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PATIENT SATISFACTION AS AN OPERATIONAL INDICATOR OF AN AESTHETIC CLINIC’S EFFECTIVENESS: ADAPTING MODELS FROM THE HOSPITALITY INDUSTRY

Summary. *This article examines patient satisfaction at an aesthetic clinic as an independent operational indicator that can be measured, managed, and predicted. The aim of the study is to justify a methodology whereby service quality assessment tools developed in the hospitality and luxury retail industries are transferred to the outpatient aesthetic medicine setting and integrated into daily management decisions. The study relies on general scientific methods of analysis, synthesis, comparison, and generalization, as well as a structural-functional approach to describing the satisfaction measurement system. The empirical basis consists of two years of operational data from Arviv Medical Aesthetics and a comparison with a control facility of the same organizational structure that did not implement the described system. Implementation of the resulting system raised the clinic’s public rating and repeat visit rate well above those of the control facility and preserved annual revenue at approximately two million dollars during a period of unfavorable macroeconomic conditions in which the control facility’s revenue declined; detailed figures are reported in the Results section. It has been shown that the strongest predictor of loyalty and willingness*

to recommend is the empathy dimension, while the most common management mistake remains the collection of satisfaction data without using it in operational decisions.

Key words: *patient satisfaction, aesthetic medicine, service quality, SERVQUAL, loyalty index, patient retention, hospitality industry.*

Introduction. Today’s aesthetic medicine market is highly competitive, and patients have long taken a doctor’s clinical skill for granted. It no longer sets one clinic apart from the rest. Instead, patients remember how they were spoken to during their first call, how they were greeted, and whether they felt cared for after the procedure. Whether a person returns to a clinic often depends on more than the treatment result. Communication, waiting time, clarity of explanations, follow-up and the general feeling of being cared for all influence this decision. At the same time, many clinics still track medical and financial indicators more carefully than patient satisfaction. Feedback is often reduced to public ratings or irregular comments from patients.

Such a narrow focus comes at a specific cost. Studies of the patient experience in medical-aesthetic services confirm that both the functional and relational dimensions of care directly and positively influence perceived quality, overall satisfaction, and loyal behavior, with the functional dimension shown to prevail over the relational one, while communication and staff engagement nonetheless exert an independent and significant effect on the patient experience alongside the outcome of the intervention [1]. It follows that a facility that measures only clinical outcomes systematically overlooks the part of the patient experience that determines their return, recommendations, and long-term value.

For decades, the hospitality and luxury retail industries have been addressing a similar challenge of managing the quality of experience in environments where the basic service function is already ensured, and competition shifts to the realm of perception. The transfer of this management

framework to aesthetic medicine is a logical yet under-explored direction in the scientific literature. The purpose of this article is to justify the methodology for such a transfer and to demonstrate how patient satisfaction becomes a measurable operational indicator integrated into the system of daily management decisions at an aesthetic clinic. To achieve this goal, the following tasks have been set: to characterize theoretical models of service quality measurement suitable for adaptation; to describe a methodology for measuring satisfaction in an aesthetic facility based on data from the Arviv Medical Aesthetics clinic; to explain the mechanism for transforming satisfaction data into specific operational decisions; to identify a minimum set of indicators suitable for implementation outside a large facility. The article is based on the author’s methodology, which Marharyta Kuzmichova developed and implemented at the Arviv Medical Aesthetics clinic upon assuming the position of its director in March 2024.

The scientific novelty of this work lies not in the individual instruments used — SERVQUAL, the willingness-to-recommend index, and the service-profit chain are all well-established — but in combining them into a single operational system for measuring patient satisfaction, adapted to outpatient aesthetic medicine and validated through a natural comparison of two institutions with a common ownership structure. To the author’s knowledge, the existing literature has not yet provided a systematic description of such a combination for this field. The contribution of this work is therefore the architecture that binds these instruments into a single operational loop in which every indicator is tied to a defined management action, rather than the discovery of a new measurement tool. An additional element of novelty is the finding that, among the SERVQUAL dimensions, empathy is most strongly linked to loyalty and willingness to recommend, as derived from the clinic’s operational data rather than from laboratory or survey samples.

Literature review. The SERVQUAL model, proposed by Parasuraman, Zeithaml, and Berry, forms the basis for most modern approaches to measuring

service quality. Its central idea is that service quality is the difference between a customer's expectations and their perception of the service actually received, measured across five dimensions: physical environment, reliability, responsiveness, assurance, and empathy [2]. In the healthcare sector, the model has gained widespread use because it focuses on the patient's subjective experience alongside structural and outcome metrics and allows for a quantitative description of the quality gap, suitable for further management [3].

