IMPACT OF FRONTLINE STAFF' BEHAVIORS AND WAITING TIME ON PATIENTS' BEHAVIOR IN THE OUTPATIENT DEPARTMENTS (OPDs): A CROSS-SECTIONAL STUDY OF TERTIARY CARE HOSPITALS

Syeda Baseerat Fatima Jafri[1], and Mirza Kashif Baig[2]*

ABSTRACT

Healthcare is a crucial service whereby frontline workers' behavior and waiting time play more critical roles in the quality of the service than other services. As patients are exposed to a more unstable psychological state, their behavioral dissonances may hinder the quality of care provided. Employee patterns of both employees and patients are critical aspects of healthcare leadership and management alike. However, frontline employee behavior and waiting time domains are missing in the emerging economies' context, especially in Pakistan, where these fundamentals of patients' resulting behaviors, remained unexplored. This study, therefore, investigated the impact of frontline employees and waiting time on the patients' behavior. A quantitative, cross-sectional approach was applied with deductive logic to conduct this study. A pre-validated structured questionnaire, adapted and cited from different sources, was administered among patients in five major, private tertiary care hospitals in Karachi, Pakistan through a non-probability judgmental sampling. The findings revealed a significant effect of both the behavior of employees and waiting time on the patients' behavior. This study can be utilized at a wider level to adopt the need for further reforms in tertiary care setups in Pakistan at the rural level and policymakers may use the findings to train empathy and a patient-centric approach to the behavior of employees to counter unpleasant patient behavior and produce satisfaction leading to improved quality of care and to combat waiting time, patient dissatisfaction, patients complains and overcrowding challenges faced by tertiary hospitals in urban areas.

Keywords: *Healthcare Management; Healthcare Strategy; Patient-Centric Care; Quality of Care; Frontline Employees; Healthcare Organizations.*

[1] Healthcare Entrepreneur, Karachi, Pakistan. Email: syedabaseerat28@gmail.com
[2] Assistant Professor at Institute of Business and Health Management, Dow University of Health Sciences, Karachi, Pakistan. Email: kashifbaig26@gmail.com
**Corresponding Author*

INTRODUCTION

The rising demand for healthcare facilities, due to increasing populations and restricted availability of primary care, results in occupied OPD and long waiting times. Across the world, suboptimal healthcare quality questions the risk to health outcomes in the rising population (Epstein et al., 2019; Kruk, Gage, Joseph, et al., 2018) and may threaten the realization of the Sustainable Development Goals (Epstein et al., 2019; Kruk, Gage, Arsenault, et al., 2018). Healthcare quality points alarm towards strengthening large population health outcomes and threatens the health system, especially long waiting times, unprofessional healthcare workers' behavior, environment, over-crowding, and availability of resources. As a result, patients wait for longer waiting times, and increase hassle on their entire health (McIntyre & Chow, 2020). A few critical consequences include undisciplined patient behavior, unwillingness to seek healthcare services, not keeping patients, leaving a hospital without seeing a doctor, and also having an impact on hospitals' reputation and profit margin. Additionally, difficult patient behavior can contribute by interrupting the patient flow and overwhelming additional resources and staff timing resulting in inconvenience in the execution of services.

Providing health services for aging and severely ill patients is another concern (Alrajhi et al., 2020). Crowding into tertiary care hospitals can be due to the uneven distribution of skilled staff, resources, finances, and operational referral systems among urban and rural areas (Zhang et al., 2014). High reputation and available experienced medical staff also make hospitals crowded in urban settings and also have an impact on patient satisfaction regarding these aspects (Ren et al., 2021). Due to these issues, some patients in the hope of getting preferential treatment even build personal relationships with health workers. These matters have caused the connection between doctors and patients to worsen (Zhang et al., 2014). To evaluate patient satisfaction, patient evaluation is an excellent tool that can provide a chance to improve strategies and rational decision-making, reduce costs, and add value to meet patients' expectations (Castle et al., 2005; Cheng et al., 2003; Kaur et al., 2020; Prakash, 2010).

Globally, healthcare quality issues are on the rise, especially with patient-centric approaches to healthcare delivery. Amid these burning issues, research on patient-centralism is still limited in Pakistan. This study provides new insight into the field of healthcare management, the role of waiting time and front-line employees' behavior have an impact on patients and how patients can interrupt the patient flow system if the waiting

time becomes too long and the interactions and information flows between the patient and the front-line employees become limited.

