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Understanding the role of (e)WOM in healthcare services: an application of social identity theory

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UNDERSTANDING THE ROLE OF (E)WOM IN HEALTHCARE SERVICES: AN APPLICATION OF SOCIAL IDENTITY THEORY

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I dedicate this work to my star in the sky, my grandmother, remembering that all people must have dignified medical care at the end of their life.

Abstract

Healthcare information plays a significant role in the health-related behaviour of individuals. Word of mouth (WOM) is essential in this context and in recent years electronic word of mouth (e-WOM) has emerged. This study aims to understand the role of word of mouth and electronic word of mouth ((e)WOM) on healthcare services before and after consumption with an application of social identity theory. Earlier research has not evaluated both phases: pre- and post-consumption, so this study furthers our understanding of the role of (e)WOM to fulfil this theoretical gap.

A qualitative approach was adopted, with semi-structured interviews targeting consumers among healthcare units. The interviews were transcribed and analysed following the principles of thematic saturation.

The findings show that, before consumption, (e)WOM will influence the hospital brand image creation and in turn hospital brand image will influence patient expectations prior to a visit. After consumption, (e)WOM can be generated, and its valence will be the reflection of the overall experience.

This study contributes to the literature by offering a theoretical model to guide future research on the role of (e)WOM in healthcare institutions.

Keywords

word of mouth (WOM); electronic word of mouth (e-WOM); social identity theory; valence; source credibility; consumer-company identification; hospital brand image; perceived service quality; patient satisfaction; loyalty; repurchase intention

Resumo

A procura de informações sobre saúde desempenha um papel significativo no comportamento dos indivíduos que recorrem a serviços de saúde. O passa a palavra tradicional *(WOM)* é essencial neste contexto e nos últimos anos surgiu o passa a palavra eletrónico *(e-WOM)*. Este estudo tem como objetivo compreender o papel do passa a palavra tradicional e eletrónico *((e)WOM)* nos serviços de saúde antes e após o consumo dos mesmos, com a aplicação da teoria da identidade social. Investigações anteriores não avaliaram as duas fases: pré e pós-consumo, portanto, este estudo amplia a compreensão do papel do passa a palavra tradicional e eletrónico, de forma a preencher este *gap* teórico.

Adotou-se a abordagem qualitativa, com recurso a entrevistas semiestruturadas direcionadas aos consumidores das unidades de saúde. As entrevistas foram transcritas e analisadas, seguindo os princípios da saturação temática.

Os resultados mostram que, antes do consumo, o passa a palavra influenciará a criação da *hospital brand image* e, por sua vez, a *hospital brand image* influenciará as expectativas do paciente antes do consumo do serviço de saúde. Após o consumo, o *(e)WOM* pode ser gerado, e a sua valência será o reflexo da experiência geral.

Este estudo contribui para a literatura ao oferecer um modelo teórico para orientar futuras investigações sobre o papel do *(e)WOM* em serviços de saúde.

Palavras-chave

word of mouth (WOM); *electronic word of mouth (e-WOM)*; teoria da identidade social; valência; credibilidade da fonte; identificação consumidor-empresa; hospital brand image; qualidade percebida do serviço; satisfação do paciente; lealdade; intenção de recompra

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Abbreviations

CSR	Corporate Social Responsibility
C-C	Consumer-Company
FGC	Firm Generated Content
UCG	User Generated Content
e-WOM	Electronic Word of Mouth
(e)WOM	Word of Mouth and Electronic Word of Mouth
WOM	Word of Mouth

1. Introduction

Growing access to health information means that patients act no longer passively in receiving healthcare services (Vahdat et al., 2014). Also, if we consider the social identity theory and apply it to the relations between companies and consumers, is known that individuals belonging to a group express their opinions and generate comments based on their experiences of purchasing and using products or services, contributing to the generation of knowledge about a company and influencing the consuming decisions of others (González-Soriano et al., 2020). This kind of interactions could be made face-to-face or electronic, by word of mouth. Therefore, healthcare institutions must be aware of the influence word of mouth or electronic word of mouth ((e)WOM) on current or potential patients (Huppertz & Otto, 2018). So (e)WOM could influence patient expectations prior to a visit, adding information to hospital brand image and perceived service quality (Dayan et al., 2021).

However, (e)WOM has an important role not only before service consumption, but also after service consumption. Costumers whose needs are satisfied have a higher probability of convincing other people to consume that service. Positive (e)WOM could leverage brand value and negative (e)WOM could destroy brand value (Ranaweera & Jayawardhena, 2014). Thus, it is essential to improve communication to remain competitive in the brand management field.

This research is relevant for the academy because there is no research that compares the role of (e)WOM before and after healthcare service consumption, so a theoretical gap has been identified. Moreover, there is lack of literature using qualitative methodology (methodological gap) (Coutinho et al., 2020). Additionally, qualitative methodology allows to obtain a richer understanding of an ongoing phenomenon. It is essential to understand why people share and look for (e)WOM about healthcare services and how/when they use the information found (Willis, 2018). For those reasons this study will be qualitative.

In this way, this research aims to understand the role of (e)WOM on healthcare services' consumption among patients that use healthcare units. The two main questions of this research are: Q1 – What is the role of (e)WOM before healthcare services' consumption; Q2 – What is the role of (e)WOM after healthcare services' consumption. To increase the power of this investigation, more variables were added, such as hospital brand image, perceived service quality, patient satisfaction, repurchase intention and loyalty. Social identity theory

was also added to investigate how consumers are encouraged to develop their belongingness to a brand.

As the world faces a pandemic (COVID-19) of a magnitude not witnessed for over 100 years, people are more aware of the fundamental role of healthcare services. Marketing and brand management in the healthcare sector has been a challenging field of study due to a complex system of consumers (patients), healthcare professionals, government agencies, health insurance providers, institutions, and others (Salama, 2020). As the business environment becomes more competitive, organizations must become more customer centric to increase their service quality to remain competitive. So, assuring patient satisfaction is a critical success factor, linked to service quality (Coutinho et al., 2020).

In structural terms, the next sections will include literature review with a conceptual model *(section 2)*, methodology with all the information about operational aspects, sample characterization and thematic saturation explanation *(section 3)* and results and analysis *(section 4)*. In *section 5* there is the discussion, in *section 6* we have the conclusion with the main theoretical contributions, managerial implications and limitations and suggestions for future research. In the *section 7* there are the appendixes.

2. Literature review

To frame and identify the variables under study, this section will analyse the state of the art of (e)WOM in healthcare services by identifying the relation between the different topics.

Social identity theory

Social identity theory postulates that the individuals will identify themselves with a social group due to their emotional attachment to that group, based on common characteristics, motivations, behaviours, and beliefs (Tajfel & Turner, 2004).

This theory has been used by many scholars to investigate how consumers feel encouraged to develop their belongingness to a brand, through a model of consumer-company identification (Black et al., 2021).

Bhattacharya and Sen (2003) developed a framework that exposes the antecedents and consequents of consumer-company (C-C) identification. As antecedents we have the link between perceived company identity and identity attractiveness, the key antecedent of C-C identification. A company's identity attractiveness depends on identity similarity (how similar it is to consumers' own identity), identity distinctiveness (its distinctiveness of traits consumers value) and identity prestige. Identity trustworthiness also influences identity attractiveness. Identity knowledge and identity coherence act as moderators of consumers' company perception. As consequents we have the link between identity attractiveness and C-C identification and its key consequences, which should be embedded consumers in their organizational folds (embeddedness), increasing the salience of company identity (identity salience). The main consequences of C-C identification are company loyalty, company promotion, customer recruitment, resilience to negative information and greater claim on the company (Bhattacharya & Sen, 2003).

Considering the C-C identification consequences, it is known that individuals belonging to a group express their opinions and generate comments based on their experiences of purchasing and using products or services, contributing to the generation of knowledge about a company and influencing the consuming decisions of others (González-Soriano et al., 2020). Moreover, Tajfel and Turner (2004) studied the mechanisms of social identity manifestation in face-to-face interactions contexts and found that the physical proximity and perceptions of natural gestures (like nodding) promoted greater participation and motivated

the person spreading WOM to continue providing information to the group. In the electronic context, this type of communication reinforcement does not occur (González-Soriano et al., 2020; Tajfel & Turner, 2004). But, what is (e)WOM?

Expectations of the healthcare service prior to consumption

Word of mouth

The concept of word of mouth (WOM) was introduced in literature in the mid-1960s (Meiners et al., 2010). However, defining WOM has been proven to be difficult. The authors started to define WOM as face-to-face communication about a product or service between individuals who do not have commercial connections to a brand (Arndt, 1967; Rosario et al., 2020). According to the literature, we can identify the following main periods of development of WOM: the mid-1960s, the mid-1980s, and after the turn of the millennium (Meiners et al., 2010). In the 1960s the focus of the scholars was on correlating WOM and advertising and innovation (Brooks, 1957). In the mid-1980s, the focus was on the relation between WOM and customer satisfaction, more precisely dissatisfaction and negative WOM (Richins, 1983). After the turn of the millennium with the internet advent, it was easier to share information, allowing people to search information anywhere anytime (Brown et al., 2007).

The proliferation of digital technologies changed the way people communicate, resulting in the emergence of electronic word of mouth (e-WOM) (Sun et al., 2021). e-WOM is defined as informal communication, in which consumers share their consumption-related opinions about a product or service (Hennig-Thurau et al., 2004). If we add the organization's perspective, the definition of e-WOM also includes shared information about products or services of a certain brand projected for current and potential consumers (Lopez & Sicilia, 2014). e-WOM can modulate decision making by patients on the following formats: blogs and virtual communities; websites; product review and hate sites; emails; newsgroups; chatrooms; instant messaging; among others. The communication mode could be synchronous or asynchronous and the format could be "one to many" or "many to one" (Litvin et al., 2008).

Considering healthcare services, WOM is more trusted regarding quality of healthcare providers than firm reports. Therefore, healthcare institutions must be aware of the influence of WOM on current or potential patients (Huppertz & Otto, 2018). Nowadays, people are more aware about their health and the recommendation from relatives or friends or even

strangers is essential in decision making (Khalid et al., 2013; Terres & Basso, 2018). However, as we are living in the digital era, so patients frequently use the Internet for health-related reasons, like seeking information or recommendation about healthcare services or practitioners (Lin & Lin, 2018; Martin & Grub, 2020). The lack of medical knowledge is also a reason to gather (e)WOM to minimise the risks and uncertainties associated with service consumption (Taheri et al., 2021). Otherwise, it is mentioned in literature that information obtained from healthcare providers can be incomplete or confusing (Willis, 2018). This way, online health information could help patients by facilitating the medical choice (Cao et al., 2017).

A systematic analyis about the role of WOM in healthcare services was made and the principals conclusions about the WOM's content, senders, receivers, motives and channles are represented in the *table I* (Martin, 2017):

Table I – Main dimensions of WOM in healthcare services.

Dimensions	**Characterization**
Content	• A specific health care provider and its services. • A specific health condition.
Senders	• Actual patient of the health care service. • Patient's family, relatives, friends, or acquaintances. • The provider staff may recommend the provider and its services. • Family, relatives, friends, colleagues (someone else with experience concerning a specific health condition).
Receivers	• Potential patients might actively seek information. • Family members, relatives, or friends may ask individuals who have either experienced a particular health care service or health care condition for their WOM.
Motives	• Altruistic (concern for others, warning them, helping them with a provider choice). • Egoistic (venting of negative feelings).
Channels	• Face-to-face. • Electronically by, for example, a social networking site, online reviews, or messages.

Source: (Martin, 2017, pp. 440-441)

In this particular context we will focus on the following aspects regarding the (e)WOM: (a) valence; (b) source credibility; (c) consumer identification.

Valence

An important concept of (e)WOM is the valence (positive, negative or neutral), affecting consumers' buying decisions (Lee & Youn, 2009). In situations in which patients are not satisfied about overall quality of healthcare service, there is a higher chance that patients will develop a negative perception, leading to negative reviews. These reviews will contaminate other patients through (e)WOM, impacting patient expectations prior to a visit (Dayan et al., 2021). In this way, healthcare service firms should develop a stable base of patients through positive WOM advocacy, to maintain the current consumers and reach new ones (Casidy & Wymer, 2015).

Source credibility

There is a tendency to pay closer attention to things that our relatives, friends or trusted colleagues point to as being interesting, useful, or otherwise noteworthy like recommendations made through WOM (Martin, 2017). However, the exposure to online health information has become part of our lives. Nowadays, people browse the Internet to look for information about a specific illness diagnosis, treatment and prognosis. However, this can be positive, as it allows for consumer empowerment, or negative, possibly leading to anxiety (Thapa et al., 2021). To solve this contradiction, source credibility plays an essential role on Internet browsing. Source credibility is the measure that assets the credibility of the source (Ayeh, 2015). The search for content in the online health field is high because the level of risk perception about health issues is quite high (Ma & Atkin, 2017). It is postulated on literature that firm-generated e-WOM (FGC) has higher source expertise and user-generated e-WOM (UCG) has higher source trustworthiness (Colicev et al., 2019). So it is important to distinguish FGC from UCG.

FGC is under the control of a brand and depends on consumer response in a range of formats: likes, shares and comments. According to positive or negative reactions to content, brand equity may be boosted or diminished (Martin & Grub, 2020; Poulis et al., 2019). On this type of generated content patients and health professionals can also use the Internet to improve communication and information between them (Cuomo et al., 2020; Li et al., 2021). In this field, it is also important to mention that advances in artificial intelligence could create

algorithmic word of mouth (a-WOM), whose content will be created and shared by automated tools (Williams et al., 2020).

