

**ISTANBUL TECHNICAL UNIVERSITY ★ GRADUATE SCHOOL OF ARTS AND
SOCIAL SCIENCES**

**ANALYZING CUSTOMER ENGAGEMENT THROUGH
CUSTOMER EXPERIENCE IN HEALTH CARE INDUSTRY**

Ph.D. THESIS

Ayşe Bengi ÖZÇELİK

Department of Management

Management Programme

MAY 2019

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İSTANBUL TEKNİK ÜNİVERSİTESİ ★ SOSYAL BİLİMLER ENSTİTÜSÜ

**SAĞLIK SEKTÖRÜNDE MÜŞTERİ DENEYİMİ VE MÜŞTERİ KATILIMI
ANALİZİ**

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Date of Submission : 03/05/2019

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Eylül'e...

FOREWORD

I would like to thank many people who have been with me throughout the journey of writing this thesis.

First, I would like to express my deepest gratitude to my thesis advisor, Prof. Dr. Şebnem BURNAZ for her endless support and patience. She has become one of the most important people in my life as a professor, as a mentor, and as a friend. I am sure we will have so many times not only to work but to enjoy the life together.

I also would like to thank Prof. Dr. Kaan VARNALI for his priceless support and belief from the beginning of my academic career. Together with Prof. Dr. Ayşe Banu ELMADAĞ BAŞ, I thank them for their precious contributions to this thesis. This thesis cannot be done without their valuable comments.

I would like to express my special thanks to my dissertation committee as well. I am grateful to Prof. Dr. Yonca ASLANBAY and Assoc. Prof. Dr. Başar ÖZTAYŞI for their valuable suggestions that will enhance my future studies. I am also grateful to Prof. Dr. Melih BULUT for supporting me and to Prof. Dr. Metin ARGAN for contributing to thesis.

Finally, with all my heart, my family deserves a special appreciation for their infinite support. I cannot think of any success without celebrating with my beloved husband, Alaz ÖZÇELİK. His support is priceless, and I am lucky to have him. I am grateful to my mothers Yasemin ÖZCİVAN and Nurten ÖZÇELİK, my fathers Zafer ÖZCİVAN and Abidin ÖZÇELİK, my lovely sister Cansu ÇELEBİ, my brothers Can ÇELEBİ and Çelik ÖZÇELİK for their endless love and support. I acknowledge their tremendous patience, support, encouragement, and trust in me throughout this journey as at each and every step of my life.

A really special appreciation is to my little sweetheart nephew Eylül Su ÇELEBİ. I cannot finish this thesis without her little heart beats and I dedicated this thesis to her.

May, 2019

Ayşe Bengi ÖZÇELİK

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ABBREVIATIONS

AGFI	: Adjusted Goodness of Fit Index
AHRQ	: Agency for Healthcare Research and Quality
AVE	: Average Variance Extracted
CFA	: Confirmatory Factor Analysis
CFI	: Comparative Fit Index
CR	: Composite Reliability
DET	: Detail
EFA	: Exploratory Factor Analysis
EFF	: Effect
ENG	: Customer Engagement
FREQ	: Frequency of hospital visit
FREQ_PRIV	: Frequency of private hospital visit
GFI	: Goodness of Fit Index
HCAHPS	: Hospital Consumer Assessment of Healthcare Providers and Systems
IFI	: Incremental Fit Index
INF	: Influence
KMO	: Keiser-Meyer-Olkin
KNOW	: Knowledge
MEM	: Autobiographical Memory
NFI	: Normed Fit Index
NHS	: National Health Service
PERI	: Periphery
PERS	: Personnel
PHY	: Physician
POW	: Power
PRO	: Provider
PUR	: Purchase
QDA	: Qualitative Data Analysis
RFI	: Relative Fit Index
RMSEA	: Root Mean Square Error of Approximation

SEM	: Structural Equation Modeling
SI	: State Insurance
SRMR	: Standardized Root Mean Residual
TLI	: Tucker Lewis Index
TRU	: Trust
VISIT_NO	: Visit Number
WOM	: Word of mouth

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ANALYZING CUSTOMER ENGAGEMENT THROUGH CUSTOMER EXPERIENCE IN HEALTHCARE INDUSTRY

SUMMARY

The unilateral relationship between brand and consumer in 1980s has become a unilateral and interactive one in which consumer is empowered. This transformation increased the competition in market and changed the approach of organizations about their clients, accordingly the importance of consumer-brand interaction is increased. In 2000s, a paradigm shift is actualized in marketing in which the service become the focus. With this shift, it is widely accepted that the critical identity of a brand is built by the service provided even if the brand is a manufacturing one. Technological developments supported this transformation by putting the information flow forward and help consumers being empowered. Hence, experience has become the new focus of marketing by converting the traditional exchange relationship.

Organizations should provide a well-designed experience story in order to sustain their existence in the market. This experience should be designed in the light of the information flowing from the consumer and of the analysis of the consumer journey. However, this analysis is getting difficult since the consumers are interacting with each other online. Even without the internet, consumers used to collect information in some way in order to make a purchase decision. After the internet, they become more and more powerful and expert in the market. Thus, all sectors focus on designing new and distinctive experiences for the customers. However, health care dissociates from other sectors with its power inequality in terms of medical knowledge. Even the internet cannot equalize the health care providers and the patients in terms of medical information. The unilateral relationship is hold for a long time. But, in recent years, patients are realized that they have the power of choosing which hospital or physician with their service information and power as consumers. They are converted into active decision makers from passive consumers. With the rising of the importance of service, the relationship between patient and provider or health care employee has become the same as the relationship between consumer and brand. Patients are now considered as consumers.

Beyond all of these developments, increasing competition puts health care in the scope of marketing. Especially the increasing number of private hospitals in Turkey and Turkey's high performance for health tourism revealed the significance of the patient experience. The legal regulations for advertising and communication implementations for healthcare limits the opportunities for hospital marketers. Hence, they focus on the in-hospital processes. The return on investment on experience provided to a patient in the hospital may be positive for the organization. Hence, the focus of hospital managers has become designing a good experience for patients. In addition to all of these, the effect of patient experience on social health in public and the patient right to have a good experience in hospitals make this subject more critical. Thus, the answers of "What are the critical dimensions for creating a well-designed patient experience?"

and “What are the consequences of a well-designed patient experience?” are critical for health care sector.

From this point of view, one of the objectives of this research is to determine the critical key points for patient experience by collecting and analyzing the perspectives of industry experts and patients. Additionally, it is aimed to find out the effects of a high perceived patient experience quality on patient behavior. Two consecutive studies are conducted in the scope of this thesis. In the first study, health care experts and patients are interviewed in order to extract the critical points of patient experience. In the light of the 5P model of patient experience which is built in the first study, second study is performed. Second study considers the association between the perceived patient experience quality dimensions and patient engagement. Besides, the effects of autobiographical memory and trust to provider on this relationship is investigated.

The results reveal that perceived patient experience quality positively influences the purchase decision and trust mediates this relationship. The positive effect of perceived experience quality on word of mouth is presented. As a contribution to the previous literature, the moderated effects of autobiographical memory dimensions to the relationship between experience and engagement via trust are observed.

These results exhibits the effects of experience on engagement and the influence of autobiographical memory on this relationship. The research contributes to the literature as providing a novel dimensional formula of patient experience and as investigating the association between experience and engagement. Also the research contributes to the field by providing a strategic guide to the hospital managers who aim to maximize perceived patient experience quality.

SAĞLIK SEKTÖRÜNDE MÜŞTERİ DENEYİMİ VE MÜŞTERİ KATILIMI ANALİZİ

ÖZET

1980’li yıllardaki tek yönlü marka-tüketici ilişkisi, günümüzde tüketicinin güç kazandığı iki yönlü ve etkileşimli bir ilişkiye dönüşmüştür. Bu durum, pazardaki rekabeti arttırarak kurumların müşterilerine olan yaklaşımlarını değiştirmiş ve tüketici-marka etkileşiminin önemi artmıştır. 2000’li yıllar pazarlamada bir paradigma dönüşümüne sahne olmuş ve hizmetin ön plana çıktığı bir döneme girilmiştir. Markanın fark yaratan, kimliğini kazanmasını sağlayan özellik, o marka ne üretirse üretsın, hizmet olmaya başlamıştır. Teknolojik gelişmeler, tüketicinin yaşadığı süreci ve bilgi akışını ön plana çıkararak, deneyimi pazarlamanın klasik değişim (exchange) ilişkisini farklı bir boyuta taşıyan yeni bir odak olarak ortaya koymuştur.

Kurumların, kendi varlıklarını kanıtlamak için tüketicilerine doğru bir deneyim hikayesi sunmaları gerekmektedir. Bu hikayeyi tüketiciden gelen bilgiyle ve tüketicinin nasıl bir yolculuk yaşadığını doğru analiz ederek tasarlamalıdır. Fakat bu analiz, tüketicilerin dijital ortamda sürekli olarak birbirleriyle etkileşim halinde olmaları ve birçok bilgiye sahip olarak güçlenmeleri sebebiyle git gide zorlaşmaktadır. Gelişen teknolojiyle birlikte tüketicinin artan ve çeşitlenen bilgisi, markaları deneyim tasarımını daha dikkatli yapmaya itmiştir. İnternet yokken bile satın alma kararı ile ilgili çevresinden bilgi toplamaya açık olan tüketiciler, internetin gelmesiyle birlikte daha bilgili olmaya başlamışlardır. Dolayısıyla tüm sektörler bilgili tüketicilere yeni ve farklı deneyimler tasarlamaya odaklanmıştır. Ancak sağlık sektörü, özellikle internet yokken, tüketicisinin, yani hastaların bilgisinin sınırlı olduğu bir alan olarak kabul edilmiştir. Bu sebeple sağlık sektöründe tek yönlü ilişki uzun yıllar devam etti. Ancak son yıllarda bilgilenen ve güçlenen hastalar, pasif tüketiciler olmaktan ziyade aktif karar vericiler konumuna gelmişlerdir. Hizmetin ön plana çıkmasıyla beraber, tıbbi bilgi kapsam dışında tutulduğunda, hasta-hastane veya hasta-sağlık çalışanı ilişkisi de tıpkı diğer sektörlerdeki gibi müşteri-marka ilişkisinden farksız hale gelmiştir. Hastalar da artık birer tüketici olarak ele alınmaktadırlar.

Bunun dışında sağlık sektöründe artan rekabet, pazarlamanın da ilgi alanına girmiştir ve sağlık pazarlaması ön plana çıkmaya başlamıştır. Özellikle özel hastane sayısının Türkiye’de artması ve sağlık turizminde Türkiye’nin ön plana çıkmasıyla birlikte gelen hastaya iyi bir deneyim yaşatmanın önemi kavranmaya başlamıştır. Hukuki olarak sağlık sektörünün reklam ve iletişim faaliyetlerinin sıkı regülasyonlara tabi olması ise yöneticilerin yatırımlarını hastane içi düzenlemelere yoğunlaştırmıştır. Böylece hastaneye gelen hastaların yaşadığı tüm sürecin iyileştirilmesi için yapılan yatırımların gelecekteki katkısı farkedilmiş ve hastanelerin odakları bu yöne kaymıştır. Tüm bunların ötesinde, hastalara yaşatılan deneyimin toplumsal sağlığa etkisi ve hasta hakları kapsamında tüm insanların iyi bir deneyim yaşama hakkı da sektörü yönlendiren önemli etkenler olmaktadır. Bütün bu gelişmeler ışığında, *“Bir özel sağlık kuruluşunun hastalarına iyi bir deneyim sunabilmesi için hangi kriterlere dikkat*

etmesi gerekir?” ve “İyi bir deneyimin sonuçları nelerdir?” sorularının cevaplarını aramak gerekliliği ortaya çıkmıştır.

Buradan hareketle, bu araştırma, özel hastanelerde hastane içindeki deneyimin iyileştirilebilmesi için ağırlık verilmesi gereken noktaları hem hastaların hem de konunun uzmanlarının katıldığı bir araştırmayla ortaya koymayı ve sonrasında bu deneyimin hastaların davranışlarını nasıl etkilediğini araştırmayı hedeflemektedir. Tez kapsamında iki çalışma yürütülmüştür.

Birinci çalışmada, iki aşamalı olarak sektör uzmanları ve hastalarla birebir görüşmeler yapılarak hasta deneyimindeki önemli unsurlar ortaya konmuştur. Öncelikle sağlık sektöründe çalışan hekim, orta ve üst düzey yönetici, akademisyen ve araştırmacılar ile birebir görüşmeler yapılmıştır. Bu görüşmelerde özellikle iki soru üzerine yoğunlaşmıştır. Birincisi, hastaların deneyimini belirleyen unsurların neler olduğunu; ikincisi ise hastane içinde hangi birimlerdeki hastalarla yapılacak görüşmelerin hasta deneyimi ile ilgili detaylı sonuç vereceğini soran sorulardır. Birinci soruya verilen cevaplar, hasta deneyimi ile ilgili olarak anali edilmiştir. İkinci soruya verilen cevaplar ise nitel çalışmanın ikinci aşaması olan hasta görüşmelerine yön vermiştir. Sektör uzmanları, bu soruya paralel cevaplar vererek onkoloji ve kadın doğum birimleri üzerinde yoğunlaşmışlardır. Her iki birimin hastalarının da tekrarlı ziyaret ve hem yatan hem ayaktan hasta olma deneyimini barındırması bakımından kapsamlı cevaplar vereceği tahmin edilmiştir. Buradan hareketle, iki özel hastane ile anlaşarak bu hastalarla iki ay boyunca birebir görüşmeler yapılmıştır. Bu hastanelerden biri üst segment ve sigorta anlaşması olmayan özel hastane, diğeri ise orta segment ve sigorta anlaşması olan özel hastanedir. Böylece her iki hastane tipi arasındaki fark da gözetilebilmiştir. Hastalarla olan görüşmelerde özellikle yaşadıkları deneyimi en başından en sonuna kadar detaylıca anlatmaları ve hatırladıkları olumlu ve olumsuz noktaları belirtmeleri beklenmiştir. Hastalarla yapılan görüşmeler sonucunda belirtilen önemli noktalar, hasta deneyimini anlamak için uzmanların belirttikleri ile de bağdaştırılarak analiz edilmiştir. Analizler sonucunda hasta deneyiminin beş maddeye bağlı olduğu ortaya konmuştur: hastane, hasta, hekim, personel, ve çevre. İngilizce isimleriyle 5P modeli olarak adlandırılan bu model ışığında ikinci çalışmaya geçilmiştir.

İkinci çalışmada ise hasta deneyiminin önemli noktaları bağımlı değişkenler olarak ele alınarak, algılanan deneyim kalitesinin katılım(engagement) davranışına nasıl etki ettiği araştırılmıştır. Ayrıca, deneyimin hatırlanmasının ve hastaneye olan güvenin bu ilişkiye olan katkısına bakılmıştır. Bu araştırma, son bir yılda özel bir hastaneden hizmet almış olan kişiler ile yüz yüze anket yöntemiyle yürütülmüştür. Yaklaşık dört yüz kişiyle yapılan araştırma sonucunda deneyim kalitesi ile katılım davranışı arasında olumlu bir etki olduğu, hastaneye olan güvenin aracı değişken olduğu ve hatırlama düzeyinin bu üçlü ilişkisi olumlu etkilediği gözlenmiştir.

Spesifik olarak sonuçlar, algılanan deneyim kalitesinin yeniden satın alma kararı üzerinde olumlu etkisi olduğunu ve bu ilişkiye hastaneye olan güvenin aracılık ettiği göstermiştir. Ayrıca, hastaneden ve hastane ortamındaki deneyimin algılanan kalitesinin önerme davranışına olumlu etkisi ortaya konmuştur. Bunun dışında, literatüre önemli bir katkı olarak, otobiyografik hafıza bileşenlerinin (etki, güç, detay), güven üzerinden ilerleyen deneyim-katılım ilişkisine olumlu etkileri gözlemlenmiştir.

Bu sonuçlar, sađlık sektöründe deneyim kalitesinin hasta katılımına olan etkisinin yanı sıra otobiyografik hafızanın bu ilişkiye olan katkısını ortaya koymaktadır. Araştırma, hasta deneyimini yeni boyutlarla bir reçete olarak sunmasıyla ve deneyim-katılım ilişkisini ölçmesiyle literatüre katkı sağlamakta, hastalarına iyi bir deneyim sunmak isteyen sađlık yöneticilerine bir rehber niteliđi taşımaktadır.

Aynı zamanda bu çalışmanın makro düzeyde tüketim kültürü açısından da literatüre katkısı bulunmaktadır. Hastaların artık bilinçli, bilgili ve güçlü tüketiciler olarak davranış göstermeleri ve karar vermeleri; hem tüketim kültürü yazını için hem sađlık yazını için önem taşımaktadır. Bunun yanı sıra bu çalışma hastane yöneticilerinin bu gibi deneyim iyileştirmelerini gözetmelerinin toplumsal sađlığa olası olumlu etkileri açısından önem arz etmektedir.

1. INTRODUCTION

Customer experience quality in service systems has become on the front burner in service systems after service dominant logic suggested by Vargo and Lusch (2004;2008) opened a new perspective for consumers. In fact, depending on the diversified and complex consumer needs, demands, and behavior, the definition of marketing has transformed into a relationship-focus one (Agariya and Singh, 2011; Barnes et al., 2004) in such a service-centric world. Additionally, consumer empowerment has become crucial for marketing since technology brings consumer-generated information to the front and it also affects changing needs, demands, and behavior of consumers. Hence, the life cycle of a consumer starts with deciding which service provider to choose, experiencing the service, continues with distilling the information from that experience and repurchasing, providing feedback, and sharing with other consumers, so-called engaging. The next consumer uses that distilled information and enters that cycle with that information in mind. Hence, the shared information should be positive in order to acquire or retain customers. In this sense, service providers need to understand the consumer behavior and serves a high experience quality in order to have engaged consumers. In this perspective, the relationship between experience and engagement is pretty critical for organizations. It is a quite new area to be researched in marketing literature by means of marketing strategy and consumer behavior fields.

Although all of the markets are affected by this cycle, one sector needs a distinct attention thanks to its specific consumers, growth, and uniqueness: health care. Health care marketing is one of the contemporary debates since the health care consumers are not counted as customers. However, in recent years, the transformation is mentioned more frequently and in Deloitte's (2019) report, the health care consumers are indicated as needing pulling solutions by themselves rather than being pushed to services. Although the deliberations about the bonds between patients, consumers, and customers continues, the competitive market of health care is growing. As a matter of fact, the market is performing a significant growth Turkey deserves specific attention

in health care thanks to the significant statistics reported by Turkish Union of Chambers and Exchange Commodities (TOBB). Every year, the market performs a 14% real growth. Besides, the number of private health care providers increased with a rate of 13% between the years 2009-2017. Considering these remarkable accruals, it can be inferred private health care needs to be analyzed as a distinct market with its unique characteristics. The sector contains different actors (physicians, nurses, administrative staff, managers, other patients, etc.). Analyzing this complex structure of health care will create a notable area for marketing with its incomparable dimensions.

Taking into account all of these notable developments, this thesis focuses on health care marketing and tries to understand what the patient experience is and what are the consequences of a high perceived patient experience quality in terms of engagement outcomes. Besides, the effects of trust and autobiographical memory are investigated. First, the critical touchpoints of patient experience are determined by a qualitative study. The results reveal a 5-point model for patient experience. In accordance with the results of qualitative phase, the association between patient experience dimensions and engagement are investigated under the mediation effect of trust to hospital and moderated mediation of autobiographical memory for the experience. The results indicate that patients who remember the hospital experience more have higher intention to be engaged for specific dimensions. The results are expected to contribute the marketing literature as it has a new perspective to healthcare experience and engagement. The contribution of this thesis is twofold: (1) the qualitative phase provides a new model of patient experience quality, (2) the quantitative phase suggests a novel approach for the literature by analyzing the effect of autobiographical memory on patient experience-engagement relationship via trust.

2. THEORETICAL FRAMEWORK

2.1 Transformation of Marketing: From Relationship Marketing to Engagement Marketing

Marketing has been changing under the effect of two parallel conversions: development of the consumer, and evolvement of the focus of marketing. Consumers have become active, informed value contributors in a changing world of marketing. Product orientation of marketing approach have been changed to a service orientation with the effect of exchange relationship perspective. These two developments together brings marketing to today, which empowered customers co-create value with firms in parallel with the experiences they lived with that firms. As it is shown in Table 1, new era of marketing lead to some changes in relationship between the firm and the consumer. In macro environment (the market), the unidirectional relationship with a sale focus is converted into a multidirectional experience focus. The relationship which was being controlled by the firm is now controlled by the relationship between customers, since the customers are connected to each other and continuously create information and publish online. Besides, there are some transformation in microenvironment (the management). Instead of designing short-term promotions, building long-term relationships with customers has gained attention. Mass segmentation, which customers must fit into firm's offerings is converted into personalization, which each and every consumer has his or her own unique characteristics. Finally, providing high quality in products, services, or experience is now the task for all employees, not only one related department. The details of these developments in marketing will be discussed in detail in the following paragraphs.

Table 2.1 : Transformation of relationship between firms and consumers (adopted from Prahalad and Ramaswamy (2005) and Bowie and Buttle (2004)).

From	To
<i>Macro</i>	
Sale focus	Experience focus
Firm to consumer	Consumer and firm together
Controlled by firm	Controlled by the relationship between customers
<i>Micro</i>	
Short term promotions	Long-term relationship building
Segmentation	Personalization
Quality as a department-specific issue	Quality is an issue for all employees

Since 1940s, marketing has changed evolutionarily in every decade in terms of the role of the buyer. Economic man in 1940s became a problem solver in 1970s and a collective decision maker in 1990s (Zaichkowsky, 1991). In 2000s and 2010s, digital era reached its climax and a digital native born to be the new buyers with their own rules. Passive consumers have been converted into active decision makers since they have become online information gatherers and have started to use the information for their decisions. This empowerment of consumers changed the marketing rules in recent years. Although consumer have been the main focus of marketing management since the early years of marketing thought, satisfying the customer needs has become an inseparable part of marketing concept with achieving organizational objectives since 1990s (Anderson et al., 1999). Becoming cognitive misers who do not spend money on unnecessary disposals, consumers have grown into collective decision makers searching for the best in 1980s and 1990s. After millennium, technology and digitalization manifested itself especially on consumer behavior. The customer has become full of knowledge, connected and active instead of uninformed, isolated and passive as in the early years of marketing (Terblanche, 2005). As digital environment sharply increased the ability of consumers to reach and use the information, they started to take an active role on value creation process. The marketers and customers together co-create value in terms of production and consumption of the product or the service (Sheth et al., 2000). Prahalad and Ramaswamy (2004) summarized this new value creation process starts with co-creating with the consumer and ends with focusing on the experience networks. This process is a circular one, since the ending point with experience will lead a new co-creation process. This circle has the

experience in the center; hence, it is inevitable for marketing to have experience as a focus.

The main focus of marketing has also been changed in years. In the beginning of 1970s, services became a separate area for marketing with its specified concepts and models (Grönroos, 1994). Hunt stated that the main focus of marketing is the exchange relationship in 1983 (Bowden et al., 2015), and Morgan and Hunt (p.22) said, “all marketing activities directed towards establishing, developing, and maintaining successful relational exchanges” about relationship marketing in 1994. However, the paradigm shift in marketing in the scope of goods and services has been started to be discussed after the study of Vargo and Lusch (2004, 2008). In their studies, it is stated that the transactional perspective of traditional marketing, so called goods-dominant logic, is converted into a relationship-based marketing, so called services-dominant logic. The S-D logic opened novel a perspective, in parallel with the transformation of consumer, which suggests that consumers are co-creates value with organizations bilaterally (Brodie et al., 2011) instead of buying goods and exiting the system unilaterally. Customers develop relationships with the sellers and this relationship creates the value (Harmeling et al., 2017). Yet, “value is always uniquely and phenomenologically determined by the beneficiary” (Vargo and Lusch, 2008). This premise is based on the experience economy, where the beneficiary is the consumer who lived the experience (Brodie et al., 2011; Pine and Gilmore, 1999). As a consequence of experience, the exchange-of-good roots of marketing has been changed to exchange-of-value (Vargo and Lusch, 2008; Prahalad and Ramaswamy, 2004). In this new experience-based era, active consumers who are connected, informed, empowered, and engaged can contribute to the value creation process (Prahalad and Ramaswamy, 2004). This perspective leads to a new era in the marketing literature with its integrative approach to goods and services. Briefly, the goods and services are not distinct marketing areas anymore since they both creates values with the service.

This transformation in marketing allowed consumers affect the marketing functions more than ever before (Kumar and Pansari, 2016). Hence, traditional company-centric approach of marketing has turned into consumer-centric approach. In order to have competitive advantage, marketers should use that consumer empowerment by influencing them by providing memorable and valuable service experience. A consumer who have a memorable experience will co-create the value instead of co-

destruct it. Hence, this era can be named as the experience dominant logic. Although every product is considered as service in service dominant logic, experience dominant logic may say that every single product and service needs to create a superior experience value in order to satisfy the consumers and have them as value co-creators with the interactive relationship.

Since it is difficult to give an exact definition for value because of its complex, fuzzy and overlapping nature (Gummesson, 2006), various outcomes may be considered as created value. It can be said that the value created with the relationship with customers is not only a financial one. The behavior beyond purchase, so-called engagement, is the new co-created consumer value for the organizations (Brodie et al., 2011). Engaged customers are one step ahead of the loyal customers who make repurchase products and services frequently (van Doorn, 2011). In engagement marketing, firms encourage customers to participate and contribute the marketing functions with such activities as word of mouth, social media participations, peer interactions, etc. Engagement activities are highly beneficial for the firm since it is many times more effective than traditional marketing communication channels (Katz and Lazarsfeld 1995; Harmeling et al., 2017). The engagement activity may vary in different sectors. For instance, compared to functional/utilitarian services, participative/co-creative services such as restaurants, tourist attractions, hairdressers etc, needs stronger customer engagement since they are relationship oriented (Bowden et al., 2015). In such market which is highly relationship oriented as healthcare, referrals are more important than purchasing behavior (van Doorn et al., 2010).

2.1.1. Relationship marketing

Marketing has changed in years (Figure 2.1). The relationship marketing is defined as a philosophy and a strategic orientation of a business that focuses on the activities in order to build, maintain and develop long-term relationship with customers, especially focusing on keeping them (Nykamp, 2001; Zeithaml and Bitner, 2000; Menconi, 1999; Berry, 1995; Berry, Shostack, and Upah, 1983). In fact, the definition of marketing can be stated as the firm-customer interactions and extendible relationship networks (Gummesson, 1999). The relationship is likely to resist if the customer needs are met with it (Falkenreck and Wagner, 2011; Cannon and Perrault, 1999).

