method, which is among the non-random sampling methods.

Patients treated in certain clinics of the hospital (psychiatry clinic, intensive care divisions, pediatric clinic) where the study was conducted, and patients' relatives were not included in the survey.

3.4.Research Method and Limitations

The survey method was used as the data collection method in the study. The surveys were applied face-to-face to inpatients and outpatients in a university training and research hospital in Turkey. Thus, two different survey forms were used. In the first section of both survey forms, there were five demographic questions about the patients (gender, marital status, age, educational status, profession) and one question about the reason for choosing that hospital.

In the survey form prepared for inpatients, there were 31 questions related to patient relationship management practices (Location and accessibility:2, general comfort and convenience:5, front office:2, medical comfort and convenience:3, care provided by nurses:3, care provided by doctors:3, laboratories and diagnoses:3, cleaning work:4, food and drinks:3, and billing:3); in the survey form prepared for outpatients, there were a total of 17 questions related to patient relationship management practices (Location and accessibility:2, general comfort and convenience:5, front office (information processing center):4, laboratories and diagnoses:3, medical comfort and convenience:1, billing:1, and cleaning work:1).

Twenty-two questions (Tangibles:4, responsiveness:4, reliability:5, empathy:5, and assurance:4) were used for the perceived service quality from the research variables, and 4 questions were asked for patient commitment.

The 5-point Likert-type scale (1: Strongly disagree, 5: Strongly agree) was employed for the questions related to the research variables.

Consequently, there are 49 questions in total in the survey form prepared for outpatients and 63 questions in total in the survey form prepared for inpatients.

Before the execution of the study, the ethics committee approval of the related university and the permission of the Provincial Directorate of Health were obtained. The study was conducted between October and November 2019.

The execution of the study only in one university training and research hospital of Turkey constitutes the most significant limitation.

IV. Research Findings

A total of 1000 survey forms were completed face-to-face with outpatients in order to increase the reliability of the study. When incomplete and incorrect survey forms were eliminated, 824 survey forms were found to be usable.

Out of 1200 survey forms distributed for inpatients, 850 were found to be usable. Thus, the return rate of the survey forms distributed for outpatients is 82.4%, and the return rate of the survey forms distributed for inpatients is 70.8%.

Findings related to the demographic characteristics of outpatients, such as their gender, marital status, age, educational status, professions, and reasons for their hospital preferences, are stated in Table 2.

Table 2.Demographic Characteristics of Outpatients

Variables	**n**	**%**
Gender		
Female	402	48.8
Male	422	51.2
Total	**824**	**100.0**
Marital Status		
Single	286	34.7
Married	538	65.3
Total	**824**	**100.0**
Age		
25 Years and below	160	19.4
26-35 Years	227	27.5
36-45 Years	240	29.1
46-55 Years	111	13.5
56-65 Years	56	6.8
66 Years and above	30	3.6
Total	**824**	**100.0**

Educational Status		
Primary education	157	19.1
Secondary education	313	38.0
Associate degree/Bachelor's degree and above	354	43.0
Total	**824**	**100.0**
Profession		
Manager	28	3.4
Professional Occupational Groups	112	13.6
Operator or Technician	27	3.3
Assisting Occupational Groups	47	5.7
Employees in Office Services	32	3.9
Employees in Agriculture, Forestry, and Aquaculture	14	1.7
Artists and Employees in Related Work	5	.6
Employees with Elementary Occupation	375	45.5
Retired	62	7.5
Unemployed	24	2.9
Student	98	11.9
Total	**824**	**100.0**
Hospital Preference		
Recommendation of a Family Doctor	42	5.1
Recommendation of an Expert	65	7.9
Own Preference	649	78.8
Recommendation of a Friend/Family	35	4.2
Other	33	4.0
Total	**824**	**100.0**

When Table 2 was examined, it was observed that outpatients consisted of almost the same number of males and females. However, most of them were married (56.3%), within the age range of 26-45 (56.6%),had associate degrees/bachelor's degrees or above (43%), had elementary occupations (45.5%), and 78.8% preferred this hospital by their own preference.