LITERATURE REVIEW

Waiting Time

The most common complaint of patients in hospital services is about waiting time visiting different uses of hospitals. In healthcare, a considerable measure of service quality is time (Aburayya et al., 2020a). Long waiting times can be due to several reasons ranging from high workload, unavailability of the health workers, supervision and management issues, health worker's attitude, work procedures, environment, and availability of administrative facilities (Aburayya et al., 2020a). The complete range of appropriate factors (e.g., disease severity, health conditions, and the perceived benefits of the visit) that may impact how patients experience are still not answered and determined by the patients, as the data are quantitative (Chu et al., 2019). The higher patronage of a healthcare facility with better infrastructure will induce longer waiting times due to staff overload or patient induce demand and hence service provision may not be of optimum quality (Olasehinde et al., 2023)

Defining Waiting Time

Waiting times can vary for both inpatients and outpatients in various situations, including waiting area time, exam room time, time spent with medical professionals, or we can say that time spent from entry to exit of the hospital (Mehra, 2016a). Patient overcrowding is one of the main causes of increased waiting time (Aboukanda & Latif, 2014a). Types of models like having electronic booking systems such as using the FIFO Model (who comes first to go first), registration process, availability of skilled staff, and specialized doctors in hospitals can reduce the waiting time (Aburayya et al., 2020a)

Frontline Employees' Behavior

Healthcare epitomizes a unique professional service framework (Hewett et al., 2009). For improving hospital performance, good integration in the organization, i.e., the coordination and alignment of tasks can advance hospital services (van der Ham et al., 2022) while a high degree of customization and management of information can be consistently made to schedule professional services (Spee et al., 2015). Medical professionals are intensely role-bound to encourage patient safety and the exchange of information in the hospital. (Hewett et al., 2009). Moreover, teamwork is attained through exchange between team members and their skills (specialized knowledge, skills, equipment, respect). This exchange follows during discussions and is a facilitator (Hewett et al., 2009). Most studies suggested that patients who visit hospitals

for intensive care may feel more about non-clinical service aspects which may foster their expectations (Taylor & Benger, 2004). To meet their expectations, authorities must incorporate rapidly at multiple edges, working across operational and four-dimensional boundaries to deliver efficient and effective care (Gifford et al., 2022). Whereas communication accommodation theory observes interpersonal communication from an intergroup perspective and has an extended history of health communication, its emphasis is on patient-practitioner communications (Hewett et al., 2009). To provide safe, efficient, and effective care, improved communication and sharing of information, synchronized functional care processes and decisions, and value-added elements can play a crucial part (Gifford et al., 2022). Increasing lead times and crowding can be due to even smaller interruptions throughout the process (Gaakeer et al., 2018). There might be a possibility that insignificant coordination of care and waits in consultations and management are major components accountable for a lengthy time when several specialists are involved (van der Veen et al., 2018). Many quality initiatives, for instance, lean process improvement, have been executed in many healthcare organizations to advance patient safety and business performance (Dobrzykowski et al., 2016). For lean advancement strains, one barrier is the amount of time medical professionals spend with each patient in developing countries (Miller & Chalapati, 2015). To strive for more perfection bearing in mind that considerable clinical time is spent communicating with the patients and understanding their concerns, the enrichment of the medical professionals' communication skills is crucial in healthcare workers and patient interactions, (Mehra, 2016b). Womack and Jones (2005) assert that the lean consumption process map is the map that helps to capture the main stakeholders that is hospital workers and their customers, and the exchange of information and communication between them also identifies and removes the waste created from the communication flows (Miller & Chalapati, 2015). Frontline healthcare providers have also faced immense strain, including a high risk of infection and higher workload due to increased numbers of patients and staff shortages, irregular working hours, frustration, and exhaustion (Noor et al., 2021). Moreover, markers of service quality may range from medical professionals' attitudes, respect for patients' privacy, supervision, and management, and handling patient complaints.

Defining Healthcare Workers Behavioral Aspects:

i. *respectful behavior,*
ii. *communication skills*
iii. *attentiveness,*
iv. *good knowledge,*

v. *speed,*
vi. *listening to patients attentively*
vii. *handling patients' complaints,*
viii. *respect for patients' privacy*

The most identified areas of importance are interpersonal skills/perceived staff behaviors and providing information/explanations regarding their issue and health conditions (Taylor & Benger, 2004). Previous studies have also suggested that patients' retention and their trust in same-care providers will promote resulting in recommending care providers and health services to others if they are satisfied (Wang et al., 2019). Other factors might also affect outpatients' satisfaction like the hospital environment (Epstein et al., 2019; Oluwole et al., 2019; Alhelalat et al., 2017).

