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Bridging the recovery gap: a qualitative comparative study of service failure, complaint behaviour and service recovery across public and private hospitals in Nigeria

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Abstract

Background

Service failures are an inevitable feature of healthcare delivery, but hospitals differ in their capacity to recover without compounding the original harm. In Nigeria, public hospitals operate under the SERVICOM service-delivery and complaint-resolution framework, although implementation is uneven across facilities. Private hospitals, in contrast, generally employ internally developed complaint-handling and service-recovery mechanisms. How patients and providers experience and enact service recovery across these sectors remains poorly understood. This study explored service failures and complaint handling from both perspectives in public and private hospitals in Ilorin, Nigeria.

Methods

We used a qualitative comparative study design, including semi-structured interviews with 10 healthcare providers and 14 patients, purposively sampled across both sectors. Data were analysed using Framework Analysis. Themes emerged inductively from participants' accounts and were then interpreted deductively in relation to Justice Theory and the Service Recovery Paradox.

Results

Six themes emerged, spanning definitional understanding, service failure experiences, complaint behaviour, provider responses, recovery outcomes, and institutional capacity. Patient and provider accounts in the private sector were more closely aligned, whereas those in the public sector showed greater divergence. Public-sector providers described defined complaint-handling procedures, but patients often avoided formal complaints for fear of reprisal from staff on whom they depended for ongoing care. Continued attendance at public hospitals was often driven by affordability, while isolated praise for individual clinicians coexisted with low institutional trust. Recovery practices also differed: private-sector providers described tangible forms of redress, including waived costs, whereas public-sector responses were predominantly verbal or procedural. Across sectors, perceptions of distributive, procedural, and interactional justice appeared to shape whether recovery restored trust or compounded the original failure.

Conclusion

Formal recovery protocols do not necessarily translate into felt resolution, particularly where power asymmetry constrains patient voice and financial constraints limit patients' ability to switch providers. The findings suggest that the conditions underpinning the service recovery paradox may not readily apply in the public-sector context studied. Effective service recovery therefore requires more than formal

complaint mechanisms; it also depends on reducing barriers to patient voice, strengthening trust, and ensuring that recovery is experienced as timely, fair, and responsive.

Introduction

Patient satisfaction is increasingly recognized as a critical indicator of hospital performance, reflecting not only clinical outcomes but the timeliness, manner, responsiveness, and empathy with which care is delivered (1). Service failures, including delays, communication breakdowns, and clinical or administrative errors, are nonetheless a routine feature of care delivery in every hospital system (2, 3). The crucial issue is therefore not whether failure occurs, but how effectively an organization identifies, responds to, and recovers from it (4).

Service failure occurs when service delivery falls below what a patient expected (5). In contrast, service recovery refers to the organizational efforts to address that failure, restore satisfaction, and preserve the provider–patient relationship (6). When handled effectively, service recovery can restore trust, strengthen loyalty, reduce negative word-of-mouth, and encourage continued service use (6, 7). This dynamic is captured by the service recovery paradox: a failure handled well can leave a patient more satisfied than if it had never occurred, whereas the same failure, when handled poorly, can compound the original harm and drive the patient away. In healthcare, where the ‘customer’ is a patient whose complaint may concern their own health or the well-being of a family member, the stakes of effective recovery are considerably higher than in many commercial services. Effective complaint handling may therefore shape not only patient satisfaction but also a patient’s willingness to continue engaging with healthcare services (8).

Complaint behaviour offers patients an opportunity to seek redress and can, in principle, improve healthcare quality, safety, and staff satisfaction by helping prevent similar failures from recurring, This, however, is possible only where organizational responses are adequate. Poor complaint handling is itself a marker of broader weakness within a health system (9, 10). In practice, many dissatisfied patients do not complain at all: they may see the process as ineffective or burdensome, be unaware of where or how to raise a concern, prefer to avoid confrontation, or feel inhibited by power imbalances and prevailing social norms (11, 12). Complaints also function as more than a satisfaction signal: they have been found to precede and predict patient safety incidents that staff incident-reporting systems alone miss (13), and patients' own accounts of unsafe or disrespectful treatment have been shown to distinguish statistically between hospitals with higher and lower mortality rates (14). An unresolved complaint is therefore not only a lost patient in a commercial sense, but a missed opportunity to catch a systemic problem before it recurs.