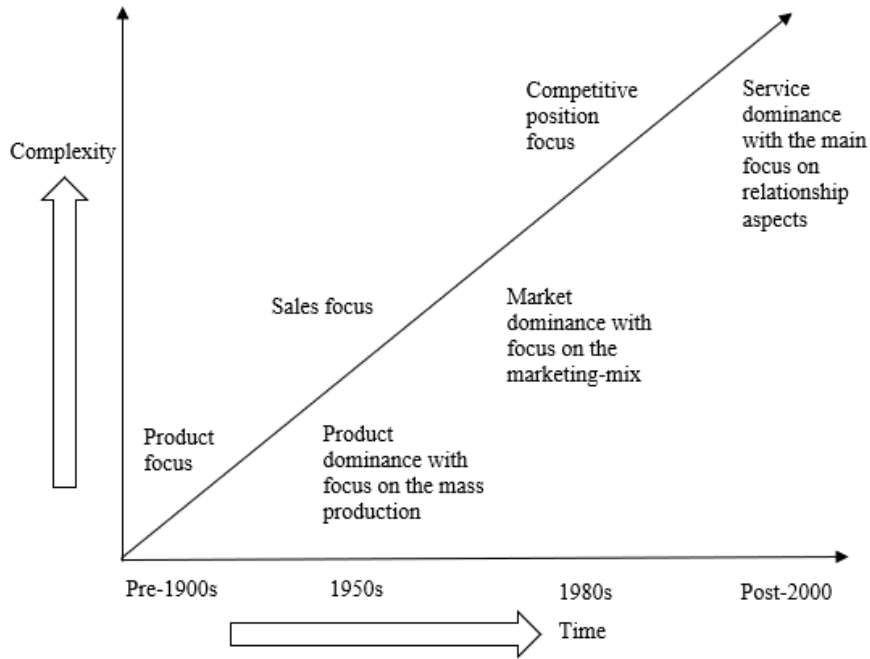


Figure 2.1 : Shift in the Marketing Approach (Ambler, 2004; Christopher et al. 1991).

In previous literature, relationship marketing is considered as a main construct including dimensions such as trust, commitment, cooperation, closeness, relationship quality, satisfaction, loyalty, service quality (Agariya and Singh, 2011; Lindgreen, 2001). Some definitions of relationship marketing can be seen on Table 2.2. In general, commitment and trust are the commonly accepted key variables of relationship marketing (Morgan and Hunt, 1994). Focusing on these two dimensions, the quality of relationship is a measurable construct of relationship marketing. It is the measure of the strength and the degree to which it meets the needs of buyers and sellers (Smith, 1998). To have a high degree of relationship quality, a customer should be confident about company's integrity and competence (Bowie and Buttle, 2004). The company's keep of promises meet the needs of customer and makes him/her feel secure, hence the long-term relationship is established on the roots of trust (Bowie and Buttle, 2004; Gronroos, 1994).

Table 2.2 : Selected definitions of relationship marketing (Adopted from Agariya and Singh, 2011).

Author and Year	Definition
Berry et al. (1983)	attracting, maintaining, and enhancing customer relationships in multiservice organizations
Gronroos (1990)	the establishment, maintenance, and enhancement of relationships with customers and other stakeholders at a profit so that the objectives of all the parties involved are met
Berry and Parasuraman (1991)	a process of attracting, developing, and retaining customer relationships
Morgan and Hunt (1994)	all marketing activities directed toward establishing, developing, and maintaining successful relational exchanges
Ballantyne (1997)	an emergent disciplinary framework for creating, developing, and sustaining exchanges of value between the parties involved, whereby exchange relationships evolve to provide continuous and stable links in the supply chain
Bowie and Buttle (2004)	both a philosophy that puts customer retention at the heart of the business process and a marketing strategy, with a set of tools and practices, which a company uses to implement relationship marketing objectives successfully
Kotler and Armstrong (2004)	the overall process of building and maintaining profitable customer relationships by delivering superior customer value and satisfaction
Lambert (2010)	as strategic, process oriented, cross-functional, and value-creating for buyer and seller and as a means of achieving superior financial performance

Relationship marketing has become popular in parallel with the rise of service sector focusing on long-term customer relationships by building customer interactions and encouraging customer participation (Gummerus et al., 2017). Interaction is a critical key for services, because it is the main difference between transactional marketing and relationship marketing (Gummesson and Mele, 2010; Lovelock and Wirtz, 2010; Gummesson, 2008; Gronroos, 2004). However, the customer now interacts with not solely one firm but the whole players such as communities of professionals, suppliers and other consumers (Prahalad and Ramaswamy, 2004). Since this provides a wide collaboration for the value creation process, consumer becomes a value creator by itself, not by helping the firm, but by working with the firm about what the value should be. In that process, the consumer is in interaction with other consumers in the

market. Consumer-to-consumer communication has become a powerful source of information, and this type of communication is independent from the firm (Prahalad and Ramaswamy, 2004). Hence, consumers have the power to choose the company they interact with.

The consumers use this power in every market. Service has an effect on our lives and well-being in all branches (Anderson and Ostrom, 2015), since consumers engage in services in daily lives by interacting with restaurants, banks, grocery stores, etc. and co-create value with the service employee (Anderson et al., 2013). Health care has a remarkable place among these markets.

2.1.1.1. Relationship marketing in health care

Relationship marketing is a highly studied concept in health care studies. According to the review of Agariya and Singh (2011), the most mentioned constructs in the studies of relationship marketing in healthcare are: satisfaction from the service and the employee in all levels (doctors or personnel), service quality, trust, communication/interaction. Over the past years, competition and market pressure in health care industry have been increased (Lindgreen et al, 2011). There are several reasons for that situation: informed and empowered patients, and the private industry which are trying to satisfy those patients. Today's healthcare providers need to find a way to meet the needs of the new patients at low cost (Stanowski et al., 2015; Lindgreen et al., 2011). The transformative service research which is defined as "the integration of consumer and service research that centers on creating uplifting changes and improvements in the well-being of consumer entities: individuals (consumers and employees), communities and the ecosystem." (Anderson et al., 2013, p.1204), have started to deal with health care. Hence, transforming service in healthcare is worth to examine.

For both developing and developed country economics, creating value in healthcare for ageing populations and in an era of continuously improving medical technology is a challenge (Zolkiewski, 2011; Speight and Reaney, 2009; Moore, 1996). Opposite of Michael Foucault's (1976) perspective of the impossibility of co-creating value with the patients, consumer research perspective argues that patients co-create value while experiencing the seeking of medical solutions (Tian et al., 2014). The value in healthcare is created since the health care industry liberates the patients from the

psychological burden (Botti, Orfali, and Iyengar 2009). However, creating value in health care industry have three types of difficulties (Dobele and Lindgreen, 2011):

- Information asymmetry between buyer and seller
- The search of good health instead of good service
- High degree of risk

In early years, health care was a sector in which consumers had been disadvantageous because of the lack of their information and expertise (Anderson et al., 2013). However, with the transformation of the consumer, patients become informed consumers who are trying to make the best decision by using their knowledge and information. The patients are no longer accepted as patients any more, they are the consumers since the information asymmetry no longer exists. On the other hand, patients as consumers, are affected by good service. In an growing healthcare sector, patients are seeking for better services and experiences. Risk is still an issue for the sector, since it is something about the human health. It is not only about wellness and aliveness but also about human right to live (Belk, 1988), so risking the human life and right is a challenge for the sector.

Healthcare is an intangible and heterogeneous service which is complex, customized, and multi-layered with various transactions, so relationship between the consumer and the provider is critical (Dellande et al 2014; Laing and Cotton 1996; Crosby et al., 1990). The interaction between the patient and the medical staff affects the patient's well-being not only physically but also psychologically because people buy services from healthcare providers at the most depressed, anxious and vulnerable times (Klaus, 2018). If the patient is the customer, then the provider becomes the seller with an objective of meeting the needs of its customers and satisfy them (Mazurenko et al., 2016). These customers with illnesses are exposed to marketing communications promising hope and treatment (Kemp et al., 2015). Accordingly, if they explore how to provide better experience, they need few resources for having higher satisfaction scores (Stanowski et al., 2015). Satisfied customers, with intrinsic or extrinsic motivation, act as lower cost part-time marketers with great impact for the firm, contributing marketing functions (Harmeling et al., 2017; Malthouse et al., 2013; Kozinets et al., 2010; Nambisan, 2002). Hence, healthcare providers should learn how

to interact with patients efficiently in order to have influence their lives positively by serving better experiences.

2.2 Reciprocity in Consumer Behavior

Reciprocity is an exchange of resources, which provides mutually pleasing, and defined by Gouldner (1960, p.174) as “insofar as men live under such rule of reciprocity, when one party benefits from another, an obligation is generated. The recipient is now indebted to the donor, and he remains so until he repays”. In parallel with this meaning, reciprocal behavior is a fair response to fruitful or detrimental acts as reward or punishment, respectively (Hahn and Albert, 2017; Sethi and Somanthan, 2003; Fehr and Gächter, 2000; Sugden, 1984). The phenomenon suggests that positive actions or resources makes recipients feel indebted and think they can only pay by reciprocation (Chan and Li, 2010; Dahl et al., 2005; Morais et al., 2004). Since reciprocity triggers the returning behavior, various studies supported the reciprocity theory empirically. The major contributions are summarized by Kolyesnikova et al. (2009):

- The rewarding behavior can be made after receiving even a small (Howard, 1995), an unsolicited or unexpected (Regan, 1971).
- Even the giver is not likeable, the favor leads to future compliance (Goei et al., 2003)
- The publicity of the favor positively affects the size of the compliance. If it is public greater compliance occurs, however, if it is received in private, the compliance will be less (Whatley et al., 1999).
- The time decreases the need for reciprocation. As the time passes since the favor is given, the need to reciprocate lowers (Burger et al., 1997).

Reciprocity can be a light for understanding consumer behavior in terms of the relationship between past experience and future behaviors. Gouldner (1960) puts gratitude and obligation in the basis of the theory as the antecedents of reciprocal action. Although the purchase may not seem as a compliance for a favor, consumers subconsciously know that the firm will benefit from that purchase and this will create a mutually beneficial reciprocity (Kolyesnikova et al., 2009). The purchase here may be seen as an expression of gratitude since the firm will get benefit from that action.

Hence, gratitude is effective on reciprocal action (Kolyesnikova et al., 2009). To illustrate, people feel obliged to purchase a product when they get a free service from a store.

In one sense, reciprocity may be considered as a personal one which consumer expects a return from the firm. For instance, a consumer who spends time, money or gives personal information may expect a beneficial return from the brand (Baird and Parasnis, 2011). Besides, consumers may expect some emotional or functional return after the engagement behavior, such as for rewarding after referral (Rehnen et al., 2017; Shi and Wojnicki, 2014) or for intrinsic motivation of an engagement activity of getting involved in a brand community (van Doorn et al., 2010; Ryan and Deci, 2000). However, on the other side, reciprocity is also made by the consumer after a favor is given by the firm. In this study, the favor-giver is considered as the firm and the reciprocal action of the customer is considered.

According to Bagozzi (1995), reciprocity, which he defines as “an essential feature of self regulation and the problem of coordinating mutual actions for parties in a marketing relationship” (p. 275), is at the heart of marketing relationships. In consumer behavior, non-contractual behaviors such as citizenship or extra-role behaviors can be counted as the results of reciprocity (Rosenbaum and Massiah, 2007). The relationship between active and interdependent relationship partners involve reciprocal exchange and all relationships are grounded to reciprocity as it is the key ingredient for a long-term customer relationship (Fournier, 1998). In general, the partnership between consumer and brand (Davies and Chun, 2003) or loyalty (Morais et al., 2004) are the reciprocal ones. Hence, the reciprocity can be considered as an investment to consumer relationships (De Wulf et al., 2011) since it converts consumer-brand relationships into meaningful actions (Fournier, 1998).

The appreciation of a person to a kind one is the same as the consumers’ reciprocal action to a favor-giving firm. A high-quality experience may result as an engagement behavior or meeting a need may motivate the customer to repurchase. Hence, a firm is rewarded if the customer perceives the firm as a favor-giver after the memorable experience is provided.

2.3 Customer Experience Quality

Customer experience quality is conceptualized as the “perceived judgement about the excellence or superiority of the customer experience” (Lemke et al., 2011). Product quality and service quality, as the more familiar concepts of marketing, are defined as a customer perception formed after a judgement on superiority of using those (Parasuraman et al., 1985, 1988; Zeithaml, 1988), in parallel with the quality definition (Zeithaml, 1988). However, in this new era, the importance of experience comes out. Since consumption experiences affect and change the customers’ perception of quality (Fatma, 2014; Thompson and Getty, 1994), the companies should focus on experience-based economy, which has an economic value (Pine and Gilmore, 1998; Holbrook and Hirschman, 1982).

The economic value created in the experience process includes searching the appropriate product or service, purchasing it, and evaluating after buying. Through this process, customer experience is being formed personally and subjectively in a holistic set of interactions across certain touchpoints of the organization (Lemke et al., 2011; Gentile et al., 2007; Meyer and Schwager, 2007). These touchpoints constitutes a set of experiences with various steps (Verhoef et al., 2009). The experiential marketing aims to create a holistic experience instead of individual one (Schmitt, 1999), considering pre and post experience (Verma and Jain, 2015; Tynan and Mckehnie, 2009). Value creation is not a linear and cognitive process restricted to only service encounters (Helkkula et al., 2012), even prepurchase influence experience in terms of creating unique and personalized value and building relationship to customers to learn their needs (Edvardsson et al., 2015) since journey has three stages: prepurchase, purchase, and postpurchase (Lemon and Verhoef, 2016). However, search is not the very first step of pre purchase. Being exposed to marketing communication activities should be counted in shaping customer experience. Additionally, in some circumstances, the points can be differentiated. To illustrate, for a hotel service, the road between the visitor’s house and the hotel is an effective step in the experience (Tribe and Snaith, 1998). Hence, considering the perceived value created through the experience process needs a process perspective, which is shaped by excellent customer experiences in any single touchpoint and in their combination (Schmitt, 2003). Monitoring the experience from touchpoints is getting more and more critical as the number of touchpoints between a customer and a company increase (Gentile et al.,

2007). According to the Theory of Exchange (Ballantyne et al., 2006), three exchange-enablers improve the value-in-use: relating for building relationships to support the creation of knowledge, communicating for interaction for developing the relationship, and knowing for improving the customer service experience.

This journey perspective puts the big picture forth about the customer. Each touchpoint even if it is under the control of the company or not, gives some clues about the process of the customer and helps exploring the experience (Verhoef et al., 2009; Swinyard, 1993). The customers do not only consider the product and service quality, they evaluate the whole experience quality proposed by the organization, in parallel with the attribution theory (Lemke et al., 2011). The theory embodies the bonds that people build between events and causes (Puccinelli et al., 2009). A customer may assign some reasons for the firm's behavior, such as promotion or new product, or experience design and reacts in parallel with the attributed cause. For instance, a hairdresser does not only serve a good haircut. Additionally, an enjoying conversation while having a haircut affects the customer experience. Since the employees is a critical element of each touchpoint, they influence the customers' perceptions about the organization (Kumar and Pansari, 2016). Furthermore, the physical appearance of the hairdresser gives some clue about the quality of the service (see Parasuraman et al., 1988). Thus, such assets of the organization deliver value propositions about the firm, which the customer attributes to. The value is co-created by the consumer who reshapes these propositions while using the service (Vargo and Lusch, 2004).

The value from experience is extracted from the perception while interacting with the consumption setting in order to meet the needs or achieve the goals (Holbrook and Hirschman, 1982). The experience and the service are two complementary assets of an organization because good customer experience can be achieved by a good customer service (Berry et al., 2006). There is a significantly positive relationship between customers' experiences and satisfaction and evaluations of a particular service (Otto and Ritchie, 1995). Creating superior experience value is one of the main objectives of service organizations (Maklan and Klaus, 2011; Verhoef et al., 2009). It is defined as a continuous, circular, and iterative process created individually and collectively (Helkkula et al., 2002). Today's consumer is searching for a memorable experience instead of a competent one provided with an aim of having financial benefit from the customer (Lemke et al., 2011; Gilmore and Pine, 2002). This creates a competitive

challenge for organizations in order to keep the customer satisfied and engaged in value co-creation process. Hence, engaging customer in the co-creation process is possible with providing a satisfying service resulting with a high experience quality.

As Helkulla (2010) states, there are three approach to experience research: phenomenological service experience, process-based service experience, and outcome-based service experience. Phenomenological one deals with the discussion of the value created, process-based relates the step-by-step consideration of the experience, outcome-based considers the experience as a variable in models of service. Customer experience is considered as a holistic process in the co-creation perspective, including a series of all interactions (Klaus and Maklan, 2012). The path includes communication, service, and usage quality (Lemke et al., 2011) which should be considered as a whole instead of distinct points. The distinction here may be made in parallel with the expectations of the consumer. Consumers do not behave only with rational reasons, they expect some experience from the brands, which influence them sensorially, emotionally, and creatively (Ebrahim et al., 2016). Only some of the touchpoints may be relevant in customer experience quality (Lemke et al., 2011). Since the customer experience is a personal and subjective process, the expectations may differ by individual or by sector. Hence, the specific components in a customer journey should be identified in order to monitor customer experience (Lemon and Verhoef, 2016). This thesis has a perspective of process-based service experience with its process approach to healthcare experience in the hospital, with an aim of extracting the critical touchpoints of patient experience to monitor.

To illustrate, the patient experience process of a patient may start with an online search of a good doctor. After searching for the doctor online or offline, the patient finds the hospital and get an appointment. In the appointment day, he/she reaches the hospital by car/by public transportation. The experience starts to be formed. Some personal perception is created in the patient's mind after entering the hospital by the smell, the physical evidence, the crowdedness, the atmosphere in general. The interaction with the employee in the desk, with the employee in the waiting room, and with the doctor in the consulting room continue shaping the experience. The service quality in this whole process, the competence of the doctor, and the responsiveness of the employee are additional factors in the experience. Treatment result and the following attitude of the doctor can be counted as the steps for the patient experience. In this example,

several touchpoints can be determined: webpage, physical atmosphere, employee-interaction (staff and doctor), patient follow-up. However, critical steps should be determined and monitored.

2.4 Patient Experience

There is an increasing demand for improved medical care services and increasing interest in hospital services, as lifestyles have been changed and needs have been differentiated (Amin and Nasharuddin, 2013). Accordingly, health care organizations have started to focus on marketing (Fortenberry and McGoldrick, 2016) since patients behave like traditional customers when they have the chance to choose between different health service alternatives, especially by searching such information online (Mazurenko et al., 2016). In such a customer-centric era, patients evaluate their alternatives although switching the hospital may not be cost-effective for them (Otani et al., 2009). Research show that patients make their hospital choice depending on the previous experience instead of clinical outcomes (Needham, 2012; Abraham et al. 2011; Kaiser Family Foundation and AHRQ 2000).

Since patient experience is a recent concept that grabs attention, several approaches exist for its definition. Klaus defines patient experience as:

A service provision in an environment where the goals of the customer can be complex, and where appropriate service to the customer may take the provider beyond the typical customer service approach of striving to provide immediate customer gratification with the ultimate outcome of improving the patient's quality-of-life perceptions (Klaus, 2018).

According to the Agency for Healthcare Research and Quality, patient experience...

...encompasses the range of interactions that patients have with the health care system [and] includes several aspects of health care delivery that patients value highly when they seek and receive care, such as getting timely appointments, easy access to information, and good communication with health care providers. (AHRQ, 2017).

The Beryl Institute (2014) defines patient experience is as "...the sum of all interactions that influence patient perceptions across a continuum of care and is

associated with patient compliance (Kenagy, Berwick, and Shore, 1999) and clinical outcomes (Pichert et al. 1998).”

The critical keywords in the definitions can be summarized as: complexity, quality-of-life, interaction, value perception, and continuum of care. These keywords can be used as the main reasons why measuring and analyzing patient experience is quite difficult and should be paid attention in detail. The critical factors those are effective on patient experience quality perception may be the relationship with medical or administrative staff (Deloitte, 2016; Granatino et al., 2013), physical environment (Deshwal and Bhuyan, 2018; Mazurenko et al. 2015; Fottler et al., 2000), or medical care (Duggirala et al., 2018; Brauer et al., 2018; Kennedy et al., 2011), etc. In experience, the total process including related dimensions that the service provider cannot control such as purpose of the customer or other influencing people is encompassed in multiple channels (Verhoef et al., 2009). According to the keywords extracted from the definitions, experience is complex in healthcare system. However, in healthcare, patients value the experience of co-creating the value with the doctor about their individual circumstances (Prahalad and Ramaswamy, 2004). This unique experience depends on the way that the patient creates her or his and may differentiate from patient to patient (Prahalad and Ramaswamy, 2004). Hence, the organizations should focus on creating a healing environment.

Majority of studies in this domain have been mainly occupied with identifying the dimensional structure of patient experience, each approaching the issue from a different angle, hence producing a plethora of higher order constructs capturing different aspects of the healthcare servicescape. Otani (2009; 2010; 2012) identified six major experience episodes that shape up the overall patient experience, namely admission process, nursing care, physician care, staff care, food, and room. Otani's works have been seminal in nature due to the fact that they aimed to capture a comprehensive understanding of patient experience as they span all of the major patient contact points in a healthcare service delivery. Following studies were more focused on specific touchpoints or branches of hospitals in assessing patient experience. Brauer et al. (2018) analyze the patient experience in primary care service and identified five dimensions: trust, general communication, first-contact accessibility, whole-person care, and respectfulness. Finding respectfulness as a separate concept is remarkable as a dimension related to human. Deshwal and Bhuyan

(2018) also find five factors to delaminate patient experience: environmental, emotive, behavioral, comfort, and social experience. Again, the majority of the factors are related to personal issues. Different from those studies, Mazurenko et al. (2015) use a different approach and conduct focus groups with the members of different levels of healthcare system. They also retrieved several concepts for only surgical patients including physical appearance, provider-patient relationship, interdisciplinary relationship, communication, staff responsiveness, and patient's emotional response. Although these studies put some clues about patient experience forth, an integrative perspective for patient experience and a macro approach to healthcare system is needed in the literature.

Some studies focus on strategic managerial improvements for higher patient experience scores. A framework beyond HCAHPS measurement is provided to improve patient experience strategically, considering the patient experience culture inside the hospital, patient-provider communication, information transparency, patient engagement, accessibility, empathetic environment, and quality outcomes by Birkelien (2017). Besides, Fottler et al. (2000) focus on creating a healing environment and consider physical environment as a crucial dimension in patient experience design and suggest a prescription. Another approach puts culture into focus and present employee-based roadmaps. These studies pay attention to internal marketing strategies mostly. In the study of Kennedy et al. (2011), management-based improvement is taken as the key and seven layers are introduced to improve service quality: multiple data sources, accountability, service consultation and improvement tools, service values and behaviors, education and trainings, ongoing monitoring and control, recognition and reward. For service values and behaviors of the employee, five dimensions are identified: solution-focused, empathetic, reliable, valuing others, exceeding patient expectations. Bonebrake and Ratchford (2017), indicates a four-step implementation strategy in order to create patient experience culture in healthcare organizations by setting common goals, deploying standard work, establishing infrastructure to ensure spread, and listening and responding to the voice of patients and their families. Fortenberry and McGoldrick (2016) consider employees as the keys to improve patient experience and suggest a roadmap for health care managers in terms of internal marketing. They formulize the roadmap in four stages: program establishment, campaign formulation, campaign implementation, and campaign evaluation. Since the

research in the literature provide several concurrent and/or varied dimensions (see Appendix B), this study aims to get the root of patient experience by going beyond the single-sided perspectives for specific branches in health care.

Experience quality in healthcare services includes functional and technical sides of the services (Brady et al., 2006; Gronroos, 1984). Technical sides include the medical treatment points (Mazurenko et al., 2015) such as, existence of post-operative complications (Danforth et al., 2014), achievement of the surgery or treatment goals (Biggs et al., 2015), patient-nurse ratios (Jha et al., 2008), or the type of medical intervention (Marks et al., 2015). Functional sides include the service out of medical services. Clinicians' perspective suggests that functional skills are critical for patient experience while patients' perspective focuses on interpersonal skills (Kim et al., 2004; Safran et al., 2003). In healthcare services, patients have some anxiety or stress because of the lack of knowledge or control about medical treatment or lack of control (Klaus 2018; Berry et al., 2015). Since hospital experience is a stressful situation (Hultman et al., 2012; Tanja-Dijkstra, 2011), an environment which reduces the stress level should be provided (Andrade and Devlin, 2015). Theory of supportive design (Ulrich, 1991) suggests that a physical environment which supports the patients' well-being with its positive nature. According to the theory, environment with positive conditions and resources such as social interactions, control, and distraction may be used to reduce the stress level (Andrade and Devlin, 2015; Ulrich, 1991). According to Distraction Theory (Shirey and Reynolds, 1988), positive distractions such as photographs, newspapers, etc. or smiling and talking people around the waiting room can help patients forget about their anxiety (Andrade and Delvin, 2015; Berman et al., 2008) However, physical environment is just a one layer of the service design (Andrade and Devlin, 2015). Social elements of the service environment should also have a supportive characteristic in order to foster the patient's well-being (Andrade and Devlin, 2015; Ulrich, 1991). Addition to the physical service environment, the interaction with physicians, nurses and administrative staff has a critical effect on experience quality perception (Gill and White, 2009). Patients even prefer only one provider for all health issues if they are familiar with the provider, thus evade the need for effective communication (Needham, 2012; Lathrop, 1993). Positive interaction increases the patients' confidence on medical advices (Sandoval et al., 2006). However, the satisfying interaction needs engaged employees who are aware of their

contribution to the experience perception of patients and continuously work for delivering excellent service. Perpetual controls and disciplinary checks should be used as effective tools for internal marketing in order to have engaged employees (Fortenberry and McGoldrick, 2016). Although it is pretty difficult to create such a culture, not only managerial staff but also the frontline employee have to care about feedback patient experience feedback in order to foster creating the patient experience centered environment (Graham et al., 2015). The leaders leverage their teams in terms of better interaction with the patients by taking the actions which provides the continuum of care at all touch points (Wolf, 2016).