Patient Behavior

Healthcare functions in a multifaceted professional service environment where some healthcare professionals believe delivering high-quality and affordable care set of goals is incompatible (Dobrzykowski et al., 2016). In healthcare organizations, building patient loyalty proactively and maximizing profitability by predicting patient behavior can help facility providers (Yan et al., 2004) whereas patient complaints provide valuable quality and service concerns and data. Decision-making is the most challenging for practical implications and to use of data (Goodman & Newman, n.d.) A major problem in the collection of customer problem data is a lack of differentiation between the reason for the complaint and the cause of the complaint. (Goodman & Newman, n.d.). Many patients insist that the healthcare service providers have a responsibility to consider them as consumers of healthcare services (Taylor, 1979) keeping in mind that patients waiting unnecessarily can be a cause of stress for both patients and healthcare providers (Adamu & Oche, 2013). Different patient behavior was observed by patients in hospitals, especially in OPD, that may impact the quality of care provided and the hospital's reputation (Aboukanda & Latif, 2014a). Previous studies indicated patients had not felt free to communicate their rights of desiring information to be a patient is a unique condition because they feel to give up the right to ask questions, while others think to accept the responsibility of answering questions and authorizing themselves to be examined while anxious patients are in the state of desiring information about their care, but fearing the costs of asking for this information (Taylor, 1979). Few studies have addressed several terms for disappointed service meetings, including deviant consumer behavior, aberrant consumer behavior, problem customers, inappropriate behavior, consumer misbehavior, and jay customers, dysfunctional

customers who purposely or unintentionally disrupt service that affects the organization or other customers in an undesirable manner (Harris & Reynolds, 2003) and that dysfunctional patient behavior may also have an effect on the quality of care supplied and on hospital's reputation (Aboukanda & Latif, 2014a). The most indicative factors that have a disapproving impact on the time of service and become problematic for the patient flow system are defensive behavior (interfering, over-involvement, demanding, anger, arguing, lack of respect), protective behavior (communication difficulties, lack of respect for the rule, e.g., jumping the queue & illness belief (AbouKanda & Latif, 2014b). There are some adoptions on how to address capacity, including handling demand, managing patient waits, improving waiting areas, informing patients of expected changes in waits, and evaluating the day of the week (seasonality) of arrivals and procedure types as patient arrivals are not uniform for better performance and to improve patient perceptions of care quality and overall satisfaction (Nottingham et al., 2018a). Communication and information theories suggest that transitional results like these (i.e., recall, interest, and perceived significance) can be important signs of behavior change (Kreuter et al., 2000). To reduce unnecessary and time-wasting face-to-face appointments, health workers have been able to utilize electronic media and make appointments through phone and messaging platforms, establishing the reliability of the healthcare system and quality (Aburayya et al., 2020b). Providing effective management becomes one of the main goals of healthcare reform to improve patient safety (Xie et al., 2019). Waiting times may become worse with poor access to treatments, increased charges, patient discomfort, and linked with patient dissatisfaction (McIntyre & Chow, 2020). The effects of such resistance on organizations can range from causing no direct harm, potentially, to destroying the reputation of a firm or brand (Harris & Reynolds, 2003). Customer behavior does not necessarily remain stable over time, since the experience acquired from past experiences means that perceptions change (Hernández et al., 2010).

Development of Theoretical Framework

1. Waiting Time & Patient Behavior

Among many studies, wait times in the waiting area are considered the most significant predictors (Nottingham et al., 2018b). One of the main causes that deteriorate healthcare workers' relationship with patients and worsen their perceived quality of care is the long waiting time (Aburayya et al., 2020a). Most patients suggest that long wait times causes them to feel stress and anxiety when receiving medical services (Aburayya et al., 2020a). Increased waiting times could lead to increased stress and frustration among patients and healthcare providers in addition to increasing the number of patients who leave without being seen