Findings related to the demographic characteristics of inpatients, such as their gender, marital status, age, educational status, professions, and reasons for their hospital preferences, are stated in Table 3.

Table 3.Demographic Characteristics of Inpatients

Variables	**N**	**%**
Gender		
Female	417	49.1
Male	433	50.9
Total	850	100.0
Marital Status		
Single	287	33.8
Married	563	66.2
Total	850	100.0
Age		
25 Years and below	73	8.6
26-35 Years	139	16.4
36-45 Years	172	20.2
46-55 Years	156	18.4
56-65 Years	153	18.0
66 Years and above	157	18.5
Total	850	100.0
Educational Status		
Primary education	288	33.9
Secondary education	340	40.0

Associate degree/Bachelor's degree and above	222	26.1
Total	850	100.0
Profession		
Manager	15	1.8
Professional Occupational Groups	80	9.4
Operator or Technician	22	2.6
Assisting Occupational Groups	83	9.8
Employees in Office Services	39	4.6
Employees in Agriculture, Forestry, and Aquaculture	50	5.9
Artists and Employees in Related Work	5	.6
Facility and Machine Operators	5	.6
Employees with Elementary Occupation	355	41.8
Retired	123	14.5
Unemployed	40	4.7
Student	33	3.9
Total	850	100.0
Hospital Preference		
Recommendation of a Family Doctor	49	5.8
Recommendation of a Senior Consultant	198	23.3
Own Preference	455	53.5
Recommendation of a Friend/Family	96	11.3
Other	52	6.1
Total	850	100.0

When Table 3 is examined, it is observed that inpatients consisted of almost the same number of males and females, like outpatients, most of them were married (66.2%), had elementary occupations (41.8%), and preferred the hospital by their own preference (53.5%). It can be said that, unlike outpatients, rather patients who were in the age group of 44-66 and above (54.9%) and secondary education graduates (40%) participated in the survey prepared for inpatients.

The results of the reliability analysis regarding the model variables are given in Table 4.

Table 4.The Results of the Reliability Analysis Regarding the Model Variables

Variables		**Number of Questions**	**Cronbach's Alpha**
Survey Form Items for Outpatients	Patient Relationship Management Practices	17	0.936
	Perceived Service Quality	22	0.957
	Patient Commitment	4	0.824
Survey Form Items for Inpatients	Patient Relationship Management Practices	31	0.961
	Perceived Service Quality	22	0.971
	Patient Commitment	4	0.901

In Table 4, Cronbach's alpha values of the survey scales prepared for both patient groups are shown. Upon the examination of the values, the reliability coefficients can be said to be quite high.

In the light of the literature studies, the research hypotheses were determined as follows:

H1: Perceived service quality plays a mediating role in the effect of patient relationship management practices on institutional commitment for outpatients.

H2: Perceived service quality plays a mediating role in the effect of patient relationship management practices on institutional commitment for inpatients.

H3: The mediating role of the perceived service quality in the effect of patient relationship management practices on institutional commitment for outpatients differs according to the demographic characteristics of patients.

$H3_1$: The mediating role of the perceived service quality in the effect of patient relationship management practices on institutional commitment for outpatients differs according to the gender of patients.

$H3_2$: The mediating role of the perceived service quality in the effect of patient relationship management practices on institutional commitment for outpatients differs according to the marital status of patients.

$H3_3$: The mediating role of the perceived service quality in the effect of patient relationship management practices on institutional commitment for outpatients differs according to the age of patients.

$H3_4$: The mediating role of the perceived service quality in the effect of patient relationship management practices on institutional commitment for outpatients differs according to the educational status of patients.

$H3_5$: The mediating role of the perceived service quality in the effect of patient relationship management practices on institutional commitment for outpatients differs according to the hospital preferences of patients.

H4: The mediating role of the perceived service quality in the effect of patient relationship management practices on institutional commitment for inpatients differs according to the demographic characteristics of patients.