Empirical studies in the healthcare sector confirm the predictive power of the model's individual dimensions. In a study of inpatient care quality, all five SERVQUAL dimensions significantly influenced patient satisfaction, with empathy having the strongest impact, followed by assurance and responsiveness [4]. For managing an aesthetic clinic, this result identifies a priority area for investment in staff competencies. At the same time, the literature notes that the classic five-dimensional structure of the model is not always consistently replicated across different service environments and requires contextual modification and supplementation with new dimensions, particularly medical professionalism and patient safety [5]. Therefore, it is advisable to adapt the model to the specifics of aesthetic medicine rather than applying it unchanged.

The second key concept is the Willingness to Recommend Index, proposed by Reichheld in the article “The One Number You Need to Grow.” The metric is based on a single standardized question about the likelihood of recommending the company to acquaintances on a scale from zero to ten, and respondents are divided into promoters, who give a score of nine or ten, passives, and detractors [6]. The author argued that this metric correlates with a company's organic growth rate better than more complex tools [6]. Subsequent replication studies cast doubt on the universality of this correlation and caution against equating correlation with causation [7]. Given these caveats, it is advisable to use the index in an aesthetic clinic as part of a multi-channel system of indicators, supplementing it with other metrics.

The third conceptual framework is the service-profit link developed by Heskett, Sasser, and Schlesinger and first presented in the Harvard Business Review in 1994. It describes the causal relationship between staff satisfaction and loyalty, service quality, customer satisfaction, customer loyalty, and the establishment's financial performance [8]. In the context of the hospitality and service industries, empirical tests of the model largely confirm the significance of most of the postulated relationships, although some studies do not find the expected mirror of satisfaction between staff and customers in all settings [9]. For aesthetic medicine, this chain is of particular importance, as the quality of clinical interaction directly depends on the stability and motivation of the staff providing it.

Waiting time management draws on Maister's classic work on the psychology of queues, which formulates eight principles of subjective perception of waiting: idle time seems longer than occupied time, unexplained waiting seems longer than explained waiting, uncertain waiting seems longer than certain waiting, and anxiety prolongs perceived time [10]. A systematic literature review of the empirical work on this topic confirms that the perceived, rather than actual, duration of a wait predominantly shapes satisfaction, and identifies active engagement of the waiting customer as a key moderating factor [11]. These principles are directly applicable to managing the waiting experience in a clinic.

The service recovery paradox describes a situation in which a client, after a successfully resolved problem, rates the organization higher than they would have if the service had been flawless, because successful recovery increases their trust and confidence [12]. In a medical context, this phenomenon transforms a patient's complaint into an opportunity to strengthen loyalty, provided there is a prepared recovery protocol [13]. Despite a significant body of literature on individual components, there is a lack of systematic material that would combine these models into a comprehensive operational system for measuring and managing satisfaction in aesthetic medicine.

Materials and methods. The study is based on general scientific methods of analysis, synthesis, comparison, generalization, and systematization, as well as on a structural-functional approach to describing the patient satisfaction measurement system. The empirical basis consists of operational data from the Arviv Medical Aesthetics clinic for the period from March 2024 to February 2026, collected in the facility’s management system, as well as public patient reviews and industry benchmarks. The adaptation of service quality tools was based on the author’s prior experience in luxury retail at LVMH, which she applied to clinic management. The author refers to the system described in this paper as the Patient Satisfaction Operations Framework (PSOF). Its methodological framework consists of the SERVQUAL model adapted to aesthetic medicine, the Willingness to Recommend Index, as well as behavioral indicators such as repeat appointments, average visit cost, and conversion of the first visit to a second.

A distinctive feature of the research design is the presence of a control facility that operated within the same organizational structure, in the same geographic market of South Florida, during the same period, and under the same macroeconomic conditions, but did not implement the described satisfaction management system. This structure forms a quasi-experimental design of a natural experiment, in which the only significant operational variable between the two facilities is the presence or absence of a satisfaction measurement and management system, which strengthens the causal argument compared to a single-site observation. The qualitative component of the study is provided by structured individual interviews with patients within the framework of follow-up protocols and an analysis of the content of open-ended feedback.

Research results

Baseline Satisfaction Measurement

At the start of the study in March 2024, patient satisfaction at the clinic was measured exclusively through a publicly available rating of 4.7 points and was

passively collected based on voluntary feedback. There was no systematic measurement outside of this channel: the rate of repeat appointments, satisfaction by individual specialists, the willingness-to-recommend index, or the conversion of first visits to second visits were not tracked. Satisfaction data was generated passively, without a defined target benchmark and without a structured process for translating it into operational improvement actions. The 4.7 rating remained a baseline with no system behind it. Indirect indicators of the patient experience included an average visit cost of \$347.01 and a high baseline staff turnover rate. The feedback collection system lacked a defined point in the patient journey where feedback was solicited, had no mechanism for privately intercepting negative feedback before it was made public, and did not designate a person responsible for systematically analyzing the feedback.