(LWBS) (Alrajhi et al., 2020) The strongest predictors of patient satisfaction which are waiting time spent in waiting area and exam room (Hill & Joonas, 2006; Kreitz et al., 2016; McMullen & Netland, 2013). If the length of the stay in outpatient and inpatient exceeds the patient's expectation, it will interrupt revenue as patients will not visit that hospital again and hence impact patient retention (Jung et al., 2021). Accordingly, the key factors in evaluating the quality of care are waiting time and the extent of stay in the OPDs (Hemmati et al., 2018). In healthcare, another focus of the studies regarding waiting time is how it influences the patient's clinical experience and delivery service perception (Aburayya et al., 2020a). To see a doctor, critically ill patients 10% of whom must wait more than an hour suffer the most while non-urgent patients experience stress and delays. Patients entering the hospital are also anxious about the whole experience they will have during their stay, while the priority is to provide high-quality health treatment (Adel & Abdelmaged, 2021) There might be possibilities that if patients are informed about delays and delivered other positive practices with the doctor can lessen undesirable reactions to a long wait (Chu et al., 2019).

2. Frontline Employees' Behavior & Patient Behavior

Patient's stress and anxiety can be reduced when they feel they are properly listened to and encourages their belief that they are well taken care of just because of proper communication and interaction between health workers and patients (Leigh & Clark, 2018; Pham Ngoc Tram et al., 2016). Communication is an important variable in our study. Difficult patients can affect health services in the resulting ways health workers may lose their tempers, be unable to perform their roles efficiently, consume more time cause further interruptions, and increase the chance of becoming the bottleneck for the system flow and processes. However, the healthcare force is also concerned with their customers when they are facing stress during certain health issues. Such stress is not only noticeable in health outcomes but patient behavior also (Koszegi, 2003). Such behavior may weaken the service system and create a state of chaos and uncertainty in the system. Indeed, cases of physical abuse and damage to hospital property and equipment by customers are becoming alarming situations (Harris & Reynolds, 2003). Studies show that good provider-patient communication is essential for patient confidence, compliance, and recall (Chen et al., 2008; Mehra, 2016b). Consequently, the following research models and hypotheses are formed.

RESEARCH MODEL & HYPOTHESES

Research Model

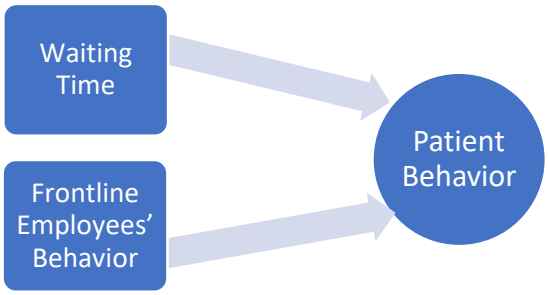

Figure 1. *Research Model*

Research Hypotheses

H1: There is a relationship between waiting times and patient behavior.

H2: There is a relationship between front-line employees' behavior and patient behavior.

METHODS

The primary quantitative method employed in this study is closed-ended questionnaires along with interviews with the patients. Non-probability judgmental sampling was performed. The sample size of this research is around 230-250. We asked 220 respondents to take part in this research while only 156 agreed to take part in the research survey. The response rate was around 70 %. The questionnaire consists of questions about the key factors of waiting time and health workers' behavior and patient behavior about waiting time and employees' behavior. We used pre-validated questionnaires to measure the constructs of waiting times, employees' behavior, and patients' behaviors from sources as mentioned in Table 1. Moreover, a five-point Likert scale was used for the measurement. The instrument was initially pilot tested on a group of 25 respondents before it was administered for a full-scale survey. The questionnaire also included demographic characteristics like gender, education, and marital status. The study sites for the survey were four different private tertiary care hospitals in Karachi city.

Instrument Building

A structured questionnaire was used to collect data with two sections. Section A is designed to register the demographic profile of patients, while they are visiting the Out-Patient Departments (OPDs) of tertiary care hospitals, as a study site. Section B consists of constructs of the designed framework. The construct items of "waiting time (WT)" were adapted such that the first item was adapted from Xie et al. (2019), the second from Nottingham et al. (2018a), and the last two from Mehra (2016a &b). In the Frontline Employees Behavior (FEB),

items 1 and 2 were adapted from Aburayya et al. (2020); items 3 to 7 from Wang et al., 2019, and the last two items from Thompson et al., (1996). The construct for Patient Behavior (PB) adapted from Aboukanda & Latif (2014) has 5 items. A five-point Likert scale from strongly disagree (coded as 1) to strongly agree (coded as 5) has been used.

Inclusion Criteria

English-published journal articles and students' papers were included. The study was carried out among registered adult patients above 16 years of age and below 70 years of age who have come at least twice before to the hospitals to assess satisfaction with different experiences with the hospital facilities.

