Brand Authenticity in Healthcare:

conceptualizing authenticity in the private hospital market

Guilherme Victorino[1] [0000-0003-2133-9815]

[1] NOVA Information Management School (NOVA IMS), Campus de Campolide, Universidade Nova de Lisboa, 1070-312 Lisboa, Portugal

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Abstract – **Brand Authenticity is foundational in the context of the rise of private healthcare provisioning in Europe. With similar offers in terms of access and quality in the public and private sector, the empowered consumer navigates in a complex service industry, full of uncertainty when choosing a provider. This study aims to integrate in the healthcare market arena the present fragmentation of research on authenticity and assist hospital managers in understanding authenticity, which may lead to better understand consumers' brand attitudes. Drawing on the accounts of consumers and healthcare professionals collected in 2 private hospitals, 32 in-depth interviews with healthcare professionals (16 doctors and 16 nurses) were conducted, as well as 8 focus groups interviews with 43 participants (hospital patients), exploring their beliefs and perceptions and identifying elements that contribute to brand authenticity in healthcare. Authenticity stood out as a distinctive characteristic of healthcare brands and new dimensions of the construct were determined paving the way for future research to understand its effects over hospital-patient relationship variables and consequently over business value.**

Keywords: Brand Authenticity, patient-brand relationship, hospital brand management.

1. INTRODUCTION

Creating and sustaining a relevant hospital brand, as a tangible asset of patient-hospital-doctor relationships, arises as a central issue for the financial survival of private healthcare

organizations. Why? On the private healthcare market, hospital managers have long focused on clinical referrals to attract patients, instead of trying to create brand value and meet increasing patient expectations. The ability to attract both physicians and patients to the private provisioning side emphasizes the need to broaden the understanding of their behaviour towards patients' expectations and perceptions. For the first time, hospitals are looking at fundamental brand management principles, proven by other service industries, to win patient satisfaction, trust and loyalty. However it is essential for marketing managers to know how consumers evaluate brands in healthcare and what the consequences are.

Different factors explain the rise of private provisioning in Europe but there are trends that lead to a broader private market, which represents almost 40% of the total healthcare provisioning in Portugal (APHP 2013). Among those trends are the higher quality and service expectations, the significant investment in advanced technologies, the rapid growth in the number of private practitioners and the fact of private hospitals increasingly perform complex procedures (Tontas *et al*, 2005). These changes had an effect both on the physicians and the patient's behaviour. The high competition between private (for profit) and public (non profit) hospitals turns brand authenticity a particularly relevant construct to healthcare provisioning because it implies high involvement services, based on complex decision making processes, grounded on trust. The need to research on brand authenticity in the hospital context is even more relevant with the rising access to information, (namely the one made possible by information technologies and the internet), previously unseen, and the expansion of private providers in the market, empowering consumer's choice in an unprecedented way.

There is a substantial research gap when it comes to authenticity's nature and role in patient-hospital relationships. In order to fill this gap, this paper provides two contributions. First, we

conceptualize perceived hospital authenticity and examine the relevance of authenticity in patient-hospital relationships. Second, we explore beliefs and perceptions of healthcare professionals (doctors and nurses) and identify elements that contribute to brand authenticity in healthcare; investigate the relationships among the elements that contribute to or inhibit the patients' experience and the perception of quality service and identify elements of peer recommendation and word-of-mouth that facilitates patients' decision towards hospital care.

This article has the following structure. First, we provide support for the relationship between trust and authenticity through a brief review of the relevant literature. Second, we outline the interpretive methods employed to address our research objectives. Third, we present our findings and identify seven dimensions underpinning relevant assessments of authenticity in healthcare (reputation, personal relationships, systems and procedures, facilities and technology, atmosphere, personalization and brand reputation and service encounters). We conclude the article pointing the contributions to marketers and researchers and its limitations and suggestions about directions for future research.

2.1 BRAND AUTHENTICITY AND BRAND TRUST

Choice is something that empowers the consumer. It can also burden the consumer with excess stress and confusion in seeking an optimal choice decision. The proliferation of choice brings uncertainty and mistrust of brand promises (Lantieri and Chiagouris, 2009). Sociologists and anthropologists have long held trust as an essential ingredient in any kind of exchange. Trust, is presented as an ambiguous construct. It's based on the analyses of past information, but it is a construct mainly oriented to the future, because it offers a guaranty regarding the motivation of staying with the chosen brand.