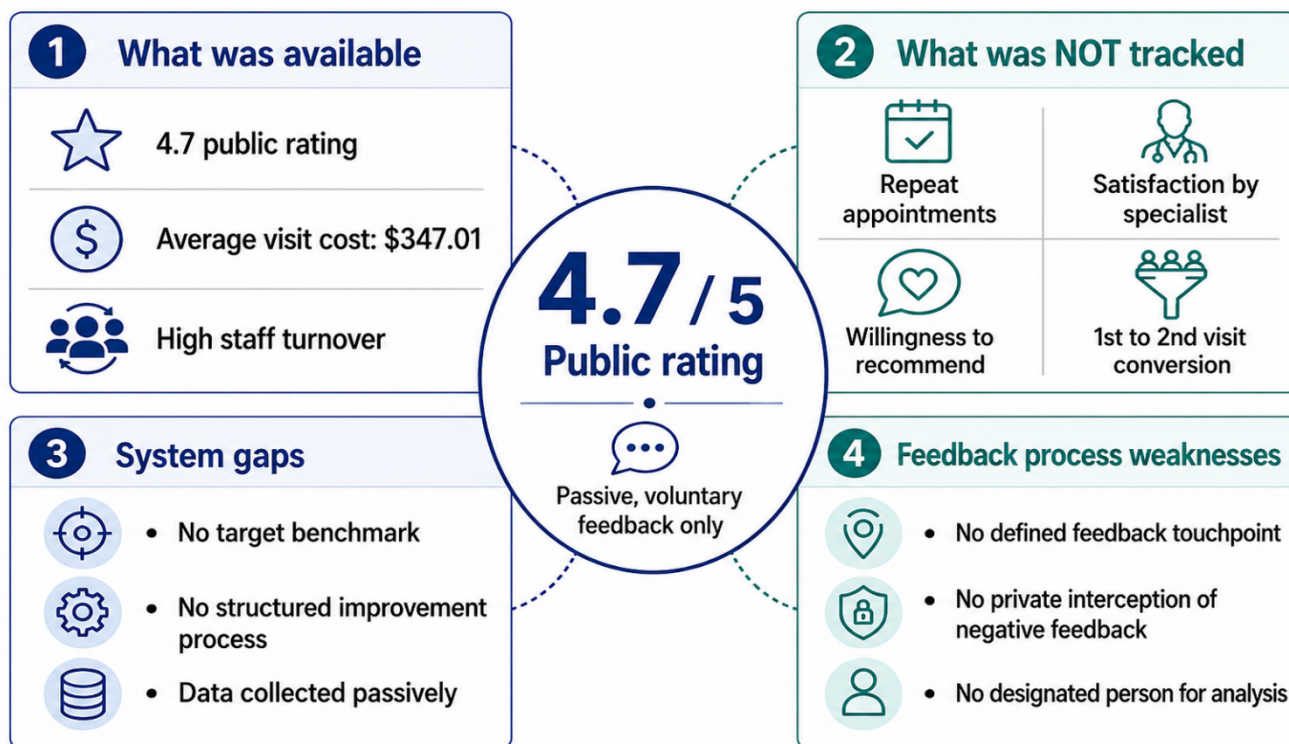


Fig. 1. Baseline Structure of Patient Satisfaction Measurement at the Clinic in March 2024

Multi-channel measurement system

The PSOF system is structured as a four-layer framework. The first layer consists of a continuous observation protocol, within which staff are trained to interpret verbal, nonverbal, and behavioral signals of the patient’s emotional state throughout the visit, starting with establishing an emotional baseline upon arrival and ending with capturing signals during subsequent care. The second layer is the willingness-to-recommend index. The patient rates the likelihood of recommending the clinic on a scale from zero to ten, and responses are categorized as promoters (nine or ten points), passives (seven or eight), and critics (zero to six). Measurements are repeated at three specific points along the patient journey: upon discharge immediately after the procedure, during follow-up within twenty-four hours, and during an in-person follow-up visit two weeks later. The third layer consists of a structured post-visit questionnaire. The fourth layer comprises the SERVQUAL model adapted for aesthetic medicine.