The continuous and repetitive assessments of patient experience is critical for adding value to the health service (Brauer et al., 2018). An extensive usage of Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys in hospitals is accepted as measuring patient experience. The HCAHPS surveys ask patients to report some certain aspects of experiences instead of asking how satisfied they are (AHRQ, 2017, <https://www.ahrq.gov/cahps/about-cahps/patient-experience/index.html>). The surveys include questions such as “During this hospital stay, how often was your pain well controlled?” or “During this hospital stay, did hospital staff talk with you about whether you would have the help you needed when you left the hospital?” (see Table 2.3). These questions ask patients if the employee did his or her job properly. This method addresses more likely to improve total performance scores of the departments or employee (Stanowski et al., 2015). Besides, these kinds of questions are insufficient to state minor problems or to foresee the patients’ opinions (Brauer et al., 2018), since patients are instructed to evaluate which kind of experience to evaluate. Measuring only the patients’ reflections, one-sided surveys do not take other health care actors and their different perspectives into consideration (Mazurenko et al., 2015). On the other hand, CollaboRATE is another measurement tool, which focuses on the perception of patients about being informed and participated in decision-making process (Forcino et al., 2017; Elwyn et al., 2013). The tool includes brief questions (see Table 2.4), thus easy to implement and cost saving (Forcino et al., 2017). Furthermore, England is a distinctive example for measuring patient perceptions. National Health Service (NHS) use Patient Opinion to gather patients’ anecdotal feedback online and National Patient Survey Programme to collect quantitative data from thousands of patients (Graham et al., 2015). Secret

shoppers have also been used as a technique for reaching the most realistic estimations of patients' view (Granatino et al., 2013) in order to understand the patients' motivations and causes about the answers they give to the surveys (Buckley and Larkin, 2007).

In a customer-centric world, the only data to bring success to healthcare organizations is the patient (customer) perception (Wolf, 2016). The critical perspective in measuring patients' view is to be able to identify who the customers are and to understand what they need (Mazurenko et al., 2015). The attempts to reach better measures for patient experience perception, recent customer experience measures such as experience quality scale (Klaus and Maklan, 2013) and behavioral outcome can be used as effective tools (Klaus, 2018) by implementing real-time surveys (Forcino et al., 2017) within days of a hospital visit (Stull et al., 2009).

Satisfying and retaining the patients as consumers by providing better medical service have been a critical issue for health care organizations (Amin and Nasharuddin, 2013; Alhashem et al., 2011; Arasli et al., 2008), since better patient experience scores result as decreased churn rates between hospitals (Colgate and Hedge, 2001), increased loyalty (Kessler and Mylod, 2011), recommendation (Long, 2012; Otani et al. 2010), revisit intention (Otani et al., 2010; Swan et al., 1985). Not only patient expectations and perceptions of quality but also the memories of experience should be taken into consideration in order to understand patient behavior (Dube et al., 2003). The challenge for healthcare organizations in such a competitive environment is to be able to win the hearts of patients by seeing the service from patients' eyes and focusing on providing memorable service experience and excellent patient satisfaction ratings (Deshwal and Bhuyan, 2018; Otani et al., 2009).

Table 2.3 : HCAHPS questionnaire.

No	Items
	<i>Your care from nurses</i>
1	During this hospital stay, how often did nurses treat you with courtesy and respect?
2	During this hospital stay, how often did nurses listen carefully to you?
3	During this hospital stay, how often did nurses explain things in a way you could understand?
4	During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?
	<i>Your care from doctors</i>
5	During this hospital stay, how often did doctors treat you with courtesy and respect?
6	During this hospital stay, how often did doctors listen carefully to you?
7	During this hospital stay, how often did doctors explain things in a way you could understand?
	<i>The hospital environment</i>
8	During this hospital stay, how often were your room and bathroom kept clean?
9	During this hospital stay, how often was the area around your room quiet at night?
	<i>Your experiences in this hospital</i>
10	During this hospital stay, did you need help from nurses or other hospital staff in getting to the bathroom or in using a bedpan?
11	How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?
12	During this hospital stay, did you have any pain?
13	During this hospital stay, how often did hospital staff talk with you about how much pain you had?
14	During this hospital stay, how often did hospital staff talk with you about how to treat your pain?
15	During this hospital stay, were you given any medicine that you had not taken before?
16	Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?
17	Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand?
	<i>When you left the hospital</i>
18	After you left the hospital, did you go directly to your own home, to someone else's home, or to another health facility?
19	During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital?
20	During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital?

Table 2.3 (continued) : HCAHPS questionnaire.

No	Items
	<i>Overall rating of hospital</i>
21	Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?
22	Would you recommend this hospital to your friends and family?
	<i>Understanding your care when you left the hospital</i>
23	During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.
24	When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.
25	When I left the hospital, I clearly understood the purpose for taking each of my medications.
	<i>About you</i>
26	During this hospital stay, were you admitted to this hospital through the Emergency Room?
27	In general, how would you rate your overall health?
28	In general, how would you rate your overall mental or emotional health?
29	What is the highest grade or level of school that you have completed?
30	Are you of Spanish, Hispanic or Latino origin or descent?
31	What is your race? Please choose one or more.
32	What language do you mainly speak at home?

Source: HCAHPS web site (<http://www.hcahpsonline.org>)

Table 2.4 : The items in CollaboRATE.

No	CollaboRATE items
1	How much effort was made to help you understand your health issues?
2	How much effort was made to listen to the things that matter most to you about your health issues?
3	How much effort was made to include what matters most to you in choosing what to do next?

Source: Elwyn et al., 2013, Developing CollaboRATE: A fast and frugal patient-reported measure of shared decision making in clinical encounters

2.5 Autobiographical Memory

In psychology literature, autobiographical memory is defined as “a complex cognitive system mediated by neural networks distributed through large areas of the neo-cortex and limbic system” (Conway and Loveday, 2015). Basically, autobiographical memory is the personal memory of past events, which is stored as long-term memory,

from someone's own life related to self (Marsh and Roediger, 2013; Haryanto, 2008; Braun et al., 2002; Baumgartner et al., 1992; Brewer, 1986). As a reflection of experiences and events in life (Garcia-Bajos and Migueles, 2013), autobiographical memory is distinguished from long term memory which is storing the information in order to keep it available when needed (Solomon, 2007).

Three types of memory exists: episodic, semantic, and procedural memory. Episodic memory is the ability to recollect and relive the experience by travelling to the past and the future with the autonoetic consciousness (Garcia-Bajos and Migueles, 2017; Fitzgerald and Broadbrige, 2013; Tulving, 1985). Semantic memory includes the belief of the memory content (Fitzgerald and Broadbridge, 2013) which can be representative about one's knowledge in the world (Tulving, 1985). Procedural memory uses the perceptual, cognitive, and motor skills and deals with how things are done (Tulving, 1985). According to Figure 2.3, three types of memories are not separate from each other, although the consciousness levels are different: autonoetic (self-knowing), noetic (knowing), anoetic (non-knowing). Since procedural memory concerns about the actual systems and procedures, it does not use personal knowledge which does not exist. However, episodic memory has autonoetic consciousness level because it needs a personal taste including past experiences (Tulving, 1985). The specific characteristics of autonoetic consciousness distinguishes episodic memory from others are perceiving, thinking, imagining, or dreaming (Tulving, 1985).

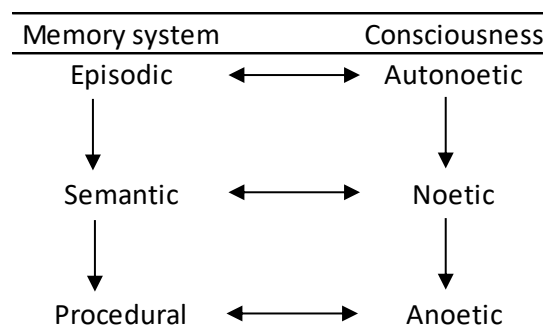


Figure 2.2 : A schematic diagram of the relations between memory systems and varieties of consciousness (Tulving, 1985).

Autobiographical memory is based on the knowledge that activates the patterns of remembering in a complex and multilayered structure, although the patterns are never inactive but different strengths of activation exist (Conway and Loveday, 2015). In this sense, episodic memory may seem to be the closest type to autobiographical memory. Although some psychology researchers use episodic memory and

autobiographical memory as synonyms (Marsh and Roediger, 2012), there is a significant difference between the two concepts. Episodic memory is the retrieval of time and place of the certain occurred events (Tulving, 1972). The episodes from life such as the last vacation brings some pictures and words as a result of episodic memory. However, autobiographical memory includes the memories with self-knowledge such as learning to ride a bicycle, grandparents, or friends (Marsh and Roediger, 2012; Conway, 2001). These memories also retrieve words or pictures. Figure 2.2 from Conway's study (2005) shows that autobiographical memory has four associated hierarchies: themes, lifetime periods, general events, and episodes. Themes are the broadest levels of one's life story referring work or social life. Lifetime periods expand on the themes and figures more detailed information about the themes, such as working areas or terms in social life. General events expand deeply on lifetime periods mentioning the specific peoples and events. When it comes to episodes, the more detailed memories are extracted, and time and place come out. An experienced episode is involved in autobiographical memory (Baumgartner et al., 1992). Hence, episodic memory is a subset of autobiographical memory in terms of the abstraction level. On the other hand, due to the amount of self-referencing; autobiographical memory can be counted as a subset of episodic memory (Tung and Ritchie, 2011). Autobiographical memory includes the knowledge from self while episodic memory involves references from others (Baumgartner et al., 1992). It can be said that autobiographical memory encompasses information, which consists not only the episodes but also facts and procedures, from semantic and episodic memory by using self-knowledge in the conceptual self (Marsh and Roediger, 2012; Conway, 2005). The distinctive formulation of autobiographical memory definition includes the importance of that information in one's personal history.

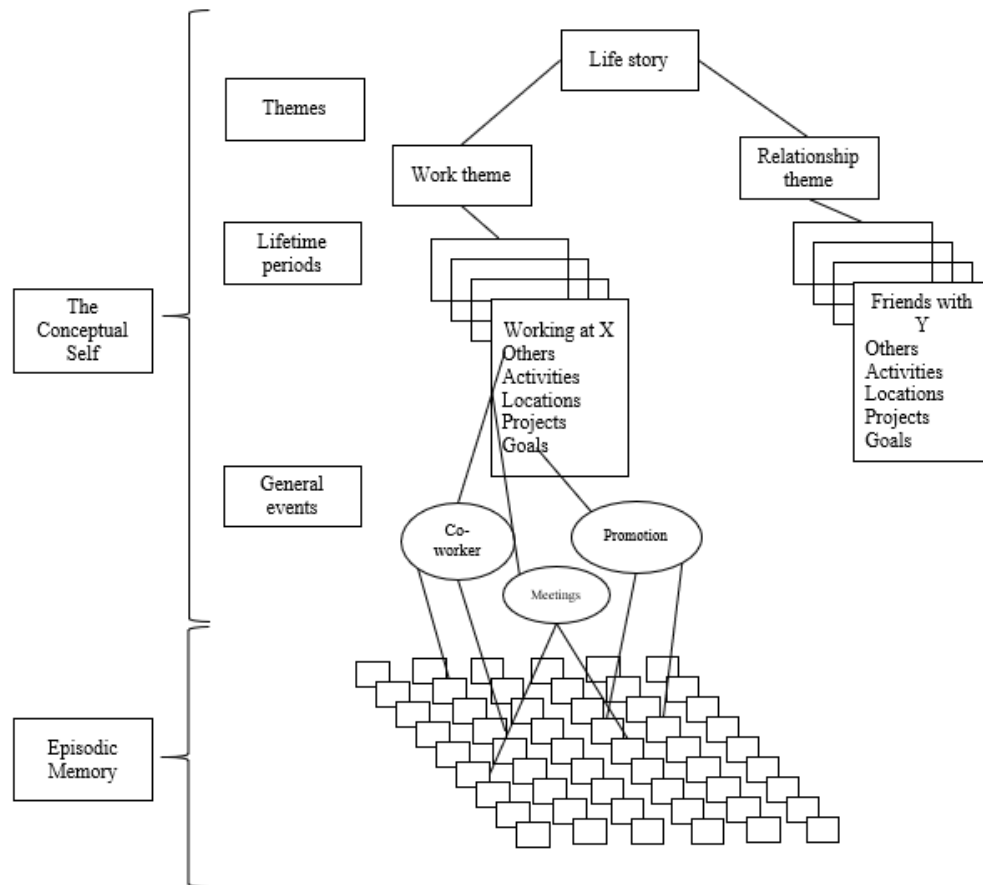


Figure 2.3 : Knowledge structures in autobiographical memory (Conway, 2005).

2.6 Memorable Customer Experience

The cumulative perception of customer during the usage of the product or service, including learning and acquiring, creates experiences (Fatma, 2014; Gentile et al., 2007; Carbone and Haeckel, 1994; Hirschman and Holbrook, 1982). As Pine and Gilmore (1998; 1999, p.2) define experience economy, they mention that process suggesting “When a person buys a service, he purchases a set of intangible activities carried out on his behalf. But when he buys an experience, he pays to spend time enjoying a series of memorable events that a company stages – as in a theatrical play – to engage him in a personal way”. Creating memorable events is in the core of experience economy, hence, the memorable experience should be considered as the main focus of having engaged customers. However, it has two sides: memory and experience. The experience is designed by the firm with strategic actions while the memory is a psychological dimension of the consumer. This intersection of psychology and marketing may have significant influence for consumers.

Since every experience has a differentiating effect on someone's nervous system by creating memory traces (Marsh and Roediger, 2013) and the effects of life events are stored in autobiographical memory (Stach, 2017; Williams et al., 2008; Mosak and Di Pietro, 2006), exploring the influence of autobiographical memory on customer's evaluation after experience can shed light to customers' decisions, attitudes, or behaviors about an experienced brand, firm or organization. Memories related to one's personal life history are related to three functions (Yin et al., 2017; Waters et al., 2014): self-definition, social connection, and directing future behavior. Self-definition addresses creating a coherent representation of self when imagining the future events or solving future problems related to past experiences (Yin et al. 2017; Waters et al. 2014; Berntsen and Jacobsen, 2008). Social connection function refers to foster social relationships, creating intimacy by sharing of experiences via a stable representation of self (Waters et al., 2014; Alea and Bluck, 2007; Bluck et al., 2005; Fivush et al., 1996; 2006) in order to easily build interpersonal communications with others (Yin et al., 2017). Finally, autobiographical memory serves as directing future behavior with its providing motivation and inspiration for future goals or problems (Yin et al, 2017; Waters et al., 2014; Kuwabara and Pillemer, 2010; Pillemer, 2003). Those functions of autobiographical memory make the effects of consumers' memories about lived experiences worth to examine since some clues can be extracted. Being self-centered, the effects of autobiographical memory on consumers' decision can only be seen about the brands which are meaningful to the consumer (Braun-LaTour et al., 2006) Only retrievable memories can have a direct influence on a consumer's future behavior (Stach, 2017; Fatma, 2014; Williams et al., 2008). Although information retrieval from memory is one of the main abilities of our cognitive system (Unsworth et al., 2014), we only remember some of the experiences. Hence, it is critical to make a customer remember the experience in order to decide the next step with the brand, firm or organization.

Autobiographical memory is a novel construct for marketing. Advertisers use autobiographical referencing by triggering consumers' memories in order to have them focus on the feelings instead of functions evoked by using the product (Braun et al., 2002; Sujan et al., 1993). For instance, a brand which is using an old campaign slogan after decades targets the childhood memories of the users. The marketing stimuli may be used as a guide for consumers' autobiographical memory (Braun et al., 2002). It is

found evoking autobiographical memories reflect the ad and brand judgements of consumers (Hartmann et al., 2016). Sujan et al. (1993) find that there is a positive relationship between positive autobiographical memory and attitude toward advertising and brand evaluation. Haryanto (2008) states that autobiographical memory positively affects the intention to consume for kids.

Although the autobiographical memory is defined with experiences, memorable customer experience and autobiographical memory relationship is merely investigated in prior literature. Generally, the antecedents of autobiographical memory are studied (e.g. Kim, 2014; Kim, 2010). However, the definitions and studies in the literature show that, a consumer's past experiences about a brand, firm, ad, or organization may affect future decisions about them (Lindstrom and Seybold 2003; Sujan et al., 1993) which makes the consequences worth to examine. Personal experience memories may be effective on future behavior (Barnes et al 2016; Kuwabara and Pillemer, 2010; Wirtz et al., 2003). For instance, in a tourism research, it is found that the future decisions of visitors, such as revisiting the destination, are based on their reactions while the experience is lived (Vaughan and Edwards, 1999). Themed hotels, parks, restaurants are designed mainly for that reason (Azevedo, 2010). Besides, it is found that satisfaction is not only result as loyalty, but also behavioral responses such as consumers' willingness to pay more for the service (Bigné et al., 2008). Hence, providing memorable service experience provides competitive advantage (Scholl-Grissemann and Stokburger-Sauer, 2012).

A consumer constantly tries to reach the fit between his/her past and self-knowledge, and social contexts (Braun et al., 2002). Hence, how the experience is remembered depends on the usage of the available information in consumer's mind (Braun et al., 2002; Thompson et al., 1996). The past experiences stored in memory has some importance for consumers (Hoch and Deighton, 1989); there is a positive relationship between the information level of the past experiences and the motivation to buy, the past experiences are valuable and reliable information sources for consumers, and future behaviors are affected by past experience. However, not all past experiences can be memorable. There are several reasons for an experience to be remembered:

Cue-priming theory. Cue-priming theory suggests that some certain signals activate the memory network by evoking the experiences, and this can diffuse to autobiographical memory network (Kvavilashvili and Mandler, 2004). If a consumer

is exposed to something that triggers the past experiences or memories, he or she can remember the event more easily.

Polyanna principle. The Polyanna Principle (Matlin and Stang, 1978) suggests that people tend to remember positive events than negative ones. Overcoming the problems in the negative events causes the emotions to be fade more over time (Garcia-Bajos, 2013; Butler and Wolfner, 2000; Walker et al., 1997). Pleasant memories can be easily recalled from autobiographical memory (Yin et al. 2017; Baumgarnter et al., 1992). Psychological research posits that positivity in memories become long-term resource since it creates more accurate knowledge (Chen and Rahman, 2018; Fredrickson and Losada, 2005; Fredrickson, 2001).

Self-congruity theory. According to the theory (Sirgy, 1982) the behavior of a consumer depends on how much he or she matches self with the product or service user image by perception. Higher congruence between the self and the brand leads higher positive attitudes and behaviors towards the brand (Yin et al., 2017; Ebrahim et al., 2016; Lin and Mao, 2015; Sirgy et al. 1997; Kamins, 1990; Belk, 1988). Hence, consumers can remember easily if the self-congruity occurs with the experience.

Social representations theory. The theory (Moscovici, 1963) refers to the effect of social environment such as culture, shared knowledge, understanding, and common sense on individual's assigning a meaning to the world. Social representations are developed by environmental stimuli such as communication cues or visual assets (Barnes et al., 2016). Especially in tourism context, the theory is used as tourists are more likely to remember the memories if the social representations around can be matched with the self.

The measurement of autobiographical memory is made by two methods: questionnaire or narrative assessments. Although questionnaire is questionable because of its restrictedly measuring specificity and regularity (Waters et al., 2014; Pillemer, 2009) are used for consumer research. Different from narrative assessments, questionnaire forms are said to be led the participant to remember certain experiences. However, specific cues help consumers remember the memories. Personal life experiences shape the autobiographical memory, and remembering these experiences examined by, for instance, recalling previous experiences (Yin et al. ,2017; Neisser, 1988). On the other hand, people may remember the events inconsistent from the actual ones while self-

reporting (Barnes et al., 2016). Memories of experiences may be forgotten over time (Wixsted, 2004). According to the interference theory, memories may be distracted by the information gained in time where new memories are interfered and displaced by existing memories (Barnes et al., 2016; Baddeley et al., 2009; Underwood and Postman, 1960; Underwood, 1957). Hence, questions can be used to trigger the participant to remember certain things and evaluate them.

2.7 Customer Engagement

Engagement is a commonly used construct in sociology, psychology, management, and marketing in cognitive, affective, behavioral and social meanings (Vivek et al., 2012). In business environment, the most frequent uses of the word are employee engagement and customer engagement. Employee engagement means the behaviors at work in order to motivate and personally develop others (Bowden, 2009) while customer engagement means the “intensity of customer participation with both representatives of the organization and with other customers in a collaborative knowledge exchange process” (Wagner and Majchrzak, 2007, p.20). Both of them indicate the individuals who are behaving out of the limits of their main objective while working or shopping, collaborating with other individuals in their environment. The interaction between the ‘engagement subject’ (e.g. customer or employee) and ‘engagement object’ (e.g., service provider/brand or employer) constitutes the engagement (Bowden et al., 2015). If both employee and the customer engages effectively and efficiently, it reflects the profit growth (Kumar and Pansari, 2016).

In marketing, the main aim of the firm is to increase profit and the key resource is the customer (Kumar and Pansari, 2016). In the literature, afore mentioned extra-role behavior (Ahearne et al., 2005) has a broader scope (Jaakkola and Alexander, 2014). Considering the primary expectation from a consumer as to purchase and consume the product or the service, the definition of “behavior beyond the purchase” (van Doorn et al., 2010; Verhoef et al., 2010; Vivek et al., 2012) fits the customer engagement well. In customer engagement, it is not necessary to purchase or plan to purchase, or to be in a process including searching, evaluation and decision making (Vivek et al., 2012). It is a voluntary contribution of the consumers as the pseudo-marketers to the firm beyond the financial patronage with a lower cost and greater influence than marketing related departments of the organization (Harmeling et al., 2017; Jaakkola and

Alexander, 2014; Kozinets et al., 2010). However, purchasing is also counted as a form of engagement (Kumar et al., 2010). According to Hollebeek (2011, p.6), customer brand engagement is “the level of a customer’s motivational, brand-related, and context-dependent state of mind characterized by specific levels of cognitive, emotional, and behavioral activity in brand interactions”. Hence, it is a behavior planned cognitively and emotionally. Engagement is possible by the participation of potential and current customers with a relational bond made up of experiences and feelings with the organization (Vivek et al., 2012). This is parallel with the description of the Economist Intelligence Unit (2007, p. 2) of “a deeper, more meaningful connection between the company and the customer” (van Doorn, 2011). This deep and meaningful connection is exhibited in Bowden’s (2009) conceptual framework for the process of engagement shown in Figure 2.3. According to this framework, both new customers and repeat customers engage with the brand with a first step of satisfaction. When new customers’ satisfaction lead to calculative commitment and accordingly customer delight, the customer returns to the brand again and become repeat customers. In a similar way, when repeat customers satisfy with the brand, it shapes trust and affective commitment, and loyalty occurs. In these two processes, feedback informs the knowledge set of the brand and a knowledge structure is developed when the customer returns and becomes loyal repeat customers.

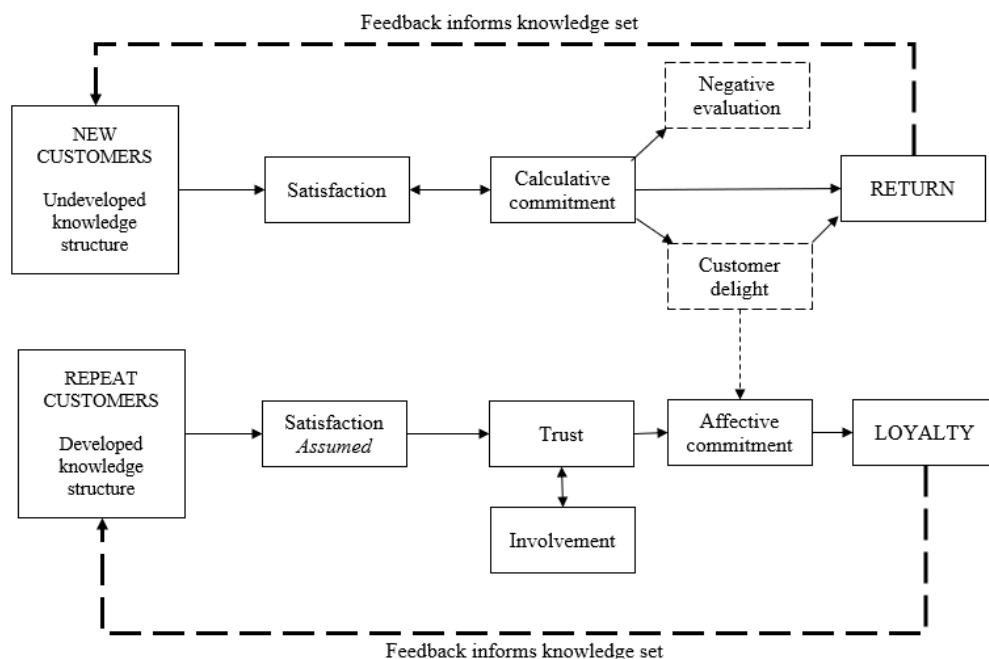


Figure 2.4 : A conceptual framework for the process of engagement (Bowden, 2009).

Although engagement is expected to occur as a result of strong relationship, consumers may expect some benefits after the engagement. Even if it is writing an online review, or attending a workshop class of a brand, people engage with the brand for them in proportion of the gains, in parallel with Reciprocal Action Theory (Vivek et al., 2012; Li and Dant, 1997; Bagozzi, 1995). Consumer expect some concrete benefits as a return for their effort on spending their time and sharing their personal information (Baird and Parasnis, 2011). The gain may be financial or emotional, and the engagement intention may be related to extrinsic or intrinsic motivation in parallel with the gain. Rewarding the customers lead to higher intention of engagement activities (Rehnen et al., 2017) such as attending referral campaigns (Shi and Wojnicki, 2014). Joining such rewarding engagement programs, customers do not only support the firm's marketing activities but also gain financial benefit (van Doorn et al., 2010) with an extrinsic motivation. Besides, consumers would like to gain some emotional satisfaction after the engagement activities. They have an intrinsic motivation when the engagement activity is rewarding in its nature (Ryan and Deci, 2000) such as getting involved in a brand community (van Doorn et al., 2010). Additionally, propensity to engage may be a moderating factor to the effects on engagement (Vivek et al., 2012) in this scope. If the consumer has a higher intention to attend this kind of engagement activities, propensity to engage will be higher and the moderating effect will be positive. Involvement may be also effective on engagement intention. For example, older people in healthcare may have higher involvement because they are more likely to search information about hospitals and physicians or visit online health forums (van Doorn et al., 2010). Furthermore, since the existence of different health branches in hospitals creates different involvement levels, this thesis focuses on only internal diseases. Since internal diseases mainly deals with basic illnesses such as cold and flu, it is the most stable branch in hospital. So, the involvement effect is minimum in that branch.

The engaged customer contributes the organization's activities by interacting with others, referring and recommending, or by interacting with the company, purchasing, suggesting, and connecting online. Current and potential customers interact with others often (Vivek et al., 2012) online and offline. In customer engagement literature, online interaction between consumers is studied under the title of blogging, e-wom, social media engagement, viral marketing etc (Brodie et al., 2011; Verhoef et al., 2010;

Grégoire et al., 2009; Hogan et al., 2003) while offline interaction is studied under the general title of referral and providing feedback (Kumar and Pansari, 2016; Kumar 2013; van Doorn et al., 2010; Verhoef et al., 2010). According to van Doorn et al. (2010), customer engagement is classified in different channels: peer to peer, retail, via the Internet, via telephone, e-mail, etc. Kumar et al. (2010) conceptualized customer engagement under the constructs of customer purchases, customer referrals, customer influence, and customer knowledge. These constructs are considered as the customer activities that co-create value for the organization.