Exclusion Criteria

Tertiary care hospitals from different cities across different provinces and areas were excluded because of time and budget constraints.

Ethical Considerations

It was ensured that patients received no harm, physical or psychological treatment during the survey, as they got the questionnaires filled out during their waiting hours for OPDs. It was also made sure to keep the respondents' anonymity. Their informed consent was taken, asking if they were willing to participate in the survey.

DATA ANALYSIS AND RESULTS

PLS-4 and SPSS were used for data analysis. PLS-SEM analysis includes the assessment of the Measurement and Structural Model. The measurement model proves the reliability and validity of the construct. The structural model finds the significance of hypothesized relationships. After data cleaning, we removed three questionnaire items that had low factor loading.

Measurement Model Results

Reliability & Validity Analysis

The reliability of the measurement model is figured out by assessing (1) Cronbach's alpha; and (2) composite reliability. A measurement model is said to have a satisfactory Cronbach's Alpha & composite reliability when the Cronbach's alpha & CR of each construct exceeds the minimum threshold value of 0.7 (Nunnally & Bernstein, 1994). Table 1 shows the Cronbach's alpha & CR of each construct ranging from 0.892 to 0.938. These results show that the items used to represent the constructs are satisfactory with Cronbach's alpha and composite

reliability. Convergent validity results based on AVE statistics. The measurement model has a reasonable Average Variance Extracted when the AVE of each construct surpasses the minimum threshold value of 0.5 (Hair et al., 2014). Table 2 shows that the AVE of each construct for this dissertation ranges from 0.628 to 0.764, these results indicate that the items used to represent the constructs possess satisfactory average variance extracted.

Table 1. Items Sources, Reliability Statistics, and Convergent Validity (AVE).

Constructs and Items	**Loadings**	**Cronbach Alpha**	**Composite Reliability**	**AVE**
Waiting Time (WT)		0.896	0.928	0.764
I feel waiting time for registration is at a satisfactory level (Xie et al., 2019)	0.823			
I feel the time spent in the waiting room (self-reported) is at a satisfactory level (Nottingham et al., 2018a)	0.894			
I feel the time spent in the exam room is at a satisfactory level (Mehra, 2016a)	0.867			
I feel time from arrival to exit/ checkout is at a satisfactory level (Mehra, 2016b)	0.909			
Frontline Employee Behavior (FEB)		0.925	0.938	0.628
I feel staff/health care workers (nurses, attendants, doctors) including registration staff know the treatment plan and process (Aburayya et al., 2020)	0.738			
I feel staff distribution planning and management are at a satisfactory level (Aburayya et al., 2020)	0.755			
I feel health workers were friendly and respectful during this visit (Wang et al., 2019)	0.717			
I feel the health workers listened to the description of my condition patiently during this visit (Wang et al., 2019)	0.797			
I feel doctor explain my condition and related issues at a satisfactory level (Wang et al., 2019)	0.772			
I feel medical professionals inform me of matters that need attention during the treatment (Wang et al., 2019)	0.841			
I feel the communication between me and the medical professional during the visits is at a satisfactory level (Wang et al., 2019)	0.913			
Would you recommend our hospital services to others (Thompson et al., 1996a)	0.865			
Would you recommend our care providers to others (Thompson et al., 1996b)	0.710			
Patient Behavior		0.892	0.921	0.700
I feel like shouting about the quality of the treatment received (Aboukanda & Latif, 2014a)	0.815			
I would like to interfere in the treatment process (Aboukanda & Latif, 2014b)	0.859			
I think I was demanding while receiving the services (Aboukanda & Latif, 2014b)	0.776			
I was angry about the treatment quality being provided (Aboukanda & Latif, 2014a)	0.898			
I argued with the staff and doctors about the quality of the medical services (Aboukanda & Latif, 2014b)	0.832			

Discriminant Validity

The degree to which measures of different concepts are distinct is known as discriminant validity. A specific construct is distinct from other constructs. The indicators should load on the relevant construct, and the constructs' measures should be different.

In this study, the square root of AVE of Frontline Employee Behavior was found greater than its correlation with other constructs are patient behavior and waiting time, while construct patients' behavior was found greater in its correlation with waiting time. Hence, discriminant validity is proven (Fornell & Larcker, 1981).