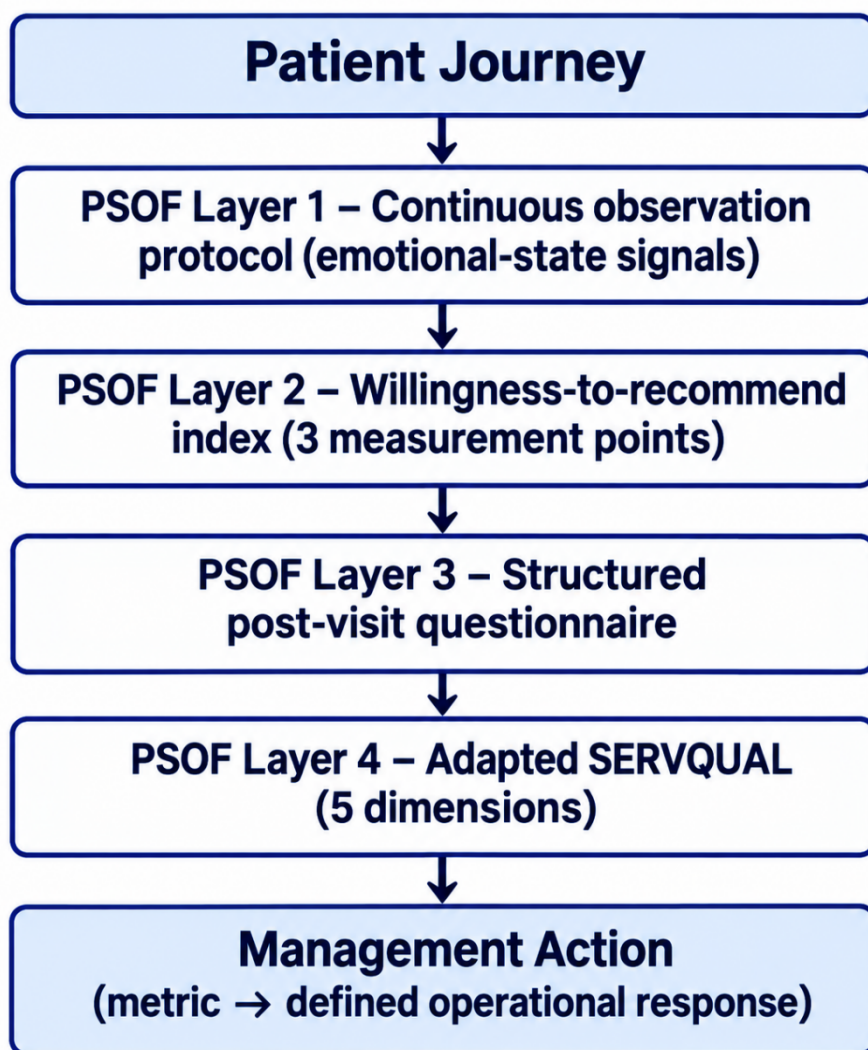


Fig. 2. The PSOF Operational Framework

The clinic retained the five SERVQUAL dimensions, but the content of each had to be adapted to aesthetic practice. The author classified the physical environment as everything the patient perceives physically, from the cleanliness of the treatment rooms and the appearance of the staff to the modernity of the equipment, the comfort of the waiting area, and the sense of privacy. The author interprets reliability as the alignment of what is received with what was promised: when the appointment starts on time, the treatment corresponds to what was agreed upon during the consultation, the price is explained correctly, and the prognosis of the result proves to be realistic. Responsiveness refers to the speed

and readiness of the team to respond, which is evident from the time it takes to answer a call and the length of the wait before the appointment. Assurance is linked to trust and a sense of security, which the patient derives from the specialist’s competence. The most subtle dimension, empathy, is assessed based on whether the patient felt heard and experienced personal care. Patients rate each of these dimensions on a five-point scale, and the questionnaire concludes with a question regarding their willingness to recommend the clinic.

Three-Point Measurement as a Methodological Contribution

For example, the willingness-to-recommend index, which in the hotel industry is a good predictor of loyalty and referrals, is measured at the clinic not at a single point but at three points along the patient’s journey. This reflects a characteristic of satisfaction with aesthetic treatment that hotel services do not have, since satisfaction evolves over time as the clinical outcome develops; therefore, a single measurement point is less representative than multi-point measurements throughout the post-procedure window. The assessment of the index at the two-week follow-up visit carries the highest predictive weight, as the clinical outcome is already visible and the patient evaluates satisfaction based on the actual result. This three-point scheme is part of Marharyta Kuzmichova’s proprietary methodology, which distinguishes it from the single-session measurement common in the hospitality industry.

In the hospitality industry the willingness-to-recommend index is captured once, at the point of departure, because the guest’s experience is essentially complete at checkout. Aesthetic medicine differs fundamentally: the clinical result is not yet visible at discharge and continues to develop over the following days and weeks. Measuring satisfaction at a single point would therefore capture an incomplete outcome. The proposed three-point scheme — at discharge, at 24-hour follow-up, and at the two-week in-person visit — is designed specifically to capture this delayed effect of a medical service, with the two-week measurement carrying the highest predictive weight because the patient evaluates an outcome

that has actually materialized. This shift from single-point to multi-point measurement constitutes one of the central methodological contributions of the framework.