$H4_1$: The mediating role of the perceived service quality in the effect of patient relationship management practices on institutional commitment for inpatients differs according to the gender of patients.

$H4_2$: The mediating role of the perceived service quality in the effect of patient relationship management practices on institutional commitment for inpatients differs according to the marital status of patients.

$H4_3$: The mediating role of the perceived service quality in the effect of patient relationship management practices on institutional commitment for inpatients differs according to the age of patients.

$H4_4$: The mediating role of the perceived service quality in the effect of patient relationship management practices on institutional commitment for inpatients differs according to the educational status of patients.

$H4_5$: The mediating role of the perceived service quality in the effect of patient relationship management practices on institutional commitment for inpatients differs according to the hospital preferences of patients.

For H1, which is expressed as "Perceived service quality plays a mediating role in the effect of patient relationship management practices on institutional commitment for outpatients," it is significant whether the following conditions are met. The conditions are as follows:

Condition 1: The presence of the effect of patient relationship management practices on patient commitment

Condition 2: The presence of the effect of patient relationship management practices on perceived service quality

Condition 3: The presence of the effect of perceived service quality on patient commitment

As can be seen in Table 5, the three conditions were met. While the regression coefficient referring to the effect of patient relationship management practices on patient commitment was 0.710, it decreased to 0.197 when it was included in the model together with the perceived service quality. The mediating role of perceived service quality in the effect of patient relationship management practices on institutional commitment for outpatients was revealed, and H1 was accepted.

Table 5:The Mediating Role of the Perceived Service Quality in the Effect of Patient Relationship Management Practices on Institutional Commitment for Outpatients.

Models	**F**	**p**	Patient Relationship

				Management Practices	
				B	**p**
Condition 1	The effect of patient relationship management practices on patient commitment	390.183	0.000	0.710	0.000
Condition 2	The effect of patient relationship management practices on perceived service quality	2.378E3	0.000		
Condition 3	The effect of perceived service quality on patient commitment	490.564	0.000		
The effect of patient relationship management practices and perceived service quality on patient commitment		251.680	0.000	0.197	0.004

For H2, which is expressed as "Perceived service quality plays a mediating role in the effect of patient relationship management practices on institutional commitment for inpatients," it is significant whether the following conditions are met: the presence of the effect of patient relationship management practices on patient commitment, the presence of the effect of patient relationship management practices on perceived service quality, and the presence of the effect of perceived service quality on patient commitment.

As can be seen in Table 6, the three conditions were met. While the regression coefficient referring to the effect of patient relationship management practices on patient commitment was 0.941, it decreased to 0.394 when it was included in the model together with the perceived service quality. The mediating role of perceived service quality in the effect of patient relationship management practices on institutional commitment for inpatients was revealed, and H2 was accepted.

Table 6:The Mediating Role of the Perceived Service Quality in the Effect of Patient Relationship Management Practices on Institutional Commitment for Inpatients

Models		**F**	**p**	Patient Relationship Management Practices	
				B	**p**
Condition 1	The effect of patient relationship management practices on patient commitment	957.339	0.000	0.941	0.000
Condition 2	The effect of patient relationship management practices on perceived service quality	1818.240	0.000		
Condition 3	The effect of perceived service quality on patient commitment	1191.247	0.000		
The effect of patient relationship management practices and perceived service quality on patient commitment		672.993	0.000	0.394	0.000

For all the sub-hypotheses of H3, which is expressed as "The mediating role of the perceived service quality in the effect of patient relationship management practices on institutional commitment for outpatients differs according to the demographic characteristics of patients" (gender, marital status, age, educational status, and hospital preferences of patients), the presence of the effect of patient relationship management practices on patient commitment, the presence of the effect of patient relationship management practices on perceived service quality, and the presence of the effect of perceived service quality on patient commitment are significant.

The results of the analysis conducted for $H3_1$, which is expressed as "The mediating role of the perceived service quality (PSQ) in the effect of patient relationship management practices (PRMP) on institutional commitment (PC) for outpatients differs according to the gender of patients," are stated in Table 7.