In today's world, the erosion of trust is largely based on corporate dissonance, where there is no link between an organization's stated goals/values and its actions/achievements (Eggers *et all*, 2012). For those companies who "aspire to build trusted brands, sustainable marketplace success and community reputation, the imperative of authenticity will inevitably grow in importance" (Arthur W. Page Society, 2007, p.7). This issue seems to be of particular importance for private health care providers that seek to appear as authentic brands when competing between each other and mainly with public providers that may still be seen by certain patients as the only "true" brands. It has become increasingly clear that marketing theory and practice must incorporate customer trust as a central construct in relationships, and must also incorporate its antecedents like authenticity.

Although, the term authenticity is gaining more and more attention in the literature and the construct is found in multiple research disciplines there does not exists a coherent body of research so far. Several authors contribute to this issue by developing advanced dimensions of the construct (table I). None of the previously presented conceptualizations that sufficiently describe the phenomenon authenticity in the health care context. Something has to be added to existing theories to fully explain the phenomenon of perceived hospital brand authenticity.

Table I here

2.2 PATIENT - BRAND RELATIONSHIPS

The healthcare market is characterized by an information asymmetry between patient and provider. We find a principal-agent relationship (Rees, 1985) when one person (the

principal/patient) gives another person (the agent/ the provider) authority to make decisions on his or her behalf. In hospital-patient relationships, this is of paramount importance because the general public cannot likely assess the rightness of a health recommendation or a given medical prescription. When the direct search for information is difficult, both information substitutes, such as brands reputation and trust gain relevance (Matzler, 2008). The importance of brands in consumers' decision making varies from market to market (Fischer, 2010). In healthcare, like in any service firm, branding plays a special role because strong brands increase trust in intangible goods (Berry, 2000), enabling customers to better visualize and understand their experience.

For labor-intensive services, however, those experiences are primarily with people rather than manufactured goods and customers perceive the source of the experience with the brand (Berry, 2007). Many studies have examined aspects of the decision process by patients (Matzeler *et al*, 2008), however physicians believe consumer-driven healthcare will cause patients to pay more attention to costs and service and that will lead to greater patient attention to quality (Ahlquist *et al*, 2007).

2.3 BRAND AUTHENTICITY IN THE CONTEXT OF HEALTHCARE

The key for successful brands in the future will be to develop a brand image that encompasses elements of heritage and authenticity (Hollfelder, 2002). However, the meaning given to authenticity is context and goal dependent (Chronis and Ronald 2008; Wang, 1999; Leigh, 2006). While consumers seek authentic brands and consumption experience, healthcare buyers appreciate authentic healthcare professionals. Like in a commercial relationship where the salesperson perceived authenticity leads to credibility, trust and ultimately facilitates long-term relationships (Berger and Henseler, 2011), healthcare professionals need credibility and trust to

commit the patient to the desired clinical outcomes and to sustain their personal reputation within the market. As most constructs in psychology, authenticity is not an observable phenomenon and, thus is called latent construct (Bagozzi and Philips, 1982). This indicates that the measurement of latent constructs needs directly measurable indicators. The importance of authenticity as a unique characteristic of service delivery (Grandey *et al*, 2005) encompasses difficulties involved in its measurement and the fact that there is no universal agreement on understanding this term (Cooper *et al*, 2005). Although the importance of authenticity is clear and its ability to improve work conditions and performances in the health care sector is known (Luthans and Avolio, 2003) there is a gap in the literature which calls for a more explicitly and more critically examination of the construct of authenticity (Wong *et al*, 2009). This study aims to integrate in the healthcare market arena the present fragmentation of research on authenticity, and assist hospital managers in understanding perceptions of authenticity, which may lead to better understand consumers' brand attitudes. Based on the previous ideas, perceived hospital brand authenticity is defined as "the extent to which a private Hospital is more focused on delivering quality healthcare rather than achieving its commercial objectives" and a conceptual framework was developed (fig.2).

Fig. 2 Here

3. METHODOLOGY

In order to identify the properties of authenticity in healthcare and to analyze the idiosyncrasies of a private hospital experience, we will draw on the accounts of consumers and healthcare professionals collected in 2 private hospitals in Portugal.