The repeat booking rate in the hotel industry corresponds to the percentage of guests who return, while in a clinic it indicates what percentage of patients schedule their next appointment before even leaving the facility. Here, the adaptation has one important difference. In a hotel, a guest may not return simply because they visited the city only once, and this does not necessarily indicate dissatisfaction. In a clinic, a patient who does not return most often has not been given a sufficient reason to return. Because of this, rebooking speaks more candidly of dissatisfaction and more accurately reflects the work of a specific specialist.

Table 1

**Transformation of Hospitality Metrics into Patient Experience Indicators
in Aesthetic Medicine**

Hospitality industry metric	Clinical equivalent in aesthetic medicine	Key adaptation in the clinic	Managerial meaning
Willingness-to-recommend index	Patient willingness to recommend the clinic or specialist	Measured at three points of the patient journey rather than once	Shows how satisfaction changes as the clinical result becomes visible
Guest return rate	Repeat booking rate	Assessed by whether the patient schedules the next visit before leaving the clinic	Reflects both satisfaction and the specialist’s ability to create a reason for continued care
Average daily rate / average check	Average patient bill	Interpreted together with treatment-plan acceptance, membership enrollment, and product purchases	Indicates the level of trust in the doctor’s recommendations
Loyalty and referral behavior	Patient retention and referral potential	Evaluated through repeated visits, recommendations, and long-term treatment commitment	Connects patient experience with financial stability and clinic growth

The equivalent of the average check for a hotel stay is the average daily rate, while in a clinic, this amount is more indicative of how much the patient trusts the doctor’s recommendations. A willingness to commit to a comprehensive treatment plan, sign up for a membership, and purchase additional care products indicates a deeper level of trust than simply agreeing to the minimum scheduled service. For this reason, the average bill serves a dual purpose: financial and relational.

Empirical Results and Comparison with a Control Institution

Between March 2025 and February 2026, the institution that implemented the system achieved the following results. Its rating on a public review platform rose from 4.7 to 4.8 thanks to an active review-generation program, for which a monthly target of twenty new reviews was set.