Otherwise, UGC is created directly by the users (Poulis et al., 2019). It is possible to say that patients themselves represent a source of healthcare content through user-generated content on social media and online communities. Many studies have reported the increasing number of people who use the Internet to look for health information and advice and to be in touch with others who share the same concerns. However, some healthcare professionals seemed sceptical because they say that UGC cannot be considered as a substitute for scientific publications and medical advice (Cuomo et al., 2020).

In summary, when people access e-WOM, the source credibility may or may not influence user evaluation about information credibility, depending on the platform upon which the information is posted (Ma & Atkin, 2017).

Consumer identification

Consumer identification exists at three different levels: with the institution (consumer-company identification), with its employees (consumer-employee identification), or with other consumers (consumer-consumer identification) (Acharya, 2021; Black et al., 2021). In the healthcare field, this theory is important because, when people identify themselves with a certain healthcare service, they will recommend it to others through WOM, and it is known that consumers trust more on the opinion of their friends and peers than otherwise (Ma et al., 2021). Moreover, WOM does not stop after a simple conversation with a friend or relative about a specific product or service; the discussion could continue online, where people comment and share content about a brand (e-WOM) (Ma et al., 2021). An example of that is the online health communities, in which a positive identification with the group leads to positive influences on their participation and ability to recommend others to become part of the group. So in this context the valence of the identification (positive, negative, or neutral) plays an essential role (Feng et al., 2021).

Nowadays, also corporate social responsibility (CSR) shown by companies, tries to engage the consumers through consumer-company provoking (e)WOM. The major objective of CSR engagement is to leave an impression of transparency on patients, and they feel comfortable enough to be treated with due care (Ma et al., 2021).

So (e)WOM could influence patient expectations prior to a visit, adding information to hospital brand image. In this way, it is important that the firm use a customer-centric healthcare strategy to attract and retain loyal patients, developing a stable source of patients through positive (e)WOM advocacy (Dayan et al., 2021). Thus, (e)WOM can influence hospital brand image.

Hospital brand image

The most important subjects of strategic brand management are to build, measure and manage brand image. Since 1990, many scholars have focused on brand image, saying that brand image is a key element that indicates how consumers feel about a brand, in a positive or negative way (Plumeyer et al., 2019). Brand image is defined by a set of perceptions about a brand that are stored in consumer's memory, in the form of associations (Keller, 1993). In this particular context, it is known that hospital brand image helps the patients in visualising, evaluating and differentiating the healthcare services (Wu, 2011). A brand is a strategic requirement which helps firms to create value for customers, assisting in the creation of sustainable competitive advantages (Kalhor et al., 2020).

Hospital brand image has a spill over effect, influencing patient's initial perception before service consumption and subsequent evaluation of the service after consumption (Cham, Cheng, et al., 2021; Cham, Lim, et al., 2021). Thus, not only does hospital brand image depend on the functional aspect of the service, but it is also influenced by social factors (Cham, Cheng, et al., 2021; Cham, Lim, et al., 2021).

Moreover, social factors play a major role in the development of brand image. There are two major information diffusers: the customer and the firm. The information shared by the customer, traditional WOM, allows the discussion of his opinions with other customers. On the other hand, firmed-created social media is used to target consumers, increasing brand image (Cham, Cheng, et al., 2021; Cham, Lim, et al., 2021). The growing of social media allowed mass communication, through e-WOM, becoming an unconventional channel for shaping consumer perceptions and behaviours (Caber et al., 2021).

In this field, many studies had to examine relationships between brand image and others marketing constructs (Plumeyer et al., 2019). It has been shown that there is a relation between hospital brand image, service quality and loyalty (Cham, Lim, et al., 2021).

As it has been demonstrated, a positive hospital brand image influences perceived service quality (Sukawati, 2021). This finding supports other studies that mention that perceived service quality is related with patient expectations. Patients form expectation before they obtain the medical service. Expectation is defined by what patients think about the medical services offered by the hospital, directly linked to the hospital brand image. During the service delivery, patients will develop perception that will be compared with the initial expectation (Wu, 2011). Hence, patient's perception of a brand before the service consumption stage may influence the evaluation of service delivery and quality after the service consumption stage (Jiang et al., 2018). Thus, based on research, it seems that hospital brand image influences perceived service quality.

Perception of the healthcare service after consumption

Perceived service quality

Perceived service quality is defined as consumer evaluation of the overall excellence of a service. In this field there is an important trade-off between consumers' expectations and service performance. When the latter exceeds the former, quality is highly perceived (Zeithaml, 1988). This area has been exhaustively explored, in part, due its significance on consumer satisfaction (Cham, Cheng, et al., 2021). Some scholars found that a high healthcare perceived service quality has a positive and direct influence on patient satisfaction (Chaniotakis & Lymperopoulos, 2009; Ladhari et al., 2017). Improving service quality has been a challenge for managers, to fulfil customers' expectations, leading to patient satisfaction (Nasir et al., 2021). So, perceived service quality affects patient satisfaction.

Quality dimensions in healthcare services

The fundamental expectation of a healthcare service is to cure a health problem. Patients cannot assess the technical quality of the service because of their lack of knowledge. However, functional quality (to be cured) is determinant for satisfaction (Rastogi & Sharma, 2020).

The SERVQUAL model has been used by many researchers to assess service quality in the healthcare field (Dayan et al., 2021). This model tries to evaluate the discrepancies between service expectations prior to the service consumption and service perception after the consumption (Parasuraman et al., 1988). However, some critiques have questioned the

SERVQUAL effectiveness, doubting about the utility of measuring expectations and saying that service performance would be a better indicator (Dandis et al., 2021).

Recently, Kumar et al. modified a model created by Dagger et al. to measure perceived service quality in the healthcare sector, adopting a 7PS marketing mix, evaluating the following variables *(see table II)* (Dagger et al., 2007; Kumar et al., 2018):

Table II – Assessing perceived service quality.

Dimension	Characterization
Physical environment	The physical environment is conditioned by three factors: atmosphere (intangible background characteristics of the service environment); tangibles (physical elements); infrastructure (service delivery facilities).
Interpersonal care activity	The interpersonal care activity is comprised of three points: interaction activity; relationship activity and physician's care.
Technical process	This process involves process expertise (competence, skill, qualifications of providers) and safety measures.
Administrative procedure	It involves timeliness of activity (appointments, ease of changing appointments and waiting time) and operational activity (facilitates the core service).
Core service	Service appropriateness, effectiveness, and benefits to customers.
Service communication	A healthcare facility that informs patients appropriately has more satisfied consumers because they have improved capability to make educated choices.
Service charge	Price perception can affect willingness to purchase.
Access convenience	Time and effort that patients spend to consume the service.
Social responsibility	Hospitals that give a fair medical treatment at reasonable price, maintaining privacy and confidentiality of patient information.

Source: (Kumar et al., 2018, pp. 604-607)

Patient Satisfaction

Patient satisfaction is evaluated by comparing the differences between patients' expectations of what ideal care is and their perception of the care that they receive (Aragon & Gesell, 2003; Kotler & Keller, 2016). The competitive advantage of the firm is accomplished when the company satisfy customers better than their rivals (Minta, 2018). If they surpass

expectations, the customer will be satisfied. Otherwise, if they do not surpass expectations, the customer will be unsatisfied (Dam & Dam, 2021).

On this field many studies have been evaluating firms' success through the relationship between customer satisfaction, loyalty, repurchase intention and word of mouth (Dam & Dam, 2021).

Costumers whose needs are satisfied have a higher probability of convincing other people to consume that service (Ranaweera & Jayawardhena, 2014). When the patients perceive a medical service has a high quality, they are satisfied and spread WOM messages to family, friends, and colleagues. However, to increase the satisfaction the hospital should adopt humane facilities and help patients conveniently (Hsu, 2018). This conclusion reveals that patient satisfaction affects (e)WOM spread.

Loyalty

Customer loyalty has been defined as a strong continuous commitment to prioritize a favoured service consecutively in the future (Oliver, 1980). In this way, customer loyalty is linked to the businesses' survival and influence future growth (Dam & Dam, 2021).

Some studies have established a connection between customer satisfaction and customer loyalty, saying that the first is an antecedent of the second (Minta, 2018). Satisfied customers are more likely to develop a long-term relationship with the firm. Loyal customers go to the same service provider and do not consider other available alternatives, spreading WOM in the process. In this context, previous researchers have treated customer loyalty as a mediator between patient satisfaction and (e)WOM spreading (Nasir et al., 2021). Thus, loyalty mediates the relationship between patient satisfaction and (e)WOM.

Repurchase intention

Repurchase intention can be defined as the willingness to rebuy a certain product or service in the future (Saleem et al., 2017). Some researchers have observed that customer satisfaction has a significant influence on repurchase intention for a range of services, being a predictor of repurchase intention and (e)WOM. So, an increased satisfaction leads to developing a profitable relationship over time, affecting others through (e)WOM spreading (Nasir et al.,

2021; Saleem et al., 2017). So, repurchase intention mediates the relationship between patient satisfaction and (e)WOM.

In *table III*, we can see the definitions of the main concepts of this theoretical framework:

Table III – Main concepts of the theoretical framework.

Concept	Definition	Source
Brand image	"Perceptions about a brand as reflected by the brand associations held in consumer memory."	(Keller, 1993, p. 3)
Word of mouth	"Face-to-face communication about a brand, product or service between people who are perceived as not having connections to a commercial entity."	(Arndt, 1967, p. 291)
Electronic word of mouth	"Any positive or negative statement made by potential, actual, or former customers about a product or company, which is made available to a multitude of people and institutions via the Internet."	(Hennig-Thurau et al., 2004, p. 39)
Perceived quality	"Quality can be defined broadly as superiority or excellence. By extension perceived quality can be defined as the consumer's judgment about a product's overall excellence or superiority."	(Zeithaml, 1988, p. 3)
Patient satisfaction	"A person's feeling of pleasure or disappointment which resulted from comparing a product's perceived performance or outcome against his/ her expectations."	(Kotler, 2006, p. 144)
Loyalty	"Strong continued commitment to repurchase or patronize a favoured product/service consistently in the future, thereby creating repeated same products/brands purchasing."	(Oliver, 1997, p. 392)
Repurchase intention	"The individual's judgement about buying again a designated service from the same company, taking into account his or her current situation and likely circumstances."	(Hellier et al., 2003, p. 1764)

Based on the study's purpose, literature review generated *figure I* that describes the proposed conceptual model, with the relation between the different dimensions.

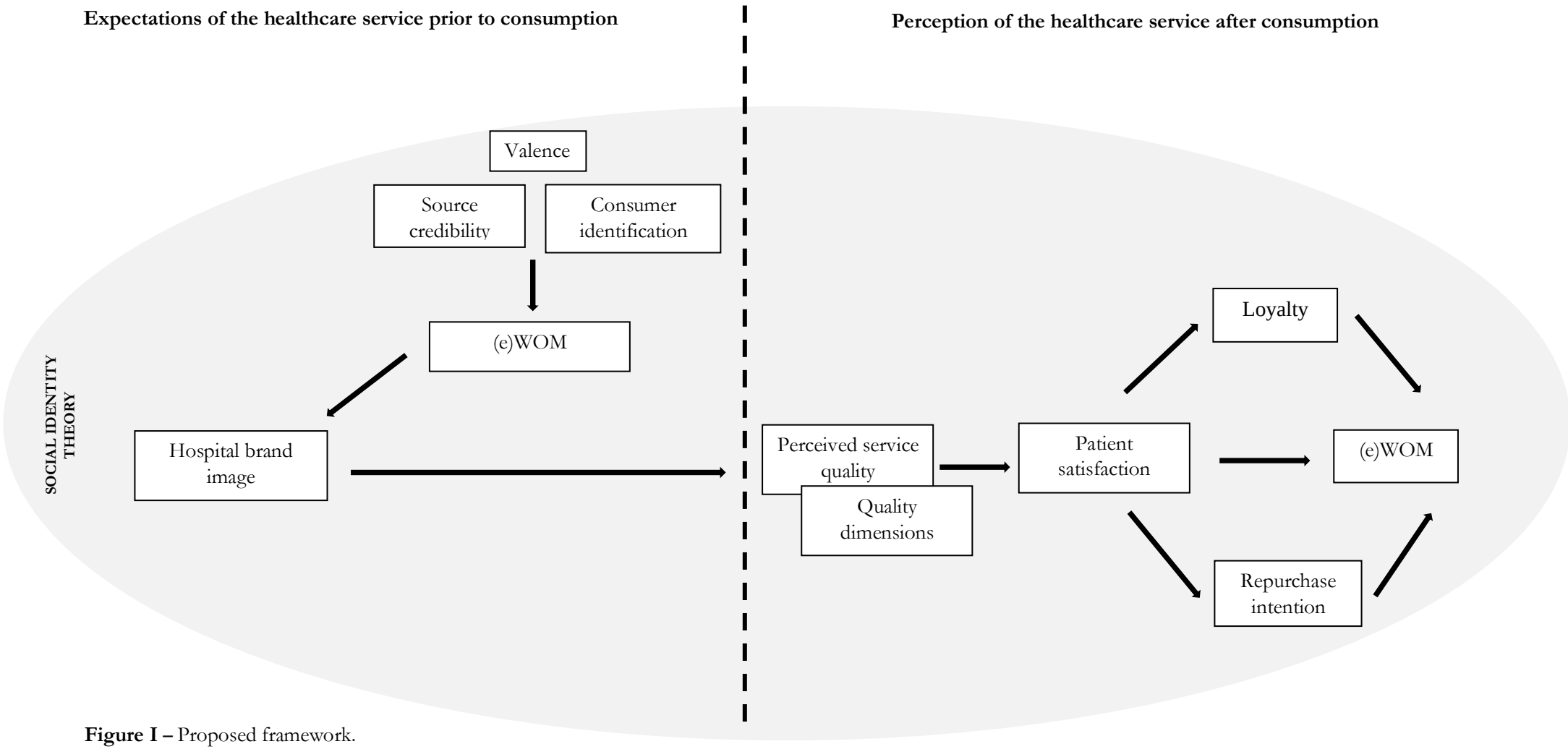


Figure I – Proposed framework.
Source: Own elaboration adapted from (Coutinho et al., 2020, p. 302), (Cham, Lim, et al., 2021, p. 7), (Dayan et al., 2021, p. 184), (Nasir et al., 2021, p. 493) and (Ma et al., 2021, p. 3).