Compared with private facilities, public hospitals in Nigeria have long been associated with concerns about service quality, including delays, discontinuity of care, unfavourable staff attitudes, and bureaucratic procedures, all of which undermine public confidence in care (8, 15). The Service Compact with All Nigerians (SERVICOM), introduced in March 2004 in response to widespread inefficiency across

the public sector, was designed to promote a service-oriented culture and to provide a framework for monitoring ministries, departments, and agencies against citizens' expectations (16, 17). These principles are particularly relevant to healthcare, where responsiveness to patient concerns is central to quality (15, 18). Empirical evaluations in hospital settings have linked SERVICOM to more timely responses to patient complaints (17), suggesting that the mandate shapes practice in public facilities bound by it. Private hospitals fall entirely outside this mandate; whatever complaint-handling practices they maintain are self-designed and market-driven, reflecting a direct commercial incentive to resolve dissatisfaction before it costs a paying patient. This creates two structurally different starting points for recovery within the same city.

How patients judge a hospital's response has been theorized as justice theory, which holds that a complaint-handling episode is evaluated along three dimensions. These are distributive justice, the fairness of the outcome itself; procedural justice, the fairness of the process used to reach it, including timeliness and voice; and interactional justice, the fairness of the interpersonal treatment received, including empathy and respect (19, 20). International evidence shows that gaps between patient and provider expectations can drive dissatisfaction with complaint handling, while provider-focused research suggests well-managed complaints support institutional learning, accountability, and quality improvement (21, 22), underscoring the value of examining both sides of the same encounter rather than either alone. On the provider side, the capacity to deliver a just recovery has itself been linked to staff empowerment: the discretion, training, and institutional support that let front-line staff resolve a complaint on the spot rather than escalate or defer it (23).

Much of this theoretical foundation, including justice theory and the service recovery paradox, was developed and tested in commercial and hospitality contexts such as restaurants, hotels, airlines, and retail banking (24), where the emotional and clinical stakes of service failure are considerably lower than in healthcare. This contextual bias is also evident in the broader service recovery literature, as a systematic review confirms (25). In Nigeria, research on complaint management has largely evaluated SERVICOM as a policy mechanism, focusing on awareness of and compliance with service charters (17, 26), rather than examining how patients experience specific recovery episodes or how providers decide how to respond when complaints arise. Moreover, existing research has largely focused on either the institutional or the patient perspective in isolation, with little research directly comparing the experiences of the two groups within the same service failure and complaint-handling context.

This study seeks to bridge this recovery gap by comparing how healthcare providers enact service recovery and how patients experience it across public and private hospitals in Nigeria.

From the patient perspective, it examines the nature of service failures experienced, how these failures were reported and responded to, and how the resolution process and the interpersonal treatment received shaped patients’ subsequent perceptions of the facility. From the provider perspective, it examines how staff understand and define service recovery, the protocols and institutional support available to them, and what they consider effective recovery.

The study contributes theoretically by extending justice theory and the service recovery paradox to the under-examined Nigerian public–private hospital context, and practically by informing more responsive, accountable, and patient-centred complaint management.

2.0 Methods

2.1 Research paradigm

The study adopts an interpretivist paradigm, viewing patients' and providers' accounts of specific service failures and recovery experiences as meaningful, context-dependent narratives (27, 28) The study draws on the Critical Incident Technique (CIT), which focuses on participants' accounts of specific service encounters and their interpretations of positive and negative experiences (29)

2.2 Research design

The study adopted a qualitative, comparative design, interviewing groups of patients and healthcare providers from the same public and private hospitals. This enabled comparison of patient and provider perspectives on service failures and recovery. Patient interviews explore specific failures, hospital responses, resolution, emotional impact, and implications for trust, while provider interviews examined their understanding of service recovery, the failures they encountered, response practices, communication challenges, and institutional support.

2.3 Study area

The study was conducted in Ilorin, Kwara State, North-Central Nigeria, across three public and two private health facilities. The public facilities were Children's Specialist Hospital, Centre Igboro; Primary Health Centre, Oja Gboro; and Primary Health Centre, Edun. All three operated within the public health system, but only Children's Specialist Hospital had a SERVICOM complaint unit and formal SERVICOM processes during the study period. The private facilities, MedCare and Molab Hospitals, were not subject to SERVICOM and used their own complaint-handling practices.

2.4 Study population

The study population comprised 24 participants from selected public and private hospitals in Ilorin, Nigeria, including 14 patients and 10 healthcare workers. The patient group included adults, or parents/guardians accompanying paediatric patients, who had experienced a specific instance of care that did not meet their expectations within the preceding six months. The healthcare worker group comprised clinical, nursing and relevant administrative staff with direct experience of handling patient complaints or service failures within their units, including dedicated complaint-desk or SERVICOM personnel where present.