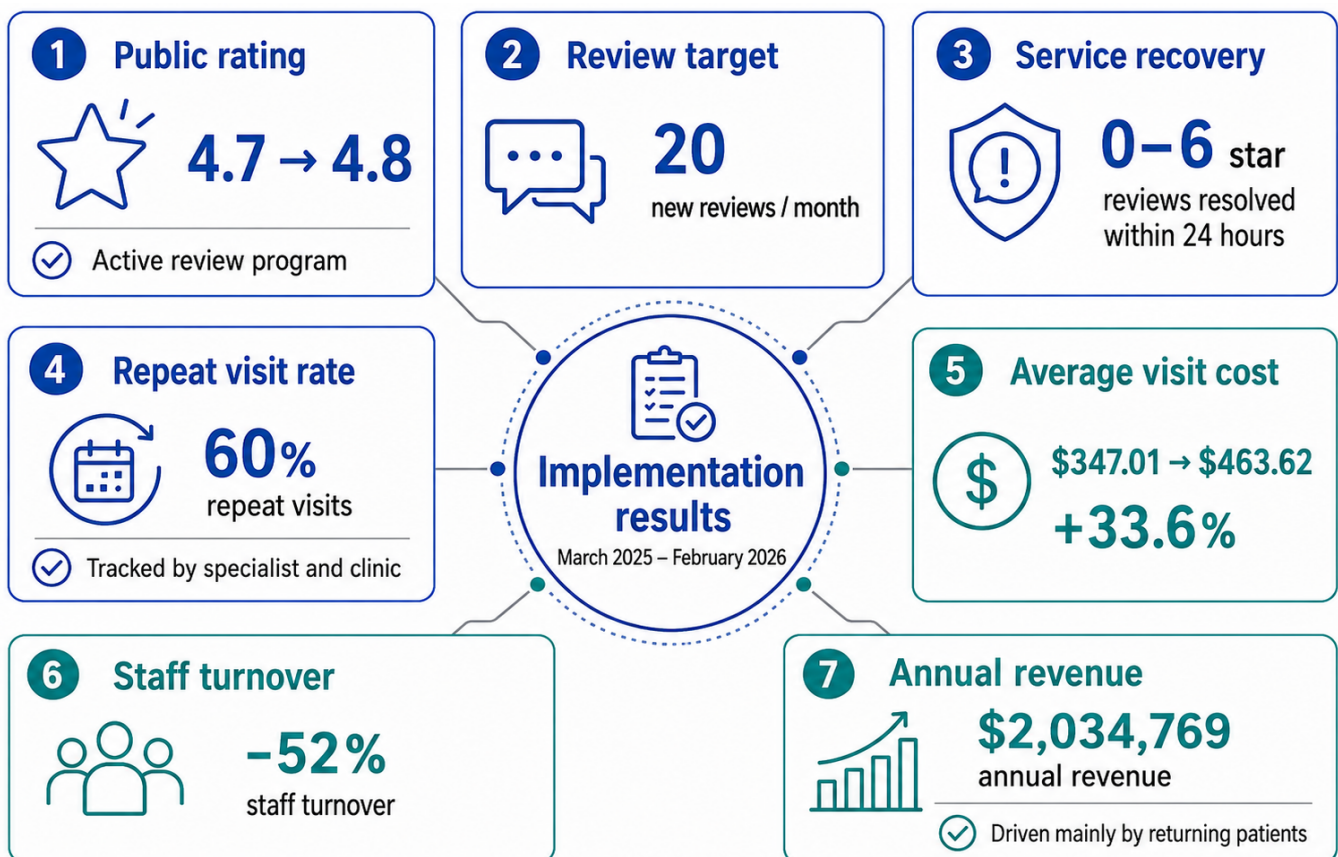


Fig. 3. Key Performance Results After Implementation of the Patient Satisfaction Management System

Every patient who scored the clinic between zero and six on the ten-point scale was included in a private recovery protocol: they were contacted personally within twenty-four hours, before the complaint became public.

The repeat visit rate averaged 60 percent, tracked both for individual staff members and the establishment as a whole. The average visit cost rose from \$347.01 to \$463.62, an increase of 33.6 percent, reflecting deeper patient trust and a willingness to undergo comprehensive treatment. Staff turnover decreased by 52 percent, ensuring continuity in the specialist-patient relationship. Annual revenue reached \$2,034,769 and remained stable despite difficult market conditions. This result was supported mainly by returning patients, while new patient acquisition had a smaller impact.

The most significant methodological finding is the comparison with the control facility. Over the same period, the facility that did not implement the system experienced a 6 percent drop in revenue, maintained an unchanged rating due to passive feedback collection, and achieved a patient retention rate of 44 percent. A gap of 16 percentage points in retention and 28.8 percentage points in revenue trajectory between the two facilities was observed under identical macroeconomic conditions in the same competitive market.

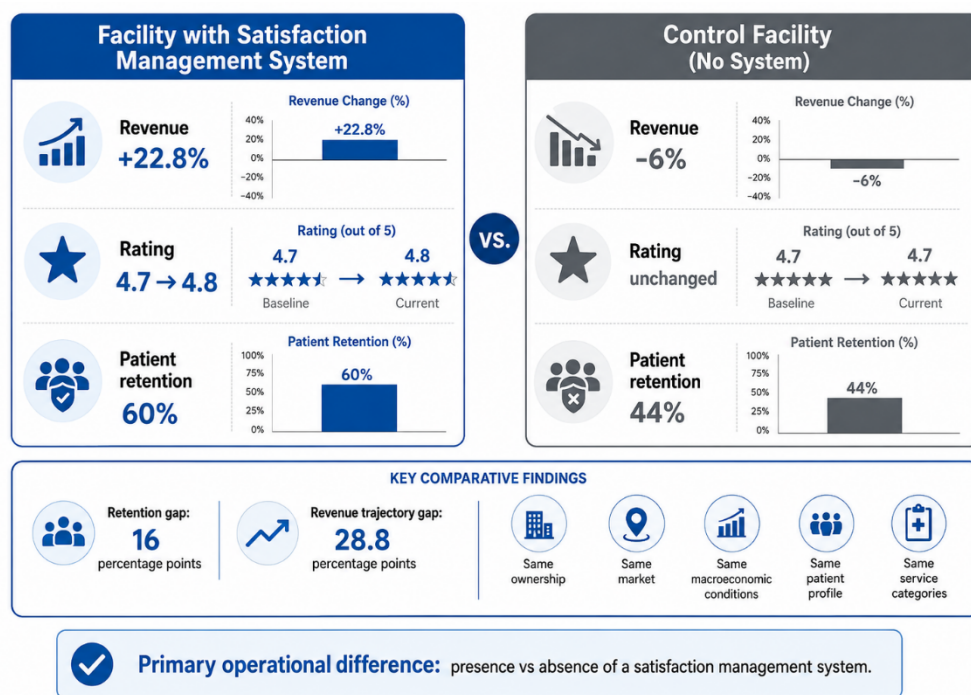


Fig. 4. Comparison of Revenue, Rating, and Patient Retention Between the Implementing and Control Facilities

Since both facilities operated under the same organizational ownership, in the same market, under the same macroeconomic environment, with the same patient demographic profile, and offering the same categories of clinical services, the only significant operational difference was the presence or absence of a satisfaction management system. This provides grounds for considering the implementation of the system as the primary operational variable explaining the difference in performance.