Table 2. Fornell-Larcker Criterion

Fornell-Larcker Criterion			
	Frontline Employees Behavior	Patient Behavior	Waiting Time
Frontline Employee Behavior	**0.793**		
Patient Behavior	-0.608	**0.837**	
Waiting Time	0.411	-0.578	**0.874**

Note: Bold values are the square root of AVE

The HTMT is a straightforward way to evaluate the correlation between the constructs. If the indicators of two constructs show an HTMT value that is visibly smaller than one, the true correlation between the two constructs is different from one. In this study, the HTMT results show in Table 3 that the HTMT ratio for our constructs is less than the required threshold of 0.90 (Hair et al., 2017).

Table 3. HTMT Ratios

Heterotrait-Monotrait Ratio (HTMT)			
	Frontline Employee Behavior	Patient Behavior	Waiting Time
Frontline Employee Behavior			
Patient Behavior	0.655		
Waiting Time	0.437	0.639	

Table 4. Demographic Profile of the Study Participants in OPD (n=156)

Variables	**Demographic Characteristics**	**OPD(N=156) N (%)**
Age	16-25	27.6%
	26-35	39.7%
	36-45	13.5%
	45-55	9%
	Above 55	10.3%
Qualification	Primary	9.6%
	Secondary	10.3%
	Higher Secondary	13.5%

	Graduation	37.8%
	Masters	18.6%
	Postgraduation & above	10.3%
Gender	Male	37.8%
	Female	62.2%
Marital Status	Married	58.35
	Unmarried	37.8%
	Divorce	1.9%
	Widow	1.9%

The demographic profile reflects a good cross-section of populations in the OPD waiting areas. Which is a positive sign and gives strength to the conclusion. The age, gender qualification, and marital status-wise distributions also show appropriate measurements of behaviors across populations, and to have a more patient-centric approach. The structural equation modeling below shows the relationship between the proposed hypotheses.

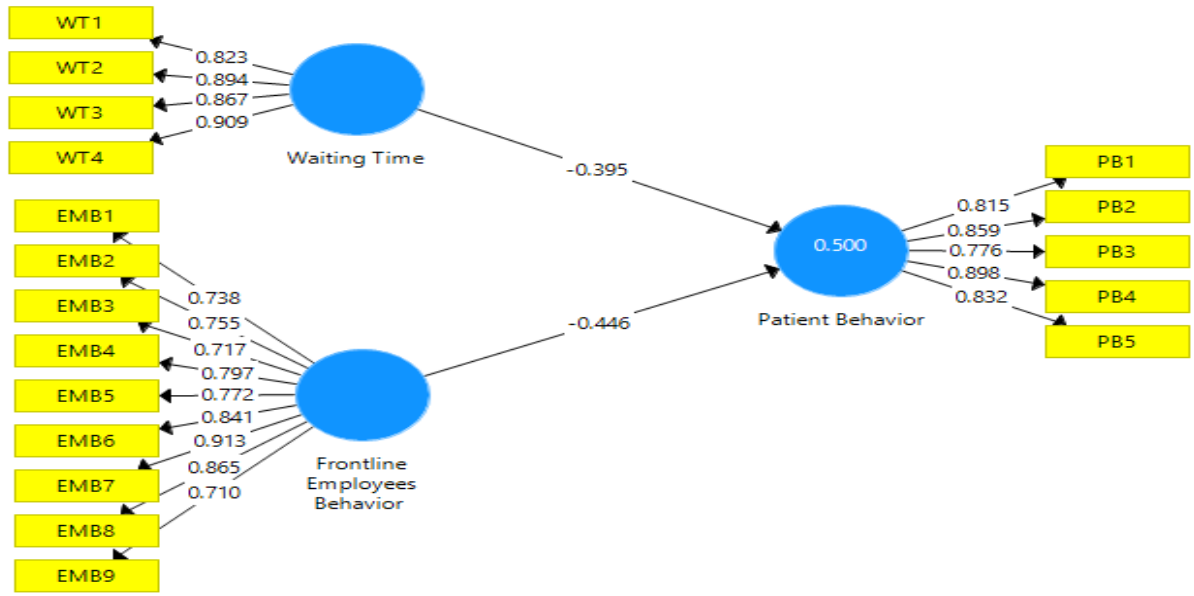

Figure 1. *Structural Model*

Results

H1: There is a meaningful relationship between waiting times and patient behavior.

H1 evaluates whether waiting time "WT" has a significant impact on the patient behavior "PB". The results revealed that WT has a significant impact on PB (t value is greater than 1.76, p <0.01). Hence H1 is supported.

H2: There is a meaningful relationship between front-line employees' behavior and patient behavior.