Since Smith and Firth (2011) had shown that qualitative approaches are appropriate for exploring the complexities of health and wellbeing and can help in creating an in-depth understanding of the patient experience, this study uses a two-stage, multi-method approach:

Stage 1 includes information drawn from one-to-one, in-depth interviews with 32 healthcare professionals (16 doctors and 16 nurses) (cf. Table AI in appendix showing the profile of participants). Depth interviews are one method of an unstructured and direct way of obtaining qualitative data. They are conducted on a one-on-one basis to uncover underlying motivations, beliefs, attitudes, and feelings on a topic (Malhotra, 2004). The unstructured interviewing involves direct interaction between the researcher and the participant. The fact that it has no formal structured instrument or protocol rather some initial guiding questions, and the possibility of the researcher to move the conversation in any direction of interest that may come up distinguishes from traditional structured interviews.

Stage 2 consists on the analyses of the transcriptions of 8 focus groups interviews with 43 participants (Cf. table AII in appendix). Focus groups can provide trustworthy naturalistic data that also lead to important insights about human behavior, but they aren't set up to generalize in the same way as survey research (Fern, 2001).

The methods used for capturing data on each of the stages were based on a script with deepening topics and a individual questionnaires to be completed by each participant. The focus groups had an average length of 2 hours and the individual in-depth interviews lasted 1 hour and were audio and video recorded.

The information collected was subject to content analysis with the main objective of identifying and understanding the dominant trends assumed regarding the issues raised in this study, but without ever losing the personal/individual perspective. The in-depth interviews and the focus

groups followed a non-structured script (table 3) with the following topics: in the introduction the skilled facilitator/interviewer made a brief presentation of the objectives of the study and asked for a individual presentation of the participant(s), namely their age, occupation and, in the case of the healthcare professionals, specialty and number of years of hospital experience. Following, a generic topic was introduced about the opinion on healthcare services and practice (patient-doctor/nurse relationships, hospital systems and procedures, facilities and equipment; general atmosphere). The types of expectations of patients (inpatients and outpatients) when they need to go to the hospital were also explored at this point.

To better understand the actual customer experience in healthcare we asked for the opinion of which are the greatest expectations of users in the provision of hospital services at the following stages: pre-hospital visit, during hospital visit and following a hospital visit? Regarding the participants' last hospital experience, we tried to understand if those expectations mentioned before were met, overcome or not met. Finally participants where asked to think of an ideal hospital and reveal what the main priorities to meet patient expectations and needs in a hospital experience are.

The opinions collected were classified into three phases of the customer experience: pre-service, service and post-service. In the pre-service phase it was intended to analyze access and scheduling procedures, medical triage system, personal contact and interactions with administrative staff, facilities and waiting times. During the service phase the personal contact and interactions with clinical staff, physical comfort, professionalism, access to necessary information, and cooperation between specialties. In the post-service phase the personal contact and interactions related to billing and payment procedures as well as information about any eventual follow up needs in terms of information or clinical support.

After discussing these topics the participants were asked to answer a structured questionnaire where one should classify /prioritize in order of importance (the most important as 1 until less important that should rank with the 18) different aspects of the hospital service (Cf. Table AIII in appendix).

4. RESULTS AND DISCUSSION

4.1 DOCTORS

Private practice physicians were predominantly self-employed, working alone or in small private-practice groups. However, since hospitals and clinics have been forming into large conglomerates, this reality changed. Physicians, facing escalating demands for lower costs, the consumer demand of having diagnose technologies at hand and close to the physician, the need to invest in expensive information technology and a more demanding accountability concerning their performance, opted to join these conglomerates. This was an extraordinary turnaround from a decade ago, when a majority were independent. They've decided to become employees, and health systems have become chains (Gawande, 2012).

Doctors are very critical about healthcare governance and the economistic predominance view of non-medical managers in both the public and private sector. There is a widespread perception of the degradation of the public sector due to lack of investment and organization. Although doctors consider the working conditions in the private sector to be more attractive, there is concern about the private oversupply relatively to the actual demand.

In the private sector doctors expect more investment in training, scientific documentation and research. They also demand more dialogue with managers.