The greatest scientific interest lies not even in the revenue growth in the first year, but specifically in its stability in the second year against the backdrop of a simultaneous decline at the control facility. Revenue in the second year was virtually identical to that of the first, while the control facility lost six percent under identical market conditions. This trend indicates structural revenue stability ensured by the satisfaction system, whereas without the control facility, such a conclusion would have remained unattainable.

Empathy as a Leading Predictor of Loyalty

A cross-analysis of satisfaction data regarding referral behavior revealed that, among all model dimensions, the strongest individual predictor of willingness to recommend is the empathy dimension, which surpasses the overall willingness-to-recommend index, ratings, and other individual dimensions in predictive power. Patients who rated empathy at four or five points generated recommendations significantly more often than patients with a rating of three or lower, regardless of ratings on other measures. Patients who achieved excellent clinical outcomes, were in a clean and professional environment, and received timely care, but did not feel genuine attention and care, generally did not leave recommendations. This finding aligns with empirical data from the healthcare industry regarding the leading role of empathy among the SERVQUAL dimensions [4] and has direct managerial implications: developing empathy competence through training in consultation quality and emotional state management proves to be one of the most effective available ways to increase the number of referrals.

Distinguishing Between Satisfaction with the Procedure and Satisfaction with the Service

Data from the clinic separately demonstrated that satisfaction with the treatment outcome and satisfaction with the service can exist independently of one another. One patient completed a full course of treatment with excellent clinical results, had no complaints, and paid his bills on time; however, he rated empathy and responsiveness at only two out of five points and, based on the willingness-to-recommend index, fell into the “critics” category. His subsequent behavior matched this assessment: his return rate was below average, his spending did not increase, he did not sign up for membership, and he left no reviews or recommendations. Based on clinical and financial metrics, the patient appeared fully satisfied, so without measuring service quality, the clinic would

have only noticed the loss when he silently failed to show up for maintenance treatment.

SERVQUAL helped the clinic understand the source of the patient’s dissatisfaction. The team responded by recognizing the patient’s concerns, offering practical solutions and maintaining regular contact. Over time, the patient stopped acting as a critic and became part of the loyalty program.

The case also led to targeted coaching for the specialist, with a focus on empathy and communication. Afterward, his empathy scores improved, and repeat appointments increased across his practice. This example shows that patient loyalty depends not only on treatment results, but also on how people feel throughout their experience at the clinic.

Table 2

Distinguishing Treatment Outcome Satisfaction from Service Experience Satisfaction

Analytical dimension	What standard metrics showed	What service-quality measurement revealed	Observed patient behavior	Managerial implication
Treatment outcome	The patient completed the full course, achieved excellent clinical results, had no complaints, and paid all bills on time.	Clinical success did not automatically indicate a positive service experience.	Based only on outcome and payment data, the patient appeared satisfied.	Clinical and financial indicators should not be used as the sole proxy for satisfaction.
Service perception	No visible dissatisfaction was recorded through ordinary complaint channels.	Empathy and responsiveness were rated only 2 out of 5; the willingness-to-recommend index placed the patient in the “critics” category.	The patient did not actively recommend the clinic and showed weak engagement after treatment.	Low emotional-service scores can predict loyalty risk even when treatment results are strong.

Retention and spending	The patient had completed the paid treatment course, so the case looked financially successful.	SERVQUAL results explained why future value was at risk.	Return rate stayed below average, spending did not increase, and the patient did not join the membership program.	Silent attrition can appear only after the clinic has already lost a maintenance or repeat-treatment opportunity.
Service recovery	The case did not require clinical correction.	The source of dissatisfaction was linked to communication, empathy, and responsiveness.	After concerns were recognized, practical solutions were offered, and regular contact was maintained, the patient’s behavior improved.	Recovery should address the experience gap, not only the clinical outcome.
Staff coaching	The specialist’s clinical performance remained strong.	A specific empathy gap was identified for the specialist.	Targeted coaching improved empathy scores and repeat appointments across the specialist’s practice.	Individual SERVQUAL dimensions can be translated into focused staff development.
Main conclusion	The patient looked satisfied under clinical and billing metrics.	The patient was dissatisfied with the service experience and at risk of leaving silently.	Loyalty improved only after the clinic responded to the service-quality gap.	Patient loyalty depends on both treatment results and the way the patient feels throughout the clinic experience.

Discussion of results. The results obtained are consistent with the findings in the literature regarding the patient experience in aesthetic medicine, where the functional dimension prevails over the relational one, while the relational dimension of care nonetheless exerts an independent and significant impact on perceived quality, satisfaction, and loyalty [1]. They also confirm the applicability of the SERVQUAL model to the aesthetic setting, provided it is contextually adapted — a necessity emphasized by the methodological literature [5]. The leading role of the empathy dimension, identified in the clinic’s data, echoes the results of an empirical study of inpatient care, where empathy had the strongest influence on satisfaction among all dimensions of the model [4].