Service dominant logic perspective can provide a theoretical perspective in the means of value co-creation effect of engagement (Rehnen et al., 2017; Jaakkola and Alexander, 2014; Brodie et al., 2013; Brodie et al., 2011; van Doorn et al., 2010). By definition, customer engagement is a result of the interaction of consumers with other consumers and with the company, so the value co-creation occurs unintentionally. The interaction is a key resource of buying decisions of consumers which is more effective than marketing related activities of the company itself (Vivek et al., 2012; Brodie et al., 2011). Engaged customers influence the long term reputation and awareness of the brand with brand communities and supporting activities such as charities (van Doorn et al., 2010). Hence, the engagement activities can have positive or negative results (Harmeling et al., 2017; Higgins and Scholer, 2009; van Doorn et al., 2010), so the value co-creation process can convert into value co-destruction process. In order to minimize the risk of value co-destruction between consumer peers and in online channels, organizations should manage the engagement antecedents strategically by customer engagement marketing. Customer engagement marketing is defined as an effort of an organization to motivate customers to contribute to marketing activities (Harmeling et al. 2017). Since this thesis deals with engagement in experience framework, the effects of creating superior customer experience value on customer engagement activities are investigated.

3. CONCEPTUAL FRAMEWORK

The scope of this thesis includes perceived patient experience quality, its consequences and the effects of autobiographical memory. In order to investigate these relationships, first, a conceptual framework was determined. Since a healthcare organization includes thousands of processes, identifying the key processes and analyzing them in flowcharts is necessary (Deming, 1986). Analyzing the healthcare quality is a system-oriented business, so it should be made in terms of components of processes (al-Assaf, 1966). Early identification of opportunities for improvements in these processes is important for initiating early interventions. Hence, this study will first determine the steps of the process. A process flow (Figure 3.1) is drawn after interviewing with 2 hospital managers and 5 patients:

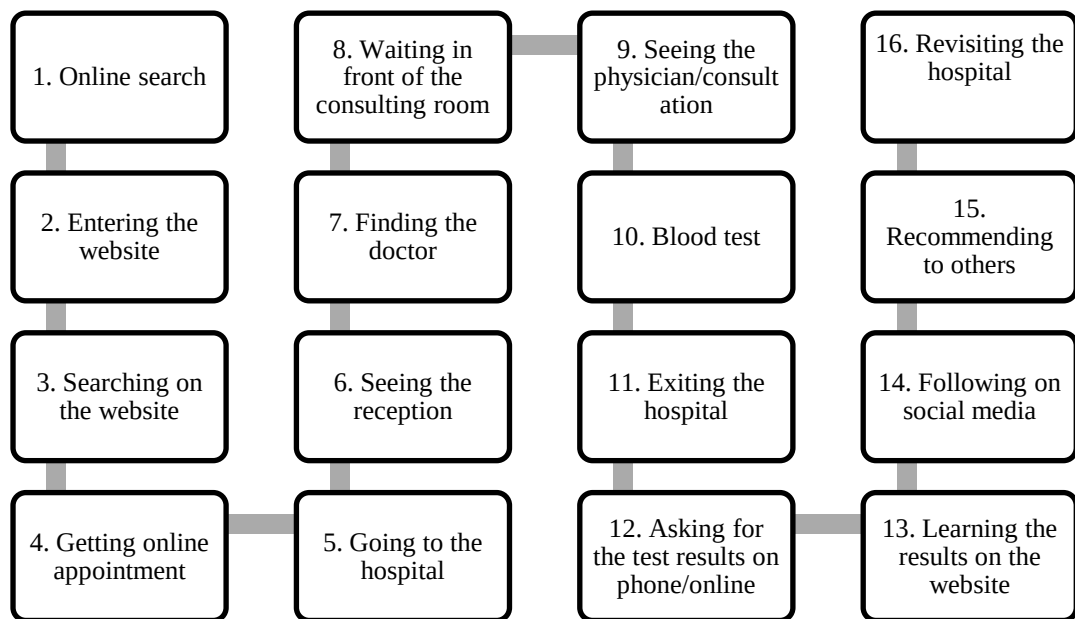


Figure 3.1 : Process flow in a hospital.

The first four steps constitute the digital user experience. Additionally, 12th and 13th steps are the constructs of digital user experience. The following four steps include physical atmosphere experience, service experience, employee interaction experience, and peer interaction experience. 9th and 10th steps are pure service experience about

the treatment. The last three steps are the behaviors after the whole service process is completed. These and further behavior may be counted as engagement activities: social media engagement, referral, and revisit intention, etc.

In the light of this process flow, this thesis aims to investigate the relationship between experience quality and engagement intention in healthcare industry via trust to provider under the moderating effect of autobiographical memory. In this sense, the research model is shown in Figure 3.2. After the preliminary analyze of process flow, the experience touchpoints are summarized as follows: online experience quality, atmosphere quality, employee-interaction quality, service quality, customer service quality. However, in order to have an accurate and standard process flow, different hospitals are observed before starting a research process. The observation gave a macro perspective for the patient experience in terms of a step-by-step process. As not all of the touchpoints in each step may be relevant for the customer experience, the critical ones should be determined in order to go one step further and measure the relationship with engagement. Since there are too many touchpoints in a patient journey, it was decided to figure out the most critical ones by a qualitative research in order to avoid an ineffective, long and detailed analysis.

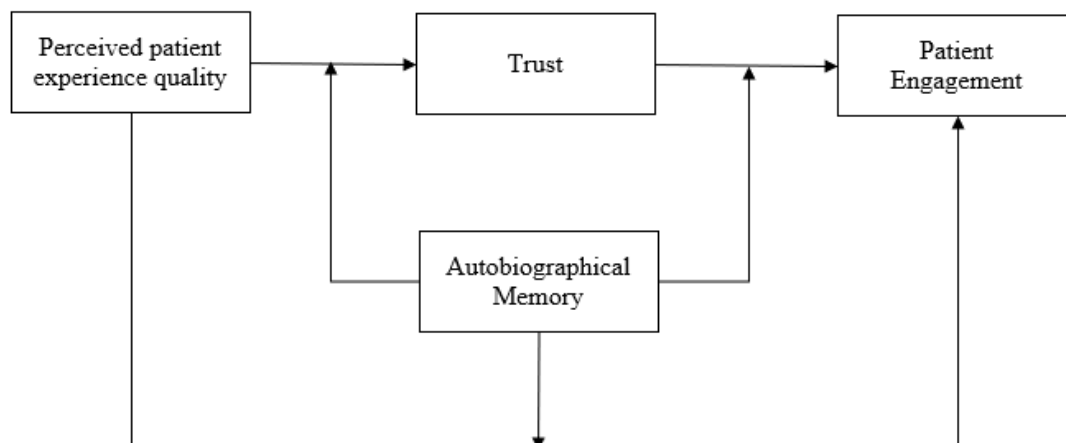


Figure 3.2 : Conceptual framework.

3.1 Research Design and Methodology

The patients see, hear, and reflect at each touchpoint of the whole hospital process from check in to check out (Fortenberry and McGoldrick, 2016). There cannot be a solution of “one-size-fits-all”, so continuous measuring and development for pathways is necessary to understand unpredictable conditions (Graham et al., 2015). However, patient satisfaction questionnaires (e.g. HCAHPS or CollaboRATE) mainly measures the skills or performances of the employee (Brauer et al., 2018). Healthcare organizations should develop new methods for measurements. In an increasing competitive environment, especially in private healthcare industry, it is also necessary for both acquisition and retention of customer base (Dobele and Lindgreen, 2011). In this study, the research is conducted considering the private healthcare firms. They are service-oriented organizations with mainly intangible products and have to keep their corporate reputation high in their institutional environment (Srivoravilai et al., 2011; Ardnt and Bigelow, 2000).

Healthcare is a system in which caregivers, doctors, nurses and other employees should work in harmony to provide solutions to patients (Klaus, 2018). Hence, in order to improve the patient experience, research should be conducted not only with specific patients but also with different members of the healthcare team such as experts or employees (Mazurenko et al., 2015). In the scope of this thesis, experts and patients as two different perspectives are interviewed. The analysis of the interviews is made by using the QDA Miner software. The words those are commonly mentioned in the interviews are reported to determine the critical touchpoints for patients.

The qualitative phase of the research is followed by a quantitative phase. In this phase, the data is collected by a survey and the analyze is conducted by using SEM in SPSS AMOS and PROCESS Macro by Hayes in SPSS. The scales in the literature are adopted to the context of the thesis. Perceived touchpoint experience quality questionnaire is formed after the qualitative phase. Since customer engagement is a multidimensional concept and includes a set of behaviors (Brodie et al., 2011; van Doorn et al., 2010), different scales exist in the literature. Kumar and Pansari (2016) uses the four-dimensional engagement scale, consisting purchase, referral, influence, and knowledge.

3.2 Qualitative Phase

Patient experience is defined as “the sum of all interactions, shaped by an organization’s culture, that influence patient perceptions across the continuum of care” (The Beryl Institute, 2018), and it is complicated to determine the critical touchpoints in that continuum. Since patients are not just patients anymore, and they are the consumers of health services (Levine, 2015), healthcare service experience become more and more complicated. In his study, John (1996) analyses the physician-patient encounter dramaturgically and finds three different regions:

- (1) Actor’s (physician’s) region: medical training, physician approach, past experience
- (2) Setting and performance – physician and patient front regions: relationship with patient, medical encounter (performance), medical condition
- (3) Audience’s (patient’s) back region: cultural values, patient expectations, past experience.

As in that analysis, hospital setting has a complex structure with different dimensions. Hence, there is a need to focus on the service experience which has a complicated set of interactions. The need for interviewing the patient arises from this point. The interviews are expected to solve the complexity and provide a clear focus about critical touchpoints.

A qualitative study was designed and conducted in order to find out the critical dimensions of patient experience. This thesis followed the methodology of Mazurenko et al. (2015) who used phenomenological approach suggested by Starks and Trinidad (2008). This method deals with a lived experience by observing and interviewing, and clusters the identifications to describe the meaning of a related phenomenon (Starks and Trinidad, 2008). Following Mazurenko et al. (2015), information about the patient experience was gathered by conducting personal interviews . In-depth interview was selected as the method for determining the touch points as it allows to analyse the processes and critical steps (Bowden et al., 2015; Creswell, 1998). In order to investigate the critical points, semi-structured in-depth interviews were conducted in two stages: (i) expert interviews, (ii) patient interviews. Both were transcribed and analyzed by using QDA miner, a text analysis software for qualitative research. The themes were listed and coded under certain categories in three steps shown in Figure 3.3. First, highly mentioned subconcepts (e.g. state insurance contract, customer type,

location etc.) were listed. Second, the subconcepts are classified in terms of some pre-defined concepts (e.g. function, interaction, environment, etc.). Then, it was realized that those concepts can be also categorized under the actors of the healthcare system (e.g. physician, personnel, etc.). That three-step categorization allowed to figure out the most critical points for patient experience in terms of actors and in terms of concepts, from both management and patient perspective.

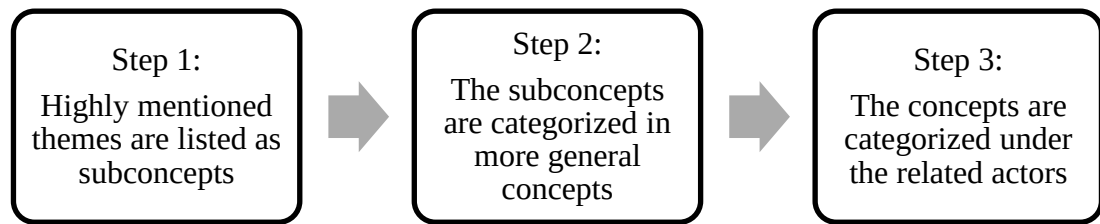


Figure 3.3 : The process of analyzing the interview results.

3.2.1 Expert interviews

In order to specify the suitable department for interviewing the patients about their experience, expert opinions were collected for one month. The major aim of the expert interviews was to understand the critical unit which might allow to interfere the patient experience most with its repetitive and multiple visiting path. For the expert interviews, top and mid-level managers or physicians at private hospitals, and academic researchers were selected for the inquiry. In total, fifteen interviews were conducted. The characteristics of the interviewees in terms of their positions, and of the organization in terms of type and state insurance (SI) contracts are shown in Table 3.1.

The semi-structured interviews with hospital employee started with the question of: “Can you name a unit where patients meet your hospital and after the experience in that unit, they select the same hospital for other needs?”. Then, a discussion about the patient experience or satisfaction measurement methods conducted in that hospital was made. The question asked to academic researchers included “...the hospital...” instead of “...your hospital...”. One of the main questions asked to every participant is “A research in which unit may provide a general result in terms of patient experience?”. The answers to this question were expected to give a support also to the first question.

Then, the most appropriate time interval for interviewing the patients was asked to the participants.

Table 3.1 : The characteristics of the interviewees.

Number	Position	Scale	Type
1	Assistant Prof.	-	University
2	Researcher	-	University
3	Physician	Large	Hospital (Private / SI)
4	Prof. Dr.	-	University
5	Assistant Strategy Director	Large	Hospital (Private)
6	Dr / Hospital manager	Large	Hospital (Private / SI)
7	Prof . Dr.	-	-
8	Dr / Hospital manager	Small	Hospital (Private / SI)
9	Patient relations	Small	Hospital (Private / SI)
10	Guest relations*	Large	Hospital (Private)
11	Hospital manager**	Large	Hospital (Private)
12	Head physician	Large	Hospital (Private)
13	Patient relations	Large	Hospital (Private / SI)
14	Head physician	Large	Hospital (Private / SI)
15	Assoc. Prof.	-	University

*Guest relations is the same position as patient relations. However, using the term “guest” instead of “patient” is an indicator of the experience approach of the hospital.

**She is the only hospital top manager without a medical background.

According to the analyses, two main groups of results were obtained: the critical experience points which are noted to be analysed together with the patient answers, and the suitable departments where patients can be interviewed. The experts agreed that Oncology and Gynecology were two branches that patients could give detailed information about the hospital experience because they visit the hospital repetitively and have experience in different branches. These patients can be called as “expert patients”.

3.2.2 Patient interviews

Due to the fact that patient confidentiality is a critical issue in hospitals, approvals from both general managers and head physicians of hospitals addition to the approval from Istanbul Technical University Social and Human Sciences Research Ethics

Committee¹ were taken, as long as any personal information of the patients were not recorded, and their privacy was protected. So the characteristics of the sample cannot be reported in this thesis. Two private hospitals accepted to participate the research. A total of 16 semi-structured interviews (10 fresh moms, 6 cancer patients) were conducted with the patients who are being treated inside the hospital at that time period (June-July 2018).

The interviews were conducted inside the hospital and take approximately 20 minutes since their psychological and physical situation did not allow more. Fresh moms were interviewed in the hospital rooms and cancer patients were interviewed in the waiting area for radiotherapy while they were waiting for their turn. Conversations were recorded by the researchers and transcribed by an independent support staff.

3.2.3 Analyses of the interviews

The answers for both interviews were written in text format and a content analysis was conducted through the text. The three-step analysis process was shown in Figure 3.3. First, highly mentioned themes (e.g. state insurance contract, customer type, location etc.) were listed. Second, the themes were classified in terms of some pre-defined concepts (e.g. function, interaction, environment, etc.) as codes. Then, it was realized that those concepts could be also categorized under the actors of the healthcare system (e.g. physician, personnel, etc.). That three-step categorization allowed to figure out the most critical points for better patient experience in terms of concepts and in terms of actors, from the management perspective.

3.2.3.1 Concepts

The concepts are the themes which become prominent in the interviews. The interviewees mainly talked about the effective factors for better patient experience, and their words come up with a list of themes. After the list of the themes were written down, they were considered as sub-concepts and grouped under the concepts. Themes (sub-concepts), concepts, and their definitions are listed in Table 3.2.

¹ This committee serve to ensure that surveys, examination, field studies and experiments involving data collection from people are carried out in accordance with universal ethical principles and laws.

Table 3.2 : Concepts extracted in interviews.

Subconcepts	Concept name	Concept definition
1. State insurance contract	Provider type	Defines the type of the private hospital
2. Treatment	Function	Defines the main objective of the healthcare provider
3. Area of specialization		
4. The ability of providing rapid and accurate solution		
5. Treatment type	Patient type	Defines the one who evaluates the experience
6. Customer type		
7. Preference of a physician	Preference	Defines the behavior whether the patient chooses the specific unit/doctor or randomly enters the hospital
8. Variety of the process	Touchpoint diversity	Defines how much different points that a patient touches in a specific unit
9. Process management		
10. Bundling the patient up	Psychology	Defines a patient's feeling of safety
11. Personnel directions		
12. Physician communication	Interaction	Defines the main information gathering and giving activities between the patient and the personnel
13. Staff communication		
14. To be remembered		
15. Location	Environment	Defines the environment other than physician, patient and administrative staff
16. Transportation		
17. Other patients		

Hospital type

Hospital type is the class of the health care provider. In Turkey, Ministry of Health, Social Insurance Organization, and Private Sector provide healthcare services (Camgoz-Akdag and Zineldin, 2010), and the hospitals can be state or private hospitals. This system creates a segment difference between patients as customers. Since the scope of this research is limited with private hospitals, the types of private hospitals are considered in the interviews.

Private hospitals are separated into two groups: hospitals with or without state insurance contract. The customers of these two groups have different characteristics. For instance, a hospital manager indicates that they have lost a group of patients after they signed a contract with state insurance: “Some people, especially the Premium segment customers, do not want to enter an organization by walking under a signboard indicating the state insurance contract. They do not feel like they belong there”. Although the state insurance allows low-income patients to be treated in private hospitals, which creates a social opportunity, some premium patients feel like the hospital is not special enough to be treated in. Hence, the hospital type is counted as an important indicator for patient experience.

Function

Function defines the main objectives of the healthcare provider. This concept has different dimensions:

(1) Treatment: Some healthcare organizations provide only check-up, blood tests, or dialysis. Some others provide a general package of treatment in various areas. Hence, the experience differentiates in different types of hospitals. An academician among the interviewees indicates that talking to check-up patients may not provide an idea about the hospital experience, because the main objective of a hospital is not a check-up test: “The function of a hospital is not diagnosis, it is treatment. Check-up patients do not see any treatment process, so they cannot have a whole experience quality perception”.

(2) Area of specialization: There are some hospitals which are specialized on Oncology, or Cardiology, etc. Especially the answers of the first question of the interview lead this theme. For instance, a manager of an Oncology-focused hospital says that their patients first visit the hospital about oncological reasons, while a Cardiology-focused hospital manager answers about cardiological reasons. Thus, the results indicate that some hospitals have an area of specialization and the experience of the patients are formed under this perception of specialization.

(3) The ability of providing rapid and accurate solution: This theme is the other main objective of a hospital. It is in parallel with one of the 5Qs in healthcare which is developed by Zineldin (2006): quality of processes. This dimension includes the functional quality about the healthcare provider’s core services. One of the managers

says “Addition to treatment, the ability of providing the accurate treatment solution rapidly is critical for a hospital to serve a good experience. The solution must exactly finish the problem and must have to be found as soon as possible. The patient does not want to wait or lose time with weak treatment types.”

Patient type

Patient type can be grouped under two different classifications: (1) treatment type, and (2) customer type. Treatment type is the area in which the patient is treated. This means that departments are separated with their patients. For instance, Pediatrics and Rheumatology have different dynamics. In Pediatrics, patient is the child, but the consumer may be the mother. The anxiety may be high because of the child. Rheumatology is mainly the second visiting point after a general inspection. Here, the anxiety level may be increased because of the uncertainty. On the other hand, patients are grouped as their customer types: inpatients and outpatients. Since outpatients do not stay at the hospital, their experience is different than inpatients. Health organizations consider these two types separately in terms of experience. Another grouping may be made by patients and their relatives. However, in the interviews, patients' relatives are never considered as separate actors in the healthcare system. The relatives and the patients are making the decisions together, so they constitute a single decision-making point.

Preference

Patients sometimes prefer some specific physicians and choose the hospitals only for the physician. For instance, Gynecology is a sensitive area for women, and they do not randomly select their Gynecologist. “A woman can visit other hospital units instantly when she visits her Gynecologist, but she does not visit Gynecology instantly when she is in hospital for some other unit” says a physician. Additionally, some physicians are famous by their names and wherever they work, patients follow them. Thus, experience perception of a patient may differ with his/her preference. Furthermore, patients may have a negative perception about the hospital, but they may still go to that hospital only for the physician. One of the interviewees who is also an Oncology patient tell her story: “I never choose that hospital because I know that they are not good at their work. However, I went there for my chemotherapy, only for the

physician. He was the assistant of my surgeon, so his suggestion is important.” Hence, physician preference becomes critical for the experience. If there is a special preference, they mention the physician especially when talking about the hospital experience.

Touchpoint diversity

Health organizations have various touchpoints, and this makes the hospital system complex. Since the experience inside the organization is considered in this thesis, the touchpoints start from the reception and ends with payment desk. Between these two touchpoints, there are a lot of different points such as departmental reception, inspection, waiting areas, other patients, etc. An example shows that, in some cases, the patients are even affected by the parking areas of the hospitals: “A woman and her husband came into the hospital. It was obvious that a problem in the parking lot came out. The husband said: ‘Is it the hospital you praised a lot?’” It is obvious that the parking problem is attributed to the hospital. On the other hand, as it is mentioned in the patient type section, patient’s relative is a decision-maker with the patient.

Additionally, process management is a critical dimension for patient experience. A head physician says: “Hospitals design the process from the entrance to the exit. However, the process should not be broken if the patient enters from the side gate. Employees should have the practical intelligence to create solutions for such instant situations.” Patients are consciously or unconsciously affected by the process they live in the hospital. Although Shostack (1982) warns that leaving services to individual talent will lead an ineffective flow, in this case, individual talent is expected to be able to rule the whole system.

Mood/Feelings/Psychology

Patient mood dimensions are highly mentioned in interviews. The human is the most effective factor on patient’s mood. One of the managers says “*The patient expects to be bundled up when he/she enters the hospital. He/she is full of questions. The critical thing is metaphorically keeping holding the hand of the patient from the beginning till the end.*” In order to improve patient experience, the patients should be welcomed and sent with a helping hand.

This helping hand can only be provided by the personnel. Since the patient expects special attention to him/herself, the medical and administrative personnel play a vital role in patient's feelings. When a patient enters the hospital, the personnel directs him/her to the relevant unit. Those directions are critical for the patient's journey in the organization. As a physician indicates, *"The satisfaction may come from the administrative staff. Patients have a general idea about the organizations by considering only to the staff"*. In line with this perspective, interaction with the patient becomes critical for keeping the mood high, hence, mood/feelings/psychology dimension was accepted as a consequence of better interaction in this study.

Interaction

Service consumption includes a set of interactions between the customer and the provider (John, 1996). In healthcare consumption process, expert interviews show that the communication between the patient and the employee is the most critical interaction. The employee, so-called the medical staff, have a great impact on healthcare (Lee et al., 2012). The medical staff can be physician, nurse, or administrative personnel as caregivers, and they have distinct interaction points. All those interaction types are mentioned as the effective experience points in the interviews. Although the physician interaction may be thought as the most critical one, nurse is as important as the physician. The interaction with physicians and also nurses has an impact on overall satisfaction of a hospital (Vinagre and Neves, 2008). "All of the operational support such as diaper changing is made by the nurse and administrative personnel. Since a physician do not and actually can not do that, staff should be considered carefully." says one of the physicians in the interviews.

During the social interaction in the service encounter, all of the staff represent their own cultural background which is shaped by the organizational culture (John, 1996). Hence, a patient-centered approach, which suggests the increased interaction quality with patients and their families, will lead higher positive outcomes (Anderson et al., 2018), and can be effective for patient satisfaction in a nervous and stressful environment (Hutton and Richardson, 1995) by overcoming patient's negative feelings (Suess and Mody, 2018). Remembering a patient during his/her second visit and asking him/her how he/she is, creates positive outcomes as several interviewees say.

Environment

The design of the environment and service include dimensions such as cleanliness, quality, accessibility and these are effective on customers' satisfaction and outcomes (Suess and Body, 2018). Environment includes the location, transportation, physical design, and other patients. Location and transportation are two of the elements about the hospital facility. One of the managers tells that after they move to a location that is near to a more luxury area and far from the transportation, they lost some of their patients. Similarly, another hospital manager says that since their hospital is in a luxurious area, their patients are more sensitive to experience quality issues. These are also related to the state insurance contract. If a healthcare organization have a state insurance contract, that organization have a different patient segment. The remarkable note by a manager about the insurance, mentioned in provider type, can be also considered as an environmental theme. The effect of "other patients" comes out with the state insurance contract. Since insurance situation indicate the hospital type, the patients existing inside the facility can be important for other patients in terms of atmosphere.

3.2.4 A new framework for patient experience: 5P model

The analyses were resulted in a new patient experience model considering the actors of health care. The actors are the players of the healthcare industry and they were grouped according to their relevance with the concepts. (Table 3.3). In conclusion, 5 actors are identified: provider, patient, physician, personnel and periphery.

Table 3.3 : Relevant actors of the concepts.

Concepts	Relevant actors
Provider type	Provider
Function	Provider
Patient type	Provider, patient, personnel
Preference	Patient, physician, periphery
Touchpoint diversity	Patient, physician, personnel
Moods/Feelings/Psychology	Patient, physician, personnel
Interaction	Physician, personnel, periphery
Environment	Periphery

Allocation of the concepts into these actors provided a framework for patient experience from both expert and patient perspective in a healthcare system (Table 3.4).

Healthcare is a system provided by the people, for the people, and of the people (Suess and Mody, 2018), so it is natural that 3 of 5 Ps are about human factor: patient, physician, and personnel. Since a service is a combination of some tangible and intangible dimensions (Bitner, 1990), the other two are the tangible factors, provider and periphery, which are about the technical characteristics of the hospital such as insurance or location.

Table 3.4 : The allocation of the concepts to actors.

Provider	Patient	Physician	Personnel	Periphery
Function	Patient type	Interaction	Interaction	Interaction
Patient type	Preference	Preference	Patient type	Environment
Provider type	Psychology	Psychology	Psychology	Preference
	Touchpoint diversity	Touchpoint diversity	Touchpoint diversity	

Some of the concepts can be seen in different actors at the same time, that's why actors are presented via the diagram including different dimensions bonded with each other in Figure 3.4. The figure emphasizes the association of the actors for a high patient experience level. Every single dimension has a bond with another, so the complex system of healthcare compels considering the actors jointly. The dimensions were explained below.