The evaluation of the service experience does not deviate much from what has been transmitted by nurses and users (Cf. Table AIV, AV and AVI in appendix) including the importance of being available and committed to the patient and his or her flow through administrative processes.

Although doctors emphasize the importance of relations and patient flow, they admit that the more frequent failures of doctors are related to not respecting default schedules, arrogance and poor humanizing relationship with the patients'.

The perceived ideal hospital for the doctors coincides largely with the view of the users inquired. The reputation of the private hospitals depends on the smaller waiting times (comparing to public provisioning), the caring relationship between healthcare professionals and patients and the external visibility of the brand.

4.2 NURSES

The critical observations of nurses regarding the health situation in Portugal mainly highlight what they perceive as a growing dehumanization, and economistic view held by managers, unfamiliar with hospitals reality.

The nurses really emphasize their proximity to patients but feel that, particularly doctors, rarely recognize their contribution. Nevertheless this vision is not coherent with the importance given by doctors to the availability and commitment of the nursing staff (Cf. Table AIV in appendix) as a key issue in the patient experience. Despite this shared view of the importance of healthcare professionals in the patient experience journey, nurses also recognize that cooperation with doctors is not always the best.

They believe that the private sector is differentiating by comfort, speed, privacy and, to some extent, also humanization. Unlike doctors, nurses believe that private hospitals are more people oriented but are very user unfriendly on bureaucratic procedures.

Regarding the perception of the ideal hospital nurses emphasize the importance of monitoring of patients after being discharged. In general terms, nurses demand more information, more training and more collective involvement.

4.3 PATIENTS/USERS

Patient complaints to public hospitals refer mainly to the difficulties of scheduling an appointment, long waiting lists, the poor humanization and poor management skills. Private hospitals are valued primarily by providing time saving, comfort and hygiene, the provision of information to users and the accountability of its employees at all levels.

The waiting time for consultation and the high expectations of competence, dedication, availability and humanity of the doctors are pointed out when compared to the ideal hospital.

The following stood out as key points to improve the perception of care in private hospitals: the speed, efficiency and flow of the check in/out procedure, the training of non clinical personnel, the reduction of bureaucracy and the scrupulous time keeping of scheduled appointments.

Apart of the mentioned human relationships importance, “time” is the most important aspect to patients (Cf. Table AVI in appendix) either in admission, waiting for the doctor or clinical tests.

4.4. Patients and healthcare professionals cues on authenticity

In services Gilmore and Pine (2007) find “exceptional authenticity when people tend to perceive as authentic that which is done exceptionally well, executed individually and extraordinarily by

someone demonstrating human care; not unfeelingly or disingenuously performed". These key aspects of authenticity in services were compared with private hospital clients' perspective on customer experience and integrated with the perceptions of healthcare professionals. This leads us to the identification of the following dimensions that may be used to support brand authenticity attributes with regard to healthcare:

1. Reputation: qualifications and technical skills of healthcare professionals are highly acknowledged and probably the key issue to hospital authenticity.
2. Personal Relationships: Importance of the disclosure of information and the ability to listen and pay attention to what patients feel and say. In terms of care, nurses are in higher consideration when it comes to patient engagement.
3. Systems and Procedures: the number of tests/analyzes requests (some will be unnecessary or at least expendable) have an impact on whether the patient gets the perception of value and that the doctor is concerned about making the best and most complete diagnosis or if these "tests in excess" may cover up inexperience or commercial interests and therefore a moment where the authenticity of the prescriber is being tested.
4. Facilities and Technology: the facilities of private hospitals are modern and comfortable. They ensure privacy, have an enjoyable and relaxing atmosphere; waiting areas are spacious, purpose built, and easily accessible; maintenance and hygiene is of a high standard. Since a Patient cannot evaluate the medical procedures in detail, there is a tendency to over evaluate all the aspects related to the experience, therefore physical clues are of major importance for the perception of authentic healthcare.
5. Atmosphere – consistent organizational culture is mandatory to authenticity perceptions; to build cohesive professional groups, trustful relationships between healthcare

professionals and managers; to achieve better coordination between services and/or professionals; to promote focus and avoid different performance "speeds"; to substantially improve internal communication.