3. Methodology

After reviewing the literature, this chapter focuses on the objective and research questions as well as the inclusion of the methodology used for the pursuit of the empirical part. To elaborate this investigation project it was essential to follow the following steps: determining the purpose and scope of the study; choosing the type of methodology; choosing and developing an appropriate data collection tool; identifying research participants; determining how data should be analysed (DeJonckheere & Vaughn, 2019).

This empirical study was based on methodological and theoretical gaps identified in literature, regarding the lack of qualitative studies on this field, hoping to contribute to the academy and management.

3.1. Goal and research questions

This research aims to understand the role of (e)WOM on healthcare services' consumption. The two main questions of this research were:

Q1 – What is the role of (e)WOM before healthcare services' consumption.

Q2 – What is the role of (e)WOM after healthcare services' consumption.

The scope of this study was healthcare services, where patients have a higher decision power and, consequently, where word of mouth assumes a more relevant role (Meleddu et al., 2020).

3.2. Type of investigation

This study used qualitative methodology. Qualitative methodology allows discovering invisible or surprising patterns. While qualitative research is common in other subjects, it is relatively underrepresented in healthcare services research (Busetto et al., 2020). Additionally, qualitative methodology allows to obtain a richer understanding of an ongoing phenomenon. It is essential to understand why people share and look for (e)WOM about healthcare services and how/when they use the information found (Willis, 2018). Qualitative research on this field could enhance bringing more light to patients' concerns regarding healthcare services (Dayan et al., 2021).

A recent study tried to determine the antecedents and outcomes of patient satisfaction, including word of mouth. This study analysed articles related to this field from 1988 to 2019 from databases. Only 3% of the articles analysed have used qualitative methodology. So there

is a lack of articles using qualitative methodology (Coutinho et al., 2020). On the other hand, given that the healthcare field is characterised by continuity of care and the diversity of respondent opinions, qualitative methodology was more appropriate for this purpose (Alizadeh et al., 2016). For those reasons, this study was qualitative, in order to compare new insights with those obtained using quantitative methods, providing additional validity to the original findings (Coutinho et al., 2020).

Qualitative research allows for a better understanding of the subjectivity of the behaviour of people and organizations (Marshall & Rossman, 2011). There are 3 types of qualitative research: inductive, deductive, and abductive. Induction is the process of recording several individual experiences in order to create a general conclusion about those individual experiences which may be true. This type of study is well suited to study new and emergent phenomena for which it is still premature to formulate specific hypotheses. Deduction is the process of deducing testable hypotheses from general theories and trying to falsify these in order to create a specific conclusion. It is presupposed that when we have some stable entity to study repeatedly and generate general knowledge induction is better. However, when we have general ideas from which we can create hypotheses to test, deduction is better. However, when we talk about volatile conversational of human beings, induction or deduction are not enough. As a consequence, in order to fill in this gap, abduction emerged (Brinkmann, 2013, pp. 47-53). Abduction is a form of reasoning used in situations of uncertainty or when we need a better explanation of something that happens. Abduction is very common in qualitative inquiry, connected to the creative moment in the analytic process, leading to the construction of new theoretical ideas and hypotheses based on empirical data. From the abductive point of view, research is never finished, as the world is constantly changing (Timmermans & Tavory, 2012)

In this context, the type of qualitative methodology used was the abductive one because the main goal was to reach a better understanding of the phenomena behind (e)WOM role before and after healthcare services' consumption.

3.3. Data collection

There are three main groups of data collection in qualitative research: interviews, observation, and document analysis. Interviews allow for a deep exploration of a certain subject and discovering unknown information. There are three types of interviews: non-

structured; semi structured and structured (Marshall & Rossman, 2011). Semi-structured interviews are the most frequently used qualitative data source in health services research. This method consists in a dialogue between researcher and participant with a flexible interview protocol, allowing for the adding of unknown information by the participants using their own vocabulary (DeJonckheere & Vaughn, 2019). The main goal of semi-structured interviews is to obtain information about a person's experiences, opinions and motivations, contributing for the abductive approach used in this research (Busetto et al., 2020).

The execution of semi-structured interviews included a preparation phase, for which an interview guide was created after reviewing the existent literature about (e)WOM on healthcare services, ensuring that all relevant themes were covered. The interview guide included several broad and open-ended questions to make sure that participants were free to elaborate by using their own vocabulary. 2 introductory questions about healthcare services were included and after that the interview guide was divided into 2 parts: expectations of healthcare service prior to consumption and perceptions of the healthcare service after consumption in order to understand the role of (e)WOM before and after service consumption. In the first part the following themes were assessed: hospital brand image; (e)WOM prior to consumption in terms of exposure, valence, source credibility and consumer identification; expectations of service quality. In the second part we tried to obtain more information about: perceptions of service quality; patient satisfaction; (e)WOM spread; loyalty and repurchase intention. All the questions were elaborated with the support of literature findings (*see appendix I)*. The interview guide was tested before application, and then revised in terms of sequence and content, according to the feedback received from 2 participants.

The interviews were conducted in Portuguese (if such was the participants' native language) or in English. The interviews were conducted face-to-face or by Google Meets, due to COVID-19 limitations and lasted 30 minutes on average. It was assured that the interviews took place in a friendly atmosphere, so that the participants could talk freely and without interruptions. The participants gave informed oral consent after receiving information about the goal of investigation, being assured that the data collected would only be used in the context of investigation. All participants were encouraged to choose a medical unit and speciality to give context and examples in the moment of answering the questions. Participants' social demographical information was also gathered: gender; age; nationality;

level of education; occupation; name of healthcare unit; medical speciality. All interviews were audio recorded, transcribed, and translated to English.

The interviews were conducted between March 2022 and April 2022 to make sure that saturation point was achieved.

3.4. Research participants

Taking into consideration that the scope of this study is the healthcare services, the sample was selected by convenience, and additionally, through the chain sampling method, with the participants referring peers (Patton, 2015). The search for participants was done between close contacts and in Facebook.

A nonexistence of sample diversity is a huge gap on this research field, so researches with a higher diversity will strengthen the literature in this topic (Coutinho et al., 2020). In order to achieve so, sample diversity was assured: both genders represented; different ages represented; local and international participants; different education levels; public and private healthcare units represented.

The target population of the present investigation were the users of private healthcare units and/or public healthcare units. Within this population and in order to make the present study feasible, it was important to collect a sample.

This study comprised of 36 individual semi-structed interviews. The research topic was explored from the participants' point of view to reach an abductive approach which brought new theoretical ideas and hypotheses based on empirical data to light.

The sociodemographic data obtained refers to age, gender, nationality, level of education and occupation. The research participants' profile is presented in *appendix II* and in *table IV* there is a sample characterization.

Regarding gender, 55.56% of respondents were female and 44.44% male. Concerning the age group, the highest percentage refers to individuals in the age group 25-34 years old (44.44%), followed by the individuals who are 18-34 years old (27.78%) and individuals who are 50-64 years old (16.67%). The lowest percentage refers to individuals in the age group 35-49 years old and ≥65 years old, each one with 5.56%.

Regarding nationality, 72.22% of individuals were Portuguese, 8.33% Brazilian and one participant of the following nationalities was also included: Canadian; Czech; Pakistani; Serbian; South African and Turkish.

About educational level, 69.44% of respondents had a bachelor's degree, 11.11% a master's degree, 8.33% a PhD, 5.56% primary education and 5.56% lower secondary education.

Regarding to occupation, 6 participants were students (16.67%) and 1 (2,78%) was retired. The leftovers respondents worked in the following sectors: management (38.89%), education (13.89%), healthcare (11.11%), hospitality (8.33%), sales (5.56%) and transports (2.78%)

Regarding the healthcare sector chosen to report their experience, 55.56% chose private sector and 44.44% the public sector. The typology with higher percentage was hospitals (63.89%), followed by healthcare centres (16.67%), clinics (13.89%) and laboratories (5.56%).

The medical speciality with more participants was the emergency room (22.22%), followed by family medicine (13.89%). More medical specialities were identified like: cardiology (8.33%), dentistry (8.33%), gynaecology (5.56%), ophthalmology (5.56%), orthopaedics (5.56%), psychiatry (5.56%), surgery (5.56%) and continuous care (2.78%). Nutrition (2.78%) and physiotherapy (5.56%) it had also been reported. In the medical exams field, COVID-19 tests (5.56%), nuclear medicine exams (2.78%) and radiology exams (2.78%) were identified.

Table IV - Sample characterization.

	Indicator		**Absolute frequency (n=36)**	**Relative frequency (%)**
Sociodemographic data	**Gender**	Male	16	44.44%
		Female	20	55.56%
	Age	18-24	10	27.78%
		25-34	16	44.44%
		35-49	2	5.56%
		50-64	6	16.67%
		≥65	2	5.56%
	Nationality	Australian	1	2.78%
		Brazilian	3	8.33%
		Canadian	1	2.78%
		Czech	1	2.78%
		Pakistani	1	2.78%
		Portuguese	26	72.22%

		Serbian	1	2.78%
		South African	1	2.78%
		Turkish	1	2.78%
	Education level	Primary education	2	5.56%
		Lower secondary education	2	5.56%
		Bachelor	25	69.44%
		Master	4	11.11%
		PhD	3	8.33%
	Occupation	Education	5	13.89%
		Healthcare	4	11.11%
		Hospitality	3	8.33%
		Management	14	38.89%
		Retired	1	2.78%
		Sales	2	5.56%
		Student	6	16.67%
		Transports	1	2.78%
Sector		Public	16	44.44%
		Private	20	55.56%
Type of unit		Clinic	5	13.89%
		Health Centre	6	16.67%
		Hospital	23	63.89%
		Laboratory	2	5.56%
Medical speciality		Cardiology	3	8.33%
		Continuous Care	1	2.78%
		COVID-19 tests	2	5.56%
		Dentistry	3	8.33%
		Emergency Room	8	22.22%
		Family Medicine	5	13.89%
		Gynaecology	2	5.56%
		Nuclear Medicine	1	2.78%
		Nutrition	1	2.78%
		Ophthalmology	2	5.56%
		Orthopedy	2	5.56%
		Physiotherapy	2	5.56%
		Psychiatry	1	2.78%
		Radiology	1	2.78%
		Surgery	2	5.56%

Source: Own elaboration.

3.5. Data analysis

The thematic content of all the transcripts was analysed with QSR International's NVivo qualitative data analysis software. The interview material was analysed following a six-step procedure to ensure trustworthiness, through an iterative and reflective process developed over time. Phase I included data preparation to ensure that all transcripts were include in the analysis. Phase II was about generating initial codes based on the literature findings, notably the concepts presented in *figure I*. Phase III included searching for themes to which a set of hierarchical categories were added, nodes in NVivo. In phase IV new subordinate categories were added and refined according to the findings from iterative readings. In phase V all themes were revisited to make some re-coding and minor refinements. Phase VI was about producing the report as we can see in the next chapters (Nowell et al., 2017).

Saturation is the most common tool for assessing the adequacy of samples in qualitative research (Hennink & Kaiser, 2022). Saturation can be defined as the point at which collecting more data about a theorical construct reveals no new issues or insights, meaning that the conceptual categories that comprise the theory are saturated (Bryant & Charmaz, 2010, p. 611). As a consequence, saturation is an important indicator that the sample is adequate for the phenomenon studied, demonstrating validity and rigor (O'Reilly & Parker, 2013). However, a suitable sample size in qualitative research is an area of debate and constitutes some practical uncertainty. To diminish this uncertainty researchers should be transparent about evaluations of their sample size sufficiency (Vasileiou et al., 2018). For those reasons 3 different approaches to assess saturation were applied:

Saturation point

Many scholars have used empirical research and mathematical models to answer the question about how many qualitative interviews are enough. In this context, a recent method was developed to assess and report saturation in the context of abductive thematic analyses. This approach includes three primary elements on its calculation and assessment: base size, run length and new information threshold (Guest et al., 2020).

The base size refers to what the minimum number of interviews is (data collection event) that we should review to calculate the amount of information already gained, which is defined in literature to be between 4 to 6 interviews. In this research our base size was 4 interviews. The run length is the number of interviews which we look to calculate new information and

for this research the run length was 2. According to this method, the new information threshold represents the proportion of new information that we should accept as evidence that saturation has been reached: ≤5% new information and no (0%) new information (Guest et al., 2020).