2.5 Sample size and sampling technique

Participants in both groups were selected using purposive, criterion-based sampling: patients were eligible only if they could recall a specific service failure or dissatisfaction episode, and providers only if they had direct experience managing patient complaints or service recovery. Within each group, maximum-variation sampling was applied across facility type (public/private) and, for patients, failure type, to capture a broad range of recovery experiences. Final sample size within each group was determined by data saturation (30).

2.6 Data collection instruments

Two complementary semi-structured interview guides were developed for patients and healthcare providers, respectively, to examine the service failure and recovery process from both perspectives. The patient guide explored specific service failures, hospital responses and resolution, communication and empathy, emotional impact, satisfaction, and subsequent perceptions of and loyalty toward the hospital. The provider guide examined the nature and frequency of service failures, response and resolution practices, complaint-handling protocols, empathy and communication challenges, and institutional training and support. The guides were deliberately aligned around corresponding stages of the service recovery process to facilitate comparative analysis of patient and provider accounts.

2.7 Data collection procedure

Patient interviews were conducted in a private setting away from clinical areas and scheduled independently of any active care episode so recounting a past complaint would not be conflated with, or influence, care currently being received. Provider interviews were conducted during work hours in a private space within the facility, away from patients and, where possible, away from direct supervisors, to reduce perceived pressure to present recovery practice more favourably than experienced. Each interview lasted approximately 30–40 minutes, was digitally audio-recorded with the participant's consent, and was supplemented with field notes. Interviews within each group and sector continued iteratively until thematic saturation was reached, and audio recordings were transcribed verbatim within 24–48 hours to preserve accuracy.

2.8 Data analysis

Data were analysed using the framework method originally developed by Ritchie and Spencer and subsequently adapted for multidisciplinary health research by Gale et al. The analysis followed five interconnected stages: familiarization, identification of a thematic framework, indexing, charting, and mapping and interpretation (31, 32). The analysis initially allowed themes and patterns to emerge inductively from participants’ accounts (33), after which the emerging themes were interpreted deductively through the conceptual lenses of justice theory (19, 20) and the service recovery paradox (34). Illustrative quotations are identified using anonymized participant codes indicating respondent group and hospital sector.

2.9 Use of Artificial intelligence

During the preparation of this work, the authors used Claude (Anthropic) and ChatGPT to improve the structure, readability, concision and language editing of the manuscript. After using this tool/service, the authors reviewed and edited the content as needed and take full responsibility for the publication's accuracy, interpretation and integrity.

2.10 Reflexivity

All interviews were conducted by the lead researcher, a physician and field epidemiologist with no prior relationship with participants or affiliation with the study facilities. The three-member team also included a health systems specialist and public health physician and an environmental health expert. The team recognized that their professional backgrounds could influence data generation and interpretation. In particular, participants might have moderated criticism when speaking to a physician, while the interviewer might have viewed service failures from a provider perspective. To mitigate this, participants were assured of confidentiality and encouraged to share both positive and negative experiences. Justice Theory served as a sensitizing framework for exploring perceptions of fairness in service recovery. The lead researcher maintained a reflexive journal, and regular team discussions challenged emerging interpretations and alternative explanations. Findings were therefore grounded in participants' accounts while acknowledging the influence of the team's disciplinary perspectives and theoretical orientation.

2.11 Patient and Public Involvement

Patients and members of the public were not involved in the design, conduct, analysis or reporting of this study. Patients participated solely as research participants through semi-structured interviews.

3.0 Results

3.1 Participant characteristics and Overview of Findings

Table 1 summarizes the sociodemographic characteristics of the participants.

Table 1
Participant characteristics by respondent group and hospital sector (n = 24)

Characteristic	Private Hospital	Public Hospital	Total
Healthcare Workers (n = 10)			
Number of participants	5	5	10
Role			
Nurse	2	2	4
Doctor	1	1	2
Laboratory scientist	1	1	2
Hospital secretary	1	1	2
Sex			
Female	3	2	6
Male	2	2	4
Age (years)			
Range	—	—	27–55
Mean	—	—	40.0
Patients (n = 14)			
Number of participants	5	9	14
Sex			
Female	5	5	10
Male	0	4	4
Age (years)			
Range	24–56	22–59	22–59
Mean	37.0	45.1	42.0

Formal complaint-handling mechanisms varied across facilities. At Children's Specialist Hospital, participants described SERVICOM as an established avenue for reporting grievances, whereas patients attending the primary health centres more often relied on informal reporting to facility managers or frontline staff. In the private hospitals, participants likewise described complaint handling primarily through facility-level channels involving managers or frontline personnel. Thus, participants' accounts indicated variation in how complaints could be raised and addressed across facilities and sectors.