Table 7. Difference Analysis of the Mediating Role of PSQ in the Effect of PRMP on Institutional Commitment for Outpatients According to Gender

				PRMP	
	Models	**F**	**p**	**B**	**p**
Femal	Effect of PRMP on PC	198.128	0.000	0.723	0.000

e	Effect of PRMP on PSQ	1099.375	0.000		
	Effect of PSQ on PC	302.059	0.000		
	Effect of PRMP and PSQ on PC	151.096	0.000	0.065	0.477
Male	Effect of PRMP on PC	182.097	0.000	0.688	0.000
	Effect of PRMP on PSQ	1241.491	0.000		
	Effect of PSQ on PC	188.859	0.000		
	Effect of PRMP and PSQ on PC	102.607	0.000	0.339	0.001

In female patients, the regression coefficient referring to the effect of PRMP on commitment became insignificant when it was addressed together with PSQ. Accordingly, PSQ plays a fully mediating role in the effect of PRMP on commitment. In male patients, the value of the regression coefficient decreased, which was significant. Therefore, it can be said that PSQ plays a partially mediating role in male patients. Thus, since there was a gender-based difference, $H3_1$ was accepted.

The results of the analysis conducted for $H3_2$, which is expressed as "The mediating role of the perceived service quality in the effect of patient relationship management practices on institutional commitment for outpatients differs according to the marital status of patients," are presented in Table 8.

Table 8.Difference Analysis of the Mediating Role of PSQ in the Effect of PRMP on Institutional Commitment for Outpatients According to Marital Status

				PRMP	
	Models	**F**	**p**	**B**	**p**
Single	Effect of PRMP on PC	170.280	0.000	0.749	0.000
	Effect of PRMP on PSQ	811.993	0.000		
	Effect of PSQ on PC	241.027	0.000		
	Effect of PRMP and PSQ on PC	121.673	0.000	0.137	0.192
Married	Effect of PRMP on PC	219.343	0.000	0.686	0.000
	Effect of PRMP on PSQ	1571.751	0.000		
	Effect of PSQ on PC	260.229	0.000		
	Effect of PRMP and PSQ on PC	134.672	0.000	0.226	0.011

In single patients, the regression coefficient referring to the effect of PRMP on commitment became insignificant when it was addressed together with perceived service quality. Accordingly, PSQ plays a fully mediating role in the effect of PRMP on commitment. In married patients, the value of the regression coefficient decreased, which was significant. Therefore, it can be said that perceived service quality plays a partially mediating role. Accordingly, since there was a marital status-based difference, $H3_2$ was accepted.

The results of the analysis conducted for $H3_3$, which is expressed as "The mediating role of the perceived service quality in the effect of patient relationship management practices on institutional commitment for outpatients differs according to the age of patients," are stated in Table 9.

Table 9.Difference Analysis of the Mediating Role of PSQ in the Effect of PRMP on Institutional Commitment for Outpatients According to Age

				PRMP	
	Models	**F**	**p**	**B**	**p**
25 years and below	Effect of PRMP on PC	59.334	0.000	0.673	0.000
	Effect of PRMP on PSQ	357.045	0.000		
	Effect of PSQ on PC	108.131	0.000		
	Effect of PRMP and PSQ on PC	53.572	0.000	-0.035	0.810
26-35 years	Effect of PRMP on PC	75.588	0.000	0.738	0.000
	Effect of PRMP on PSQ	448.686	0.000		
	Effect of PSQ on PC	98.552	0.000		
	Effect of PRMP and PSQ on PC	50.885	0.000	0.225	0.112
36-45 years	Effect of PRMP on PC	160.025	0.000	0.762	0.000
	Effect of PRMP on PSQ	825.319	0.000		
	Effect of PSQ on PC	169.431	0.000		