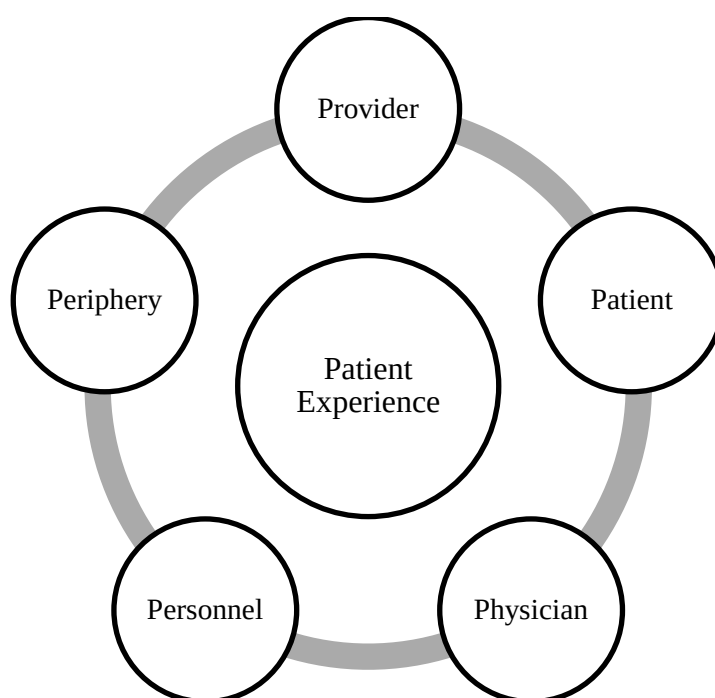


Figure 3.4 : The 5P model: The dimensions of patient experience.

Provider

Provider dimension includes the subconcepts which concern about the general structure of the health care organization such as the focus branch of the hospital, or government assurance situation (with or without). Mainly, provider characteristics may put the hospital in a segment in patients' mindset in terms of service variety and patient profile. To illustrate, the experience in a cardiology-focused hospital with government assurance and in a general hospital which equally focuses on every branch without government assurance differs according to patients. They consciously shape and evaluate their experience in parallel with this information. Mainly, provider characteristics may affect the patient profile inside the hospital and patients' responses to the experience is formed under this effect. Hence, the information collected before visiting the hospital also affects the experience as brand perception. The quotation from a hospital manager can exemplify the effect:

"We did not have a contract with the government assurance before, so our patient target was premium-segmented. After we signed the contract and hang the signboard written 'Government assurance agreement signed' on, some of our former patients did not want to enter the hospital through under that signboard'".

Hospital structure, branch focus and main objective of establishment also brings management issues process management or systematic operations on the agenda. The variety of service, and accuracy and speed of the treatment are two critical subtitles of provider dimension. Patients expect an ultimate support about their health needs by seeing all necessary branch physicians in a timely manner. Unless a patient is fully informed about what is to be done in the whole medical and managerial process by all of the touchpoint staff in a collaborative way in a reasonable period, it is too hard to mention a high level of patient experience quality.

Additionally, as an observation, experts respond the question of the critical branch for patient experience by considering the focus of their hospitals. It seems that patients also consider the focus:

"I prefer a specialized health care organization rather than a general hospital, because in a focused one, I do not have to shuttle between the branches downstairs or upstairs."

Patient

Patient, addition to being the person who lives the experience, also is the one who affects his or her own and others' experiences. Various reasons why patients are in the hospital cause various experiences. The feelings, mood, or psychology of the patients shape the perceived experience. In medical education, the mantra *"It is not the disease, it is the patient"* helps physicians and nurses evaluating each case for each patient particularly. One of the radiology patients indicates that the people in the hospital influence his feelings before the treatment:

"...i was really scared before I came here, but when I see the people here, I left negative thoughts behind. They were nice to me and it made me comfortable... They remembered that I am a human being..."

In order to improve patient experience, the patients should be welcomed and sent with a helping hand. One of the managers says,

"The patient expects to be bundled up when he/she enters the hospital. The critical thing is metaphorically keeping holding the hand of the patient from the beginning till the end."

Another subdimension of patient is the patient's relative. It is observed that relatives are not isolated from the experience of a patient. Their observations may also be effective for the patient while evaluating the experience. The patients generally await for approval from their relatives while telling their own hospital experiences.

Physician

One of the main critical points is the physician, not surprisingly. The physicians are not only evaluated by their medical competency but also their personal communication skills with the patients. Friendliness, trust, giving enough information, listening to the patient are listed as the clues of a good physician by the patients. The most important power of a physician is found as his or her existence in a hospital so that patients can follow him or her to choose the hospital to be treated. Though, recommendation of a physician depends on his or her communications skills.

“This hospital was a popular one but we decided to come here only when our physician transfers here. We think that what really matters is the physician, not the hospital...”

One of the expert interviewees who is also an Oncology patient tell her story which points out the importance of physician preference:

“I would never choose that hospital because I know that they are not good at their work. However, I went there for my chemotherapy, only for the physician. He was the assistant of my surgeon, so his suggestion was important.”

Personnel

Personnel includes the nurses and the administrative staff. During the interviews, it is observed that patients mentions personnel as these two groups, that's why a dimension of “personnel” comes out as a separate one. Since the patients are in communication with the personnel in all stages of the hospital experience, it is a critical factor. Especially the interaction and communication skills of the personnel directly touch to the patients' psychological situation, so they can easily memorize the interaction quality when considering the total experience. For instance, a fresh mother mentions the importance of the personnel at the pre-birth moments:

“There was a team of 10-12 people who were wonderful! They convinced me for epidural anesthesia in a joyful manner... Thanks to them, I saw my twins and went to my room so happily. Unless, I can even pass out with fear. I was really in a bad situation but the team was so great that I could handle it.”

Although the physician interaction may be considered as the most critical interaction point, nurse is as important as the physician. One of the physicians in the interviews mentions about it:

“All of the operational support such as diaper changing is made by the nurse and administrative personnel. Since a physician do not and actually can not do that, staff should be considered carefully.”

Periphery

Although physical appearance, location, extra services can be considered as secondary important issues, patients pay attention to those kind of assets while evaluating the experience. Especially location is a critical factor for patients when choosing which

hospital to visit. One of the managers tells that after they move to a location that is near to a more luxury area and far from the transportation, they lost some of their patients. During the interviews, the sentence of *“I prefer this hospital because I live in the neighborhood”* is frequently used. Additionally, physical appearance is found as one of the critical points which patients pay attention to. Patients evaluate the experience both for the appearance and going between the branches:

“...such a superclass hospital should be more presentable and luxurious. In the end, we pay a lot here!”

“...when I first enter here, it does not seem like a hospital. It is more like a comfy and luxurious hotel, or even a space shuttle. Everywhere is bright and shining. The hospital had been designed in a really luxurious way.”

3.2.5 Results

Five dimensions of patient experience were extracted in qualitative phase of the study: patient, provider, periphery, physician and personnel. All these dimensions were found as effective experience branches according to the views of patients and experts. The main contribution to the field is providing this framework which was built upon combining the different perspectives. Both experts and patients agreed on the dimensions of patient experience. Provider addresses to the managerial operations of the health care organization, such as process management, state or private insurance contracts, etc. Periphery comprises the ambiance of the hospital including the hygiene, crowd, extra services, etc. Physician addresses to the interaction between the physician and the patient, communication quality, helpfulness, etc. Personnel includes the same dimensions with physician, but since the participants mentioned personnel as nurses and staff different than physicians, this is a distinct dimension. Last, patient itself was found as an experience dimension with its sub-meanings of treatment type, insurance usage, patient type, etc. All the dimensions of experience quality included in the research model except patient. As it can be inferred from the quotations, mood/feeling/psychology of a patient is built before he/she came to the hospital and directly affected by the attitudes of the medical or administrative staff. Thereby, the dimension of patient can be divided among physician and personnel. Besides, patient itself is not an experience quality dimension, which the hospital can organize, and patients can evaluate, so it is excluded from the model.

All of the four dimensions were used as a guide for designing the research model and hypothesis testing.

3.3 Quantitative Phase

The qualitative phase of the study built a base for the quantitative phase. In the light of interview results, the perceived experience quality dimensions were determined as personnel, physician, provider, and periphery. Patient was excluded because a hospital cannot control the patient type. Thus, the research model can be seen in Figure 3.5.

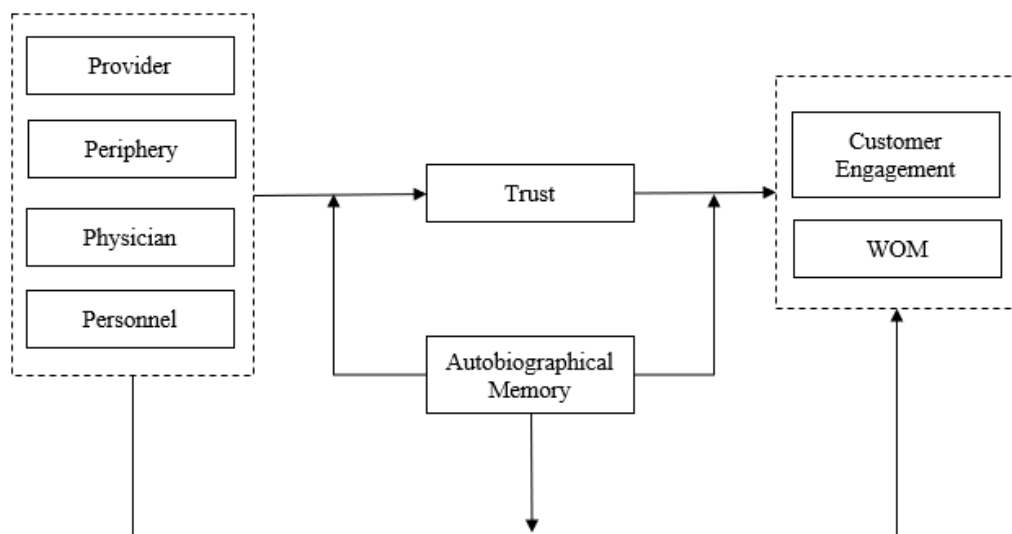


Figure 3.5 : The research model.

Next sections include the hypotheses development and testing. According to the research model, the relationships between experience quality dimensions, engagement dimensions, and the effects of trust and autobiographical memory on those relationships were tested. The hypotheses were constructed, and statistical tests were conducted.

3.3.1 Customer Experience-Customer Engagement Relationship

In healthcare sector, the behavior beyond purchase is important because one of the main objectives of the hospitals is having a high reputation instead of having financial superiority. Patients are highly intended to return to same doctor and recommend him/her to others if they are satisfied with the service (Mittal and Baldasare, 1996). The customer engagement activities may provide critical insights about patients, physicians, hospital customer service, administrative staff, etc. (Rehnen et al., 2017).

So, the insight collected from engagement activities is a critical performance indicator of marketing and service quality in hospitals.

In order to collect valuable insight from the customers for themselves and to spread preferred information about the firm, organizations should encourage consumers to engage by customer engagement marketing activities by customer engagement marketing. Addition to purchase, firms must encourage customers by referral, feedback, or social media interaction (Pansari and Kumar, 2017; Kumar 2013). Customer engagement marketing is the intentional attempts of the organization to motivate and empower its customers to voluntarily contribute the marketing activities apart from financial transaction (Harmeling et al., 2017).

The theory of consumption values (Sheth et al., 1991) and the consumer values perspective (Holbrook, 2006) suggests that there is a positive relationship between the consumers' expectations about the value of an experience and the intention to engage (Vivek et al., 2012). For instance, if a tourist is satisfied with the service of the hotel, he/she is more likely to write a review on tourism website. When the tourist is dissatisfied with the service, it is also highly possible that he/she would write a review. This is the process of cocreating value after an experience in order to influence others to have and/or directing the service providers to create a better experience (Brodie et al., 2011; van Doorn et al., 2010). A customer may spend more money, provide more feedback to the firm, and spread more suggestions to other consumers if he/she has a positive experience with the firm (Kumar and Pansari, 2016).

Since CE is a relational bond between the firm and the customer who have an experience with the firm's offering (Vivek et al., 2012), and customer experience quality includes the quality assessment of the customer with other customers (Lemke et al., 2011); there is a positive relationship between customer experience and customer engagement. In this study, engagement is considered as a dimensional construct with three sub-dimensions. Experience quality is considered also as a dimensional construct with four sub-dimensions. Hence, there are 12 hypotheses for the direct effect:

H1: Provider experience quality has a positive effect on engagement.

H1a: Provider experience quality has a positive effect on purchase.

H1b: Provider experience quality has a positive effect on knowledge.

H1c: Provider experience quality has a positive effect on influence.

- H2: Provider experience quality has a positive effect on WOM.
- H3: Periphery experience quality has a positive effect on engagement.
- H3a: Periphery experience quality has a positive effect on purchase.
- H3b: Periphery experience quality has a positive effect on knowledge.
- H3c: Periphery experience quality has a positive effect on influence.
- H4: Periphery experience quality has a positive effect on WOM.
- H5: Physician interaction quality has a positive effect on engagement.
- H5a: Physician interaction quality has a positive effect on purchase.
- H5b: Physician interaction quality has a positive effect on knowledge.
- H5c: Physician interaction quality has a positive effect on influence.
- H6: Physician interaction quality has a positive effect on WOM.
- H7: Personnel interaction quality has a positive effect on engagement.
- H7a: Personnel interaction quality has a positive effect on purchase.
- H7b: Personnel interaction quality has a positive effect on knowledge.
- H7c: Personnel interaction quality has a positive effect on influence.
- H8: Personnel interaction quality has a positive effect on WOM.

3.3.2 Mediating effect of trust

According to social exchange theory, the interaction between the firm and the customer indicates the closeness of the relationship (Rehnen et al., 2017; Thibaut and Kelley, 1959). In the study of Vivek et al. (2012), one of the propositions says that “customer engagement will be positively associated with an individual’s trust in the organization he or she associates with his or her focus of engagement”. They state that engagement and trust have a positive relationship because a firm that allows to be engaged makes consumers feel that the firm cares their thoughts. Considering trust as the confidence of the relational partner’s reliability (Morgan and Hunt, 1994), it can be an antecedent and also a consequence of engagement.

As van Doorn et al. (2011) states, trust might be both consequence (Brodie et al., 2011) or antecedent (Grégoire et al., 2009). In healthcare sector, trust is a critical construct

to build a relationship with the hospital. It is expected in this study that if a patient is satisfied with the experience quality, he/she will have higher commitment and trust levels, and this lead a higher customer engagement intention. Hence;

H9a: Provider experience quality has a positive effect on trust.

H9b: Periphery experience quality has a positive effect on trust.

H9c: Physician interaction quality has a positive effect on trust.

H9d: Personnel interaction quality has a positive effect on trust.

H10: Engagement is positively affected by trust.

H10a: Purchase is positively affected by trust.

H10b: Knowledge is positively affected by trust.

H10c: Influence is positively affected by trust.

H11: WOM is positively affected by trust.

H12: Trust mediates the relationship between provider experience quality and engagement.

H12a: Trust mediates the relationship between provider experience quality and purchase.

H12b: Trust mediates the relationship between provider experience quality and knowledge.

H12c: Trust mediates the relationship between provider experience quality and influence.

H13: Trust mediates the relationship between provider experience quality and WOM.

H14: Trust mediates the relationship between periphery experience quality and engagement.

H15a: Trust mediates the relationship between periphery experience quality and purchase.

H15b: Trust mediates the relationship between periphery experience quality and knowledge.

H15c: Trust mediates the relationship between periphery experience quality and influence.

H16: Trust mediates the relationship between periphery experience quality and WOM.

H17: Trust mediates the relationship between physician interaction quality and engagement.

H17a: Trust mediates the relationship between physician interaction quality and purchase.

H17b: Trust mediates the relationship between physician interaction quality and knowledge.

H17c: Trust mediates the relationship between physician interaction quality and influence.

H18: Trust mediates the relationship between physician interaction quality and WOM.

H19: Trust mediates the relationship between personnel interaction quality and engagement.

H19a: Trust mediates the relationship between personnel interaction quality and purchase.

H19b: Trust mediates the relationship between personnel interaction quality and knowledge.

H19c: Trust mediates the relationship between personnel interaction quality and influence.

H20: Trust mediates the relationship between personnel interaction quality and WOM.

3.3.3 Moderating effect of autobiographical memory

Autobiographical memory stores the effects of life events (Stach, 2017; Williams et al., 2008; Misak and Di Pietro, 2006), and consumers store their experiences in life (Stach, 2017). They make their behavioral decisions in the light of those memories (Barnes et al 2016; Lindstrom and Seybold 2007). In previous literature, consumers' autobiographical memory is analyzed in tourism context and the effect of experience memory on future decisions are found (Vaughan and Edwards, 1999). Health care studies did not investigate the effect of autobiographical memory on patients'

behavioral outcomes. However, a significant influence of autobiographical memory of patients on their experience-engagement relationship may exist, because the more a patient remembers a hospital experience, the more he/she may tell it to other people and keep that hospital in mind for future decisions. In this sense, this research proposes that autobiographical memory moderates the relationship between experience and engagement via trust. For the moderating mediation effect of autobiographical memory, the hypotheses are listed below.

H21: Autobiographical memory would moderate the indirect association between provider experience quality and engagement via trust. Specifically, the indirect association between provider experience quality and engagement would be much stronger with higher levels of autobiographical memory.

H21a: Autobiographical memory would moderate the indirect association between provider experience quality and purchase via trust. Specifically, the indirect association between provider experience quality and purchase would be much stronger with higher levels of autobiographical memory.

H21b: Autobiographical memory would moderate the indirect association between provider experience quality and knowledge via trust. Specifically, the indirect association between provider experience quality and knowledge would be much stronger with higher levels of autobiographical memory.

H21c: Autobiographical memory would moderate the indirect association between provider experience quality and influence via trust. Specifically, the indirect association between provider experience quality and influence would be much stronger with higher levels of autobiographical memory.

H22: Autobiographical memory would moderate the indirect association between provider experience quality and WOM via trust. Specifically, the indirect association between provider experience quality and WOM would be much stronger with higher levels of autobiographical memory.

H23: Autobiographical memory would moderate the indirect association between periphery experience quality and engagement via trust. Specifically, the indirect association between provider experience quality and engagement would be much stronger with higher levels of autobiographical memory.

H23a: Autobiographical memory would moderate the indirect association between periphery experience quality and purchase via trust. Specifically, the indirect association between provider experience quality and purchase would be much stronger with higher levels of autobiographical memory.

H23b: Autobiographical memory would moderate the indirect association between periphery experience quality and knowledge via trust. Specifically, the indirect association between provider experience quality and knowledge would be much stronger with higher levels of autobiographical memory.

H23c: Autobiographical memory would moderate the indirect association between periphery experience quality and influence via trust. Specifically, the indirect association between provider experience quality and influence would be much stronger with higher levels of autobiographical memory.

H24: Autobiographical memory would moderate the indirect association between periphery experience quality and WOM via trust. Specifically, the indirect association between provider experience quality and WOM would be much stronger with higher levels of autobiographical memory.

H25: Autobiographical memory would moderate the indirect association between physician interaction quality and engagement via trust. Specifically, the indirect association between provider experience quality and engagement would be much stronger with higher levels of autobiographical memory.

H25a: Autobiographical memory would moderate the indirect association between physician interaction quality and purchase via trust. Specifically, the indirect association between provider experience quality and purchase would be much stronger with higher levels of autobiographical memory.

H25b: Autobiographical memory would moderate the indirect association between physician interaction quality and knowledge via trust. Specifically, the indirect association between provider experience quality and knowledge would be much stronger with higher levels of autobiographical memory.

H25c: Autobiographical memory would moderate the indirect association between physician interaction quality and influence via trust. Specifically, the indirect association between provider experience quality and influence would be much stronger with higher levels of autobiographical memory.

H26: Autobiographical memory would moderate the indirect association between physician interaction quality and WOM via trust. Specifically, the indirect association between provider experience quality and WOM would be much stronger with higher levels of autobiographical memory.

H27: Autobiographical memory would moderate the indirect association between personnel interaction quality and engagement via trust. Specifically, the indirect association between provider experience quality and engagement would be much stronger with higher levels of autobiographical memory.

H27a: Autobiographical memory would moderate the indirect association between personnel interaction quality and purchase via trust. Specifically, the indirect association between provider experience quality and purchase would be much stronger with higher levels of autobiographical memory.

H27b: Autobiographical memory would moderate the indirect association between personnel interaction quality and knowledge via trust. Specifically, the indirect association between provider experience quality and knowledge would be much stronger with higher levels of autobiographical memory.

H27c: Autobiographical memory would moderate the indirect association between personnel interaction quality and influence via trust. Specifically, the indirect association between provider experience quality and influence would be much stronger with higher levels of autobiographical memory.

H28: Autobiographical memory would moderate the indirect association between personnel interaction quality and WOM via trust. Specifically, the indirect association between provider experience quality and WOM would be much stronger with higher levels of autobiographical memory.

3.3.4 The scales

According to the research model, different scales in the literature were used and the questionnaire is finalized (see Appendix A). The sources of the scales can be seen on Table 3.5.

Table 3.5 : Scales used in the questionnaire.

Scale	Author, Year
Autobiographical memory	Fitzgerald and Broadbridge, 2013
Trust	Crosby et al., 1990
Engagement	Kumar and Pansari, 2016
WOM	Romero, 2017
Physician interaction quality	Kim and Choi, 2013
Personnel interaction quality	Kim and Choi, 2013
Periphery experience quality	Kim and Choi, 2016
Provider (peace of mind)	Klaus and Maklan, 2013

3.3.5 Pilot study

In order to test the scales, a pilot study was conducted before the main quantitative study. A sample of 45 participants answered the questionnaire via an online survey website. The data was collected during a week. As participants reported, the questionnaire can be done in 15 minutes maximum. The results were extracted in excel format analyzed by using SPSS 24.0. Factor analyses and reliability analyses were conducted, and results were reported in terms of validity and reliability. The reliability analysis results of the pilot analyses were reported below (Table 3.6).

Two questions from autobiographical memory (from rehearsal and impact dimensions) scale were eliminated after the analyses in order to have higher reliability values (Two questions are: “Would you be confident enough in your memory of the event to testify in a court of law?” and “Since it happened, I have talked about this event”). Besides, according to the observation while answering the questionnaire, deleted questions were hardly understood by most of the participants because of the linguistic issues. There were some additional items that alpha value will be higher when deleted. However, the sample size of the pilot study (n=45) was not acceptable for deleting items according to their effect on alpha value. Hence, the final questionnaire was obtained for the main study.

Table 3.6 : Reliability results after pilot study.

Scale	Author, Year	Cronbach's alpha
Autobiographical memory	Fitzgerald and Broadbridge, 2013	0,89
<i>Recollection</i>		0,70
<i>Belief</i>		0,77
<i>Rehearsal</i>		0,77 (0,67)*
<i>Impact</i>		0,76 (0,63)*
Trust	Crosby et al., 1990	0,82
Engagement	Kumar and Pansari, 2016	0,88
<i>Purchase</i>		0,76
<i>Knowledge</i>		0,88
<i>Influence</i>		0,94
WOM	Romero, 2017	0,95
Physician interaction quality	Kim and Choi, 2013	0,97
Personnel interaction quality	Kim and Choi, 2013	0,94
Periphery experience quality	Kim and Choi, 2016	0,93
Provider (peace of mind)	Klaus and Maklan, 2012	0,91

*The values in the parantheses are the Cronbach's alpha values before the relevant items were deleted.

3.3.6 Main study

After the pilot study, the questionnaire was finalized as it is shown in the Table 3.8. The original version of the survey form can be seen in Appendix A. The scales with proven validity and reliability in the previous literature were adapted for the purpose of this research. Each of the items in Table 3.7 was measured on a seven-point scale (1: strongly disagree, 7: strongly agree). Autobiographical memory was measured by the scale of Fitzgerald and Broadbridge (2013). Although it originally has four sub-dimensions and 18 items, this study extracts three sub-dimensions using 15 items after pilot analysis, EFA, and CFA which will be explained in the next sections. The scale for trust with 9 items was taken from Crosby et al. (1990). Again, after CFA, four items were deleted because of low factor loadings. Provider experience quality items were taken from Klaus and Maklan (2012), which they named as peace of mind in their study. Five items decreased to four after CFA. Periphery experience quality (Kim and Choi, 2016), physician interaction quality (Kim and Choi, 2013), and personnel interaction quality (Kim and Choi, 2013) include three items for each. Customer

engagement measure was adapted from Kumar and Pansari (2016). It originally has four sub-dimensions, however, the fourth one, referral, was not used in this study since it has some senseless items when translated to Turkish in healthcare context. The questions mainly measure the referral behavior in parallel with a monetary reward. Since monetary reward is not a common usage in healthcare sector in Turkey, the referral questions were not used in the research. Instead, a WOM scale including 6 items from Romero (2017) was used. Like other constructs, this construct has also lost its two questions after CFA.

Table 3.7 : Measures in the study.

Construct	Item	Item code	Source
Autobiographical memory		MEM	Fitzgerald and Broadbridge, 2013
	<i>Power</i> I believe the event in my memory really occurred in the way I remember it and that I have not imagined or fabricated anything that did not occur.	POW1	
	Sometimes people know something happened to them without being able to actually remember it. As I think about the event, I can actually remember it rather than just knowing that it happened.	POW2	
	As I remember the event, it comes to me in words or in pictures as a coherent story or episode and not as an isolated fact, observation, or scene.	POW3	
	As I remember the event, I am aware of the time of day.	POW4	
	As I remember the event, it comes to me in words.	POW5	
	As I remember the event, I can recall the setting where it occurred.	POW6	
	As I remember the event, I know its spatial layout.	POW7	
	<i>Detail</i> As I remember the event, I can hear it in my mind.	DET1	
	As I remember the event, I feel as though I am reliving the original event	DET2	

Table 3.7 (continued): Measures in the study.

Construct	Item	Item code	Source
Trust	As I remember the event, I can see it in my mind.	DET3	Crosby et al., 1990
	As I remember the event, I can feel now the emotions that I felt then.	DET4	
	As I remember the event, I feel that I travel back to the time when it happened, that I am a participant in it again, rather than an outside observer tied to the present	DET5	
	This memory is significant for my life because it imparts an important message for me or represents an anchor, critical juncture, or a turning point.	EFF1	
	This memory has consequences for my life because it influenced my behaviour, thoughts, or feelings in noticeable ways.	EFF2	
	Since it happened, I have thought about this event.	EFF3	
	My hospital can be relied upon to keep his/her promises.	TRU1	
	There are times when I find my hospital to be a bit insincere.*	TRU2	
	I find it necessary to be cautious in dealing with this hospital.*	TRU3**	
	This hospital is trustworthy.	TRU4	
Effect	This hospital and I are in competition-they are trying to sell me a lot of services and I am trying to avoid buying it.*	TRU5	
	This hospital puts the customer's interests before his/her own.	TRU6**	
	Some hospitals including this one are not above bending the facts to create the impression they want.*	TRU7**	

Table 3.7 (continued): Measures in the study.