3.2 Theme 1: Understanding of service recovery

3.2.1 Relational understanding

Private-hospital healthcare workers characterized service recovery predominantly in interpersonal and emotional terms, framing it as a function of the individual provider–patient relationship rather than an institutional process:

"Service recovery is the process whereby you manage or look for a way to make your patient satisfied." (HCW 03, Private)

"It involves your mental relationship with your patients; it involves listening attentively to your patients, to know exactly the next step to take to settle the issue on the ground." (HCW 01, Private)

3.2.2 Procedural understanding

By contrast, public-hospital healthcare workers defined service recovery as a formal, systematic function anchored in complaint handling and documentation rather than the individual encounter:

"Service recovery is a systematic process of identifying a failure in the delivery of expected care — be it clinical, communicative, or logistical." (HCW 02, Public)

"Service recovery is the official procedure for managing patient grievances." (HCW 04, Public)

This sectoral distinction — a customer-oriented, relational framing in the private hospital against a bureaucratic, policy-driven framing in the public hospital — was the most consistent line of divergence in the healthcare-worker data and recurred, in varying form, across every subsequent theme.

3.3 Theme 2: Experiences of service failure

3.3.1 Types of failures

Failures reported by private-hospital patients were narrow in scope, centring almost exclusively on temporary staff unavailability:

"The nurses are not usually available to check on the patient at intervals." (Patient 06, Private)

Public-hospital patients described a wider range of failure types, spanning waiting times, medication stock-outs, and staff conduct:

"The main problem was the long waiting time. I came early in the morning, but I didn't see the doctor until almost afternoon." (Patient 02, Public)

"After seeing the doctor, I was told the hospital pharmacy didn't have most of the prescribed drugs." (Patient 05, Public)

"One of the nurses shouted at me when I asked a question about my prescription." (Patient 04, Public)

3.3.2 Perceived causes

Providers in both sectors attributed failures to operational rather than individual factors, though the specific mechanisms differed. Private-hospital workers pointed to manual, non-digitised processes:

"Time duration can delay the service due to the use of manual machines which use longer time to process." (HCW 04, Private)

Public-hospital workers attributed failures to structural strain on the system itself:

"On a busy ward, it could be a delay in answering a call bell, a medication given slightly later than scheduled, or a relative feeling we are not providing them enough information." (HCW 01, Public)

3.3.3 Frequency and severity

Provider and patient accounts converged within each sector on both the frequency and severity of failures. Private-hospital providers estimated failures as relatively uncommon:

"Not so often, at 20–50%." (HCW 02, Private)

Public-hospital providers described failures as a near-daily occurrence:

"They happen quite often, I would say daily." (HCW 03, Public)

Correspondingly, private-hospital patients reported fewer and less severe incidents, whereas public-hospital patients independently corroborated the higher frequency reported by their providers, describing more numerous and more severe incidents.

3.4 Theme 3: Complaint behaviour following service failure

3.4.1 Complaint pathways

Healthcare workers in both sectors described defined, if structurally different, channels for escalating complaints. In the private hospital, escalation was informal and hierarchical:

"We report to the head of department and work together, and if there's need to be to get anything in place, it is reported to HR." (HCW 05, Private)

In the public hospital, escalation followed a formal, multi-level protocol, including a designated complaint mechanism:

"We are supposed to report any patient complaint to the in-charge nurse or matron. There is also a suggestion box and a formal complaint to SERVICOM." (HCW 05, Public)

3.4.2 Reporting behaviour

Patients' actual reporting behaviour diverged sharply by sector. Private-hospital patients reported failures directly and without apparent hesitation:

"Yes, I did report to the nurse." (Patient 09, Private)

Some public-hospital patients, despite the formal SERVICOM channel described above, often did not report failures through official channels, instead voicing complaints informally to bystanders or to staff not responsible for resolution.

"I didn't report it officially. I just complained to another mother sitting next to me in the waiting area. I didn't want to cause trouble or make the nurse angry with me." (Patient 04, Public)

"I was too tired and sick to report it properly. I just complained to the pharmacist in a frustrated tone." (Patient 01, Public)

3.4.3 Barriers to reporting

Where public-hospital patients explained their non-reporting, the barrier identified was fear of retaliatory treatment rather than lack of awareness of the formal channel:

"No, I didn't report it because I was afraid they might treat me worse next time." (Patient 03, Public)

One public-hospital provider's account offered a parallel institutional observation, noting that the formal protocol served internal administrative functions more than patient-facing ones:

"The protocol is more effective for internal quality control than for immediate patient satisfaction." (HCW 05, Public)