	Effect of PRMP and PSQ on PC	91.338	0.000	0.354	0.005
46-55 years	Effect of PRMP on PC	48.802	0.000	0.601	0.000
	Effect of PRMP on PSQ	350.005	0.000		
	Effect of PSQ on PC	53.516	0.000		
	Effect of PRMP and PSQ on PC	28.072	0.000	0.250	0.151
56-65 years	Effect of PRMP on PC	40.695	0.000	0.740	0.000
	Effect of PRMP on PSQ	365.162	0.000		
	Effect of PSQ on PC	53.329	0.000		
	Effect of PRMP and PSQ on PC	26.125	0.000	-0.018	0.953
66 years and above	Effect of PRMP on PC	14.592	0.001	0.675	0.001
	Effect of PRMP on PSQ	158.956	0.000		
	Effect of PSQ on PC	16.051	0.000		
	Effect of PRMP and PSQ on PC	7.924	0.002	0.221	0.631

Considering that perceived service quality played a partially mediating role only in the 36-45 age group among the six age groups, the effect of PRMP became fully insignificant together with PSQ, and PSQ played a fully mediating role in the other age groups, $H3_3$ was accepted due to this resulting difference.

The results of the analysis conducted for $H3_4$, which is expressed as "The mediating role of the perceived service quality in the effect of patient relationship management practices on institutional commitment for outpatients differs according to the educational status of patients," are presented in Table 10.

Table 10.Difference Analysis of the Mediating Role of PSQ in the Effect of PRMP on Institutional Commitment for Outpatients According to Educational Status

				PRMP	
	Models	**F**	**p**	**B**	**p**
Primary education	Effect of PRMP on PC	105.862	0.000	0.866	0.000
	Effect of PRMP on PSQ	418.144	0.000		
	Effect of PSQ on PC	122.098	0.000		
	Effect of PRMP and PSQ on PC	65.271	0.000	0.352	0.024
Secondary education	Effect of PRMP on PC	105.366	0.000	0.597	0.000
	Effect of PRMP on PSQ	1005.248	0.000		
	Effect of PSQ on PC	118.367	0.000		
	Effect of PRMP and PSQ on PC	61.645	0.000	0.222	0.059
Associate degree/ Bachelor's degree and above	Effect of PRMP on PC	180.809	0.000	0.742	0.000
	Effect of PRMP on PSQ	951.499	0.000		
	Effect of PSQ on PC	252.873	0.000		
	Effect of PRMP and PSQ on PC	127.829	0.000	0.142	0.154

In Table 10, it is observed that the regression coefficient referring to the effect of PRMP on commitment in patients who were secondary education graduates and had associate degrees/bachelor's degrees and above became insignificant when it was addressed together with perceived service quality, and PSQ played a fully mediating role in the effect of PRMP on commitment. In patients who were primary education graduates, it is possible to say that the value of the regression coefficient decreased and the model was significant. Consequently, PSQ seems to play a partially mediating role in the effect of PRMP on commitment in patients who were primary education graduates. Accordingly, since there was an educational status-based difference, $H3_4$ was accepted.

The results of the analysis conducted for $H3_5$, which is expressed as "The mediating role of the perceived service quality in the effect of patient relationship management practices on institutional commitment for outpatients differs according to the reasons for hospital preferences of patients," are given in Table 11.

Table 11.Difference Analysis of the Mediating Role of PSQ in the Effect of PRMP on Institutional Commitment for Outpatients According to Reasons for Hospital Preferences