6. Personalization and brand reputation: authentic private hospitals attract the best doctors and nurses available. Integrating more inexperience doctors and nurses could impact brand reputation and the perception of quality care.
7. Service encounters: although technical and professional competence and experience of doctors are highly considered, the ability to earn and deserve the trust of users without being arrogant is a central question. In the private sector there is a sense of greater accountability of staff's actions and behavior.

5. Conclusions / Implication for management and research

In Portugal, despite having access to public sector healthcare provision, there is a rising number of citizens willing to pay a charge to access private healthcare. Whether to avoid long queues, to address specific medical procedures or to avoid the perceived risk of lower customer service and lower levels of comfort, by 2008 more than 20% of the population had a private health insurance - growing at a rate of 9.6% a year (CEA 2008). The growing demand for private healthcare provisioning in the last decade was followed by the increase of the offer of private hospital beds (20 new hospitals since 2006) representing 15% of the total number of beds in Portugal (APHP 2013). This results in a rise of competition and consumer sensitivity towards customer service. As a consequence, hospital marketing managers need to find a way to stand out in order to convince the consumers of their brands.

In an immature market as in the case of Portugal, where patients are still reluctant to establish a relationship with a health brand, the concept of authenticity in relation to this field is still being shaped in patients' minds. The perceived risk of lower customer service in the public sector, the increase access through private insurance and possibly other variables such as access to information and patient empowerment have an impact on the emergence of authenticity as a strategic asset for consumer-brand relationships in healthcare. Hence this is an opportunity for private hospitals to craft authenticity as a unique characteristic of their brand and service delivery.

The customer experience with both front office and clinical activities may sometimes damage the client perception of quality service and create a tension that will affect the customer sense of authenticity, which may cause a dissonance between the brand promise, and the actual service provided. In the pre-Internet days, the power of influence the experience belonged entirely to the healthcare professionals, and the customer had little opportunity to validate, cross-reference or fact-check what their hospital authenticity stood for. Today, the pendulum of power is changing and patients' conduct entire decision cycles using the online information available to evaluate hospitals' marketing communication, social media footprint and customer references sometimes without even engaging with a healthcare provider.

Authenticity is not about whether the communication is perceived as authentic It is instead about whether the company as a whole is authentic or not (Weinberger, 2008). In this context, the challenge is not to communicate about brand authenticity, but to foster organizational cultures that encourage and enhance it.

However healthcare context encompasses difficulties in measuring authenticity and there is no consensus or one single understanding of the term "authenticity". The dimensions identified in

this study (reputation, personal relationships, systems and procedures, facilities and technology, atmosphere, personalization and brand reputation and service encounters) may be used to develop a hospital brand authenticity index or scale, which could then be used to measure the effectiveness of brand management efforts and techniques in healthcare. Valuing brand authenticity within hospital brand management strategies might increase patient satisfaction and encourage loyalty, which will ultimately help hospitals to create value from a customer perspective and remain competitive in today's market.

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APPENDIX

Table AI here

Table AII here

Table AIII here

Table AIV here

Table AV here

Table AVI here

Table I: Brand Authenticity Dimensions – Literature Review Summary

Reference	Dimensions	Authors	Definition
Authentic Brand Index (2006)	originality personal utility declared beliefs sincerity familiarity momentum heritage	Principals (brand consultancy) Synovate (market research company)	Authenticity is about practicing what you preach; being totally clear about who you are and what you do best.
Consumer-based brand authenticity (CBBA) scale (2013)	quality commitment, sincerity, heritage.	Julie Napoli, Sonia J. Dickinson, Michael B. Beverland, Francis Farrelly	Brand authenticity is a subjective evaluation of genuineness ascribed to a brand by consumers.
Brand Authenticity: Scale Development and Validation (2010)	Real vs. contrived True self vs. overreacting Commercialization Unique vs. mass product. Rich vs. no history Community link Empowerment	Djavlonbek Kadirov	Brand authenticity refers to consumer judgment about the extent to which a brand is considered to be authentic (or inauthentic).
Building Brand Authenticity. 7 Habits of Iconic Brands. (2009)	Storytelling Appearing as artisanal amateurs Sticking to your roots Loving the doing Market immersion Being at one with the community Indoctrinating staff into the brand cut	Beverland, M.	Authenticity refers to the manifestation of the search for what is real.
More Than Fit: Brand Extension Authenticity (2012)	Maintaining brand standards and style, Honoring brand heritage, preserving brand essence, avoiding brand exploitation	Spiggle, S., Nguyen, H.T. and Caravella, M.	Brand extension authenticity represents a consumer's sense that a brand extension is a legitimate, culturally con-sistent extension of the parent brand.
The impact of brand authenticity on brand trust and SME growth: A CEO perspective. (2012)	Congruency, Consistency, Customer orientation.	Eggers, F. et al.	Real brand authenticity as perceived by SME CEOs as being conceptualized as consisting of three factors, brand consistency, customer orientation, and congruency
Perceived Salesperson Authenticity in B2B-Relationships: A Qualitative Study.	Presence Empathy Competency Experience	Berger, K. and Henseler, J.	While consumers seek authentic brands and consumption experience, industrial buyers