Construct	Item	Item code	Source
Provider	This hospital is dishonest.*	TRU8	Klaus and Maklan, 2011
	I suspect that this hospital has sometimes withheld certain pieces of critical information that might have affected my decision-making.*	TRU9	
	I am confident in their expertise; they know what they are doing.	PRO1	
	The whole process was so easy; they took care of everything.	PRO2	
	It is not just about the now; this hospital is looking after me.	PRO3	
Periphery	I am already a customer; they know me and take good care of me, so why should I go elsewhere?	PRO4	Kim and Choi, 2016
	I have dealt with them before, so being treated in the same hospital was really easy.	PRO5**	
	I would say that experience at this hospital is excellent.	PERI1	
	I believe that I get a superior experience when compared to other hospitals at this hospital.	PERI2	
	I think that this hospital is excellent at total patient experience procedure.	PERI3	
Physician	I think that the quality of my interaction with the physician is excellent.	PHY1	Kim and Choi, 2013
	I would say that the physician is interested in the patients.	PHY2	
	I believe that the physician is caring the patients.	PHY3	
Personnel	I think that the quality of my interaction with the personnel is excellent.	PERS1	Kim and Choi, 2013
	I would say that the personnel is interested in the patients.	PERS2	
	I believe that the personnel is caring the patients.	PERS3	
Customer engagement		ENG	Kumar and Pansari, 2016
Purchase	I will continue buying the products/services of this hospital in the near future.	PUR1	
	My purchases with this hospital make me content.	PUR2	
	I do not get my Money's worth when I purchase this hospital.*	PUR3**	
	Owning the products/services of this hospital makes me happy.	PUR4	

Table 3.7 (continued): Measures in the study.

Construct	Item	Item code	Source
Influence	I love talking about my hospital experience.	INF1	Romero, 2017
	I discuss the benefits that I get from this hospital with others.	INF2	
	I am a part of this hospital and mention it in my conversations.	INF3	
	I provide feedback about my experiences with the hospital to the firm.	INF4	
Knowledge	I provide suggestions for improving the performance of the hospital.	KNOW1	
	I provide suggestions/feedbacks about the new product/services of the hospital.	KNOW2	
	I provide feedback/suggestions for developing new products/services for this hospital.	KNOW3	
WOM	I mention to others that I purchase from this hospital.	WOM1**	
	I make sure that others know that I purchase from this hospital.	WOM2**	
	I recommend this hospital to family members.	WOM3	
	I speak positively of this hospital to others.	WOM4	
	I recommend this hospital to acquaintances.	WOM5	
	I recommend this hospital to close personal friends.	WOM6	

*Reverse questions

**Deleted questions after CFA

With the financial research support of Istanbul Technical University Scientific Research Project, the survey was conducted by a professional research company. Trained fieldworkers were used to collect the data. The data was collected face-to-face from each and every district of Istanbul, in parallel with the distribution of address-based population registration system (see Table 3.9). The data was collected over a two-week period during March and April 2019. A total of 506 fully filled surveys were reached at the end of the field study.

Table 3.8 : The distribution of number of surveys.

District	Population	Ratio	Number of surveys
BAKIRKÖY	222,370	2%	8
BEŞİKTAŞ	185,447	1%	6
BEYKOZ	251,087	2%	9
BEYOĞLU	236,606	2%	8
EYÜPSULTAN	381,114	3%	13
FATİH	433,873	3%	15
GAZİOSMANPAŞA	497,959	3%	17
KADIKÖY	451,453	3%	15
KARTAL	463,433	3%	16
SARIYER	344,876	2%	12
ŞİŞLİ	274,196	2%	9
ÜSKÜDAR	533,570	4%	18
ZEYTİNBURNU	287,378	2%	10
BÜYÜKÇEKMECE	243,474	2%	8
KAĞITHANE	442,694	3%	15
KÜÇÜKÇEKMECE	770,393	5%	26
PENDİK	698,260	5%	24
ÜMRANİYE	699,901	5%	24
BAYRAMPAŞA	274,197	2%	9
AVCILAR	435,682	3%	15
BAĞCILAR	748,483	5%	25
BAHÇELİEVLER	598,454	4%	20
GÜNGÖREN	296,967	2%	10
MALTEPE	497,586	3%	17
SULTANBEYLİ	329,985	2%	11
TUZLA	252,923	2%	9
ESENLER	454,569	3%	15
ARNAVUTKÖY	261,655	2%	9
ATAŞEHİR	423,372	3%	14
BAŞAKŞEHİR	396,729	3%	13
BEYLİKDÜZÜ	314,670	2%	11
ÇEKMEKÖY	248,859	2%	8
ESENYURT	846,492	6%	29
SANCAKTEPE	402,391	3%	14
SULTANGAZİ	528,514	4%	18
Total	14,729,612	100%	500

SPSS 25 was used to analyze the data. The data was prepared for the statistical analyses. After coding, missing data (5) were replaced with the average of the related item. As a second step, reverse questions were computed into different variables. The average values of the constructs were calculated. Reliability analyses were conducted, and Cronbach's alpha values were calculated. Then, exploratory factor analyses (EFA) was performed in order to explore the underlying structure of the items of especially the constructs with sub-dimensions, customer engagement and autobiographical memory. Results were reported in terms of validity and reliability. In order to test the structural model proposed in this study, AMOS 25 and Hayes's PROCESS macro were used.

3.3.7 Results

3.3.7.1 Demographics of the participants

The demographics of the participants were measured by age, income, gender, and education. The values can be seen on Table 3.9. The distribution of age was found as nearly equal except for 66 and above. Only 4% of the participants were at the age of higher values. The gender distribution was 50%-50%. Most of the participants were lastly graduated from high school, with an income of 3000 TL and below.

Additionally, the behavioral measures were asked to participants (Table 3.10). The last visit of a private hospital was asked in order to eliminate the patients who had a last visit of 1 year ago or older. Most of the participants have visited a private hospital within 1-6 months (78%). Additionally, the branches visited were also asked. A variety of branches reflected on answers, but the most visited branch was found as internal diseases (23%) followed by gynecology (13%) and otorhinolaryngology (12%). In the table, the item mentioned as other includes ophthalmology (8%), cardiology (7%), dental diseases (5%), dermatology (5%), orthopedics (4%), neurology (3%), emergency (3%), general surgery (2%), physiotherapy (2%), gastroenterology (2%), urology (2%), check-up (1%), chest diseases (1%), nephrology (1%), brain surgery (1%), psychiatry (1%), rheumatology (1%), oncology (1%), and hematology (~1%). 83% of the participants were treated as outpatients. 56% of them visited the same hospital for a couple of times before while 26% of them always visit the same hospital. Assurance usage was 52% private assurance, 12% state assurance, and 36% cash. 81%

of the participants mentioned that the hospital they visit have a contract with state insurance.

Table 3.9 : Sample characteristics.

Measures	Items	Frequency	Percentage
Age	18-25	127	25%
	26-35	116	23%
	36-50	149	29%
	51-65	96	19%
	66-	18	4%
Gender	Female	251	50%
	Male	255	50%
Education	Primary school	155	31%
	High school	225	44%
	Graduate	111	22%
	Postgraduate	15	3%
Income	3000 TL and below	272	54%
	3001-6000 TL	198	39%
	6001-9000 TL	21	4%
	9001-12000 TL	8	2%
	12001-15000 TL	1	0%
	15001 TL and above	4	1%
	No answer	2	0%

Table 3.10 : Hospital visit frequencies of the sample.

Measure	Item	Frequency	Percentage
Hospital visit frequency	Once in a month	36	7%
	Once in 2-3 months	131	26%
	Once in 4-6 months	159	31%
	Once in 7-9 months	77	15%
	Once in 10-12 months	103	20%
Private hospital visit frequency	Once in a month	21	4%
	Once in 2-3 months	95	19%
	Once in 4-6 months	145	29%
	Once in 7-9 months	97	19%
	Once in 10-12 months	148	29%

Table 3.11 : Behavioral measures of the sample.

Measures	Items	Frequency	Percentage
Last visit	In a week	53	10%
	In a month	111	22%
	Within 2-6 months	285	56%
	Within 6-12 months	57	11%
Branch	Internal diseases	119	23%
	Gyneacology	68	13%
	Otorhinolaryngology	60	12%
	Other	263	52%
Patient type	Outpatient	421	83%
	Inpatient	85	17%
Visiting frequency	First visit	91	18%
	Visited before	282	56%
	Always visit the same	133	26%
Revisit as relative	Yes	161	32%
	No	345	68%
Payment method	Private assurance	29	6%
	State assurance	229	45%
	Cash	184	36%
	Partial pay	64	13%
State assurance	Yes	409	81%
	No	64	13%
	No idea	33	6%

Visiting habits of participants were asked in terms of hospital visit and private hospital visit (Table 3.11). Both of the questions have a similar distribution. Most of the participants visit hospitals once in 4-6 months and visit private hospitals in the same frequency.

4. HYPOTHESES TESTS

This thesis handles the model in two alternatives: main model and dimensional model. Main model includes only the general constructs by calculating the grand mean. To illustrate, the model takes autobiographical memory as one dimension instead of three (power, detail, and effect) and engagement also as one dimension instead of three (purchase, knowledge, and influence). On the other hand, dimensional model considers all sub dimensions as distinct constructs. Experience quality is not considered as a construct with sub-dimensions since the 4P dimensions are composed by the researcher. It is not a solitary construct in the literature. The conceptual frameworks for both models can be seen in Figures 4.1 and 4.2. The exploratory factor analysis considering the measurement tools was conducted once, but the confirmatory factor analysis and hypotheses tests were conducted separately for both models.

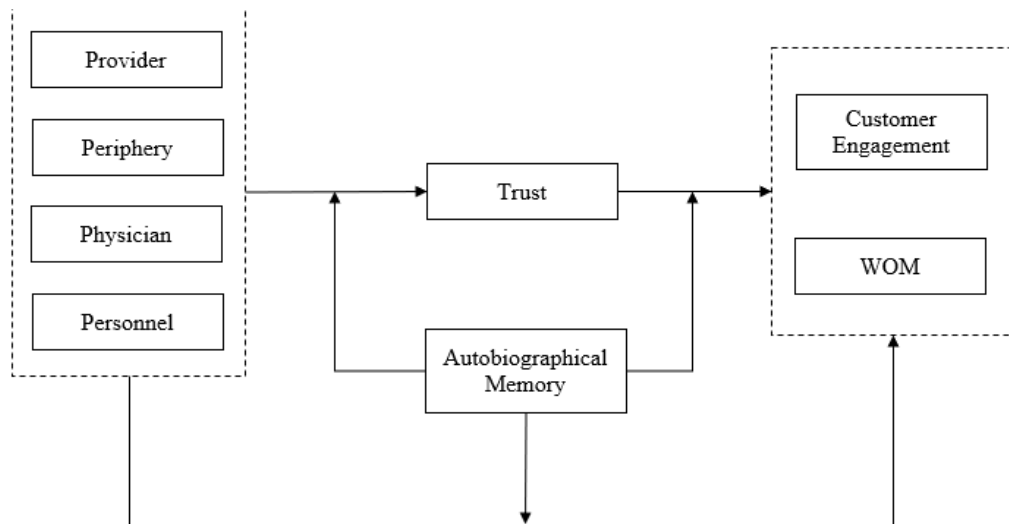


Figure 4.1 : Main model.

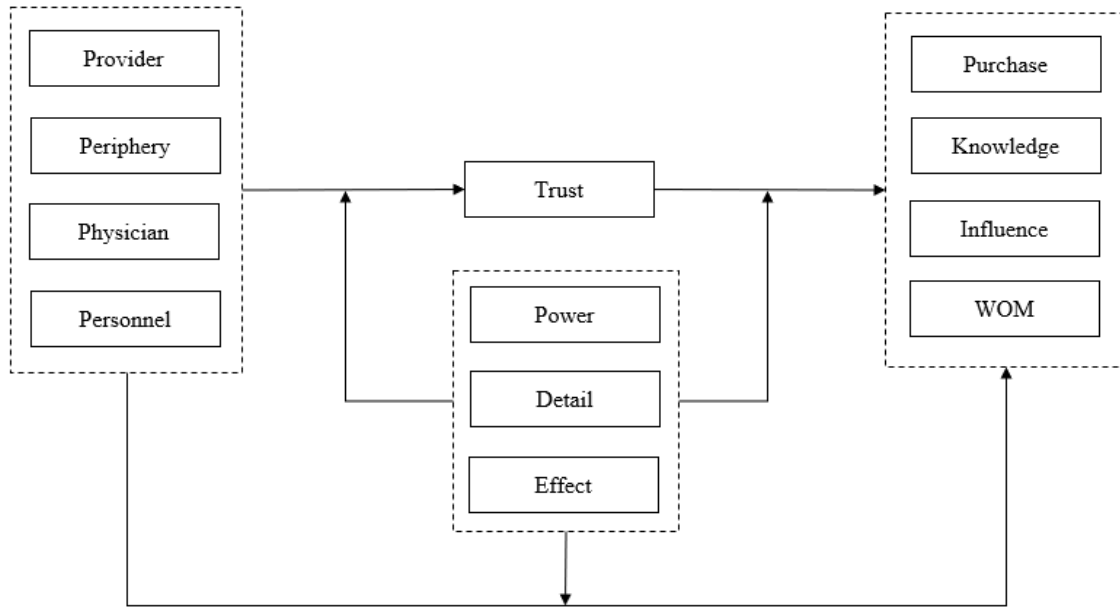


Figure 4.2 : Dimensional model.

4.1 Exploratory Factor Analysis (EFA)

Before testing the fit of the measurement model, verification of the contracts was necessary because there are some constructs with subdimensions (Tonder and Petzer, 2018). Following Tonder and Petzer (2018), EFA was conducted for each construct, with varimax rotation. Autobiographical memory and customer engagement have several subdimensions, hence it is critical to be sure about the underlying structure of each. Additionally, other constructs were also tested in terms of the underlying structure.

The findings showed that for all constructs, the Kaiser-Meyer-Olkin Measure of Sampling Adequacy exceeds 0.6 which is the cut-off point for factor analysis, and the p values for the Bartlett's Test of Sphericity were significant. For autobiographical memory, rotated component matrix showed that (Table 4.1) three factors were extracted instead of four identified by Fitzgerald and Broadbridge (2013): power (Cronbach's alpha=0.916), detail (Cronbach's alpha=0.913), and effect (Cronbach's alpha=0.875). The bold values were used for further analysis. One question ("As I recall them now, I would you rate the emotions I experienced during the event...") was eliminated from the scale since it is not loaded in any of the factors.

Table 4.1 : Rotated component matrix for autobiographical memory.

Rotated Component Matrix			
	Factor Loadings		
	1	2	3
POW1	0,851		
POW2	0,820		
POW3	0,760		
POW4	0,730		
POW5	0,726		
POW6	0,647		
POW7	0,638	0,504	
DET1		0,870	
DET2		0,835	
DET3		0,766	
DET4		0,739	
DET5	0,510	0,620	
EFF1			0,890
EFF2			0,886
EFF3			0,823
Impact2 (<i>deleted</i>)			

For customer engagement, EFA was necessary to understand the structure of the scale since it also has sub-dimensions. The results showed that as in the original, the construct was separated under three factors: purchase (Cronbach's $\alpha=0.913$), influence (Cronbach's $\alpha=0.839$), and knowledge (Cronbach's $\alpha=0.931$). The influence dimension has some differences from the original. The item for social media engagement was not included in any factors, so it was deleted. Additionally, one question from the knowledge dimension ("I provide feedback about my experiences with the hospital to the firm") was counted in influence dimension. The rotated component matrix shows the factor loadings (Table 4.2).

Table 4.2 : Rotated component matrix for engagement.

Rotated Component Matrix			
	Factor Loadings		
	1	2	3
PUR1	0,909		
PUR2	0,866		
PUR3**	0,847		
PUR4	0,665		
INF1		0,861	
INF2		0,859	
INF3		0,717	
INF4		0,715	
KNOW1			0,893
KNOW2			0,893
KNOW3			0,800
SocMed (<i>deleted</i>)			

**Deleted item after CFA

EFA was employed also for other constructs. Trust (Cronbach's $\alpha=0.861$) was found as one factor with 9 items, in which three of the items were eliminated after CFA. Periphery experience quality (Cronbach's $\alpha=0.905$), physician interaction quality (Cronbach's $\alpha=0.968$) and personnel interaction quality (Cronbach's $\alpha=0.971$) were each loaded in one factor with 3 items. Provider experience quality (Cronbach's $\alpha=0.884$) was also found as one factor with 5 items, in which one of the items was deleted after CFA. Finally, WOM (Cronbach's $\alpha=0.979$) was found as one factor with 6 items, in which 2 of them is eliminated after CFA. Cronbach's α was a value that shows the internal consistency of the constructs and it should be higher than 0.60 (Hair, 2010). The α values shown in the table were calculated after the items are deleted according to the CFA which will be explained below (Table 4.3).

Table 4.3 : Reliability values of the scales.

Scale	Author, Year	Cronbach's alpha
Autobiographical memory	Fitzgerald and Broadbridge, 2013	0.938
	<i>Power</i>	0.916
	<i>Detail</i>	0.913
	<i>Effect</i>	0.875
Trust	Crosby et al., 1990	0.861
Engagement	Kumar and Pansari, 2016	
	<i>Purchase</i>	0.913
	<i>Knowledge</i>	0.931
	<i>Influence</i>	0.839
WOM	Romero, 2017	0.979
Physician interaction quality	Kim and Choi, 2013	0.968
Personnel interaction quality	Kim and Choi, 2013	0.971
Periphery experience quality	Kim and Choi, 2016	0.905
Provider experience quality (peace of mind)	Klaus and Maklan, 2011	0.884

4.2 Differences Among Groups

For controlling purposes, some questions were added to the survey (Table 4.4). Visiting frequency of a hospital and a private hospital, the number of the visit to same hospital, treatment type, etc. were asked in order to investigate their effect on answers. The questions can be seen on Table 4.4. Additionally, it was checked whether there was a significant difference between gender, income, and education categories.

Table 4.4 : Control questions.

Item	Code	Measures
How often do you visit hospitals for your own health purposes?	FREQ	Once in a month Once in 2-3 months Once in 4-6 months Once in 7-9 months Once in a year
How often do you visit private hospitals for your own health purposes?	FREQ_PRIV	Once in a month Once in 2-3 months Once in 4-6 months Once in 7-9 months Once in a year
Was your last visit, the first visit to that hospital?	VISIT_NO	First visit Been there for a couple of times Always go the same hospital
After your last hospital visit, did you go to the same hospital as a patient relative?	PATIENT_RELATIVE	Yes No
Were you treated as an inpatient or an outpatient?	TREATMENT_TYPE	Outpatient Inpatient
Did the hospital in you last visit have the state insurance contract?	INSURANCE_CONTRACT	Yes No No idea
Did you use the insurance or pay by yourself?	INSURANCE_USAGE	Used private insurance Used state insurance Paid by myself Partially paid by the insurance

In order to test the group differences, first the test of normality for dependent variables was conducted. As can be seen on Table 4.5, the variables did not perform a normal distribution ($p < 0.05$). Hence, ANOVA cannot be used for comparing means. The non-parametric test of Kruskal-Wallis was used for the data.

Table 4.5 : Tests of Normality.

	Kolmogorov-Smirnov ^a			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
PRO	.133	506	.000	.905	506	.000
PERI	.119	506	.000	.931	506	.000
PHY	.220	506	.000	.764	506	.000
PERS	.199	506	.000	.842	506	.000
TRU	.138	506	.000	.903	506	.000
MEM	.056	506	.001	.971	506	.000
PUR	.129	506	.000	.924	506	.000
WOM	.196	506	.000	.850	506	.000

a. Lilliefors Significance Correction

The group differences for different frequencies of visiting hospitals can be seen on Table 4.6. There was a statistically significant difference between different frequencies of visiting hospitals for periphery experience quality [$\chi^2(2)=23.936$, $p<0.05$], with a mean rank score of 291.22 for once in a month, 279.63 for once in 2-3 months, 258.80 for once in 4-6 months, 185.12 for once in 7-9 months, 250.01 for once in a year. Another statistically significant difference was found for memory between different frequencies of visiting hospitals [$\chi^2(2)=13.575$, $p<0.05$], with a mean rank score of 291.28 for once in a month, 280.03 for once in 2-3 months, 246.82 for once in 4-6 months, 211.36 for once in 7-9 months, 248.37 for once in a year. Besides, purchase was found as statistically significantly different among groups [$\chi^2(2)=15.130$, $p<0.05$], with a mean rank score of 306.03 for once in a month, 268.05 for once in 2-3 months, 243.34 for once in 4-6 months, 207.97 for once in 7-9 months, 266.35 for once in a year. Lastly, there was a statistically significant difference between different groups for WOM [$\chi^2(2)=9.569$, $p<0.05$], with a mean rank score of 236.44 for once in a month, 278.53 for once in 2-3 months, 247.59 for once in 4-6 months, 218.97 for once in 7-9 months, 262.55 for once in a year.

Table 4.6 : The group differences for FREQ.

Dependent variable	Category	N	Mean Rank	χ^2	p
PRO	Once in a month	36	264.24	6.687	0.153
	Once in 2-3 months	131	260.11		
	Once in 4-6 months	159	249.39		
	Once in 7-9 months	77	219.4		
	Once in a year	103	273.18		
PERI	Once in a month	36	291.22	23.936*	0.000
	Once in 2-3 months	131	279.63		
	Once in 4-6 months	159	258.8		
	Once in 7-9 months	77	185.12		
	Once in a year	103	250.01		
PHY	Once in a month	36	265.5	1.816	0.77
	Once in 2-3 months	131	261.56		
	Once in 4-6 months	159	246.37		
	Once in 7-9 months	77	241.81		
	Once in a year	103	258.79		
PERS	Once in a month	36	225.33	2.123	0.713
	Once in 2-3 months	131	260.54		
	Once in 4-6 months	159	250.73		
	Once in 7-9 months	77	250.2		
	Once in a year	103	261.13		
TRU	Once in a month	36	273.39	5.133	0.274
	Once in 2-3 months	131	268.89		
	Once in 4-6 months	159	251.87		
	Once in 7-9 months	77	224.94		
	Once in a year	103	250.83		
MEM	Once in a month	36	291.28	13.575*	0.009
	Once in 2-3 months	131	280.03		
	Once in 4-6 months	159	246.82		
	Once in 7-9 months	77	211.36		
	Once in a year	103	248.37		
PUR	Once in a month	36	306.03	15.13*	0.004
	Once in 2-3 months	131	268.05		
	Once in 4-6 months	159	243.34		
	Once in 7-9 months	77	207.97		
	Once in a year	103	266.35		
WOM	Once in a month	36	236.44	9.569*	0.048
	Once in 2-3 months	131	278.53		
	Once in 4-6 months	159	247.59		
	Once in 7-9 months	77	218.97		
	Once in a year	103	262.55		

*p<0.05

The group differences for different frequencies of visiting private hospitals can be seen on Table 4.7. There was a statistically significant difference between different frequencies of visiting hospitals for provider experience quality [$\chi^2(2)=11.433$, $p<0.05$], with a mean rank score of 296.55 for once in a month, 279.91 for once in 2-3 months, 263.76 for once in 4-6 months, 221.18 for once in 7-9 months, 241.57 for once in a year. Another statistically significant difference was found for periphery experience quality between different frequencies of visiting private hospitals [$\chi^2(2)=30.772$, $p<0.05$], with a mean rank score of 317.76 for once in a month, 288.29 for once in 2-3 months, 281.52 for once in 4-6 months, 205.37 for once in 7-9 months, 226.15 for once in a year. Besides, trust was found as statistically significantly different among groups [$\chi^2(2)=17.059$, $p<0.05$], with a mean rank score of 299.57 for once in a month, 281.92 for once in 2-3 months, 273.87 for once in 4-6 months, 222.42 for once in 7-9 months, 229.14 for once in a year. There was also a statistically significant difference between different groups for memory [$\chi^2(2)=11.310$, $p<0.05$], with a mean rank score of 292.95 for once in a month, 284.48 for once in 2-3 months, 255.32 for once in 4-6 months, 219.24 for once in 7-9 months, 248.69 for once in a year. Purchase is also found as significantly different among groups [$\chi^2(2)=26.75$, $p<0.05$], with a mean rank score of 350.36 for once in a month, 288.81 for once in 2-3 months, 265.34 for once in 4-6 months, 216.66 for once in 7-9 months, 229.64 for once in a year. Lastly, there was a statistically significant difference between groups for WOM [$\chi^2(2)=13.310$, $p<0.05$], with a mean rank score of 235.6 for once in a month, 288.48 for once in 2-3 months, 269.46 for once in 4-6 months, 227.73 for once in 7-9 months, 234.84 for once in a year.

Table 4.7 : The group differences for FREQ_PREV.