Read through the lens of procedural justice—the perceived fairness of the process by which a complaint is handled—these accounts indicate that a formal, multi-level channel in the public hospital did not, by itself, confer perceived fairness on the reporting process for patients who feared reprisal. Procedural justice in the private hospital instead appeared to rest on the perceived accessibility and responsiveness of an informal channel:

"The bone of contention should be addressed by the nurses, but if they can't handle it, it can be reported to the head nurse or admin and if necessary to the doctor in charge." (HCW 04, Private)

3.5 Theme 4: Provider response and recovery practices

3.5.1 Immediate response

Private-hospital providers described an immediate, relational response oriented toward pacifying the patient and offering direct restitution:

"The patient is pacified, and if it involves being tested, the patient is tested without payment; then after, an apology is made to the patient." (HCW 04, Private)

"Keep mute and listen to the patient's complaints and vents. If the patient is lousy and angry, then find a way to calm him/her down. And communicate properly with respect." (HCW 03, Private)

The tangible restitution described here — a free repeat test alongside a direct apology — reflects distributive justice, the perceived fairness of the tangible outcome offered in response to a failure.

3.5.2 Procedural response

Public-hospital providers described a more formalized, multistep response involving documentation and referral rather than immediate direct resolution:

"I receive the complaint politely and document the details. I then identify the root of the problem. .. I channel it to the correct department head and follow up." (HCW 01, Public)

"My first step is to create a private setting, acknowledge their frustration, apologize for the shortcoming, and then clinically assess the current situation to ensure patient safety." (HCW 03, Public)

3.5.3 Patient experiences of recovery

Patient accounts closely tracked the sectoral pattern in provider-described response. Private-hospital patients described staff explaining the failure and taking visible corrective action:

"She explained the reasons why she wasn't available, being that she went to check on other patients too." (Patient 04, Private)

"She apologized and did what was needed to be done." (Patient 08, Private)

Public-hospital patients, by contrast, most often described a dismissive non-response with no substantive corrective action, even where providers had described a defined procedural response as standard practice:

"She just said there were too many patients and that I had to be patient." (Patient 04, Public)

"Honestly, nothing was done differently. We still had to wait." (Patient 02, Public)

Because these accounts arose despite providers describing a defined procedural response as standard practice, the gap is better characterized as a breakdown in interactional justice — the perceived fairness of the interpersonal treatment, explanation, and respect a patient receives during the recovery encounter — than as an absence of procedure per se.

3.6 Theme 5: Outcomes of service recovery

3.6.1 Empathy and communication

Providers in both sectors affirmed empathy as central to recovery but identified different obstacles to sustaining it. Private-hospital workers cited difficult patient conduct:

"Human beings generally are difficult to manage, so are some patients even when you try your best to be nice and understanding. Bad attitudes and ego from patients." (HCW 01, Private)

Public-hospital workers cited time pressure and the emotional labour required under aggressive or personal complaints:

"Time pressure is the main challenge. .. Also, when complaints are aggressive or personal, it requires significant emotional regulation to remain empathetic." (HCW 02, Public)

Patients' perceptions of the attitude actually received mirrored the sectoral pattern seen throughout the results. Private-hospital patients described staff as apologetic and communicative:

"She apologized and that she took to correction." (Patient 02, Private)

"Her communication was good about 70%." (Patient 05, Private)

Public-hospital patients frequently described staff as uncaring or unprofessional, with communication experienced as inadequate:

"The pharmacist wasn't rude, but there was no compassion either. It felt like they didn't care." (Patient 05, Public)

"There was no empathy. The communication was harsh and unprofessional." (Patient 02, Public)

This sectoral contrast maps onto interactional justice—the perceived fairness of interpersonal treatment, respect, and explanation received during service recovery—which patients in the private hospital experienced as largely satisfied and patients in the public hospital as largely absent.

3.6.2 Emotional impact

Public-hospital patients consistently described frustration, humiliation, and heightened stress following a service failure:

"I felt frustrated and neglected. I was even thinking of leaving to try a private clinic." (Patient 01, Public)

"I felt humiliated and disrespected. It added to my stress." (Patient 04, Public)

"I felt helpless and uncared-for. When you are sick, you need help, not more problems. It made my stress worse." (Patient 03, Public)

Private-hospital patients did not report comparable emotional distress in their accounts of service failure and recovery.

3.6.3 Trust and quality perception

Public-hospital patients frequently held mixed perceptions of quality: several praised doctors' clinical competence, even when their overall impression of the hospital remained negative.