		PRMP

	Models	F	p	B	p
Recommendation of a Family Doctor	Effect of PRMP on PC	13.933	0.001	0.648	0.001
	Effect of PRMP on PSQ	90.543	0.000		
	Effect of PSQ on PC	16.656	0.000		
	Effect of PRMP and PSQ on PC	8.537	0.001	0.236	0.448
Recommendation of an Expert	Effect of PRMP on PC	11.213	0.001	0.474	0.001
	Effect of PRMP on PSQ	154.040	0.000		
	Effect of PSQ on PC	22.093	0.000		
	Effect of PRMP and PSQ on PC	11.194	0.000	-0.170	0.492
Own Preference	Effect of PRMP on PC	260.027	0.000	0.672	0.000
	Effect of PRMP on PSQ	1811.999	0.000		
	Effect of PSQ on PC	343.072	0.000		
	Effect of PRMP and PSQ on PC	173.892	0.000	0.144	0.065
Recommendation of a Friend/ Family	Effect of PRMP on PC	64.141	0.000	0.922	0.000
	Effect of PRMP on PSQ	65.155	0.000		
	Effect of PSQ on PC	15.535	0.000		
	Effect of PRMP and PSQ on PC	35.259	0.000	1.186	0.000
Other	Effect of PRMP on PC	80.836	0.000	1.082	0.000
	Effect of PRMP on PSQ	212.963	0.000		
	Effect of PSQ on PC	115.068	0.000		
	Effect of PRMP and PSQ on PC	56.844	0.000	0.209	0.487

When Table 11 is examined, it is observed that the value of the regression coefficient decreased only in patients who preferred the hospital with the recommendation of their friends/families, which was among the reasons for hospital preferences, and the model was significant, in other words, PSQ played a partially mediating role in the effect of PRMP on commitment. Considering that the effect of PRMP became fully insignificant together with PSQ, and PSQ played a fully mediating role in the Recommendation of a Family Doctor and an Expert, Own Preference, and Other groups, $H3_5$ was accepted due to this resulting difference.

For all the sub-hypotheses of H4, which is expressed as "The mediating role of the perceived service quality in the effect of patient relationship management practices on institutional commitment for inpatients differs according to the demographic characteristics of patients" (gender, marital status, age, educational status, and hospital preferences of patients), the presence of the effect of patient relationship management practices on patient commitment, the presence of the effect of patient relationship management practices on perceived service quality, and the presence of the effect of perceived service quality on patient commitment are significant.

The results of the analysis conducted for $H4_1$, which is expressed as "The mediating role of the perceived service quality in the effect of patient relationship management practices on institutional commitment for inpatients differs according to the gender of patients," are presented in Table 12.

Table 12.Difference Analysis of the Mediating Role of PSQ in the Effect of PRMP on Institutional Commitment for Inpatients According to Gender

				PRMP	
	Models	**F**	**p**	**B**	**p**
Female	Effect of PRMP on PC	427.499	0.000	0.950	0.000
	Effect of PRMP on PSQ	829.490	0.000		
	Effect of PSQ on PC	471.601	0.000		
	Effect of PRMP and PSQ on PC	277.664	0.000	0.467	0.000
Male	Effect of PRMP on PC	538.162	0.000	0.933	0.000
	Effect of PRMP on PSQ	990.338	0.000		
	Effect of PSQ on PC	768.806	0.000		
	Effect of PRMP and PSQ on PC	417.955	0.000	0.318	0.000

It is observed that the value of the regression coefficient decreased in both gender groups, the model was significant, and consequently, PSQ played a partially mediating role in the effect of PRMP on commitment. Thus, $H4_1$ was rejected.

The results of the analysis conducted for $H4_2$, which is expressed as "The mediating role of the perceived service quality in the effect of patient relationship management practices on institutional commitment for inpatients differs according to the marital status of patients," are given in Table 13.

Table 13.Difference Analysis of the Mediating Role of PSQ in the Effect of PRMP on Institutional Commitment for Inpatients According to Marital Status

				PRMP	
	Models	**F**	**p**	**B**	**p**
Married	Effect of PRMP on PC	368.765	0.000	1.020	0.000
	Effect of PRMP on PSQ	573.341	0.000		
	Effect of PSQ on PC	365.935	0.000		
	Effect of PRMP and PSQ on PC	231.266	0.000	0.565	0.000
Single	Effect of PRMP on PC	589.485	0.000	0.901	0.000
	Effect of PRMP on PSQ	1246.199	0.000		
	Effect of PSQ on PC	828.464	0.000		
	Effect of PRMP and PSQ on PC	445.783	0.000	0.302	0.000

In Table 13, it is observed that the value of the regression coefficient decreased in both married and single patient groups, the model was significant, and consequently, PSQ played a partially mediating role in the effect of PRMP on commitment. Thus, $H4_2$ was rejected.