Dependent variable	Category	N	Mean Rank	x ²	p
PRO	Once in a month	21	296.55	11.433*	0.022
	Once in 2-3 months	95	279.91		
	Once in 4-6 months	145	263.76		
	Once in 7-9 months	97	221.18		
	Once in a year	148	241.57		
PERI	Once in a month	21	317.76	30.772*	0.000
	Once in 2-3 months	95	288.29		
	Once in 4-6 months	145	281.52		
	Once in 7-9 months	97	205.37		
	Once in a year	148	226.15		
PHY	Once in a month	21	262.19	6.746	0.150
	Once in 2-3 months	95	275.29		
	Once in 4-6 months	145	264.49		
	Once in 7-9 months	97	231.65		
	Once in a year	148	241.83		
PERS	Once in a month	21	234.26	2.789	0.594
	Once in 2-3 months	95	269.53		
	Once in 4-6 months	145	260.06		
	Once in 7-9 months	97	247.22		
	Once in a year	148	243.64		
TRU	Once in a month	21	299.57	17.059*	0.002
	Once in 2-3 months	95	281.92		
	Once in 4-6 months	145	273.87		
	Once in 7-9 months	97	222.42		
	Once in a year	148	229.14		
MEM	Once in a month	21	292.95	11.310*	0.023
	Once in 2-3 months	95	284.48		
	Once in 4-6 months	145	255.32		
	Once in 7-9 months	97	219.24		
	Once in a year	148	248.69		
PUR	Once in a month	21	350.36	26.075*	0.000
	Once in 2-3 months	95	288.81		
	Once in 4-6 months	145	265.34		
	Once in 7-9 months	97	216.66		
	Once in a year	148	229.64		
WOM	Once in a month	21	235.6	13.310*	0.010
	Once in 2-3 months	95	288.48		
	Once in 4-6 months	145	269.46		
	Once in 7-9 months	97	227.73		
	Once in a year	148	234.84		

*p<0.05

The group differences for the visiting number of the hospital can be seen on Table 4.8. The significant difference between groups of first visit, been there for a couple of times, and always got to the same hospital is found for all variables except personnel interaction quality. There was a statistically significant difference between different visiting number of the hospital for provider experience quality [$\chi^2(2)=20.765$, $p<0.05$], with a mean rank score of 209.34 for the first visitors, 247.20 for the ones who been there for a couple of times, 297.06 for the ones who always go to the same hospital. Another statistically significant difference is found for periphery experience quality between different visiting number of the hospital [$\chi^2(2)=31.815$, $p<0.05$], with a mean rank score of 223.89 for the first visitors, 234.41 for the ones who been there for a couple of times, 314.23 for the ones who always go to the same hospital. Besides, physician interaction quality is found as statistically significantly different among groups [$\chi^2(2)=11.202$, $p<0.05$], with a mean rank score of 221.74 for the first visitors, 249.54 for the ones who been there for a couple of times, 283.63 for the ones who always go to the same hospital. There was also a statistically significant difference between different groups for trust [$\chi^2(2)=20.604$, $p<0.05$], with a mean rank score of 220.08 for the first visitors, 241.92 for the ones who been there for a couple of times, 300.92 for the ones who always go to the same hospital. Memory is also found as significantly different among groups [$\chi^2(2)=7.133$, $p<0.05$], with a mean rank score of 231.31 for the first visitors, 247.82 for the ones who been there for a couple of times, 280.72 for the ones who always go to the same hospital. Purchase was also found as statistically significantly different among groups [$\chi^2(2)=36.129$, $p<0.05$], with a mean rank score of 207.65 for the first visitors, 238.99 for the ones who been there for a couple of times, 315.65 for the ones who always go to the same hospital. Lastly, there was a statistically significant difference between groups for WOM [$\chi^2(2)=26.502$, $p<0.05$], with a mean rank score of 212.74 for the first visitors, 242.07 for the ones who been there for a couple of times, 305.62 for the ones who always go to the same hospital.

Table 4.8 : The group differences for VISIT_NO.

Dependent variable	Category	N	Mean Rank	χ^2	p
PRO	First visit	91	209.34	20.765*	0.000
	Been there for a couple of times	282	247.2		
	Always go the same hospital	133	297.06		
PERI	First visit	91	223.89	31.815*	0.000
	Been there for a couple of times	282	234.41		
	Always go the same hospital	133	314.23		
PHY	First visit	91	221.74	11.202*	0.004
	Been there for a couple of times	282	249.54		
	Always go the same hospital	133	283.63		
PERS	First visit	91	233.44	5.109	0.078
	Been there for a couple of times	282	249.71		
	Always go the same hospital	133	275.27		
TRU	First visit	91	220.08	20.604*	0.000
	Been there for a couple of times	282	241.92		
	Always go the same hospital	133	300.92		
MEM	First visit	91	231.31	7.133*	0.028
	Been there for a couple of times	282	247.82		
	Always go the same hospital	133	280.72		
PUR	First visit	91	207.65	36.129*	0.000
	Been there for a couple of times	282	238.99		
	Always go the same hospital	133	315.65		
WOM	First visit	91	212.74	26.502*	0.000
	Been there for a couple of times	282	242.07		
	Always go the same hospital	133	305.62		

*p<0.05

The group differences for whether or not the participants have visited the same hospital after their own experience can be seen on Table 4.9. The significant difference between groups of visitors and nonvisitors was found for provider experience quality, physician interaction quality, memory, purchase and WOM. There was a statistically significant difference between two groups for provider experience quality [$\chi^2(2)=4.023$, $p<0.05$], with a mean rank score of 272.52 for the first visitors, 244.62 for the nonvisitors. Another statistically significant difference is found for physician interaction quality between visitors and nonvisitors [$\chi^2(2)=7.803$, $p<0.05$], with a mean rank score of 278.80 for the visitors, 241.69 for the nonvisitors. Besides, memory is found as statistically significantly different among groups [$\chi^2(2)=8.978$, $p<0.05$], with a mean rank score of 282.00 for the visitors, 240.20 for the nonvisitors. There was also a

statistically significant difference between different groups for purchase [$\chi^2(2)=4.683$, $p<0.05$], with a mean rank score of 273.98 for the visitors, 243.94 for the nonvisitors. Lastly, there was a statistically significant difference between groups for WOM [$\chi^2(2)=4.019$, $p<0.05$], with a mean rank score of 272.28 for the visitors, 244.73 for the nonvisitors.

Table 4.9 : The group differences for PATIENT_RELATIVE.

Dependent variable	Category	N	Mean Rank	χ^2	p
PRO	Yes	161	272.52	4.023*	0.045
	No	345	244.62		
PERI	Yes	161	270.54	3.242	0.072
	No	345	245.55		
PHY	Yes	161	278.8	7.803*	0.005
	No	345	241.69		
PERS	Yes	161	256.37	0.096	0.858
	No	345	252.16		
TRU	Yes	161	264.64	1.377	0.241
	No	345	248.3		
MEM	Yes	161	282	8.978*	0.003
	No	345	240.2		
PUR	Yes	161	273.98	4.683*	0.03
	No	345	243.94		
WOM	Yes	161	272.28	4.019*	0.045
	No	345	244.73		

* $p<0.05$

The group differences for treatment type (outpatient vs inpatient) can be seen on Table 4.10. The significant difference between groups of outpatients and inpatients was found for all variables except memory and purchase. There was a statistically significant difference between two groups for provider experience quality [$\chi^2(2)=5.110$, $p<0.05$], with a mean rank score of 246.92 for the outpatients, 286.09 for the inpatients. Another statistically significant difference is found for periphery interaction quality between outpatients and inpatients [$\chi^2(2)=7.717$, $p<0.05$], with a mean rank score of 245.43 for the outpatients, 293.48 for the inpatients. Besides, physician interaction quality is found as statistically significantly different among groups [$\chi^2(2)=8.895$, $p<0.05$], with a mean rank score of 245.21 for the outpatients, 294.56 for the inpatients. There was also a statistically significant difference between different groups for personnel interaction quality [$\chi^2(2)=3.982$, $p<0.05$], with a mean rank score of 247.82 for the outpatients, 281.63 for the inpatients. Besides, trust is

found as statistically significantly different among groups [$\chi^2(2)=4.883$, $p<0.05$], with a mean rank score of 247.06 for the outpatients, 285.39 for the inpatients. Lastly, there was a statistically significant difference between groups for WOM [$\chi^2(2)=4.883$, $p<0.05$], with a mean rank score of 247.14 for the outpatients, 284.98 for the inpatients.

Table 4.10 : The group differences for TREATMENT_TYPE.

Dependent variable	Category	N	Mean Rank	χ^2	p
PRO	Outpatient	421	246.92	5.110*	0.024
	Inpatient	85	286.09		
PERI	Outpatient	421	245.43	7.717*	0.005
	Inpatient	85	293.48		
PHY	Outpatient	421	245.21	8.895*	0.003
	Inpatient	85	294.56		
PERS	Outpatient	421	247.82	3.982*	0.046
	Inpatient	85	281.63		
TRU	Outpatient	421	247.06	4.883*	0.027
	Inpatient	85	285.39		
MEM	Outpatient	421	249.03	2.344	0.126
	Inpatient	85	275.64		
PUR	Outpatient	421	248.53	2.922	0.087
	Inpatient	85	278.1		
WOM	Outpatient	421	247.14	4.883*	0.027
	Inpatient	85	284.98		

* $p<0.05$

The group differences whether the hospital has insurance contract (yes) or not (no) and the ones without this information (no idea) can be seen on Table 4.11. The significant difference between those three groups about insurance was found for all variables except memory and purchase. There was a statistically significant difference between two groups for provider experience quality [$\chi^2(2)=17.218$, $p<0.05$], with a mean rank score of 263.21 for the hospitals with insurance contract, 182.98 for the hospitals without insurance contract, 269.97 for no idea. Another statistically significant difference is found for periphery interaction quality between groups [$\chi^2(2)=12.663$, $p<0.05$], with a mean rank score of 262.62 for the hospitals with insurance contract, 193.12 for the hospitals without insurance contract, 257.61 for no idea. Besides, physician interaction quality is found as statistically significantly different among groups [$\chi^2(2)=8.272$, $p<0.05$], with a mean rank score of 260.58 for the hospitals with insurance contract, 206.82 for the hospitals without insurance contract, 256.27 for no idea. There was also a statistically significant difference between different groups for

personnel interaction quality [$\chi^2(2)=6.621$, $p<0.05$], with a mean rank score of 258.19 for the hospitals with insurance contract, 212.16 for the hospitals without insurance contract, 275.56 for no idea. Besides, trust is found as statistically significantly different among groups [$\chi^2(2)=16.466$, $p<0.05$], with a mean rank score of 258.35 for the hospitals with insurance contract, 193.10 for the hospitals without insurance contract, 310.53 for no idea. Lastly, there was a statistically significant difference between groups for WOM [$\chi^2(2)=17.779$, $p<0.05$], with a mean rank score of 262.62 for the hospitals with insurance contract, 193.12 for the hospitals without insurance contract, 268.18 for no idea.

Table 4.11 : The group differences for INSURANCE_CONTRACT.

Dependent variable	Category	N	Mean Rank	χ^2	p
PRO	Yes	409	263.21	17.218*	0.000
	No	64	182.98		
	No idea	33	269.97		
PERI	Yes	409	262.62	12.663*	0.002
	No	64	193.12		
	No idea	33	257.61		
PHY	Yes	409	260.58	8.272*	0.016
	No	64	206.82		
	No idea	33	256.27		
PERS	Yes	409	258.19	6.621*	0.036
	No	64	212.16		
	No idea	33	275.56		
TRU	Yes	409	258.35	16.466*	0.000
	No	64	193.1		
	No idea	33	310.53		
MEM	Yes	409	254.88	0.594	0.743
	No	64	240.91		
	No idea	33	260.85		
PUR	Yes	409	258.44	5.187	0.075
	No	64	215.16		
	No idea	33	266.59		
WOM	Yes	409	263.4	17.779*	0.000
	No	64	182.65		
	No idea	33	268.18		

* $p<0.05$

The group differences for the insurance usage can be seen on Table 4.12. The significant difference between groups of private insurance, state insurance, cash

payment, and partially payment is found for all variables. There was a statistically significant difference between insurance usage groups for provider experience quality [$\chi^2(2)=28.633$, $p<0.05$], with a mean rank score of 301.14 for the private insurance users, 226.28 for the state insurance users, 253.33 for the cash payers, 329.80 for partial payers. Another statistically significant difference is found for periphery experience quality between groups [$\chi^2(2)=19.684$, $p<0.05$], with a mean rank score of 326.24 for the private insurance users, 228.55 for the state insurance users, 258.26 for the cash payers, 296.13 for partial payers. Besides, physician interaction quality is found as statistically significantly different among groups [$\chi^2(2)=18.765$, $p<0.05$], with a mean rank score of 292.02 for the private insurance users, 227.50 for the state insurance users, 263.01 for cash payers, 301.74 for partial payers. There was also a statistically significant difference between different groups for personnel interaction quality [$\chi^2(2)=19.125$, $p<0.05$], with a mean rank score of 302.43 for the private insurance users, 232.42 for the state insurance users, 251.79 cash payers, 311.66 partial payers. Trust is also found as significantly different among groups [$\chi^2(2)=23.791$, $p<0.05$], with a mean rank score of 288.83 for the private insurance users, 225.31 for the state insurance users, 259.99 cash payers, 319.70 partial payers. Memory was also found as statistically significantly different among groups [$\chi^2(2)=8.151$, $p<0.05$], with a mean rank score of 305.66 for the private insurance users, 236.47 for the state insurance users, 260.26 cash payers, 271.37 partial payers. Purchase is also found as significantly different among groups [$\chi^2(2)=8.674$, $p<0.05$], with a mean rank score of 303.64 for the private insurance users, 241.86 for the state insurance users, 248.22 cash payers, 287.61 partial payers. Lastly, there was a statistically significant difference between groups for WOM [$\chi^2(2)=16.726$, $p<0.05$], with a mean rank score of 321.40 for the private insurance users, 234.09 for the state insurance users, 251.52 cash payers, 297.87 partial payers.

Table 4.12 : The group differences for INSURANCE_USAGE.

Dependent variable	Category	N	Mean Rank	x ²	p
PRO	Used private insurance	29	301.14	28.633*	0.000
	Used state insurance	229	226.28		
	Paid by myself	184	253.33		
	Partially paid by the insurance	64	329.8		
PERI	Used private insurance	29	326.24	19.684*	0.000
	Used state insurance	229	228.55		
	Paid by myself	184	258.26		
	Partially paid by the insurance	64	296.13		
PHY	Used private insurance	29	292.02	18.765*	0.000
	Used state insurance	229	227.5		
	Paid by myself	184	263.01		
	Partially paid by the insurance	64	301.74		
PERS	Used private insurance	29	302.43	19.125*	0.000
	Used state insurance	229	232.42		
	Paid by myself	184	251.79		
	Partially paid by the insurance	64	311.66		
TRU	Used private insurance	29	288.83	23.791*	0.000
	Used state insurance	229	225.31		
	Paid by myself	184	259.99		
	Partially paid by the insurance	64	319.7		
MEM	Used private insurance	29	305.66	8.151*	0.043
	Used state insurance	229	236.47		
	Paid by myself	184	260.26		
	Partially paid by the insurance	64	271.37		
PUR	Used private insurance	29	303.64	8.674*	0.034
	Used state insurance	229	241.86		
	Paid by myself	184	248.22		
	Partially paid by the insurance	64	287.61		
WOM	Used private insurance	29	321.4	16.726*	0.001
	Used state insurance	229	234.09		
	Paid by myself	184	251.52		
	Partially paid by the insurance	64	297.87		

*p<0.05

4.3 Analysis for Main Model

The main model (Figure 4.1) includes variables of provider, periphery, physician, personnel, trust, autobiographical memory, engagement, and WOM. This model does not consider the sub-dimensions of the variables. By testing this model, results provided a general approach for the relationships between experience, engagement, trust, and autobiographical memory. Testing the model fit by exploratory factor analysis, investigating the differences among groups by Kruskal-Wallis test, testing the measurement tools by confirmatory factor analysis, testing the common method bias by Harman's one factor test were conducted and path analysis was made by SEM-AMOS. Further, mediation and moderated-mediation analyses were made by using Hayes's PROCESS macro. The procedure and results were explained below.

4.3.1 Measurement model

After the exploratory factor analysis, a confirmatory factor analysis (CFA) is employed for each model by using SPSS AMOS 25.0. in order to assess the psychometric properties of the measures. CFA provides the ability to evaluate the validity of the measurement model, which means to investigate if the observed variables accurately measure what they are supposed to measure (Cook & Campbell, 1979). As a result of this analysis, some goodness of fit (hereafter, GFI) indices are reported (Wang & Sun, 2010): the Chi-square, comparative fit index (CFI), the root mean square error of approximation (RMSEA), the incremental index of fit (IFI), and the goodness-of-fit index (GFI). The thresholds for the measures can be seen on Table 4.13.

Table 4.13 : Threshold values for goodness of fit measures

MEASURE	THRESHOLD
Chi-Square /df (cmin/df)	<3 good; <5 Sometimes permissible
P- value for the model	>.05
CFI	>.95 Great; >.90 traditional; >.80 Sometimes permissible
GFI	>.95
AGFI	>.80
RMSEA	<.05 Good; .05-.10 moderate; >.10 Bad
SRMR	<0.09

The CFA results for main model did not give the satisfactory results first (cmin/df= 5.537; GFI= 0.630; AGFI= 0.586; IFI= 0.808; CFI= 0.807; RMSEA= 0.091). Hence, the factor loadings of items are checked, and weak items (<0.60) are eliminated from

the model. After the elimination, all of the effect items (EFF1, EFF2, EFF3) of autobiographical memory and all influence (INF1, INF2, INF4) and knowledge (KNOW1, KNOW2, KNOW3) items and one purchase item (PUR3) are deleted for the customer engagement because of the weak scores. Since only purchase remains for the engagement construct, it will be mentioned as PUR. Additionally, three items from trust (TRU3, TRU6, TRU7), two items from word of mouth (WOM1, WOM2) and one item for provider (PRO5). In a questionnaire with 56 items, deleting 9 items does not cause a problem since the threshold of 20% is not exceeded (Kline, 2005). After this elimination, some modifications are made through the modification indices of the model. Then the CFA is reconducted and the values reached to satisfactory levels (cmin/df=2.758; GFI=0.838; AGFI=0.809; IFI=0.947; CFI=0.947; RMSEA=0.059; SRMR=0.046). All remained standardized factor loadings were significant ($p < 0.001$) and all above 0.60, with majority being above 0.80 (Table 4.14).

Table 4.14 : Standardized Regression Weights of the main model.

Item		Construct	Estimate
PRO1	<---	PROVIDER	,902
PRO2	<---	PROVIDER	,897
PRO3	<---	PROVIDER	,861
PRO4	<---	PROVIDER	,646
PERI1	<---	PERIPHERY	,814
PERI2	<---	PERIPHERY	,852
PERI3	<---	PERIPHERY	,967
PHY1	<---	PHYSICIAN	,880
PHY2	<---	PHYSICIAN	,990
PHY3	<---	PHYSICIAN	,993
PERS1	<---	PERSONNEL	,914
PERS2	<---	PERSONNEL	,984
PERS3	<---	PERSONNEL	,976
TRU1	<---	TRUST	,860
TRU2R	<---	TRUST	,638
TRU4	<---	TRUST	,841
TRU5R	<---	TRUST	,601
TRU8R	<---	TRUST	,673
TRU9R	<---	TRUST	,607
WOM3	<---	WOM	,936
WOM4	<---	WOM	,905
WOM5	<---	WOM	,986
WOM6	<---	WOM	,997
POW1	<---	MEM	,694
POW2	<---	MEM	,710
POW3	<---	MEM	,782
POW4	<---	MEM	,701
POW5	<---	MEM	,775
POW6	<---	MEM	,802
POW7	<---	MEM	,820
DET1	<---	MEM	,658
DET2	<---	MEM	,681
DET3	<---	MEM	,765
DET4	<---	MEM	,744
DET5	<---	MEM	,797
PUR1	<---	ENG	,837
PUR2	<---	ENG	,941
PUR4	<---	ENG	,880

4.3.2 Common method bias

After eliminating the items, Harman's one factor test was employed for common method bias. In order to conduct the test, factor analysis was conducted with 1 fixed factor. The result reveals that 37,32% of the total variance is explained by one factor. Hence, no single factor accounted for the majority of the variance in the variables (Harman, 1976). Additionally, the correlation matrix of the constructs. was examined and none of the correlations were found above 0.90, which is a critical threshold for common method bias (Pavlou et al., 2007). These two tests together provided that there was not a common method bias threat.

4.3.3 Convergent validity and discriminant validity

Convergent validity and discriminant validity were tested in order to assess the scales' fit to the model. Convergent validity measures if the items are theoretically accurate for the scale (Li, Liu, Xu, Heikkila, & van der Heijden, 2015). Composite reliability (CR) and average variance extracted (AVE) formulas were calculated (Fornell & Larcker, 1981) according to the formulas shown in the figures below (Figure 4.3 and Figure 4.4).

$$CR = \frac{(\sum_{i=1}^n \lambda_i)^2}{(\sum_{i=1}^n \lambda_i)^2 + (\sum_{i=1}^n \delta_i)}$$

Figure 4.3 : Composite reliability formula.

$$AVE = \frac{\sum \lambda_i^2}{\sum \lambda_i^2 + \sum_i \text{var}(\varepsilon_i)}$$

Figure 4.4 : Average variance extracted formula.

All of the AVE values of all factors were above 0.50, and CR values of all factors were above 0.80. Overall, the values reported in Table 4.15 provide evidence for convergent validity and internal consistency of measurement items (Hair et al., 2006). The dimension of ENG was the same as PUR since other items are eliminated after CFA.

Table 4.15 : Measurement values for factors.

Construct	Item	Mean	SD	Factor loading	AVE	α	Composite reliability (CR)
PRO	PRO1	5.57	1.6	0.90	0.69	0.88	0.9
	PRO2	5.65	1.53	0.90			
	PRO3	5.45	1.67	0.86			
	PRO4	4.62	1.95	0.64			
PERI	PERI1	5.11	1.77	0.81	0.77	0.91	0.91
	PERI2	4.66	1.83	0.85			
	PERI3	4.8	1.79	0.97			
PHY	PHY1	6	1.4	0.88	0.91	0.97	0.97
	PHY2	5.88	1.47	0.99			
	PHY3	5.85	1.48	0.99			
PERS	PERS1	5.64	1.52	0.91	0.92	0.97	0.97
	PERS2	5.56	1.57	0.98			
	PERS3	5.56	1.56	0.98			
MEM	POW1	5.43	1.43	0.69	0.56	0.94	0.92
	POW2	5.43	1.46	0.71			
	POW3	5.16	1.5	0.78			
	POW4	5.1	1.7	0.70			
	POW5	5.29	1.54	0.78			
	POW6	5.38	1.53	0.80			
	POW7	5.26	1.66	0.82			
	DET1	4.56	2.1	0.66			
	DET2	4.5	2.07	0.68			
	DET3	4.94	1.82	0.77			
	DET4	4.72	1.95	0.74			
	DET5	4.84	1.78	0.80			
TRU	TRU1	5.41	1.88	0.86		0.51	0.86
	TRU2	5.17	2	0.64			
	TRU4	5.57	1.67	0.84			
	TRY5	5.11	2.07	0.61			
	TRU8	5.61	1.67	0.69			
PUR	TRU9	5.73	1.61	0.63			
	PUR1	5.29	1.6	0.84	0.79	0.91	0.92
	PUR2	5.01	1.75	0.94			
	PUR4	4.86	1.77	0.88			
WOM	WOM3	5.23	1.91	0.94	0.92	0.98	0.98
	WOM4	5.18	1.91	0.91			
	WOM5	5.21	1.93	0.99			
	WOM6	5.2	1.92	1.00			

All constructs are well performed for the average variance extracted values which were higher than squared correlations with other factors (Fornell and Larcker, 1981), providing evidence for discriminant validity (Table 4.16).

Table 4.16 : Discriminant validity.

	PRO	PERI	PHY	PERS	MEM	TRU	ENG	WOM
PRO	0.69							
PERI	0.47	0.77						
PHY	0.51	0.30	0.91					
PERS	0.43	0.28	0.41	0.92				
MEM	0.02	0.04	0.02	0.00	0.56			
TRU	0.52	0.39	0.34	0.20	0.03	0.51		
ENG	0.42	0.41	0.34	0.18	0.09	0.43	0.79	
WOM	0.57	0.43	0.42	0.32	0.05	0.51	0.52	0.92

4.3.4 Path analysis

The path analysis was made without the moderator (MEM) in the model in order to test the direct and indirect effects. First, the measurement model fit measures were checked. The model fit values were found as satisfactory (cmin/df=3.40; GFI= 0.870; AGFI=0.837; RFI=0.932; IFI=0.958; CFI=0.958; RMSEA=0,069; SRMR=0.505). The direct effects were found significant except four of them: the effect of provider on purchase and WOM, the effect of physician on WOM, and the effect of personnel on purchase (Table 4.17).

Table 4.17 : Summary of the hypotheses.

Hypothesis	Result
H1 Provider experience quality has a positive effect on engagement.	N/A
H1a Provider experience quality has a positive effect on purchase	Rejected
H2 Provider experience quality has a positive effect on WOM	Rejected
H3 Periphery experience quality has a positive effect on engagement.	N/A
H3a Periphery experience quality has a positive effect on purchase	Supported
H4 Periphery experience quality has a positive effect on WOM	Supported
H5 Physician interaction quality has a positive effect on engagement.	N/A
H5a Physician interaction quality has a positive effect on purchase	Supported
H6 Physician interaction quality has a positive effect on WOM	Rejected
H7 Personnel interaction quality has a positive effect on engagement.	N/A
H7a Personnel interaction quality has a positive effect on purchase	Rejected
H8 Personnel interaction quality has a positive effect on WOM	Supported
H9a Provider experience quality has a positive effect on trust	Supported
H9b Periphery experience quality has a positive effect on trust	Supported
H9c Physician interaction quality has a positive effect on trust	Supported
H9d Personnel interaction quality has a positive effect on trust	Supported
H10 Engagement is positively affected by trust.	N/A
H10a Purchase is positively affected by trust	Supported
H11 WOM is positively affected by trust	Supported
H12 Trust mediates the relationship between provider experience quality and engagement.	N/A
H12a Trust mediates the relationship between provider experience quality and purchase.	Supported
H13 Trust mediates the relationship between provider experience quality and WOM.	Supported
H14 Trust mediates the relationship between periphery experience quality and engagement.	N/A
H14a Trust mediates the relationship between periphery experience quality and purchase.	Supported
H15 Trust mediates the relationship between periphery experience quality and WOM.	Supported
H16 Trust mediates the relationship between physician interaction quality and engagement.	N/A
H16a Trust mediates the relationship between physician interaction quality and purchase.	Supported
H17 Trust mediates the relationship between physician interaction quality and WOM.	Supported

Table 4.17 (continued) : Summary of the hypotheses.

Hypothesis	Result
H18 Trust mediates the relationship between personnel interaction quality and engagement.	Supported
H18a Trust mediates the relationship between personnel interaction quality and purchase.	Supported
H19 Trust mediates the relationship between personnel interaction quality and WOM.	Supported

Most of the effects of experience quality constructs on trust and engagement outcomes are found significant. Provider experience quality is found to have a significant positive effect on only trust ($\beta=0.742$, $p<0.001$). Periphery experience quality has positive effects on trust ($\beta=0.221$, $p<0.001$), purchase ($\beta=0.301$, $p<0.001$), and WOM ($\beta=0.088$, $p<0.05$). Physician interaction quality is found to have positive effects on trust ($\beta=0.011$, $p<0.05$) and purchase ($\beta=0.184$, $p<0.001$). Personnel interaction quality was found to have positive effect on trust ($\beta=0.189$, $p<0.001$), and on WOM ($\beta=0.130$, $p<0.05$). As hypothesized, trust has positive effects on purchase ($\beta=0.565$, $p<0.001$), and WOM ($\beta=0.536$, $p<0.001$).

4.3.5 Mediation analysis

Addition to the path analysis, mediation analysis was conducted in order to test the hypotheses involving mediation effect. PROCESS macro in SPSS suggested by Hayes (2013) is used to test mediation effects. For all of the models in Figure 4.5, the mediation is found as significant.