"The doctor, when I finally saw him, was kind and thorough. That part was good." (Patient 02, Public)

"It reduced my trust in the hospital. I would only return because it's affordable, but I would not recommend it to others." (Patient 04, Public)

"It reduced my confidence in the hospital. It felt like patients' lives are not valued enough." (Patient 01, Public)

Private-hospital patients reported a uniformly positive and largely unchanged view of the hospital following any service failure:

"My experience has been really, really good, and the view about the hospital remains positive and unchanged." (Patient 07, Private)

Providers in both public and private hospitals described resolving service failures successfully as an opportunity to restore or strengthen patient trust. Some providers suggested that patients could retain a positive view of the hospital following an effective response to a complaint, despite the initial service failure. These accounts were consistent with the service recovery paradox, whereby effective recovery following a service failure may result in more favourable evaluations than an otherwise satisfactory encounter:

"A successful service recovery can paradoxically strengthen the patient's trust. It demonstrates accountability and a commitment to their well-being." (HCW 04, Public)

"A patient who has a problem that is well-resolved is more likely to return than one who had a perfect experience but no connection." (HCW 05, Public)

3.6.4 Loyalty and recommendations

Public-hospital patients' continued attendance was frequently conditional on affordability rather than satisfaction, and several stated they would not recommend the facility to others:

"I would only come again if we can't afford a private hospital. Otherwise, I prefer to avoid it." (Patient 02, Public)

"Better triage system, faster attention to weak patients, and more caring attitude from nurses." (Patient 05, Public)

Private-hospital patients expressed continued, largely unprompted loyalty, with suggestions for improvement oriented toward incremental service refinements rather than trust repair:

"There should be more nurses available to attend to patients." (Patient 05, Private)

"There should have been someone available to help call on the nurse or a bell to ring." (Patient 07, Private)

Loyalty patterns across the two sectors thus track the distribution of perceived justice documented above: private-hospital patients, whose failures were met with distributive and interactional justice, remained loyal without qualification, while public-hospital patients' loyalty was contingent on affordability rather than on any restored sense of fair treatment.

3.7 Theme 6: Institutional capacity for service recovery

3.7.1 Training

Providers in both sectors reported an almost complete absence of formal service recovery training, regardless of sector:

"No formal training." (HCW 03, Private)

"No formal training. Medical school and residency focused on clinical knowledge and procedural skills, not on service recovery." (HCW 02, Public)

3.7.2 Organizational support

Where public-hospital staff had received any orientation relevant to complaint handling, it was described as administrative rather than skills-focused:

"I received some basic orientation on the hospital's complaint procedure, but it was more about paperwork flow than practical skills like communication and empathy." (HCW 04, Public)

3.7.3 Suggested improvements

Providers' recommendations for strengthening institutional capacity split along sectoral lines. Private-hospital staff prioritized staff-facing fixes:

"Addressing your staff respectfully before your patients, even in cases of service failure, makes them feel valued." (HCW 03, Private)

"Provision of a suggestion box, equipping the hospital with needed digital machines and also good salaries should be paid to staff." (HCW 01, Private)

Public-hospital staff prioritized systemic fixes alongside a shared demand, echoed by private-hospital staff, for structured training in de-escalation and communication:

"Provide training focused on customer service for healthcare. Also, management should address the systemic issues that cause most complaints, like understaffing and equipment maintenance." (HCW 05, Public)

"Regular training! Teach us how to de-escalate conflict and communicate better. Also, management should have our backs when a patient is being unreasonable, so we don't feel thrown under." (HCW 02, Public).

4.0 Discussion

4.1 Overview

This study explored how healthcare workers and patients in public and private Nigerian hospitals conceptualize service failure, experience critical service failures, decide whether to voice complaints, perceive provider responses, and evaluate service recovery outcomes across different institutional contexts.

4.2 Justice Theory and the patient experience of recovery

The private-hospital data show a pattern in which distributive and interactional justice were both delivered close to the point of failure. Patients described receiving a tangible remedy (a free repeat test), a direct apology, and an explanation offered in person by the responsible staff member. This convergence of tangible and interpersonal fairness offers one plausible explanation for why private-hospital patients reported stable trust and largely unprompted loyalty even after acknowledging failures.

The public-hospital data complicate a purely procedural account of fairness. In the public hospitals, a formal, multi-level complaint mechanism existed on paper, including a suggestion box, a matron-in-charge pathway, and a SERVICOM protocol in one hospital, which, by conventional definitions of procedural justice, might be expected to support patients' sense of fair treatment. Yet patients largely did not use it, and when they explained why, they cited not unfamiliarity with the channel but fear of being treated worse as a result of complaining. This suggests that procedural justice, as experienced by patients, is not reducible to the existence of a mechanism; it appears to depend on patients trusting that using the mechanism will not itself carry a cost. One public-hospital provider's own description of the protocol as "more effective for internal quality control than for immediate patient satisfaction" is consistent with this reading. In other words, the complaint-handling structure on the ground is coherent for the institution, but not necessarily experienced as safe or accessible by the individual complainant.