In operational terms, the saturation point was calculated as follows:

1. The number of unique themes for base was found: 34

Interview number	I01	I02	I03	I04
New themes per interview	17	9	6	2
Base themes				**34**

2. The number of unique themes for the first run was found: 6

Interview number	I05	I06
New themes per interview	5	1
Base themes		**6**

3. The saturation ratio was calculated: 17.65%

New themes/run	6	**17.65%**
Base themes	34	

The quotient reveals 17.65% new information. This is not bellow our ≤5% threshold, so we continue:

4. The number of unique themes for the next run in the series was found and the saturation ratio was updated. At this point, the proportion of new information added by the last run is bellow the 2.94% ≤ 5% threshold we established, meaning that the amount of new information is diminishing.

Interview number	I06	I07
New themes per interview	1	0
Base themes		**1**

New themes/run	1	**2.94%**
Base themes	34	

Since the last two interviews did not add substantially to the body of information collected, we can say that saturation point was reached at interview 5. Even though we know that the rate at which new information emerges decrease over time and that the most common and salient themes are generated early, we decided to continue with the interviewing process to assure that new themes emerging later in the data collection process were not missed and to achieve sampling requirements and richness and volume of data.

Meeting sampling requirements

We also have tried to achieve the maximum variation sampling in terms of participant social demographical data (Vasileiou et al., 2018). The recruitment continued until sampling frame requirements were met for diversity in gender, age, nationality, education level and occupation. We have also tried to find a balance between the number of participants who chose the public healthcare sector and the private healthcare sector.

Richness and volume of data

The richness, detailed nature and data volume was also a request (Vasileiou et al., 2018). The material collected was considerable and extremely detailed. When a high degree of consensus had begun to emerge among those interviewed the number was felt to be sufficient to satisfy the aims of this investigation.

4. Results and analysis

The main findings herein presented follow the two research questions and related themes: what is the role of (e)WOM before healthcare services' consumption and what is the role of (e)WOM after healthcare services' consumption to contribute to our understanding about the role of (e)WOM on healthcare services consumption. The main codes identified with NVivo software are represented in the next table:

Table V – Codes/themes identified with NVivo software.

Codes	**Absolut frequency (n)**
Expectations of healthcare services prior consumption	
Hospital brand image - description	
Positive description	25
Negative description	6
Mixed description	5
WOM exposure	
Tradicional WOM	13
e-WOM	12
Traditional WOM and e-WOM	6
No exposure	5
Comparation with other units	31
WOM on waiting room	2
Role of doctor in WOM	5
WOM valence	
Recall of positive WOM	20
Recall of negative WOM	18
The most impactful message	-
Positive	12
Negative	10
Both	1
No impact	0
WOM source credebility	
Consumers	23
Firms	5
Consumers' and firms' content	8
WOM consumer identification	
Positive relationship	23

Negative relationship	5
Neutral relationship	8
Expectations of service quality	
High expectations	28
Low expectations	8
Perceptions of healthcare services before consumption	
Perceptions of service quality	
Overall experience	-
Positive	25
Negative	7
Mixed	4
Did the quality experienced exceed expectations	-
Was higher	17
Was lower	7
Was equal	12
Quality dimensions	36
Patient satisfaction	
Satisfaction level	36
Will recomend this unit	0
Yes	33
No	3
WOM spread	
Traditional WOM	29
e-WOM	2
No spreading	5
Why people spread more negative WOM than positive?	2
Loyalty and repurchase intention	
Would you use this unit again?	-
Yes	35
No	1
Consider trying another institution?	-
Yes	18
No	18

Source: Own elaboration.

To have a better understanding of the relationships between the different themes, a comparative table was made (Creswell, 2009):

Table VI – Relations between the different themes.

Participant	Hospital brand image	WOM exposure	WOM valence	WOM source credibility	WOM consumer identification	Expectations	Overall experience	Did the quality exceed expectations?	Would you recommend this unit?	WOM spread	Would you consider using this unit again?	Would you consider trying another unit?	Type of unit
I01	Positive	WOM	Positive	Consumers	Positive	High	Positive	Higher	Yes	WOM	Yes	Yes	Private
I02	Negative	No	Negative	Consumers	Neutral	Low	Positive	Equal	No	WOM	Yes	No	Public
I03	Mixed	Both	Both	Both	Neutral	High	Positive	Equal	Yes	WOM	Yes	Yes	Private
I04	Positive	WOM	None	Consumers	Neutral	High	Positive	Higher	Yes	WOM	Yes	No	Private
I05	Negative	e-WOM	Negative	Consumers	Neutral	High	Positive	Higher	Yes	None	Yes	Yes	Public
I06	Mixed	WOM	Both	Consumers	Negative	High	Positive	Higher	Yes	WOM	Yes	Yes	Public
I07	Positive	WOM	None	Consumers	Positive	High	Positive	Higher	Yes	WOM	Yes	Yes	Private
I08	Positive	WOM	Both	Both	Positive	High	Positive	Equal	Yes	WOM	Yes	Yes	Private
I09	Positive	WOM	Both	Consumers	Positive	High	Positive	Higher	Yes	WOM	Yes	Yes	Public
I10	Positive	Both	Positive	Consumers	Positive	Low	Mixed	Equal	Yes	None	Yes	Yes	Private
I11	Positive	Both	Negative	Firms	Positive	High	Negative	Lower	Yes	None	Yes	Yes	Private
I12	Positive	Both	Both	Both	Positive	Low	Positive	Higher	Yes	WOM	Yes	Yes	Private
I13	Negative	WOM	Negative	Consumers	Positive	High	Positive	Equal	Yes	WOM	Yes	No	Public
I14	Positive	No	None	Firms	Positive	High	Positive	Higher	Yes	WOM	Yes	No	Private
I15	Negative	WOM	None	Consumers	Neutral	High	Positive	Equal	Yes	WOM	Yes	No	Public

I16	Positive	Both	Positive	Consumers	Positive	Low	Negative	Lower	Yes	WOM	Yes	Yes	Public
I17	Positive	e-WOM	Negative	Consumers	Positive	High	Positive	Equal	Yes	WOM	Yes	No	Private
I18	Positive	WOM	Negative	Both	Positive	High	Positive	Higher	Yes	WOM	Yes	No	Public
I19	Negative	e-WOM	Both	Consumers	Negative	Low	Positive	Equal	No	WOM	Yes	Yes	Public
I20	Positive	e-WOM	Positive	Consumers	Positive	High	Positive	Higher	Yes	WOM	Yes	Yes	Private
I21	Positive	Both	Positive	Consumers	Positive	Low	Mixed	Higher	Yes	None	Yes	No	Private
I22	Negative	e-WOM	Negative	Firms	Negative	High	Negative	Lower	No	WOM	No	Yes	Public
I23	Mixed	WOM	None	Both	Negative	High	Positive	Equal	Yes	WOM	Yes	Yes	Public
I24	Positive	WOM	Both	Consumers	Positive	High	Positive	Equal	Yes	WOM	Yes	No	Public
I25	Positive	e-WOM	Positive	Consumers	Neutral	High	Positive	Equal	Yes	WOM	Yes	No	Private
I26	Positive	e-WOM	Both	Both	Positive	High	Negative	Lower	Yes	WOM	Yes	No	Private
I27	Mixed	No	None	Consumers	Neutral	High	Negative	Lower	Yes	WOM	Yes	Yes	Public
I28	Positive	No	None	Consumers	Neutral	High	Negative	Lower	Yes	None	Yes	Yes	Public
I29	Mixed	WOM	Negative	Both	Positive	High	Mixed	Higher	Yes	WOM	Yes	No	Public
I30	Positive	e-WOM	Positive	Both	Positive	High	Mixed	Higher	Yes	WOM	Yes	No	Private
I31	Positive	e-WOM	None	Consumers	Positive	Low	Positive	Higher	Yes	WOM	Yes	No	Private
I32	Positive	e-WOM	Both	Consumers	Positive	High	Positive	Higher	Yes	e-WOM	Yes	No	Private
I33	Positive	e-WOM	Both	Consumers	Positive	High	Positive	Higher	Yes	e-WOM	Yes	No	Private
I34	Positive	WOM	Positive	Firms	Positive	High	Positive	Equal	Yes	WOM	Yes	No	Private
I35	Positive	e-WOM	Positive	Consumers	Positive	High	Positive	Higher	Yes	WOM	Yes	Yes	Private
I36	Positive	No	Positive	Firms	Positive	Low	Negative	Lower	Yes	WOM	Yes	No	Public

Source: Own elaboration.

All the different categories were analysed in the light of the social identity theory, always relating to the role of WOM. The main findings herein presented follow the research questions and related themes to understand the role of (e)WOM before and after healthcare services consumption.

The role of (e)WOM before healthcare services' consumption

Word of mouth

Exposure

Participants were asked if they looked for information about healthcare institutions and what source they used to have access to that information. Most of the participants have looked for information about a specific health care provider and its services (n=31). The main channels used were face-to-face interactions and electronic channels. The participants who were exposed to traditional WOM (n=13) from friends and relatives said that prefer this source for a "question of trust" in a person that had previous experience with a specific health unit.

I have informed myself with relatives and friends. It is a question of trusting and there's no one better than those who are the closest to us. (I01)
I've only recurred to friends and relatives. The question of the family's doctor is of the essence. Do I know him? Can I trust him? A substantial amount of feedback concerning the doctors who work there is very good, in terms of word-of-mouth. (I09)

The participants that were exposed to e-WOM (n=12) were looking for a more specific and detailed data about a certain service. The main sources were Google Review, Facebook, and website of the healthcare institution. The participant from Australia also identified Care Opinion Australia as a source of e-WOM.

Yes, I found this lab through a Google search putting "labs near me". Then I saw the reviews I had on Google, and people said it was very good, with fast results and caring professionals. (I25) **Google Review**
Yes, what treatments do they do and their benefits. They put this kind of information on Facebook and I'm curious to learn more about the services that exist. (I20) **Facebook**
Yes, I'm mainly looking for the doctor's résumé. It will help to solve my problem and verify the type of

experiences you have already had in your clinical practice, to be able to help me in the best way. (I26)

Website of the healthcare institution

I start to look about mental hospitals during the pandemic because I was with mental issues. So, in the website "Care Opinion Australia", which is an independent site where anyone can share their stories about their experience of care, I looked for health services and read personal experiences, good or bad, of the care system. So many people talked good about (name of healthcare institution) that I decided to make an appointment. (I33)

Specific platforms for sharing information about healthcare services

The participants that combined traditional WOM with e-WOM (n=6) had done it to combine the last two justifications: trust plus more detailed information.

For me, when it comes to health issues, word of mouth doesn't happen at the moment when you need something, but it happens in a more intense way before in the past and then you remember said word of mouth. I always go to the Internet as an alternative. First, I ask my friends and relatives. If I don't have the information, then I go to the Internet. Or I go to the Internet to search for complementary information. Nevertheless, when the search is only based on the Internet, it is more difficult, because there is no relationship of trust as that with friends and relatives. (I03)

5 participants refer that they did not look for recommendations and the two main reasons for that were that, as some of them are healthcare professionals, they are their own recommendation, and that for simple procedures (e)WOM is not necessary.

Regarding to (e)WOM exposure, participants also mentioned 3 additional important factors not identified when the conceptual framework was elaborate: the comparison with other units; the WOM on waiting room; the role of the doctor on WOM.

Some participants said that they can be their own source of WOM by establishing comparation with other units (n=31). People remember their previous experiences and make comparisons in terms of waiting times and the healthcare professionals' care:

In services, when I establish comparisons, I use the following topics: waiting times and if I'm taken in by the right person at the right time. (I09)

Participants I05 and I09 mentioned an important aspect related to the WOM generated in the waiting room and how this could condition their expectations:

I remember arriving there and hearing people complaining that there was only one person taking you in, doctors were late and that the delays were not communicated to the patients. When a doctor is good and has 500 scheduled appointments, it is enough for one to be missed and everything becomes delayed. Consequently, a negative word-of-mouth is generated in the waiting room. This is true because most people tend to relate to one another when they speak ill about things. It has already happened to me to be in the waiting room and someone asking me, "What doctor are you coming to?". After I said the doctor's name, they told me, "That one is quite rude." I entered the appointment expecting the worst, thinking that I was not even hearing a "good day", but the opposite ended up happening. It is very difficult to filter that and not to be conditioned by it. You haven't yet gone there, and you already don't want to go because you know that it is bad. (I09)

5 participants revealed that when they are looking for healthcare recommendations, they are not looking for an institution but for a doctor:

Medical care makes all the difference, it's what will bring you security throughout the procedure, a good conversation is half a cure. When the doctor is attentive, caring, and professional, the patient feels safe. If we are going to analyse in health, what we most recommend is a doctor and not an institution. The doctor has a fundamental role and only then does the institution come because you can have a good doctor and the other professionals are not capable, destroying the whole experience.