(2011)	Out-of-the-box Thinking Genuineness Stability of character Congruency		appreciate authentic salespersons.

Fig. 2: Conceptual Framework

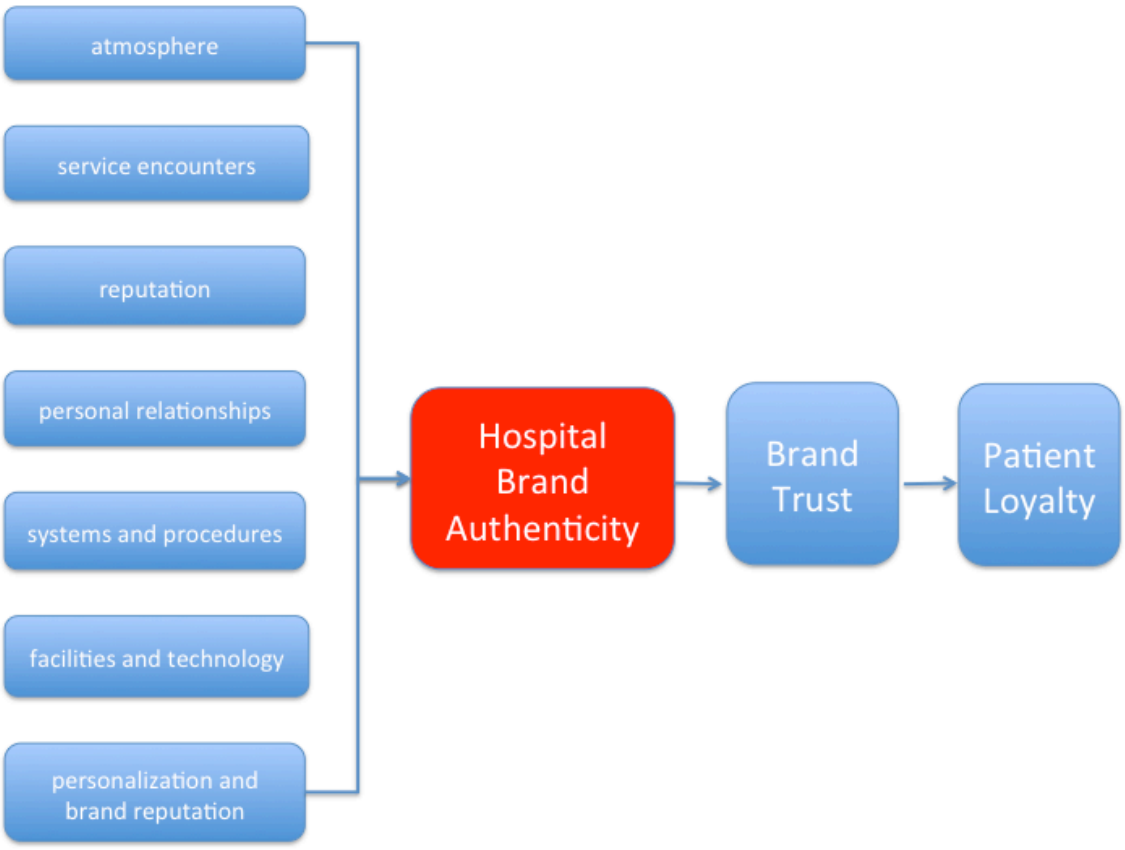

Table AI: Profile of participants / stage 1 & 2

Location	Method	Sample Characteristics	# Participants
Lisbon	In Depth Interview with Medical Doctors	- 6 Female. Age range from 38 to 49 years old; - 2 Male. Age range from 47 to 52 years old - Specialties: Physical Medicine and Rehabilitation, Surgery, Oncology, Immunohemotherapy, Pediatrics, Radiology, Pathology, Ophthalmology.	8
OPorto	In Depth Interview with Medical Doctors	- 6 Female. Age range from 30 to 43 years old; - 2 Male. Age range from 46 to 47 years old - Specialties: Psychiatrist, Oncology, Obstetrics, Anaesthesiologist, General Surgeon, Orthopaedics	8
Lisbon	In Depth Interview with Nurses	- 5 Female. Age range from 30 to 47 years old; - 2 Male. Age range from 31 to 39 years old - Specialties: Generalist, Pediatrics / Neonatology, Specialist in Pediatrics, Gynecology.	8
OPorto	In Depth Interview with Nurses	- 6 Female. Age range from 28 to 58 years oldFemale: 26 years; Generalist; - 2 Male. Age range from 27 to 43 years old - Specialties: Anesthetist; Operating Room; Generalist; Nurse Graduate Child Health and Pediatrics; Orthopedics.	8
Lisbon	Focus Group with Patients	- 16 Female. Age range from 21 to 68 years old; - 4 Male. Age range from 20 to 67 years old.	20 participants 4 sessions
OPorto	Focus Group with Patients	- 12 Female. Age range from 21 to 55 years old; - 11 Male. Age range from 21 to65	23 participants 4 sessions

Table AII: SCRIPT – Individual Interviews with Doctors/Nurses

Introduction	Brief presentation of the objectives of the interview. Individual presentation of the interviewed - Age - Specialty - Number of years of hospital experience
Generic topic	In general, what is your opinion on healthcare services and practice in Portugal (patient-doctor/nurse relationships, hospital systems and procedures, facilities and equipment; general atmosphere) What are the types of expectations of patients (inpatients and outpatients) when they need to go to the hospital?
Deepening topic	In your opinion, what are the greatest expectations of users in the provision of hospital services at the following times: pre-hospital visit, during hospital visit and following a hospital visit? Where these expectations met, overcome or not met?