A parallel pattern emerges at the interactional level. Public-hospital providers described a defined procedural response, such as documenting the complaint, identifying its root cause, and referring it to the relevant department. These activities broadly mirror recognized service recovery practice. However, patients' accounts of the same type of encounter most often described being told to wait, with no substantive action taken, and staff attitudes experienced as unsympathetic rather than empathetic. This disjuncture between a provider-described procedure and a patient-experienced non-response points to interactional justice, more than procedural justice per se, as the dimension most directly implicated in the public hospital's recovery shortfall.

These findings broadly align with a comparative study of service recovery across hospital sectors in India. Gupta, Arora and Sharma, applying justice theory to 300 patients across government and private hospitals in India, similarly found that patients were more satisfied with the recovery process and patient care facilities in private hospitals than in government facilities (35). They also found that service failures in government hospitals clustered around administrative and management shortcomings, rather than the treatment duration or billing issues reported in private facilities. This pattern aligns with the operational-versus-structural attribution of failure causes found in our study.

Studies in Nigeria, in particular, that used SERVQUAL in public hospitals both identified "being valued and listened to" as a relatively low-performing domain of patient-perceived service quality compared with more tangible or clinically oriented domains (36, 37). This closely mirrors the interactional-justice gap exhibited by public-hospital respondents in our study, even though neither investigation used a justice-theory- or qualitative-based approach.

4.3 The Service recovery paradox: conditions for its occurrence

Public-hospital providers used the service-recovery paradox to justify recovering from service encounters and increasing trust beyond its original level. However, patients' descriptions of their experiences in our study did not align with this expectation. Patients who withheld formal complaints did so out of fear of retaliation from healthcare workers or further substandard treatment. Patients who voiced complaints reported being sidelined by healthcare workers and did not experience corrective action. These recovery encounters lacked distributive, procedural, and interactional justice, leading patients to trust the service less. Thus, the service-recovery paradox is not an inevitable outcome of engaging in recovery efforts. As with McCollough et al.'s (34) and Bitner, Booms and Tetreault's (29) findings that failure to adequately respond to service breakdowns can result in a service failure, these results show that failure to respond to service failures with adequate recovery can lead to double deviation, especially if the inadequate response comes after an actual complaint was made. Therefore, recovery formalities or provider motivation are not enough.

4.4 Relational and procedural recovery approaches

The definitional divergence identified at the outset of the findings, that is, private-hospital providers framing service recovery in relational, emotion-focused terms, and public-hospital providers viewing it as a systematic, protocol-driven process, extended beyond terminology to shape the recovery pathway. It influenced how service failures were attributed, how complaints were escalated, and what constituted an adequate response. Although both sectors adopted internally coherent recovery approaches, the relational approach more consistently delivered the interactional and distributive justice patients associated with restored trust.

This contrast should not be interpreted as a lower commitment to patient wellbeing among public-hospital providers. Providers in both sectors regarded empathy as central to service recovery, though

public-hospital providers described the challenge of sustaining empathy amid heavy workloads, time pressure, and difficult patient interactions. From a health policy and systems research perspective, these differences reflect structural conditions that shape recovery practice rather than differences in provider commitment.

Nigeria's public health workforce operates under substantial strain, with physician burnout reported at 75.5% across five tertiary institutions and workforce attrition contributing to increased workloads (38). The World Health Organization's Workload Indicators of Staffing Need methodology recognizes adequate staffing as essential to delivering responsive, individualized care (39). Consistent with providers' accounts in this study, sustained workload pressure may therefore constrain the time and emotional capacity required for empathetic, interactionally just recovery, irrespective of individual provider commitment.

SERVICOM, where operational, provides a formal complaint infrastructure within Nigeria's public health system, but its implementation has been characterized by limited statutory enforcement power and inconsistent compliance across ministries, departments, and agencies (16, 17). In this study, the gap between the availability of a formal SERVICOM pathway at one public facility and patients' reluctance to use it aligns with broader implementation challenges reported in the SERVICOM literature, rather than being solely a facility-specific anomaly.