The results of the analysis conducted for $H4_3$, which is expressed as "The mediating role of the perceived service quality in the effect of patient relationship management practices on institutional commitment for inpatients differs according to the age of patients," are presented in Table 14.

Table 14.Difference Analysis of the Mediating Role of PSQ in the Effect of PRMP on Institutional Commitment for Inpatients According to Age

				PRMP	
	Models	**F**	**p**	**B**	**p**
25 years and below	Effect of PRMP on PC	41.228	0.000	0.713	0.000
	Effect of PRMP on PSQ	161.526	0.000		
	Effect of PSQ on PC	69.824	0.000		
	Effect of PRMP and PSQ on PC	34.587	0.000	0.074	0.683
26-35 years	Effect of PRMP on PC	260.363	0.000	1.129	0.000
	Effect of PRMP on PSQ	360.696	0.000		
	Effect of PSQ on PC	142.904	0.000		
	Effect of PRMP and PSQ on PC	130.584	0.000	1.020	0.000
36-45 years	Effect of PRMP on PC	154.208	0.000	0.912	0.000
	Effect of PRMP on PSQ	219.721	0.000		
	Effect of PSQ on PC	261.256	0.000		
	Effect of PRMP and PSQ on PC	144.620	0.000	0.319	0.001
46-55 years	Effect of PRMP on PC	172.931	0.000	0.918	0.000
	Effect of PRMP on PSQ	343.386	0.000		
	Effect of PSQ on PC	249.135	0.000		
	Effect of PRMP and PSQ on PC	133.510	0.000	0.302	0.007
56-65 years	Effect of PRMP on PC	175.633	0.000	0.849	0.000
	Effect of PRMP on PSQ	325.719	0.000		
	Effect of PSQ on PC	305.371	0.000		
	Effect of PRMP and PSQ on PC	157.223	0.000	0.189	0.057
66 years	Effect of PRMP on PC	119.863	0.001	0.911	0.000

and above	Effect of PRMP on PSQ	394.662	0.000		
	Effect of PSQ on PC	162.201	0.000		
	Effect of PRMP and PSQ on PC	84.040	0.002	0.266	0.068

It is observed that the effect of PRMP became fully insignificant together with PSQ and PSQ played a fully mediating role in the 25 years and below,56-65 years, and 66 years and above patient groups, the value of the regression coefficient decreased, the model was significant, and consequently, PSQ played a partially mediating role in the effect of PRMP on commitment in the other age groups. Thus, due to this resulting difference, $H4_3$ was accepted.

The results of the analysis conducted for $H4_4$, which is expressed as "The mediating role of the perceived service quality in the effect of patient relationship management practices on institutional commitment for inpatients differs according to the educational status of patients," are given in Table 15.

Table 15.Difference Analysis of the Mediating Role of PSQ in the Effect of PRMP on Institutional Commitment for Inpatients According to Educational Status

				PRMP	
	Models	**F**	**p**	**B**	**p**
Primary education	Effect of PRMP on PC	387.929	0.000	1.002	0.000
	Effect of PRMP on PSQ	764.553	0.000		
	Effect of PSQ on PC	418.243	0.000		
	Effect of PRMP and PSQ on PC	244.268	0.000	0.492	0.000
Secondary education	Effect of PRMP on PC	267.869	0.000	0.832	0.000
	Effect of PRMP on PSQ	652.859	0.000		
	Effect of PSQ on PC	485.074	0.000		
	Effect of PRMP and PSQ on PC	246.997	0.000	0.153	0.040
Associate degree/ Bachelor's degree and above	Effect of PRMP on PC	299.211	0.000	1.024	0.000
	Effect of PRMP on PSQ	391.378	0.000		
	Effect of PSQ on PC	250.337	0.000		
	Effect of PRMP and PSQ on PC	176.971	0.000	0.658	0.000

In Table 15, it is observed that the value of the regression coefficient decreased in all the patient groups with different educational levels, the model was significant, and consequently, PSQ played a partially mediating role in the effect of PRMP on commitment. Therefore, $H4_4$ was rejected.