H2 evaluates whether frontline employees' behavior "EMB" has a significant impact on the patient behavior "PB". The results revealed that EMB has a significant impact on PB (t value is greater than 1.76, p <0.01). Hence H2 is supported.

Table 5. Measurement of Structural Model

	Beta Coefficient	Standard Deviation (STDEV)	T Statistics (|O/STDEV|)	P Values
Frontline Employees Behavior -> Patient Behavior	-0.446	0.052	8.517	0.000
Waiting Time -> Patient Behavior	-0.395	0.058	6.824	0.000

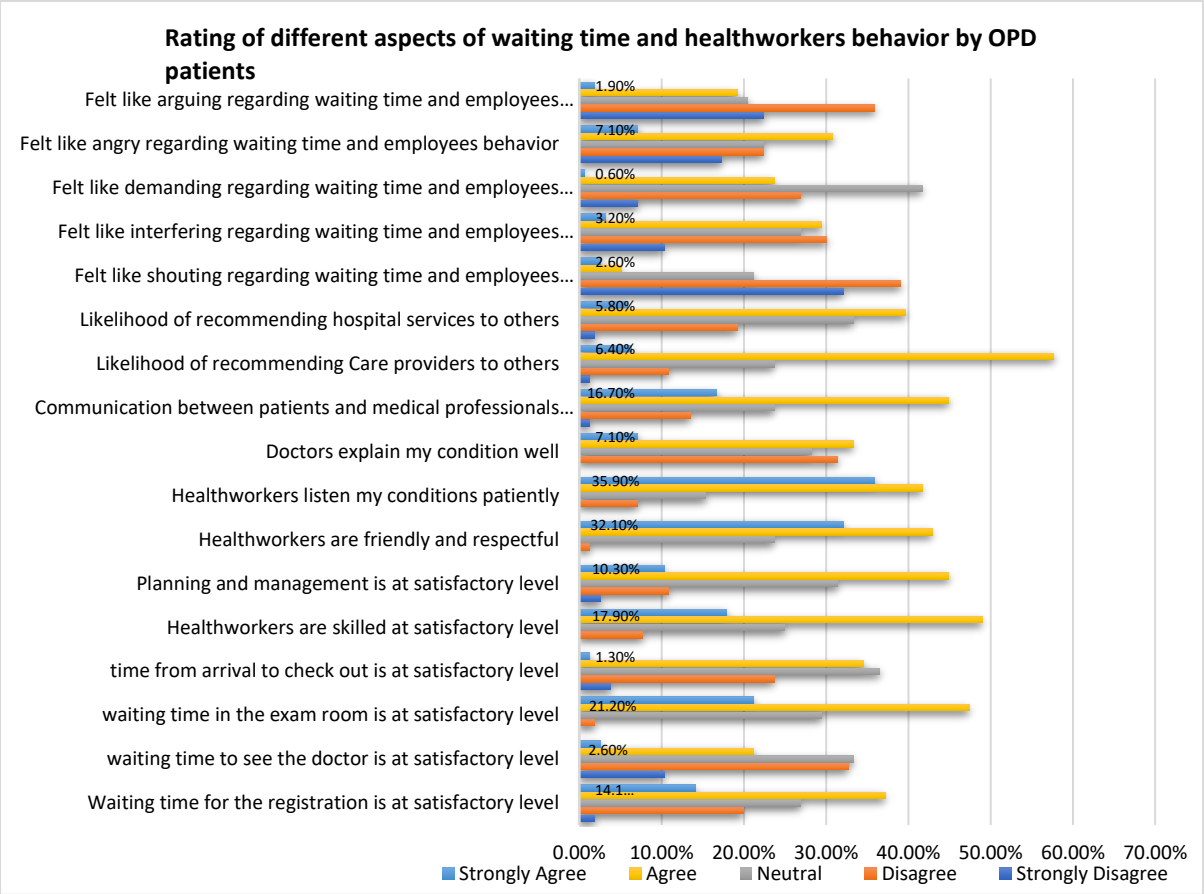

Figure 3. *Rating of Different Aspects of Waiting Time and Healthworks's Behaviors*