4.5 Emotional impact and patient-centred communication

The emotional impact patients described including frustration, humiliation, and heightened stress following an unresolved failure, was reported exclusively in the public-hospital sample. This pattern aligns with broader literature linking the quality of provider–patient communication to patients' trust and psychological experience of care. Hong and Oh, analysinga large US patient survey, found that patient-centred communication was associated with greater trust in healthcare providers, and that this trust mediated patients' evaluation of care quality (40). A rapid review of communication and patient-centred outcomes similarly concluded that communication quality is consistently associated with patients' emotional and psychological wellbeing during care (41). Read alongside these findings, the distress reported by public-hospital patients in this study supports the proposition that unresolved interactional injustice compounds, rather than merely coexists with, the psychological burden of the original clinical encounter. For patients already burdened by ill health, a recovery encounter experienced as dismissive does not simply fail to repair trust; it appears to add a further, potentially avoidable, layer of distress.

4.6 Institutional capacity: training and structural support

The near-universal absence of formal service recovery training across both sectors is notable, given that the private hospital's comparatively more successful recovery outcomes were achieved without a structured training advantage. Staff in both settings reported developing recovery skills primarily through on-the-job experience, suggesting that the sectoral differences identified are unlikely to be addressed by generic customer-service messaging alone. Providers across both sectors called for structured training in communication and de-escalation, while public-hospital providers additionally highlighted the need for

managerial support when handling unreasonable complaints. This institutional-support gap may constrain providers' ability to deliver interactionally just recovery and aligns with health-systems-responsiveness scholarship, which emphasizes that prompt attention, effective communication, and respect for patient dignity depend on organizational support as well as individual provider behaviour (16).

Variation in complaint-handling mechanisms indicated uneven institutional capacity for service recovery across facilities and sectors. Public hospitals differed in the visibility of SERVICOM pathways, particularly between the secondary (specialist) hospital and primary health centres, while private hospitals relied on facility-specific approaches. This suggests that formal policies do not necessarily ensure accessible or trusted complaint mechanisms at the point of care.

4.7 Strengths and limitations

A key strength of this study is its comparative qualitative design, which incorporated the perspectives of both healthcare workers and patients across public and private hospitals. This enabled triangulation of experiences within each sector and identification of convergences and divergences in how service failures, complaint behaviours, and recovery responses were perceived and enacted. Applying justice theory and the service recovery paradox as an explicit a priori analytical framework further strengthened interpretation by situating these patterns within established service recovery theory in a healthcare context.

The findings should be interpreted within the study's qualitative scope. Rather than seeking statistical generalizability, the study aimed for transferability through rich contextual description, enabling readers to assess the applicability of the findings to similar healthcare settings, consistent with Lincoln and Guba (42). Provider and patient accounts were not linked to the same service encounters; consequently, the findings describe patterns in perceived and reported service recovery across public and private hospitals rather than matched patient–provider accounts of identical incidents. In addition, variation in the implementation of formal complaint-handling mechanisms across public facilities should be considered when interpreting public-sector service recovery experiences.

4.8 Conclusion

Altogether, our results suggest that formal service-recovery infrastructure cannot compensate for failings in patient trust when service recovery efforts fall short. Although public hospitals reported more formalized complaint systems and greater knowledge of service recovery principles overall, respondents more often rated service recovery experiences at private hospitals as fairer, more responsive to their concerns, and more protective of trust. Successful service recovery may therefore hinge less on formal recovery mechanisms than on the justice of how recovery efforts are executed.

Abbreviations

• CIT

Critical Incident Technique
• HCW
Healthcare Worker
• SERVICOM
Service Compact With All Nigerians

Declarations

Ethics approval and consent to participate:

The study was conducted in accordance with the principles of the Declaration of Helsinki (43) and received ethical approval from the Kwara State Ministry of Health Ethical Research Committee, Nigeria (Approval ID: ERC/MOH/2025/07/453). We also obtained permission from the participating hospitals to conduct the study. We obtained written informed consent, including consent to audio recording, from all participants. Participants were informed of their right to decline questions, pause, or withdraw without consequence. We emphasized patient confidentiality and anonymity, particularly when discussing potentially distressing experiences, and assured providers that supervisors or facility management would not receive identifiable responses. We anonymized facility and participant identities and securely stored audio recordings and transcripts, restricting access to the research team.

Consent for publication:

We obtained written informed consent from all participants to publish anonymized quotations from their interviews. No personally identifiable information is reported.

Competing interests:

The authors declare that they have no competing interests.

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Author Contribution

AEK conceptualised the study, developed the methodology, conducted the investigation and formal analysis, and wrote the original draft. OEK and MSO reviewed and edited the manuscript. All authors approved the final version and agree to be accountable for all aspects of the work.

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Data Availability

The datasets generated and analysed during this study are not publicly available because they contain potentially identifiable qualitative interview data from participants. The manuscript includes de-identified excerpts supporting the findings. Additional anonymised data may be available from the corresponding author upon reasonable request, subject to ethical approval and participant confidentiality requirements.

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