Final topic	Think of an ideal hospital. What do you consider to be the main priorities to meet patient expectations and needs?

Table AIII: Final Questionnaire

The interviewed/participant was asked to classify /prioritize in order of importance (the most important as in 1 the following as in 2 and so on until less important that should rank with the 18) the following aspects of hospital service:

1. Admission time (response)
2. Availability and commitment by physicians
3. Individual patient privacy
4. Waiting time for consultation (in the day)
5. Hospital cleanliness / hygiene
6. Availability and commitment of nursing staff
7. Providing information about the waiting time for consultation
8. Information on the best way to use health services in Hospitals
9. Waiting time for tests / analysis (in the day)
10. Comfort / convenience of waiting area
11. The Hospital be Accredited or Certified
12. Information about patient conditions to family or friends
13. Equipment and Technology Availability
14. Availability and commitment by non clinical staff
15. Food Quality
16. Billing Services
17. Availability and helpfulness of reception desk
18. Time to leave the Hospital after being seen by the doctor

Table AIV: Doctors Questionnaire Results

	Total: 16 Doctors					
	Q1	Q2	Q1+Q2	Q3	Q4	Q3+Q4
Admission time (response)	7	6	**13**	3	-	**3**
Availability and commitment by physicians	16	-	**16**	-	-	**-**
Individual patient privacy	7	5	**12**	3	1	**4**
Waiting time for consultation (in the day)	3	9	**12**	2	2	**4**
Hospital cleanliness / hygiene	5	8	**11**	5	-	**5**
Availability and commitment of nursing staff	11	2	**13**	3	-	**3**
Providing information about the waiting time for consultation	-	4	**4**	11	1	**12**
Information on the best way to use health services in Hospitals	-	3	**3**	8	5	**13**
Waiting time for tests / analysis (in the day)	2	6	**8**	7	1	**8**
Comfort / convenience of waiting area	1	8	**9**	6	1	**7**
The Hospital be Accredited or Certified	2	2	**4**	5	7	**12**
Information about patient conditions to family or friends	2	8	**10**	6	-	**6**
Equipment and Technology Availability	2	9	**11**	3	2	**5**
Availability and commitment by non clinical staff	4	4	**8**	1	7	**8**
Food Quality	-	1	**1**	6	9	**15**
Billing Services	-	-	**-**	2	14	**16**
Availability and helpfulness of reception desk	5	2	**7**	7	2	**9**
Time to leave the Hospital after being seen by the	-	2	**2**	3	11	**14**