The stability of revenue in the second year against the backdrop of a decline at the control facility is best explained by the service-profit link, as investment in satisfaction and staff retention — manifested in a 52 percent reduction in turnover — ensured the continuity of the specialist-patient relationship, which fosters loyalty and long-term patient value [8; 9]. Waiting experience management, based on Maister’s principles - particularly the priority of proactive communication over the actual reduction of waiting time - aligns with the contemporary reinterpretation of these principles through the categories of tolerance for waiting and a sense of progress [10; 11]. Turning a dissatisfied patient into a more loyal one through a prepared recovery protocol aligns with the concept of the service recovery paradox; however, empirical studies indicate that this effect is limited. A large-scale study of the banking sector showed that the paradox is a rare phenomenon with a modest effect size [12], and experimental data confirm that the magnitude of the effect depends on the severity of the failure and the quality of recovery, with satisfaction after recovery not exceeding the level of error-free service under certain conditions [13]. This justifies prioritizing failure prevention alongside the existence of a recovery protocol.

At the same time, the study’s limitations must be acknowledged. The structure of the natural experiment is not a randomized controlled trial and therefore does not completely rule out the influence of unobserved variables. Critical literature on the willingness-to-recommend index cautions against equating the correlation of this indicator with growth with a causal relationship [7]; therefore, in the described system, the index is deliberately applied as an element of a multi-channel structure in which behavioral metrics of repeat visits and average check size verify stated loyalty with actual behavior. Satisfaction data broken down by individual specialists and patient segments were obtained within a single organizational context; therefore, their generalization to other types of facilities requires further verification.

The clinic’s experience highlights a distinction the author considers central: the difference between measuring satisfaction and managing it. The most common and costly mistake made by aesthetic clinics is the presence of measurement without management - that is, collecting data on ratings and the willingness-to-recommend index without linking this data to specific operational decisions, individual staff accountability, and defined improvement actions. The maturity of the system can be assessed by a manager’s ability to explain, for each metric, what action is triggered when a certain value is reached. A drop in the repeat visit rate below a defined threshold triggers a coaching conversation with a specific specialist; an empathy score below the threshold triggers an individual development plan; a critical assessment of the index triggers personal contact regarding recovery within twenty-four hours. An indicator that cannot be linked to a specific managerial response remains a reporting tool and does not function as a management tool. It is precisely this binding of every metric to a managerial response that turns a set of borrowed tools into an original operational system.

Conclusions. This study shows that patient satisfaction should be treated as a separate part of clinic management, not just as a sign of good clinical results. It can be measured regularly and used to understand why patients return, recommend the clinic or stop treatment.

To build this system, the study combined SERVQUAL, the Willingness to Recommend Index, the service-profit link, expectation psychology and the service recovery paradox. Together, these tools helped turn patient feedback into practical information for everyday management decisions.

Empirical results confirm the effectiveness of this approach: the facility’s public rating, repeat visit rate, and average visit revenue all improved, staff turnover declined, and annual revenue remained stable despite unfavorable market conditions (see Figures 3–4 for detailed figures). The resulting retention and revenue gap relative to the control facility, achieved under identical external conditions, provides grounds for considering the satisfaction management system

as the primary operational variable explaining the difference in performance. The strongest predictor of loyalty and referral behavior turned out to be the empathy metric, which determines the priority direction of investment in staff competence.

The minimum set of metrics suitable for implementation in a facility of any size without additional technological investments consists of the repeat visit rate, the rating along with the volume of reviews, and the average visit check. The PSOF system is replicable because it relies on standard models and data that the clinic already collects, so another facility can replicate it without changing its software. It is scalable because it works equally well in a small practice with a minimal set of metrics as it does in a network, where a recommendation index, a full SERVQUAL questionnaire, and analysis broken down by individual specialists are added. This provides the industry with a transferable method for managing patient retention, rather than merely recording it after the fact. Areas for further research include standardizing the measurement methodology across various types of institutions to verify the reproducibility of identified patterns, as well as developing predictive models of satisfaction based on accumulated longitudinal data.

Significance of the Study. The author sees the theoretical significance of this work in the fact that it brings together several previously separate service models into a single system and applies them to a field where they have been rarely used, partially filling a gap identified in the existing literature. The practical benefit lies in the fact that this approach enables the director of an aesthetic clinic to identify patient attrition due to service quality before it impacts revenue and to make specific staffing and operational decisions based on this data. If other institutions adopt a similar system, the industry’s managerial focus will gradually shift from clinical outcomes alone to the patient’s overall experience, upon which patient retention and long-term value depend.

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