If something goes wrong and if the doctor is good, the situation will be eased:

On the other hand, we may also think that the procedure is possible to fail in technical terms and so we may think that "that doctor is worthless" but if he/she is a person that is willing to assume his/her mistakes and to work with you, you will think otherwise. When you have this type of treatment, you won't change your doctor because you know that it is rare to find one like that. The risk to lose this closer interpersonal relationship is not worth taking. (I09)

In short, the receivers of (e)WOM, could have access to information if they had actively sought for information or by someone else that is reporting some experience and they will use this information on the future. And about, the senders of (e)WOM, what are the main reasons to do it? These motives could altruistic (concerning in helping the others) or egoistic (venting negative feelings) (Martin, 2017):

In general, my whole family uses (name of the hospital) and they say it works well, it is safe, fast and you don't have to wait. You receive a "cleaner" treatment. (I08) **Altruistic motivations**
A friend of mine was operated on a cyst on her chest, but she was taken in at the end of a shift and everything went wrong. They were in a rush and were not humane at all with her. I've also heard that she developed bruises and had a lot of pain, even though I am not aware if that is normal or not. She was not ready for that, though. (I03) **Egoistic motivations**

Valence

Participants were able to similarly recall both episodes of positive and negative (e)WOM regarding healthcare institutions. The main positive episodes (n=20) were related with the way that friends and family were treated in healthcare institutions. Otherwise, the negative episodes (n=18) were about waiting times and medical procedures that went wrong:

When asked about the most impactful message received through (e)WOM, the positive or negative one, participants were divided. It seems that both (positive (n=12) or negative (n=10) messages) will influence patient expectations prior to a visit to a healthcare unit.

Source credibility

Participants were asked about what the most credible source on the Internet is for looking up recommendations about healthcare services. Most of participants (n=23) mentioned that the other consumers' content is more credible, 5 identified the firms' content as the most credible source and 8 considered both (the consumers' and the firms') credible.

Participants consider consumers' content as more authentic than the firms' content, but some of them said that is important to evaluate the quality of the comment:

I think it is the one from consumers, as long as we can see that they are, in fact, real people and not bots, such as some kind of fake account created by the company to promote itself. Well, it is what they want to promote and so it will always be biased. (I01)
Other consumers, but only after a careful analysis. If it is a comment which is quite detailed and with relevant information, I pay attention to it. However, if we are talking about "cheap" comments such as "I liked/didn't like it", I do not pay attention. In this latter case I prefer to recur to my friends and family members since I trust them more than strangers. (I16)

The main reason illustrated to consider the firms' content more credible was that healthcare is a very delicate field and professionals' opinion is more appropriated, and most consumers do not have enough knowledge to talk about it:

The hospitals, for sure. I think that, when it comes to healthcare services, the topic is quite more delicate, and the opinions are a little bit more biased. On the other hand, if we are talking about trips, I look for opinions from other consumers. (I11)

Some consumers classified consumers' content as a complement of the firms':

Institutions, because the consumer's opinion is subjective from the start. What for me is a good service for someone else may not be so. The services would all go well if there were no people. But for example, if the initial results of a Google search for an institution also show sites like "Portal da Queixa", then I'm curious to see what's going on. (I18)

Consumer identification

Participants were asked to define their relationship with the healthcare institution to understand their identification with a brand. Most of participants (n=23) mentioned that they had had a positive one, 5 a negative one and 8 a neutral relationship. "Trust", "safety", "humanization of care" and "flexibility" were the main words used to describe a positive relationship with a certain healthcare institution:

Trust, because after the experience that I had, I feel as though that, if I come back there, I will be well taken care of and my problem will be given attention to. (I07)

"Disorganization" and "distance" were the 2 words used to describe a negative relationship. The main reason for a neutral relationship is that the experiences do not have a pattern of quality:

Ambivalent and dissonant, there are good days and bad days. (I15)
(…) *the way people treat you in healthcare services always depends on the person that will take care of us.* (I03)

Hospital brand image

To evaluate the hospital brand image, participants were asked to describe the healthcare institution chosen to talk about. Regarding the description of the healthcare institution, most of the participants (n=25) made a positive description, 6 a negative description and 5 a mixed description. The main aspects about the institution were related to infrastructures, human resources, and administrative procedures.

From these 25 positive statements, only 6 of them were about the public sector. Regarding the infrastructures, many participants refer the modern facilities, hygiene, and organization as positive. All the participants mentioned caring healthcare professionals. In terms of administrative procedures, protocols with insurances were referenced as a positive aspect when going to private facilities. The schedule availability and easiness of making the appointment (through an application) were also mentioned:

It has modern facilities and good infrastructures. The healthcare professionals treat you very well in general. Even when it comes to its administrative services, those are good as well. They have something very advantageous, which is their card, which allows any person to have a discount (…) They also offer some insurances of their own, which seem to have some interesting perks, even though I have never adhered to any. In terms of the scheduling of appointments, this is also good and normally it is even possible to schedule an appointment on its eve because they have a lot of schedule availability. The scheduling has to be done through the app and it's only a question of 3 minutes. One chooses the facilities, speciality, doctor and the schedule that one wants. It is easily schedulable from one day to the other. (I01)

All the negative descriptions mentioned were about the public sector. The main complaints were about administrative procedures and waiting lines. Issues about the way that healthcare professionals take patients in were also mentioned.

There are always administrative and internal management issues that make the process difficult and not exactly the medical care. The family doctor is spectacular and there is a great relationship of closeness and trust with her. It's a health centre that doesn't answer phone calls, you must make complaints so that we can be tended to. Regarding my family doctor, I send her an email and she gives me an immediate response, with a clear discrepancy between the administrative part and the medical part. (I15)
However, the human resources should be more humane with people. "A good way of tending to people is half-healing for the patient". In the private sector they treat people better because you're paying for it. If we are talking about the blood donation unit, then everything is different. The treatment is completely different since we are carrying out a service to the hospital. As we are helping, we are better taken care of. (I13)

The 5 participants that made a mixed description essentially talked about the unbalance in the professionalism of different teams:

> *The quality is determined by the professionals who are working there, they can be very good or very bad. Facilities are good. It takes a long time, except if you are referred by the SNS 24.* (I29)

When talking about healthcare facilities, participants mentioned some differences between the public and private sector in terms of waiting lines and price:

> *In general terms, I don't think they're great, but the private sector works better than the public one. This is even truer if we have insurance, which is great, because I don't think that the price is well adjusted to the service, because it's not a luxury one (…) I think that the greatest difference is regarding the waiting times.* (I08)

Participants I01, I03, I12 and I29 also mentioned that for complicated healthcare issues they prefer the public sector:

> *Nevertheless, I have the perfect notion that some things are only available in the public sector: intensive care units, if one stays in a coma, if you have a very grave complication, a cardiorespiratory arrest, births… The private sector has no capability for that.* (I03)

Participant I12 also mentioned that private hospitals refer patients to public hospitals in cases of very serious situations, in which death is a possible scenario, to be well positioned in the rankings:

> *I have friends who are doctors and who tell me that, when someone is in a bad way in private hospitals, they always send them to the public hospital right away because the fatality numbers are inferior. This is for them to be better positioned in the statistics.* (I12)

From the 20 private units identified by the participants, 19 had a positive hospital brand image and 1 a mixed hospital brand image. From the 16 public units identified, 6 had a positive hospital brand image, 6 a negative one and 4 a mixed one.

Participants were also asked about the impact of COVID-19 in healthcare services. The higher digitalization in the healthcare sector is seen as a good aspect of COVID-19. However, for the participants, the digitalization must be a complement and not a substitute:

In it there has been more openness towards the hybrid systems, such as tele-appointments. I think they aren't going anywhere anytime soon. They are indeed a new addition to healthcare services. (I12)

As negative aspects of COVID-19, participants emphasized: longer waiting times; rescheduling or cancelled appointments; social distancing. Only 3 participants mentioned that there were no changes.

However, not only does hospital brand image depend on the functional aspect of the service like the main aspects pointed out by the participants related to infrastructures, but also human resources, administrative procedures, and differences between public and private sector play a major role on brand image. Hospital brand image is also influenced by social factors (Cham, Lim, et al., 2021). Thus, in the social factors, the information shared by consumers regarding the healthcare institution, defined as (e)WOM, will influence hospital brand image.

Hospital brand image and (e)WOM valence

Participants were asked about the valence of the (e)WOM that they had accessed previously to the experience. All the participants (100%) that remembered positive episodes of (e)WOM regarding healthcare institutions had a positive hospital brand image. Most participants that remembered negative episodes of (e)WOM had a negative hospital brand image (50%). Participants that remembered positive and negative episodes had essentially a positive hospital brand image (70%). Participants that did not remember any (e)WOM about the institution had essentially a positive hospital brand image (62,5%) *(see table VII)*. As said by participants I16 and I19:

The positive ones (WOM) influence the desire to go there as a first reference. Consequently, to continue the service I would say no, that depends on my experience. (I16)
It influences my expectations negatively (negative WOM), but I am not afraid to go to the hospital. Lower expectations but the relationship of trust remains. (I29)

Table VII – (e)WOM valence and hospital brand image.

(e)WOM valence	Hospital brand image		
		n	%
Positive (n=10)	Positive	10	100
Negative (n=8)	Positive	3	37,5
	Negative	4	50
	Mixed	1	12,5
Positive and negative (n=10)	Positive	7	70
	Negative	1	10
	Mixed	2	20
No WOM (n=8)	Positive	5	62,5
	Negative	1	12,5
	Mixed	2	25

Source: Own elaboration.

Hospital brand image and (e)WOM source credibility

Participants were asked about the source credibility of the (e)WOM that they had accessed previously to the experience. The participants that considered consumer's (e)WOM as more credible had essentially a positive hospital brand image (69,67%). The higher positive hospital brand image relative frequency (80%) was illustrated by people who consider the firm's content as more credible, because the firms always try to pass a positive image. The participants that consider both sources as credible did not mention any negative hospital brand image, because consumers and firms' content acts as complementary sources and this helps to minimise the uncertainties related to the institution quality that could possibly lead to a negative hospital brand image (*see table VIII)*.

Table VIII – (e)WOM source credibility and hospital brand image.

(e)WOM source credibility	Hospital brand image		
		n	%
Consumers (n=23)	Positive	16	69,57
	Negative	5	21,74
	Mixed	2	8,70
Firms (n=5)	Positive	4	80
	Negative	1	20
Both (n=8)	Positive	5	62,5
	Mixed	3	37,5

Source: Own elaboration.

Hospital brand image and (e)WOM consumer identification

Participants were asked about their relationship with the institution. The participants who had essentially a positive relationship with the healthcare institution had a positive hospital brand image (91,27%). Participants who had a negative relationship with the institution were divided between negative hospital brand image (50%) and mixed hospital brand image (50%). Participants who had a neutral relationship with the institution had 3 possible types of hospital brand image: positive (37,5%), negative (37,5%) and mixed (25%) *(see table IX)*.

Table IX – (e)WOM consumer identification and hospital brand image.

(e)WOM consumer identification	**Hospital brand image**		
		n	%
Positive (n=24)	Positive	22	91,67
	Negative	1	4,17
	Mixed	1	4,17
Negative (n=4)	Negative	2	50
	Mixed	2	50
Neutral (n=8)	Positive	3	37,5
	Negative	3	37,5
	Mixed	2	25

Source: Own elaboration.

Hospital brand image and perceived service quality

In this study, out of the 25 participants that made a positive description about the healthcare unit, 19 of them had high expectations and 6 low expectations regarding the service quality. From the 6 participants that made a negative description about the healthcare unit, 4 of them had high expectations and 2 low expectations regarding the service quality. All the 5 participants that made a mixed description had high expectations. Concerning evaluation of the service after consumption, out of the 25 participants that made a positive description, 17 of them had a positive experience, 5 a negative experience and 3 a mixed experience. From the 6 participants that made a negative description, 5 had a positive experience and 1 a negative one. From the 5 participants that made a mixed description, 3 had a positive experience, 1 a negative one and 1 a mixed one *(see table X)*. Thus, it is possible to verify that although different hospital brand images exist, the majority of participants had high expectations (n=28) and a positive overall experience (n=25).

Table X – Hospital brand image, expectations, and overall experience.

Hospital brand image	**Expectations**			**Overall experience**		
		n	%		n	%
Positive (n=25)	High	19	76	Positive	17	68
	Low	6	24	Negative	5	20
				Mixed	3	12
Negative (n=6)	High	4	66,67	Positive	3	50
				Negative	1	16,67
	Low	2	33,33	Positive	2	33,33
Mixed (n=5)	High	5	100	Positive	3	60
				Negative	1	20
				Mixed	1	20

Source: Own elaboration.

Perceived service quality

Expectations

People were asked about their previous expectations before the healthcare service consumption. Most of them (n=28) mentioned high expectations and 8 low expectations. The main high expectations were related to previous experiences, previous recommendations, waiting lines and the role of healthcare professionals.

My expectation continues to be grounded on the great services that I have always experienced. I hope not to get disappointed. (I01)
They were high because the recommendations were also high and also because it is a renowned clinic. (I10)
Let it be fast (waiting time), because I have already waited longer than I thought that a private service is supposed to wait. I also hope to get out of there with my problem solved. (I18)
Professionalism from the staff and efficiency. (I33)

The low expectations were related to waiting lines and previous bad experiences:

I was expecting having to ask for the yellow book to be able to have access to an appointment. For me, it is always with anxiety and nervous that I go to the health Centre as I have to wake up early to have access to the booking of an appointment. The administrative process is always quite complicated. (I15)

The role of (e)WOM after healthcare services' consumption

Overall experience

Concerning the experience itself, most of participants (n=25) had a positive experience, 7 a negative one and 4 a mixed experience.

Out of the 25 participants that had an overall positive experience: 9 of them had previous high expectations and considered that the quality was equal to their expectations; 12 had previous high expectations and considered that the quality exceeded their expectations; 2 had previous low expectations and considered that the quality exceeded their expectations; 2 had previous low expectations and considered that the quality was equal to their expectations.