doctor						

(Q1) number participants that ranked the item from 1 to 4

(Q2) number participants that ranked the item from 5 to 9

(Q3) number participants that ranked the item from 10 to 14

(Q4) number participants that ranked the item from 15 to 18

Table AV: Nurses Questionnaire Results

	Total: 16 Nurses					
	Q1	Q2	Q1+Q2	Q3	Q4	Q3+Q4
Admission time (response)	10	4	**14**	2	-	**2**
Availability and commitment by physicians	16	-	**16**	-	-	**-**
Individual patient privacy	2	10	**12**	4	-	**4**
Waiting time for consultation (in the day)	-	9	**9**	6	1	**7**
Hospital cleanliness / hygiene	-	12	**12**	3	1	**4**
Availability and commitment of nursing staff	16	-	**16**	-	-	**-**
Providing information about the waiting time for consultation	1	2	**3**	10	3	**13**
Information on the best way to use health services in Hospitals	2	4	**6**	7	3	**10**
Waiting time for tests / analysis (in the day)	-	6	**6**	8	2	**10**
Comfort / convenience of waiting area	2	8	**10**	5	1	**6**
The Hospital be Accredited or Certified	2	2	**4**	3	9	**12**
Information about patient conditions to family or friends	1	4	**5**	9	2	**11**
Equipment and Technology Availability	4	6	**10**	5	1	**6**
Availability and commitment by non clinical staff	2	4	**6**	9	3	**12**
Food Quality	-	3	**3**	6	7	**13**
Billing Services	1	-	**1**	-	15	**15**
Availability and helpfulness of reception desk	6	5	**11**	2	3	**5**

Time to leave the Hospital after being seen by the doctor	-	-	-	3	13	**16**

(Q1) number participants that ranked the item from 1 to 4

(Q2) number participants that ranked the item from 5 to 9

(Q3) number participants that ranked the item from 10 to 14

(Q4) number participants that ranked the item from 15 to 18

Table AVI: Patients Questionnaire Results

	Total: 40 Patients					
	Q1	Q2	Q1+Q2	Q3	Q4	Q3+Q4
Admission time (response)	28	7	**35**	1	4	**5**
Availability and commitment by physicians	34	5	**39**	-	1	**1**
Individual patient privacy	14	14	**28**	9	3	**12**
Waiting time for consultation (in the day)	11	18	**29**	10	1	**11**
Hospital cleanliness / hygiene	15	18	**33**	7	-	**7**
Availability and commitment of nursing staff	24	10	**34**	6	-	**6**
Providing information about the waiting time for consultation	4	12	**16**	21	3	**24**
Information on the best way to use health services in Hospitals	2	7	**9**	16	15	**31**
Waiting time for tests / analysis (in the day)	6	23	**29**	9	2	**11**
Comfort / convenience of waiting area	1	16	**17**	15	8	**23**
The Hospital be Accredited or Certified	6	10	**16**	12	12	**24**
Information about patient conditions to family or friends	3	15	**18**	14	8	**22**
Equipment and Technology Availability	6	14	**20**	15	5	**20**
Availability and commitment by non clinical staff	3	18	**21**	11	8	**19**
Food Quality	1	2	**3**	12	25	**37**
Billing Services	-	3	**3**	9	28	**37**
Availability and helpfulness of reception desk	1	7	**8**	19	13	**32**

Time to leave the Hospital after being seen by the doctor	1	1	**2**	13	25	**38**

(Q1) number participants that ranked the item from 1 to 4

(Q2) number participants that ranked the item from 5 to 9

(Q3) number participants that ranked the item from 10 to 14

(Q4) number participants that ranked the item from 15 to 18