The results of the analysis conducted for $H4_5$, which is expressed as "The mediating role of the perceived service quality in the effect of patient relationship management practices on institutional commitment for inpatients differs according to the reasons for hospital preferences of patients," are presented in Table 16.

Table 16.Difference Analysis of the Mediating Role of PSQ in the Effect of PRMP on Institutional Commitment for Inpatients According to Reasons for Hospital Preferences

				PRMP	
	Models	**F**	**p**	**B**	**p**
Recommendation of a Family Doctor	Effect of PRMP on PC	72.722	0.001	1.006	0.000
	Effect of PRMP on PSQ	295.512	0.000		
	Effect of PSQ on PC	70.695	0.000		
	Effect of PRMP and PSQ on PC	38.572	0.001	0.560	0.81
Recommendation of an Expert	Effect of PRMP on PC	160.177	0.001	0.892	0.000
	Effect of PRMP on PSQ	270.571	0.000		
	Effect of PSQ on PC	290.979	0.000		
	Effect of PRMP and PSQ on PC	154.769	0.000	0.260	0.005
Own Preference	Effect of PRMP on PC	551.588	0.000	0.915	0.000
	Effect of PRMP on PSQ	924.295	0.000		
	Effect of PSQ on PC	624.123	0.000		

	Effect of PRMP and PSQ on PC	370.851	0.000	0.441	0.000
Recommendation of a Friend/ Family	Effect of PRMP on PC	45.170	0.000	0.856	0.000
	Effect of PRMP on PSQ	223.990	0.000		
	Effect of PSQ on PC	67.730	0.000		
	Effect of PRMP and PSQ on PC	33.835	0.000	0.135	0.537
Other	Effect of PRMP on PC	168.157	0.000	1.173	0.000
	Effect of PRMP on PSQ	266.921	0.000		
	Effect of PSQ on PC	172.566	0.000		
	Effect of PRMP and PSQ on PC	101.971	0.000	0.592	0.007

When the results of the analysis are examined (Table 16), it is observed that the effect of PRMP became fully insignificant together with PSQ and PSQ played a fully mediating role in the patient groups who preferred the hospital with the recommendation of their family doctors and friends/families, and the value of the regression coefficient decreased, the model was significant, and consequently, PSQ played a partially mediating role in the effect of PRMP on commitment in the other patient groups. Therefore, $H4_5$ was accepted.

V. Conclusion and Recommendations

Health services, which are very significant for the service industry, are provided by the Ministry of Health, private sector establishments, and universities in Turkey, but it is known that patients mostly prefer training and research hospitals of universities.

Although university hospitals have differences compared to other institutions when it comes to specialized personnel, advanced technology, financial power, etc., their survival depends on being preferred by a lot more patients. This is possible with the commitment of patients, who prefer them for the first time, to the institution.

However, a patient's commitment to the related health institution can take place with the effect of many variables. At this point, the most essential matter is, perhaps, how health services are perceived and the patient relationship management practices of the health institution for patients.

According to the results of the study, it was found out that the perceived service quality played a mediating role in the effect of patient relationship management practices on institutional commitment in both outpatients and inpatients, and the mediating role of the perceived service quality in the effect of patient relationship management practices on institutional commitment differed according to all the demographic characteristics (gender, marital status, age, educational status, and hospital preference) of patients and only the age and hospital preferences of inpatients. The mediating role of the perceived service quality in the effect of patient relationship management practices on institutional commitment varies according to the gender, age, marital status, educational status, and hospital preferences of outpatients of health institutions which adopt a patient-centered understanding, on the other hand, the mediating role of the perceived service quality in the effect of patient relationship management practices on institutional commitment changes according to the age and hospital preferences of inpatients.

Since this study was carried out only in one university hospital in Turkey, it is not possible to generalize the results. However, it can be recommended to conduct similar studies for overall Turkey and the areas of the sector in the future.

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