From the 7 participants that had an overall negative experience: 5 of them had previous high expectations and considered that the quality was lower to their expectations; 2 had previous low expectations and considered that the quality was lower to their expectations.

Out of the 4 participants that had a mixed overall experience: 2 had high expectations and consider that the quality exceeded their expectations; 1 had low expectations and considered that the quality was equal to their expectations; 1 had low expectations and considered that the quality exceeded their expectations *(see table XI)*.

Table XI – Perceived service quality and expectations.

Overall experience	**Expectations**			**Did the quality exceed expectations?**		
		n	%		n	%
Positive (n=25)	High	21	84	Higher	12	48
				Equal	9	36
	Low	4	16	Higher	2	8
				Equal	2	8
Negative (n=7)	High	5	71,43	Lower	5	71,43
	Low	2	28,57	Lower	2	28,57
Mixed (n=4)	High	2	50	Higher	2	50
	Low	2	50	Higher	1	25
				Equal	1	25

Source: Own elaboration.

In short, most of the participants that had a positive experience, had previous high expectations and considered that the quality exceeded or equalled their expectations (84%).

And most the participants that had a negative experience, had previous high expectations and considered that the quality was lower to their expectations (71,43%).

Quality dimensions

Participants were also asked to evaluate quality dimensions (physical environment, interpersonal relations, technical procedure, administrative procedure, quantity of services, communication of the service, price and access and convenience) in a scale 1-5 to compare the qualitative data with this one. A mean of these 8 quality dimensions was made. Participants were also asked to evaluate their satisfaction level in a scale 1-5. Comparing the mean of quality dimensions and the satisfaction level, some participants had a higher mean and a lower satisfaction level and vice versa, meaning that some dimensions of quality have a higher impact than others *(see table XII)*.

Table XII – Quality dimensions and level of satisfaction.

Participant	Physical environment	Interpersonal relations	Technical procedure	Administrative procedure	Quantity of services	Communication of the service	Price	Access and convenience	Mean	Level of satisfaction
I01	5	5	5	4	3	5	4	4	4,375	5
I02	3	3	3	3	4	3	4	4	3,375	3
I03	4	3	2	4	5	2	1	5	3,25	3
I04	5	4	4	5	5	4	3	5	4,375	5
I05	5	3	4	1	2	2	3	5	3,125	2
I06	3	2	5	1	3	1	4	5	3	3
I07	5	4	4	5	5	5	4	4	4,5	4
I08	4	4	5	5	5	4	3	5	4,375	4
I09	3	4	4	4	3	4	4	3	3,625	4
I10	4	5	5	4	5	4	4	3	4,25	5
I11	5	4	4	4	4	5	3	5	4,25	5
I12	4	5	5	5	5	4	3	5	4,5	5
I13	4	3	3	2	4	3	5	2	3,25	4
I14	5	5	5	5	5	5	5	4	4,875	5

I15	3	3	5	2	3	3	5	4	3,5	3
I16	4	4	5	4	4	5	3	4	4,125	4
I17	4	5	5	4	5	5	5	4	4,625	4
I18	4	5	5	4	4	3	4	5	4,25	5
I19	4	2	3	3	5	2	5	5	3,625	3
I20	4	5	5	5	4	4	4	3	4,25	4
I21	2	5	4	5	5	4	5	5	4,375	4
I22	2	1	1	4	1	2	5	4	2,5	1
I23	3	4	5	2	4	4	5	4	3,875	3
I24	5	5	5	4	3	4	4	3	4,125	5
I25	5	4	5	4	4	4	4	5	4,375	4
I26	4	4	4	4	5	4	5	4	4,25	3
I27	3	3	4	2	3	3	5	4	3,375	3
I28	4	5	4	5	5	4	5	5	4,625	5
I29	4	5	5	5	0	5	5	5	4,25	5
I30	5	4	5	5	5	5	4	5	4,75	5
I31	5	4	5	4	5	4	5	5	4,625	5
I32	4	5	4	4	5	4	3	5	4,25	4
I33	4	5	5	5	5	4	5	5	4,75	5
I34	5	5	5	5	5	5	3	5	4,75	5
I35	4	4	4	4	4	4	5	5	4,25	4
I36	4	4	4	4	4	4	5	5	4,25	4

Source: Own elaboration.

Concerning the corporate social responsibility, only 11 participants had knowledge about some activities developed by the institutions like: volunteering programs; home support; health education workshops; donations to people in need; discounts for employees and family members. Participants considered this type of activities important.

Patient satisfaction

As said previously, participants were asked to evaluate their satisfaction level in a scale 1-5. Participants that had a negative experience have a satisfaction level mean of 2,67, a mixed experience a mean of 3,5, a positive experience a mean of 4,42.

To have a deep understanding of this topic, participants were also asked if they recommend the healthcare institution chosen to talk: 33 said "yes" and 3 said "no". From these 33 participants, 26 had a positive experience, 4 a negative experience and 3 a mixed experience. From the 3 participants that would not recommend this unit, 2 had a negative experience and 1 a mixed experience. Customers whose needs are satisfied have a higher probability of convincing other people to try that service.

(e)WOM spread

Participants were asked if after the experience they shared a message about what happened and what source they chose to share: traditional WOM or e-WOM.

From the 29 participants shared a message by traditional WOM with their friends and relatives, 23 had a positive experience, 4 a negative experience and 2 a mixed one.

Only 2 international participants (I32 and I33) shared an electronic message about their experience. Participant I32 made a comment on Google Review and I33 made a post on Care Opinion Australia. Both of participants had previous high expectations, a positive experience and consider that the quality exceeded their expectations.

From 5 participants that did not share any information, 1 had a positive experience, 2 a negative one and 2 a mixed one.

Concerning the spread of negative WOM, people were asked about the main motivations for spreading negative opinions. 4 justifications were identified:

Dissatisfaction as a motivator:

> *On the Internet, people post more when they are very dissatisfied because "dissatisfaction is a powerful motivator". For example, people do not go out on strike because they are dissatisfied.* (I23)

People fear complaining face-to-face:

> *People want to complain and since they don't do it face to face they hide behind a screen.* (I24)

The facilities themselves encourage negative comments:

> *I think that usually, in all areas, we are always more inclined to comment on the negative than the positive. However, certain online platforms also encourage this because they have a place to place a "complaint" but no place to insert a "compliment".* (I22)

There are 3 important lines:

> *Since people are more likely to leave negative information than positive, because whenever people try a certain service, they always have an expectation, and there is a limit to whether the experience is successful or not, I would say this range goes from neutral to good. For the person to leave a positive comment the following must be true: either the person has this habit, or the service was very good, exceeding expectations. For the person to leave a negative comment this happened: he/she had an experience below neutral.* (I25)

Loyalty and repurchase intention

To evaluate loyalty and repurchase intention participants were asked if they would use the healthcare unit again and if they consider trying another healthcare facility. Only I22 said that they would not use the health unit in question again and this was the participant with the lowest satisfaction level (1).

Regarding trying another healthcare facility, 18 considered so and 18 did not. The main exposed reason to not trying another healthcare institution was concerning loyalty to the doctor:

> *I would consider trying it out if it was a specialty in which I wasn't yet accompanied. Medical care makes all the difference. It's what will bring you security throughout the procedure. A good conversation is half a cure. When the doctor is caring, careful, and professional, the patient feels safe. If we are going to analyse it in terms of healthcare, what we most recommend is a doctor and not an institution. The doctor has a fundamental role and only then does the institution come because you can have a good doctor and the other professionals are not capable, destroying the whole experience.* (I26)

The main exposed reason to try another healthcare institution was related to recommendations by friends or relatives:

> *Concerning the new service, I would consider trying it if it was recommended to me by a friend or relative. Nevertheless, if it was suggested on the Internet, I wouldn't consider so. I need to have a safety and trustworthiness relationship with something to take me to try something new.* (I08)

5. Discussion

The primary purpose of this qualitative study was to understand the role of (e)WOM in healthcare services, answering to the 2 research questions: Q1 – What is the role of (e)WOM before healthcare services consumption; Q2 – What is the role of (e)WOM after healthcare services consumption.

To answer to Q1, participants were asked why they search for WOM before healthcare service consumption. It is known that nowadays people are more aware about their health and the recommendation from relatives or friends or even a stranger is essential in decision making (Khalid et al., 2013; Terres & Basso, 2018). The lack of medical knowledge is also a reason for searching for (e)WOM to minimise the uncertainties associated with the service consumption (Taheri et al., 2021). All this information was mentioned by the participants and additionally participants said that when it is time to look for (e)WOM, people also make comparations between healthcare units and look essentially for a doctor recommendation and not an institution recommendation. However, for simple medical procedures (for example, doing a COVID-19 test) people don't look for recommendations.

As shown, it can be concluded that the main sources of (e)WOM are face-to-face interactions or electronic information posted on social media, Google Review, healthcare institution websites and specific online healthcare platforms, this information is in line with the study of Litvin et al. (2018). Some participants combined the 2 sources, because they consider traditional WOM more trustworthy as the information comes from friends and relatives and because e-WOM allows the access to more detailed information, this information is also aligned with the investigation of Colicev et al. (2019).

Regarding (e)WOM valence, participants were divided, and it seems that both positive or negative messages influence patients' expectations prior to a visit to a healthcare unit, these findings are in accordance with Lee & Youn (2009). Based on participants' statements, it seems that firm-generated content has a higher source expertise and user-generated content has higher source trustworthiness as also was demonstrated by Colicev et al. (2019).

Most of the participants mentioned that they have a positive relationship with the healthcare institution, using words and phrases like "trust", "safety", "flexibility", and "humanization of care" to describe it. Disorganization and distance were associated with negative relationships. When there is absence of a pattern of quality over time, participants described

their relationships with healthcare institutions as neutral. Considering the social identity theory, when there is a consumer-company identification (or non-identification), (e)WOM will spread, because it is known that individuals belonging to a group express their opinions and generate comments based on their experiences of purchasing and using products or services, influencing decisions of others (Brown, 2020; González-Soriano et al., 2020).

Taking into consideration the framework developed by Bhattacharya and Sen (2003), which is based on social identity theory, it is possible to highlight the antecedents of consumer-company (C-C) identification from information mentioned by the participants in this study. As antecedents we have the link between perceived company identity and identity attractiveness. A company's identity attractiveness depends on identity similarity (if we have a consumer that is extremely punctual, he will prefer an institution with low waiting times), distinctiveness (an institution with distinctive characteristics from the competitors will be the consumer's choice) and prestige (an institution with reputable doctors will be the consumer's choice). Identity trustworthiness also influences identity attractiveness based on previous experiences and reputation of the healthcare institution. Identity knowledge and identity coherence act as moderators of consumer's company perception. Identity knowledge can be promoted by identity communication through (e)WOM spreading from firms or other consumers. Identity coherence emerges from the distinct and stable patterns of behaviour variability over time. If all these dimensions were aligned there will be a positive C-C identification. Otherwise, there will be a negative C-C identification. Let us see this example of positive C-C identification pointed out by participant I04:

> *I think their service is great. They do everything to make sure that people feel they are the priority at that moment. There were things that happened to me there that I was not aware to like before I had gone there. Every time I went there (I have already been to 3 different specialities) the doctor always started the appointment by referring to what had taken place in the previous appointment (did the problem get solved?). In the other places, I wait, and it is almost as though it has to be me apologizing for waiting. There, no. They constantly apologize for making me wait and I almost wait for no time. There is greater caring and a different service, which is oriented towards the customer and not towards the doctor (unlike in other places).* (I04)

The investigation of Dayan et al. (2021) only considered the impact of WOM on patient satisfaction and patient loyalty. This study adds new information by correlating WOM (valence, source credibility and consumer-company identification) with hospital brand image. Thus, participants that remembered positive episodes of (e)WOM regarding healthcare institutions had a positive hospital brand image. Most participants that remembered negative episodes of WOM had a negative hospital brand image. The participants that considered consumer WOM as more credible had essentially a positive hospital brand image. The higher positive hospital brand image relative frequency was illustrated by people who consider the firms' content as more credible, because the firms always try to pass a positive image. The participants who had essentially a positive relationship with the healthcare institution had a positive hospital brand image. Participants who had a negative relationship with the institution were divided between negative hospital brand image and mixed hospital brand image. Thus, it seems that the valence, source credibility and consumer identification of (e)WOM will influence hospital brand image, because the other consumers opinion will contribute to create a hospital brand image, influencing patient expectations prior to a visit. Another interesting finding was the WOM generated in waiting rooms, which can influence patients' expectations in a positive or negative way.

In this study, most of the participants that made a positive description about the healthcare unit had high expectations. However, it is possible to verify that although different hospital brand images exist (positive, negative, or mixed), most participants had a positive overall experience. Therefore, a previous negative hospital brand image does not necessarily mean a negative experience, because as it was said before, hospital brand image has a spill-over effect and a subsequent evaluation of the service after consumption will be compared to the initial expectation, as also has been demonstrated by Wu (2011).

Social responsibility activities help to create a positive hospital brand image, as Ma et. al (2021) has proven. This study also identified the higher digitalization emerging from COVID-19 as an inductor of positive hospital brand image.

On the other hand, this investigation also identified that the public health sector is more associated with a negative hospital brand image.