THEORETICAL IMPLICATIONS

Professional competence, communication between providers and patients, and waiting time were the most crucial variables for outpatients at tertiary care hospitals, contrasted with primary health care setups in rural areas. They assumed hospitals in urban areas are more equipped with technology and equipment (Wang et al., 2019). Among different variables, communication and information between health workers and patients is most important, while the most discouraging experiences by outpatients were that doctors' explanation of their illness

conditions, going along with intensive issues, was not enough satisfactory. Policymakers should take this into their consideration compared with the other aspects relevant to the "process" of care delivery (Sofaer & Irminger, 2005; Tasso et al., 2002; Wang et al., 2019). Customers still feel less trust regarding the quality of services offered at primary healthcare setups even after a huge investment in primary health care hospitals and the implementation of strategies for training medical staff (Wang et al., 2019). Although no proper referral system in primary care hospitals resulting in urban and tertiary hospitals are continuing to rule the health sector (Wang et al., 2019; Yip & Hsiao, 2014).

CONCLUSION

Patients suggest that they mind and feel stressed if the length of their stay in OPDs is extended from more than an hour to see the doctor while some suggest that they don't mind waiting time if it is around 30 minutes, but few patients don't want to wait even for 30 minutes, they want prompt advice from medical professionals. A few studies have shown that some patients, to get their treatments from experienced doctors, do not mind, and can wait an average of between 30 and 45 minutes. In healthcare, another focus of the studies regarding waiting time is how it influences the patient's clinical experience and delivery service perception (Aburayya et al., 2020a). Among different variables, communication and information between health workers and patients is most important, while the most discouraging experiences by outpatients were that doctors' explanation of their illness conditions, going along with matters that need attention during treatment, was not enough satisfactory. When distributing health care funds stakeholders, policymakers and leadership should be concerned with public and private hospital reforms regarding outpatients seeking health services at tertiary care hospitals. However, outpatients' experiences of the hospital's overall waiting time patients' and medical professionals' behavior were acceptably related to the patient behavior among respondents, whereas their experiences of the skilled medical staff and their communicational aspect were intensely related to their satisfaction. However difficult behavior can discount when long waiting times and delays should be informed and communicated before making payment for any doctor consultation but might not be enough to change their perception. In a systematic manner, healthcare administrators must mitigate and handle patient complaints while they wait (Alrasheedi et al., 2019). Previous studies have also suggested that patients' retention and trust in the same care providers will promote resulting in recommending care providers and health services to others if they are satisfied (Wang et al., 2019).

These aspects may provide opportunities for improvement and can build trust in the quality of medical services given at primary healthcare hospitals. This study should be conducted at a wider level across Pakistan by adding more variables and with a greater sample size to make our results more generalized. To reduce no-shows, patients can be notified of the change in appointment through text or email, reducing wait time even further in the event of an unexpected delay which costs hospitals a lot of time and money (Adel & Abdelmaged, 2021). Furthermore, patients need to be diverted from tertiary care hospitals to primary care hospitals by more effective strategies in urban areas to overcome overcrowding and waiting time issues further improvement and development in tertiary care hospitals in rural areas of Pakistan can also reduce overcrowding, long waiting times and mitigate difficult patients' behavior. For this purpose, we can also adopt a lean management system like other developed countries are using to reduce loss and waste.

Although there is no proper referral system in primary care hospitals, urban and tertiary hospitals continue to rule the health sector. Furthermore, regardless of the severity and complexity of the health condition, patients are concentrated in tertiary care hospitals. These aspects may provide opportunities for improvement and can build trust in the quality of medical services given at primary healthcare hospitals while also retaining patients and causing improved profit for the health sector.

MANAGERIAL IMPLICATIONS

Clinical decision-makers can use smart data analysis to improve decision-making (Yousef Shaheen, n.d.). The registration process needs to be updated by providing a call/online appointment system to avoid hassle-free walk-in registration at the counter to reduce waiting time and delays. Management staff also need advancement like the use of application computer simulation to reduce waiting time. (Adamu & Oche, 2013). A system for patient feedback should be institutionalized at all healthcare facilities to improve patients' satisfaction and quality of care to avoid difficult patient behavior. Moreover, training for medical staff should be held on to regular basis for improved behavior, communication gaps and to combat workload challenges. To encourage health professionals' knowledge regarding different processes and promote more positive approaches which can potentially boost their confidence and skills. (Branquinho et al., 2022) Staff training should be supervised by a designated person from the hospital, should have training curriculums that should be updated regularly, and its effectiveness should be regularly assessed. There should be a patient relationship officer at each hospital to manage patients' complaints and take monthly feedback reports. Patients need

to be diverted from tertiary care hospitals to primary care hospitals by more effective strategies for further reforms in Pakistan.

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