Thus, the answer for the research question 1 is that (e)WOM will influence the hospital brand image creation, and, in turn, hospital brand image will influence patient expectations prior to a visit. Regarding Q2, what is the role of (e)WOM after service consumption?

Most of the participants that had a positive experience had previous high expectations and considered that the quality exceeded their expectations. Moreover, most of the participants that had a negative experience had previous high expectations and considered that the quality was lower than their expectations, as also has been demonstrated by Aragon & Gesell (2003). Comparing the mean of quality dimensions and the satisfaction level, some participants had a higher mean and a lower satisfaction level and vice versa, meaning that some dimensions of quality have a higher impact than others, this information has also been proven by Kumar et al. (2018). Most of the participants that had a positive experience said that they recommend the healthcare institution, this information is aligned with the study of Ranaweera & Jayawardhena (2014). In this way, customers whose needs are satisfied have a higher probability of convincing other people to try that service through (e)WOM. On the other hand, people who are unsatisfied could spread negative (e)WOM. Regarding the source of spreading, most of the participants choose the face-to-face interactions. Only 2 international participants spread their opinion electronically. In the literature there is not a clear distinction of the WOM source (face-to-face or electronic).

The reasons for (e)WOM spreading can be altruistic (concerning in helping the others) or egoistic (venting negative feelings) as has been identified by Martin (2017). However, 1 participant gave an interesting explanation for real justifications for (e)WOM spreading: people would spread a positive message if they had this habit or if the service quality exceeded his expectations; people would spread a negative message if they had an experience bellow neutral.

Regarding the loyalty repurchase intention only 1 participant, who had a negative overall experience, said that he/she will not use the unit again. Half of the participants consider not changing of institution because of their relationship with the doctor, as also has been proven by Dayan et al. (2021). The participants that consider tyring other institution said that they will do it if that institution was a friend or a relative's recommendation, this finding is also aligned with the investigation of Dayan et al. (2021).

Once again and taking into consideration the framework developed by Bhattacharya and Sen (2003), which is based on social identity theory, it is possible to highlight the consequents of consumer-company identification: company loyalty (patients consider to be loyal to the institutions existing services and to try its new ones), company promotion (spreading positive (e)WOM through company and its services or defending the company in public), customer recruitment (influencing people from their extant social networks to be new customers of the company), resilience to negative information (they will forgive the companies for minor mistakes) and greater claim on the company (consumers perceive their claim on the institution as more legitimate and urgent particularly in long term relationships).

Thus, the answer for the research question 2 is that (e)WOM can be generated after a healthcare experience and that its valence will be the reflection of the overall experience. In this case, positive (e)WOM can help maintain the current consumers and reach new ones.

6. Conclusion

In this section, the theoretical contributions and managerial implications were identified. In addition, limitations and suggestions for further research were presented.

Theoretical contributions

To the best of the current our knowledge, there is no up-to-date literature focusing on the role of (e)WOM before and after healthcare service consumption. In this way, this qualitative study presents evidence on the connection between (e)WOM and service delivery in the healthcare context. While the existing literature has focus on evaluating the influence of (e)WOM sorting out the pre-consumption and the post-consumption, the perspective taken in this study targets healthcare institutions and examines: (1) what is the role of (e)WOM before healthcare service consumption; and (2) what is the role of (e)WOM after healthcare service consumption. The data analysis is in line with the theoretical framework elaborated based on the existing literature, consider dimensions as hospital brand image, perceived service quality, patient satisfaction, loyalty and repurchase intention, but enhances it with the addition of social identity theory. The origin, valence, source credibility and consumer identification of (e)WOM were explored. Previous studies didn't consider all this dimensions. It is important to note that this research included international participants susceptible to multiple sources of interpersonal influence. This model paves the way for future research in the fields of (e)WOM in healthcare services, with a new theoretical model and new dimensions that emerged from this study, as new relationships between concepts, extending the theoretical knowledge on (e)WOM in general and in particular in the healthcare services.

Managerial implications

The managerial implications of the current study are also important especially from the point of view of the healthcare service. It is known that to minimise the uncertainties associated with the service consumption, people search for (e)WOM and it is also known that the (e)WOM that is more trustworthy comes from friends and relatives. Therefore, when patients have a good experience at a specific healthcare institution, they share their experience with their friends and relatives or even strangers (through e-WOM) and this is more important than paid advertising, influencing hospital brand image. Thus, this study recommends that healthcare institutions must encourage the generation of informative and relevant (e)WOM. WOM generation can be promoted through sharing positive content by the company on social networks; creation of loyalty programs; keep customers engaged

through after-sales contact or by continuing to provide value with useful and/or informative content. In spite of this, the company should also be open to negative messages and answer to these with relevant information for the consumers, helping to minimise the uncertainties related to the institution.

When looking for a healthcare recommendation, most of the consumers look essentially for a doctor recommendation and not an institution recommendation. In this way, to overcome this obstacle, firms can generate their own (e)WOM demonstrating that they have reputable doctors through identity prestige. Having information about the doctor's curriculum on the institution's website seems like good practice.

The major goal of the companies must be to establish a C-C identification through practices that stimulate the identity attractiveness of the company. Making the patients feel connected to their treatment plan and engaged in their care is important and this can be stimulated through an application that patients can use to make appointments, have information about exams or even to self-manage their care with educational support. Nevertheless, this attractiveness should be maintained over time to promote company loyalty, company promotion and customer recruitment, helping in the differentiation from other institutions. In sum, it is essential to develop a stable base of patients through positive (e)WOM to maintain the current consumers and reach new ones. To encourage this spreading, healthcare institutions must focus on exceeding the patients' expectations (to promote positive (e)WOM) or on maintaining a pattern of quality in terms of infrastructures, human resources, and administrative procedures (to avoid negative (e)WOM). This pattern of quality will help manage patients' expectations because most of the participants that had a negative experience had previous high expectations and considered that the quality was lower than their expectations.

Organizations should also be concerned with the WOM that is generated in the waiting room and that can influence patients' expectations. Consequently, healthcare institutions must adopt strategies to avoid patients' dissatisfaction, such as: minimizing the waiting lines; having means of distraction in the waiting room such as television; having modern, hygienic, and organized facilities; having protocols with health insurances; easiness of making the appointment through an application; having caring healthcare professionals; transmitting trust during all the medical procedures.

Regarding the different quality dimensions, institutions must value each of them, because they can have different impacts on the overall patient satisfaction. The different sectors (public vs private) also must evaluate what their shortcomings are, and each dimension must be better worked upon.

Institutions should also pay attention to social responsibility activities, given that it seems they stimulate a positive hospital brand image: a fair medical treatment at reasonable price and community awareness of certain diseases and preventive measures. Regarding COVID-19, organizations can also take advantages of it related with the higher digitalization, trough creation of an application for patients' management. These are pointed out as a positive aspect of COVID-19 by the participants of this study.

Limitations and suggestions for future research

The presented study has some limitations. First, the applied theory (social identity theory) does not have exclusive validity for the healthcare sector, interpreting (e)WOM only in general aspects. Another limitation is that this research presents WOM and e-WOM in a combined model. To further validate these results, face-to-face and electronic WOM could be evaluated separately.

Furthermore, only 27,78% of the participants are international. In this way, research into cultural differences could be more focused by making additional WOM studies comparing countries to provide new scientific insights. Future studies could also examine additional stakeholders involved in the WOM creation, like other patients that are present in the waiting room or even a doctor that recommends a certain healthcare institution.

Another limitation is that this research presents public and private healthcare units in a combined model. To further validate these results, public and private units could be evaluated separately.

Finally, the interviews took place in a single moment, evaluating the expectations (before the consumption) and the perception (after the consumption) simultaneously. Further research could use a longitudinal design, in which participants are interviewed in 2 phases: before and after the medical procedure, providing a better clarification of the cause-and-effect relationships between the identified dimensions.

7. Appendixes

Appendix I: Interview guide

Interview guide
Introduction
• Give some information to the participant about the investigation. • Commitment that the information will be only used for the purpose of the study. • Ask for the oral consent of the participant and permission to record the interview. • Ask for honesty during the interview. • Ask for any questions that the participant could have.
Participant background information
• Age • Gender • Nationality • Level of education • Occupation • Name of health unit and medical speciality chosen to talk about
Introductory question
1. What do you think about healthcare services? **2.** Do you think that COVID-19 was affected the way health services are provided?
A. Expectations of the healthcare service prior to consumption
Hospital Brand Image
3. How would you describe *(name of the healthcare facility)* to someone who does not know it?

Notes from LR (Literature review):

- Question 3: Brand image is defined by a set of perceptions about a brand that are stored in consumers' memory, in the form of associations (Keller, 1993). In this particular context, it is known that hospital brand image helps the patients in visualising, evaluating and differentiating the healthcare services (Wu, 2011); Patients form expectation before they obtain the medical service. Expectation is defined by what patients think about the medical services offered by the hospital, directly linked to the hospital brand image. During the service delivery, patients will develop perception that will be compared with the initial expectation (Wu, 2011).

(e)WOM

Exposure

4. Have you looked for information about *(name of healthcare facility)* on the Internet? Why/Why not? And about traditional WOM? Have you looked for it?
5. Where did you get this information from?
6. Have you compared information about *(name of healthcare facility)* to other healthcare facilities? Why/Why not?

Notes from LR:

- Question 4: e-WOM is defined as informal communication, in which consumers share their consumption-related opinions about a product or service (Hennig-Thurau et al., 2004);
- Question 5: e-WOM can modulate decision making by patients on the following formats: blogs and virtual communities; websites, product review and hate sites; emails; newsgroups; chatrooms; instant messaging; among others (Litvin et al., 2008);
- Questions 6: Nowadays, people are more aware about their health and the recommendation from relatives or friends is essential in decision making (Khalid et al., 2013; Terres & Basso, 2018). However, we are living in the digital era, so patients frequently use the Internet for health-related reasons, like seeking information or recommendation about healthcare services or practitioners (Lin &

Lin, 2018; Martin & Grub, 2020). The lack of medical knowledge is also a reason to gather e-WOM to minimise the risks and uncertainties associated with service consumption (Taheri et al., 2021).

Valence

7. Do you remember any positive (e)WOM about *(name of healthcare facility)*?
    a. What was it about?
    b. Where did you find the information?
    c. Do you know the sender of the message?
    d. Do you think that this information is credible?
    e. Do you feel that this message had influence on your decision to make this appointment?
8. Do you remember any negative (e)WOM about *(name of healthcare facility)*?
    a. What was it about?
    b. Where did you find the information?
    c. Do you know the sender of the message?
    d. Do you think that this information is credible?
    e. Do you feel that this message had influence on your decision to make this appointment?
9. What was the most impactful message received through (e)WOM about *(name of healthcare facility)* for you?

Notes from LR:

- Questions 7/8/9: An important concept of (e)WOM is the valence (positive, negative or neutral), affecting consumers' buying decisions (Lee & Youn, 2009). Online health information could help patients by facilitating the medical choice (Cao et al., 2017). In situations in which patients are not satisfied about overall quality of healthcare service, there is a higher chance that patients will develop a negative perception, leading to negative reviews. These reviews will contaminate other patients through (e)WOM, impacting patient expectations prior to a visit (Dayan et al., 2021).

Source Credibility

10. What is a credible source of information on the Internet when it comes to get the information about healthcare services for you? Firms' content or other consumers' content?

Notes from LR:

- Question 10: The search for content in the online health field is high because the level of risk perception about health issues is quite high (Ma & Atkin, 2017). FGC is under the control of a brand and depends on consumer response in a range of formats: likes, shares and comments Otherwise, UGC is created directly by the users (Martin & Grub, 2020; Poulis et al., 2019). It is postulated on literature that firm-generated e-WOM (FGC) has higher source expertise and user-generated e-WOM (UCG) has higher source trustworthiness (Colicev et al., 2019).

Consumer Identification

11. How do you define your relationship with *(name of healthcare facility)*? And with its employees? And regarding the other consumers?

Notes from LR:

- Question 11: The social identity theory postulates that the individuals will identify themselves with a social group due to their emotional attachment to that group, based on common characteristics, motivations, behaviours, and beliefs (Brown, 2020). Consumer identification exists at three different levels: with the institution (consumer-company identification), with its employees (consumer-employee identification), or with other consumers (consumer-consumer identification) (Acharya, 2021; Black et al., 2021).

Service Quality - Expectations

12. What are you expecting about *(name of healthcare facility)* quality?

Notes from LR:

- Question 12: Perceived service quality is defined as consumer evaluation of the overall excellence of a service. In this field there is an important trade-off between consumers' expectations and service performance. When the latter exceeds the former, quality is highly perceived (Zeithaml, 1988).

B. Perceptions of the healthcare service after consumption

Service Quality – Perceptions

13. How was your overall experience at *(name of the healthcare facility)*?

14. Did the quality experienced exceed your expectations? Or did it not meet your expectations? Why?

15. How do you describe *(name of the healthcare facility)* in terms of this following quality dimensions? Please use a scale of 1 (less satisfied) to 5 (more satisfied).

- **a.** Physical environment (atmosphere; tangibles; infrastructures)
- **b.** Interpersonal care activity (interaction; relationship; physician's care)
- **c.** Technical process (process expertise; safety measures)
- **d.** Administrative procedure (timeliness of activity; operational activity)
- **e.** Core service (range of services)
- **f.** Service communication (information)
- **g.** Service charge (price)
- **h.** Access and convenience
- **i.** Social responsibility (ethical questions)

Notes from LR:

- Question 13/14: Improving service quality has been a challenge for managers, to fulfil customers' expectations, leading to patient satisfaction (Nasir et al., 2021);
- Question 15: Kumar et al. modified a model created by Dagger et al. to measure perceived service quality in the healthcare sector, adopting a 7PS marketing mix, evaluating variables specific for healthcare services (Dagger et al., 2007; Kumar et al., 2018).

Patient Satisfaction

16. How would you rate your experience with the service? Are you satisfied? Please use a scale of 1 (less satisfied) to 5 (more satisfied).
17. How likely is that you would recommend the *(name of the healthcare facility)* to a friend or colleague? Have you done it?

Notes from LR:

- Question 16: Patient satisfaction is evaluated by comparing the differences between patients' expectations of what ideal care is and their perception of the care that they receive (Aragon & Gesell, 2003; Kotler & Keller, 2016);
- Question 17: Costumers whose needs are satisfied have a higher probability of convincing other people to consume that service (Ranaweera & Jayawardhena, 2014). When the patients perceive a medical service has a high quality, they are satisfied and spread WOM messages to family, friends, and colleagues (Hsu, 2018).

(e)WOM

18. Have you shared an electronic message about *(name of healthcare facility)*? Or traditional WOM message. If yes, please explain:
    a. What is it about?
    b. Was it a positive or negative message?
    c. Where did you post it?
    d. Were you the message producer or was it a repost from another source?
    e. Did your message have any shares?

Notes from LR:

- Question 18: Costumers whose needs are satisfied have a higher probability of convincing other people to consume that service (Ranaweera & Jayawardhena, 2014). When the patients perceive a medical service has a high quality, they are satisfied and spread WOM messages to family, friends, and colleagues (Hsu, 2018). The social identity theory postulates that the individuals will identify themselves

with a social group due to their emotional attachment to that group, based on common characteristics, motivations, behaviours, and beliefs (Brown, 2020).
Loyalty/Repurchase Intention
19. Would you use *(name of the healthcare facility)* services again? Why/Why not? If a friend recommends you another healthcare institution, would you consider trying it? **Notes from LR:** • Question 19: Some studies have established a connection between customer satisfaction and customer loyalty, saying that the first is an antecedent of the second (Minta, 2018). Satisfied customers are more likely to develop a long-term relationship with the firm. Loyal customers go to the same service provider and do not consider other available alternatives (repurchase intention), spreading WOM in the process. In this context, previous researchers have treated customer loyalty as a mediator between patient satisfaction and WOM (Nasir et al., 2021).
Final Notes
• Register a word of acknowledgment for the participant accepting to do this interview.

Source: Own elaboration.

Appendix II: Research participants'profile

Table XIII – Research participants' profile.

Code	Gender	Age	Nationality	Education level	Ocuppation	Sector	Type of unit	Medical specialty
I01	Male	27	Portuguese	Bachelor's degree	Education	Private	Hospital	Dentistry
I02	Female	32	Portuguese	Bachelor's degree	Management	Public	Hospital	Emergency Room
I03	Female	22	Portuguese	Bachelor's degree	Management	Private	Hospital	Emergency Room
I04	Female	23	Portuguese	Bachelor's degree	Management	Private	Hospital	Ophthalmology
I05	Female	25	Portuguese	Bachelor's degree	Sales	Public	Health Centre	Emergency Room
I06	Female	51	Portuguese	Bachelor's degree	Management	Public	Health Centre	Family Medicine
I07	Female	28	Portuguese	Bachelor's degree	Sales	Private	Hospital	Cardiology
I08	Female	22	Portuguese	Bachelor's degree	Student	Private	Hospital	Emergency Room
I09	Male	28	Portuguese	Bachelor's degree	Management	Public	Health Centre	Family Medicine
I10	Female	25	Portuguese	Bachelor's degree	Student	Private	Clinic	Orthopedics
I11	Female	22	Portuguese	Bachelor's degree	Student	Private	Hospital	Gynaecology

I12	Female	24	Portuguese	Bachelor's degree	Student	Private	Hospital	Ophthalmology
I13	Male	52	Portuguese	Secondary education	Management	Public	Hospital	Emergency Room
I14	Female	56	Portuguese	Primary education	Hospitality	Public	Health Centre	Family Medicine
I15	Female	26	Portuguese	Master's degree	Management	Public	Health Centre	Family Medicine
I16	Male	22	Portuguese	Bachelor's degree	Management	Private	Hospital	Orthopedics
I17	Male	43	Brazilian	Master' degree	Management	Public	Health Centre	Family Medicine
I18	Male	39	Portuguese	Bachelor's degree	Transport	Private	Clinic	Dentistry
I19	Female	34	Brazilian	Bachelor's degree	Management	Public	Hospital	Emergency Room
I20	Female	26	Portuguese	Master's degree	Healthcare	Private	Clinic	Physiotherapy
I21	Female	29	Serbian	PhD	Education	Public	Hospital	Gynaecology
I22	Male	32	Portuguese	Master's degree	Hospitaly	Public	Hospital	Emergency Room
I23	Male	34	Portuguese	Bachelor's degree	Student	Public	Hospital	Surgery
I24	Female	23	Portuguese	Bachelor's degree	Management	Private	Dental Clinic	Dentistry
I25	Male	27	Brazilian	Bachelor's degree	Management	Private	Laboratory	COVID-19 tests

I26	Female	65	Portuguese	Bachelor's degree	Education	Private	Hospital	Surgery
I27	Female	24	Portuguese	Bachelor's degree	Healthcare	Public	Hospital	Radiology
I28	Female	33	Czech	PhD	Education	Private	Laboratory	COVID-19 tests
I29	Male	23	Portuguese	Bachelor's degree	Management	Public	Hospital	Emergency Room
I30	Female	51	Portuguese	Secondary education	Hospitaliy	Private	Clinic	Nutrition
I31	Male	23	Portuguese	Bachelor's degree	Student	Private	Hospital	Cardiology
I32	Male	51	Turkish	Bachelor's degree	Management	Private	Hospital	Cardiology
I33	Male	30	Australian	PhD	Healthcare	Public	Hospital	Psychiatry
I34	Male	80	Canadian	Primary education	Retired	Private	Hospital	Continuous Care
I35	Male	25	South African	Bachelor's degree	Education	Private	Hospital	Physiotherapy
I36	Male	50	Pakistani	Bachelor's degree	Healthcare	Public	Hospital	Nuclear Medicine

Source: Own elaboration.

Appendix III: Example of an interview transcript

Participant I03

1. **What do you think about the healthcare services?**

In general terms, I make a distinction between public and private healthcare services, from the experience I've had or from what I've been observing from friends and relatives. In my very sincere opinion, the SNS is very disorganized, and I try to avoid it as we (my family and I) have private healthcare insurances so that we can go to the private sector. On the other hand, I also prefer the private healthcare services because of their schedule availability. My mother had a very grave illness and only the private sector was able to find a solution for her problem. When there are emergency situations and we are taken into an ambulance, we are taken to the SNS. However, we ask to be transferred to the private sector. Moreover, we also know some doctors that work both for the public and the private sector, which facilitates the process. Nevertheless, I have the perfect notion that some things are only available in the public sector: intensive care units, if one stays in a coma, if you have a very grave complication, a cardiorespiratory arrest, births… The private sector has no capability for that. There may be public hospitals that work well and so there may be those that work badly. For instance, I know the (name of a public maternity), which my family says to work very well.

2. **Do you think that COVID-19 has altered the way in which healthcare services are tended to?**

I think so and much, both in the private and the public sector. When being exposed to a healthcare service it is essential that we have someone accompanying us to guarantee the comfort and even to hear the information that directly comes from the doctor as it is different if notifications/information are/is communicated through the phone. On the other hand, in the case of inpatient services, there are no more visiting hours. The more humane part, the most important when administering a healthcare service, which can go very well or very bad, helps to manage the expectation of the patient and his/her family. How do you communicate the death of a relative through the phone? The perception and the image of the happening is different. There isn't an emotional bond. Also, we being present (during visiting hours) gives another perception to the healthcare professionals: this person in

important for the family and so we will try our best during treatment. Moreover, this also helps in the transmission of information to the relatives because it is much easier than through the phone and it builds confidence.

3. **How do you describe (name of the healthcare institution) to someone who is not acquainted with these facilities?**

It is a hospital that has a lot of appointment and infirmary attendance. However, the reality of the ER is different. It is very calm when compared to the public sector. Nevertheless, I've noticed some lack of preparation to act. A simple procedure such as suturing took too much time to be put in place. It is expensive but it is inviting. It is white, which transmits tranquillity and trustworthiness. As in any place, there are good and bad professionals. In my case, they were very kind.

4. **Did you search for information about (name of the healthcare institution) on the Internet before you made your appointment? Why/why not? Did you recur to other sources of WOM?**

Usually when I need any medical speciality, I search for the doctors on the Internet and I read their resumé. I can see (names of different private hospitals) and those websites have different information amongst them.

On the other hand, I have relatives that work in the healthcare field who know many doctors and so I always try to ask them for information/opinions. It ends up being a great resource, because you may not need that information at that moment but in the future you might be in a situation in which you need it and you remember that recommendation. For me, when it comes to health issues, word of mouth doesn't happen at the moment when you need something, but it happens in a more intense way before in the past and then you remember said word of mouth.

I always go to the Internet as an alternative. First, I ask my friends and relatives. If I don't have the information, then I go to the Internet. Or I go to the Internet to search for complimentary information. Nevertheless, when the search is only based on the Internet, it is more difficult, because there is no relationship of trust as that with friends and relatives.

5. **Where did you obtain this information?**

Internet, friends and relatives.

6. **Have you ever compared (name of the healthcare institution) to other facilities? Why?**

Yes. For example, I've compared it to (name of a private hospital), which has more protocols with insurance companies.

7. **Do you remember any positive message about (name of the healthcare institution) on the Internet or outside of the Internet?**

My grandmother had a grave problem on her leg and it was solved. Somehow that gave me more confidence to go back there.

8. **Do you remember any negative message about (name of the healthcare institution) on the Internet or outside of the Internet?**

A friend of mine was operated on a cyst on her chest, but she was taken in at the end of a shift and everything went wrong. They were in a rush and were not humane at all with her. I've also heard that she developed bruises and had a lot of pain, even though I am not aware if that is normal or not. She was not ready for that, though.

9. **Which message (positive or negative) has had a bigger impact for you?**

The positive one, because my grandmother is closer to me and I accompanied her up close. I was there. Regarding my friend, as I was not accompanying her, I was not there and so there wasn't any impact.

10. **Which is the most credible source regarding the obtention of information about healthcare services on the Internet? Content produced by the institution itself or content generated by other users?**

It depends on what you are searching for. For me, none of them is 100% credible. When it comes to healthcare services, it can go well or bad. It varies from person to person, from their own perception, from their preparation and from how they manage their expectations. To read reviews from people can let you down or can raise your expectations too much. I think when it comes to healthcare services, no one expresses their opinion because they like it more or less. Normally, people only express their opinion when something goes wrong. How can I consider the content to be credible if the content is generated by the user who is

always negatively biased? And what if the content generated by the hospital is quite factual: numbers, prises? The finality of both is very different.

In order to make up for the bias of the consumers' comments, transparency regarding everything that can happen is necessary. Patients' expectations need to be managed.

11. How do you define your relationship with (name of the healthcare institution)? What about the people who work there? What about the people who go there?

Occasional. If I need to, I will go there. If I don't, I don't go there. Whereas I'm not loyal to the hospital, I go there at least because of the professionals more than I do because of the hospital itself. I have an insurance so I can go to any facilities that have a protocol with it.

12. What were your expectations regarding the quality of (name of the healthcare institution)?

I was expecting that there would be a lot of people, but there wasn't. I was expecting there to be a doctor sorting through patients, but there wasn't one. I also expected that it wouldn't be so expensive. To be sutured in five places on the foot I paid €300.

13. How was your experience in (name of the healthcare institution)?

They had to call a doctor and a nurse from the inpatient services. I had to wait a bit. When the doctor came, I noticed that she was very insecure. That didn't transmit confidence to me. She sutured my foot and I walked out normally. The experience was quick and simple. If it had been something graver, I would have probably not gone there, because a few days after I found out that I should have had been sutured in more places and that I should have had used crutches. If the haste hadn't been the most important thing, I would have chosen a different place.

14. Did the quality exceed your expectations? Why/why not?

It was inferior.

15. On a scale from 1 to 5 (1 being low and 5 being high), how do you describe (name of the healthcare institution) in terms of:

Physical environment: 4; Interpersonal relations: 3; Technical procedure: 2; Administrative procedure: 4 ; Quantity of services: 5; Communication of the service: 2; Price: 1; Access and convenience: 5; Social responsibility: I am not aware of any situation.

16. **How do you classify your experience from 1 to 5?**

3. It was a simple thing.

17. **Would you recommend (name of the healthcare institution) to any friend or relative? Have you done it before?**

Yes, but not the ER.

18. **Have you shared any electronic/traditional message about (name of the healthcare institution)?**

I have shared this occurrence with my friends and relatives. My friends and relatives have also shared it with others because they have a strong emotional bond with me.

19. **Would you use the services of (name of the healthcare institution) again? If a friend/relative recommended another place, would you try it?**

It depends on the situation. If it was a simple one, I would say yes. If it is something complicated, I would say no because I didn't see their capability to take care of more complex things. If a friend or relative recommends another place, I would consider trying it.

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