The effect of the provider experience quality on trust is positive and significant ($b = 0.69$, $p < 0.001$), and trust in turn exerts a significant positive effect on purchase ($b = 0.44$, $p < 0.001$). Further, the results using bootstrapping also indicate that the indirect effect of provider on the engagement through trust ($b = 0.39$) is significant, as the 95% confidence interval ([0.30; 0.50]) does not contain 0. Thus, H12a is supported.

The effect of the provider experience quality on trust is positive and significant ($b = 0.69$, $p < 0.001$), and trust in turn exerts a significant positive effect on WOM ($b = 0.48$, $p < 0.001$). Further, the results using bootstrapping also indicate that the indirect effect of provider on the WOM through trust ($b = 0.63$) is significant, as the 95% confidence interval ([0.53; 0.72]) does not contain 0. Thus, H13 is supported.

The effect of the periphery experience quality on trust is positive and significant ($b = 0.53, p < 0.001$), and trust in turn exerts a significant positive effect on purchase ($b = 0.46, p < 0.001$). Further, the results using bootstrapping also indicate that the indirect effect of periphery on the purchase through trust ($b = 0.37$) is significant, as the 95% confidence interval ($[0.30; 0.44]$) does not contain 0. Thus, H14a is supported.

The effect of the periphery experience quality on trust is positive and significant ($b = 0.53, p < 0.001$), and trust in turn exerts a significant positive effect on WOM ($b = 0.67, p < 0.001$). Further, the results using bootstrapping also indicate that the indirect effect of periphery on the WOM through trust ($b = 0.39$) is significant, as the 95% confidence interval ($[0.31; 0.47]$) does not contain 0. Thus, H15 is supported.

The effect of the physician interaction quality on trust is positive and significant ($b = 0.58, p < 0.001$), and trust in turn exerts a significant positive effect on purchase ($b = 0.53, p < 0.001$). Further, the results using bootstrapping also indicate that the indirect effect of physician on the purchase through trust ($b = 0.34$) is significant, as the 95% confidence interval ($[0.26; 0.43]$) does not contain 0. Thus, H16a is supported.

The effect of the physician interaction quality on trust is positive and significant ($b = 0.58, p < 0.001$), and trust in turn exerts a significant positive effect on WOM ($b = 0.69, p < 0.001$). Further, the results using bootstrapping also indicate that the indirect effect of physician on the WOM through trust ($b = 0.45$) is significant, as the 95% confidence interval ($[0.36; 0.55]$) does not contain 0. Thus, H17 is supported.

The effect of the personnel interaction quality on trust is positive and significant ($b = 0.42, p < 0.001$), and trust in turn exerts a significant positive effect on purchase ($b = 0.65, p < 0.001$). Further, the results using bootstrapping also indicate that the indirect effect of personnel on the purchase through trust ($b = 0.18$) is significant, as the 95% confidence interval ($[0.10; 0.25]$) does not contain 0. Thus, H18a is supported.

The effect of the personnel interaction quality on trust is positive and significant ($b = 0.42, p < 0.001$), and trust in turn exerts a significant positive effect on WOM ($b = 0.77, p < 0.001$). Further, the results using bootstrapping also indicate that the indirect effect of personnel on the purchase through trust ($b = 0.38$) is significant, as the 95% confidence interval ($[0.30; 0.45]$) does not contain 0. Thus, H19 is supported.

The values of the significant paths are shown in Figure 4.18.

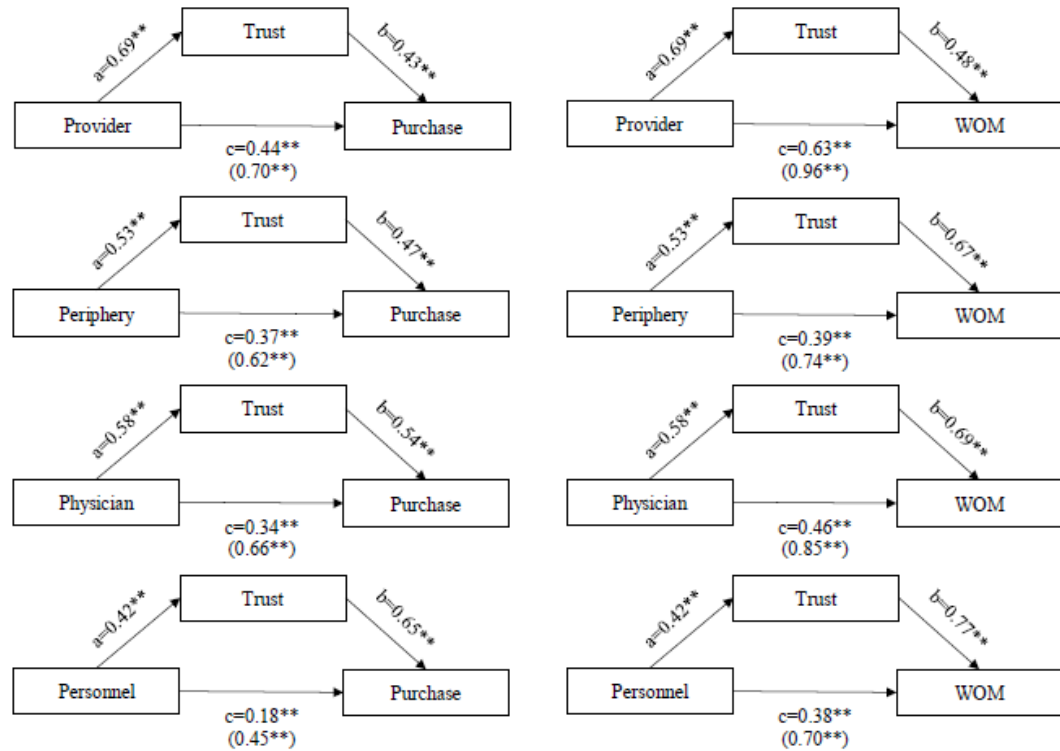


Figure 4.5 : Mediation analysis results – paths.

Table 4.18 : Mediation analysis results – values.

Model	Path	Coef	SE	p	LLCI	ULCI
Model 1a	PRO -> TRU -> PUR	0.3022	0.0435	<0.001	0.2175	0.3903
Model 1b	PRO -> TRU -> WOM	0.3334	0.0454	<0.001	0.2448	0.4231
Model 2a	PERI -> TRU -> PUR	0.2473	0.0335	<0.001	0.1831	0.3157
Model 2b	PERI -> TRU -> WOM	0.3546	0.0358	<0.001	0.2854	0.4256
Model 3a	PHY -> TRU -> PUR	0.3109	0.0404	<0.001	0.2358	0.3932
Model 3b	PHY -> TRU -> WOM	0.3978	0.0443	<0.001	0.3169	0.4909
Model 4a	PERS -> TRU -> PUR	0.2734	0.0308	<0.001	0.2154	0.3365
Model 4b	PERS -> TRU -> WOM	0.323	0.0351	<0.001	0.255	0.3916

4.3.6 Moderated mediation analysis

The moderated mediation analyses were performed to further explore the relationship between experience quality dimensions and engagement dimensions, by using conditional process modeling suggested by Hayes (2013), named model 59 (Figure 4.6). The moderated mediation is used for understanding the effect of the value of a moderator on the magnitude of a mediator (Hayes, 2013). The moderated mediation occurs if either or both paths are moderated: (a) the path between experience quality

(X) and trust (M) is moderated by autobiographical memory (W) (path-a), (b) the path between trust (M) and engagement (Y) is moderated by autobiographical memory (W) (path-b). Since there is four different experience quality dimensions (provider, periphery, physician, personnel) and two engagement outcomes (purchase, WOM); eight different analyses were employed.

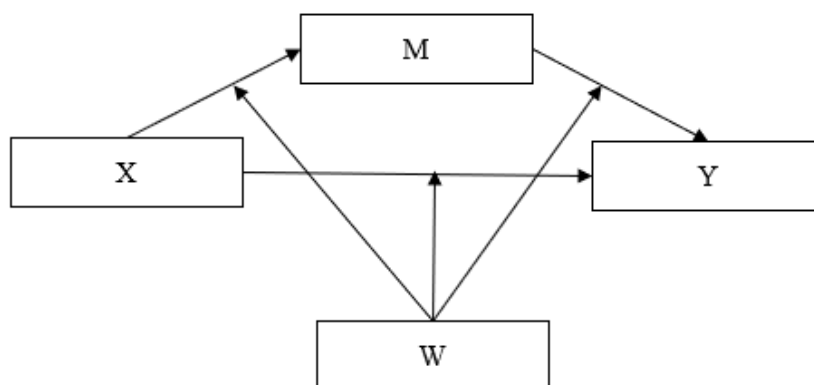


Figure 4.6 : Model 59 suggested by Hayes (2013).

Table 4.19 shows the results of moderated mediation. According to the hypotheses, autobiographical memory may function as a moderator between provider experience quality and purchase either separately, or both in the direct effect (PRO-->PUR) and indirect effect (path a: PRO-->TRU and path b: TRU-->PUR). However, autobiographical memory did not play a moderating role in the direct effect (PRO-->PUR) of the mediation model (PRO * MEM: $B = -0.0168$, 95% CI: $-0.105, 0.0713$) or the indirect effect of provider experience quality on purchase through trust (PRO-->TRU: $B = 0.0412$, 95% CI $-0.0127, 0.0951$; TRU-->PUR: $B = 0.0059$, 95% CI $-0.8931, 0.0916$). The results signify that the direct or indirect effect of provider experience quality on purchase was not moderated by autobiographical memory. Thus, H21a is rejected.

Table 4.19 : PRO-PUR moderated mediation results.

Outcome: Trust						
Variable	B	SE	t	p	LLCI	ULCI
Provider	0.4842	0.1356	3.5711***	0.0004	0.2178	0.7507
Memory	-0.1549	0.1574	-0.984	0.3256	-0.4642	0.1544
Provider x Memory	0.0412	0.0274	1.5003	0.1342	-0.0127	0.0951
Outcome: Purchase						
Variable	B	SE	t	p	LLCI	ULCI
Provider	0.4681	0.2125	2.2035*	0.028	0.0507	0.8856
Trust	0.3825	0.2049	1.8664	0.0626	-0.0201	0.7852
Memory	0.2874	0.189	1.5204	0.1291	-0.084	0.6588
Provider x Memory	-0.0168	0.0449	-0.3753	0.7076	-0.105	0.0713
Trust x Memory	0.0059	0.0436	0.1345	0.8931	-0.0798	0.0916

*p < 0.05 **p < 0.01 ***p < 0.001

Table 4.20 showed the results of moderated mediation. According to our hypothesis, autobiographical memory may function as a moderator between provider experience quality and WOM either separately, or both in the direct effect (PRO-->WOM) and indirect effect (path a: PRO-->WOM and path b: TRU-->WOM). However, autobiographical memory did not play a moderating role in the direct effect (PRO-->WOM) of the mediation model (PRO * MEM: B = -0.0589, 95% CI: -0.1494, 0.0315) or the indirect effect of provider experience quality on WOM through trust (PRO-->TRU: B = 0.0412, 95% CI -0.0127, 0.0951; TRU-->WOM: B = 0.0319, 95% CI -0.0560, 0.1198). The results signify that the direct or indirect effect of provider experience quality on WOM was not moderated by autobiographical memory. Thus, H22 is rejected.

Table 4.20 : PRO-WOM moderated mediation results.

Outcome: Trust						
Variable	B	SE	t	p	LLCI	ULCI
Provider	0.4842	0.1356	3.5711***	0.0004	0.2178	0.7507
Memory	-0.1549	0.1574	-0.984	0.3256	-0.4642	0.1544
Provider x Memory	0.0412	0.0274	1.5003	0.1342	-0.0127	0.0951
Outcome: WOM						
Variable	B	SE	t	p	LLCI	ULCI
Provider	0.8934	0.218	4.0984***	0	0.4651	1.3216
Trust	0.3229	0.2103	1.5355	0.1253	-0.0902	0.736
Memory	0.2866	0.1939	1.4776	0.1401	-0.0945	0.6676
Provider x Memory	-0.0589	0.0461	-1.28	0.2011	-0.1494	0.0315
Trust x Memory	0.0319	0.0448	0.713	0.4762	-0.056	0.1198

*p < 0.05 **p < 0.01 ***p < 0.001

Table 4.21 showed the results of moderated mediation. According to our hypothesis, autobiographical memory may function as a moderator between periphery experience quality and purchase either separately, or both in the direct effect (PERI-->PUR) and indirect effect (path a: PERI-->PUR and path b: TRU-->PUR). Autobiographical memory play a moderating role in the direct effect (PERI-->PUR) of the mediation model (PERI * MEM: B = -0.0712, 95% CI: -0.1334, -0.0991). However, the results of moderated mediation showed that autobiographical memory did not moderate the indirect effect of periphery experience quality on purchase through trust (PERI-->TRU: B = 0.0385, 95% CI -0.0109, 0.0879; TRU-->WOM: B = 0.0643, 95% CI -0.0097, 0.1383). The results signify that the direct effect of periphery experience quality on purchase was moderated by autobiographical memory, but a moderated mediation did not occur on the indirect effect of periphery experience quality on purchase through trust. Thus, H23a is rejected.

Table 4.21 : PERI-PUR moderated mediation results.

Outcome: Trust						
Variable	B	SE	t	p	LLCI	ULCI
Periphery	0.3406	0.1228	2.7736**	0.0057	0.0993	0.5819
Memory	-0.1383	0.1348	-1.0258	0.3055	-0.4032	0.1266
Periphery x Memory	0.0385	0.0251	1.5304	0.1265	-0.0109	0.0879
Outcome: Purchase						
Variable	B	SE	t	p	LLCI	ULCI
Periphery	0.6765	0.151	4.4792***	0	0.3798	0.9732
Trust	0.1539	0.1813	0.8486	0.3965	-0.2024	0.5101
Memory	0.2011	0.1712	1.1747	0.2407	-0.1352	0.5374
Periphery x Memory	-0.0712	0.0316	-2.2528*	0.0247	-0.1334	-0.0991
Trust x Memory	0.0643	0.0376	1.7081	0.0882	-0.0097	0.1383

*p < 0.05 **p < 0.01 ***p < 0.001

The significant moderation model was further tested by analyzing the direct effect of provider experience quality on purchase at different levels of autobiographical memory. As shown in Table 4.22, autobiographical memory was divided into low (the mean minus one SD), moderate (the mean) and high (the mean plus one SD). Specifically, the association between provider experience quality and purchase is significantly negatively moderated by the autobiographical memory.

Table 4.22 : Conditional direct effects of PERI on PUR at values of autobiographical memory.

	Effect	SE	LLCI	ULCI
Low memory	0.4295	0.0523	0.3267	0.5323
Moderate memory	0.3345	0.0377	0.2605	0.4086
High memory	0.2496	0.057	0.1376	0.3616

Table 4.23 showed the results of moderated mediation. According to our hypothesis, autobiographical memory may function as a moderator between periphery experience quality and WOM either separately, or both in the direct effect (PERI-->WOM) and indirect effect (path a: PERI-->TRU and path b: TRU-->WOM). However, autobiographical memory did not play a moderating role in the direct effect (PERI-->WOM) of the mediation model (PERI * MEM: B = -0.0539, 95% CI: -0.1232, 0.0153) or the indirect effect of periphery experience quality on WOM through trust (PERI-->TRU: B = 0.0385, 95% CI -0.0109, 0.0879; TRU-->PUR: B = 0.0645, 95%

CI -0.0179, 0.1470). The results signify that the direct or indirect effect of provider experience quality on purchase was not moderated by autobiographical memory. Thus, H24 is rejected.

Table 4.23 : PERI-WOM moderated mediation results.

Outcome: Trust						
Variable	B	SE	t	p	LLCI	ULCI
Periphery	0.3406	0.1228	2.7736**	0.0057	0.0993	0.5819
Memory	-0.1383	0.1348	-1.0258	0.3055	-0.4032	0.1266
Periphery x Memory	0.0385	0.0251	1.5304	0.1265	-0.0109	0.0879
Outcome: WOM						
Variable	B	SE	t	p	LLCI	ULCI
Periphery	0.6237	0.1683	3.7046***	0.0002	0.2929	0.9544
Trust	0.359	0.2021	1.7763	0.9763	-0.0381	0.7561
Memory	0.0239	0.1908	0.1255	0.9002	-0.351	0.3989
Periphery x Memory	-0.0539	0.0353	-1.5294	0.1268	-0.1232	0.0153
Trust x Memory	0.0645	0.042	1.5381	0.1247	-0.0179	0.147

*p < 0.05 **p < 0.01 ***p < 0.001

Table 4.24 showed the results of moderated mediation. According to our hypothesis, autobiographical memory may function as a moderator between physician interaction quality and purchase either separately, or both in the direct effect (PHY-->PUR) and indirect effect (path a: PHY-->TRU and path b: TRU-->PUR). However, autobiographical memory did not play a moderating role in the direct effect (PHY-->PUR) of the mediation model (PHY * MEM: B = -0.015, 95% CI: -0.0909, 0.061) or the indirect effect of physician interaction quality on PUR through trust (PHY-->TRU: B = 0.0102, 95% CI -0.0521, 0.0726; TRU-->PHY: B = 0.0297, 95% CI -0.0448, 0.1041). The results signify that the direct or indirect effect of provider experience quality on purchase was not moderated by autobiographical memory. Thus, H25a is rejected.

Table 4.24 : PHY-PUR moderated mediation results.

Outcome: Trust						
Variable	B	SE	t	p	LLCI	ULCI
Physician	0.5185	0.1556	3.3327***	0.0009	0.2128	0.8242
Memory	0.045	0.1971	0.2282	0.8196	-0.3423	0.4322
Physician x Memory	0.0102	0.0317	0.3224	0.7473	-0.0521	0.0726

Outcome: Purchase						
Variable	B	SE	t	p	LLCI	ULCI
Physician	0.4028	0.1884	2.1385*	0.033	0.0327	0.7729
Trust	0.365	0.1854	1.9686*	0.0496	0.0007	0.7292
Memory	0.1483	0.2032	0.7301	0.4656	-0.2508	0.5475
Physician x Memory	-0.015	0.0387	-0.3871	0.6988	-0.0909	0.061
Trust x Memory	0.0297	0.0379	0.783	0.434	-0.0448	0.1041

*p < 0.05 **p < 0.01 ***p < 0.001

Table 4.25 shows the results of moderated mediation. According to our hypothesis, autobiographical memory may function as a moderator between physician interaction quality and WOM either separately, or both in the direct effect (PHY-->WOM) and indirect effect (path a: PHY-->WOM and path b: TRU-->WOM). Autobiographical memory is found to play a moderating role in the direct effect (PHY-->WOM) of the mediation model (PHY * MEM: B = -0.0984, 95% CI: -0.1796, 0.0173). The results of moderated mediation showed that the indirect effect of physician interaction quality on WOM through trust (PHY-->TRU: B = 0.0102, 95% CI -0.0521, 0.0726; TRU-->PHY: B = -0.0984, 95% CI -0.1796, -0.0173) is moderated by autobiographical memory. The results signify that both of the direct and indirect effect of physician experience quality on WOM was moderated by autobiographical memory. Thus, H26 is supported.

Table 4.25 : PHY-WOM moderated mediation results.

Outcome: Trust						
Variable	B	SE	t	p	LLCI	ULCI
Physician	0.5185	0.1556	3.3327***	0.0009	0.2128	0.8242
Memory	0.045	0.1971	0.2282	0.8196	-0.3423	0.4322
Physician x Memory	0.0102	0.0317	0.3224	0.7473	-0.0521	0.0726

Outcome: WOM						
Variable	B	SE	t	p	LLCI	ULCI
Physician	0.915	0.2012	4.5479***	0	0.5197	1.3103
Trust	0.2287	0.198	1.1547	0.2488	-0.1604	0.6177
Memory	0.2161	0.217	0.9959	0.3198	-0.2102	0.6425
Physician x Memory	-0.0984	0.0413	-2.3842*	0.0175	-0.1796	-0.0173
Trust x Memory	0.0924	0.0405	2.2827*	0.0229	0.0129	0.1719

*p < 0.05 **p < 0.01 ***p < 0.001

The significant moderated mediation model was further tested by analyzing the indirect effect of physician interaction quality on WOM at different levels of autobiographical memory. As shown in Table 4.26, autobiographical memory was divided into low (the mean minus one SD), moderate (the mean) and high (the mean plus one SD). Autobiographical memory, at any value, could moderate the association between physician interaction quality and WOM through trust.

Table 4.26 : Conditional indirect effects of physician on WOM at values of autobiographical memory.

	Effect	SE	LLCI	ULCI
Low memory	0.3041	0.062	0.1928	0.4322
Moderate memory	0.3816	0.0448	0.2972	0.4736
High memory	0.4536	0.733	0.32	0.6073

The significant moderation model was further tested by analyzing the direct effect of physician interaction quality on WOM at different levels of autobiographical memory. As shown in Table 4.27, autobiographical memory was divided into low (the mean minus one SD), moderate (the mean) and high (the mean plus one SD). Specifically, the association between physician interaction quality and WOM is significantly negatively moderated by the autobiographical memory.

Table 4.27 : Conditional direct effects of physician on purchase at values of autobiographical memory.

	Effect	SE	LLCI	ULCI
Low memory	0.4295	0.0523	0.3267	0.5323
Moderate memory	0.3345	0.0377	0.2605	0.4086
High memory	0.2496	0.057	0.1376	0.3616

Table 4.28 shows the results of moderated mediation. According to our hypothesis, autobiographical memory may function as a moderator between personnel interaction quality and purchase either separately, or both in the direct effect (PERS-->PUR) and indirect effect (path a: PERS-->PUR and path b: TRU-->PUR). However, autobiographical memory did not play a moderating role in the direct effect (PERS-->PUR) of the mediation model (PERS * MEM: B = -0.0312, 95% CI: -0.093, 0.0306) or the indirect effect of personnel interaction quality on purchase through trust (PERS-->TRU: B = -0.0129, 95% CI -0.0733, 0.0475; TRU-->PERS: B = 0.0320, 95% CI -0.0364, 0.1004). The results signify that the direct or indirect effect of personnel interaction quality on purchase was not moderated by autobiographical memory. Thus, H27a is rejected.

Table 4.28 : PERS-PUR moderated mediation analysis results.

Outcome: Trust						
Variable	B	SE	t	p	LLCI	ULCI
Personnel	0.4733	0.1546	3.0613**	0.0023	0.1695	0.777
Memory	0.2365	0.1834	1.2895	0.1978	-0.1238	0.5968
Personnel x Memory	-0.0129	0.0307	-0.4202	0.6745	-0.0733	0.0475
Outcome: PUR						
Variable	B	SE	t	p	LLCI	ULCI
Personnel	0.3291	0.1578	2.0858*	0.0375	0.1235	0.6391
Trust	0.4591	0.1708	2.6881**	0.0074	0.1235	0.7947
Memory	0.2419	0.2036	1.188	0.2354	-0.1581	0.6419
Personnel x Memory	-0.0312	0.0315	-0.9916	0.3218	-0.093	0.0306
Trust x Memory	0.032	0.0348	0.9183	0.3589	-0.0364	0.1004

*p < 0.05 **p < 0.01 ***p < 0.001

Table 4.29 shows the results of moderated mediation. According to our hypothesis, autobiographical memory may function as a moderator between personnel interaction quality and WOM either separately, or both in the direct effect (PERS-->WOM) and

indirect effect (path a: PERS-->WOM and path b: TRU-->WOM). However, autobiographical memory did not play a moderating role in the direct effect (PERS-->PUR) of the mediation model (PERS * MEM: B = -0.0312, 95% CI: -0.093, 0.0306) or the indirect effect of personnel interaction quality on purchase through trust (PERS-->TRU: B = -0.0129, 95% CI -0.0733, 0.0475; TRU-->PERS: B = 0.0320, 95% CI -0.0364, 0.1004). The results signify that the direct or indirect effect of personnel interaction quality on purchase was not moderated by autobiographical memory. Thus, H28 is rejected.

Table 4.29 : PERS-WOM moderated mediation analysis results.

Outcome: Trust						
Variable	B	SE	t	p	LLCI	ULCI
Personnel	0.4733	0.1546	3.0613**	0.0023	0.1695	0.777
Memory	0.2365	0.1834	1.2895	0.1978	-0.1238	0.5968
Personnel x Memory	-0.0129	0.0307	-0.4202	0.6745	-0.0733	0.0475
Outcome: WOM						
Variable	B	SE	t	p	LLCI	ULCI
Personnel	1.0498	0.1612	6.5124***	0	0.7331	1.3665
Trust	0.3093	0.1745	1.7723	0.077	-0.0336	0.6522
Memory	0.4539	0.208	2.1819*	0.0296	0.0452	0.8625
Personnel x Memory	-0.1383	0.0321	4.3026***	0	-0.2014	-0.0751
Trust x Memory	0.0906	0.0356	2.5470*	0.0112	0.0207	0.1605

*p < 0.05 **p < 0.01 ***p < 0.001

4.3.7 Results

The main model basically tests the hypotheses considering the experience-engagement relationship and the mediating effect of trust and moderated mediating effect of autobiographical memory. Since engagement dimensions are eliminated after CFA, only purchase is remained as engagement. Hence, the relationship between purchase and other dimensions are tested.

The results of testing these hypotheses show some various relationships. First, all of the experience quality dimensions have a positive effect on purchase. Higher experience quality with provider, periphery, physician, and personnel addresses to higher purchase intention for patients. The positive effect on WOM is only found for periphery. Patients who experienced a high quality with the ambiance of the hospital

are likely to recommend that hospital to others. Contrary to expectations, experience quality of provider, physician, and personnel do not affect recommending the hospital. The effect of trust is found positive in every path: direct effects and mediation effects are found significant. Experience quality for all dimensions positively affects trust, and trust also positively affect purchase. Besides, all of the indirect paths between experience quality dimensions, and purchase and WOM are mediated by trust. The moderated mediation effect of autobiographical memory gives some surprising results. The significant effect is found for only one path. The physician-trust-WOM relationship is under the negative moderated mediation effect of autobiographical memory. The mediating effect of trust is weaker when the patient remembers the experience better. The results are discussed under the Discussion section.

4.4 Analysis for Dimensional Model

4.4.1 Measurement model

After the exploratory factor analysis, a confirmatory factor analysis (CFA) is employed for each model by using SPSS AMOS 25.0. in order to assess the psychometric properties of the measures. CFA provides the ability to evaluate the validity of the measurement model, which means to investigate if the observed variables accurately measure what they are supposed to measure (Cook & Campbell, 1979). As a result of this analysis, some goodness of fit (hereafter, GOF) indices are reported (Wang and Sun, 2010): the Chi-square, comparative fit index (CFI), the root mean square error of approximation (RMSEA), the incremental index of fit (IFI), and the goodness-of-fit index (GFI). The thresholds for the measures can be seen on Table 4.30.

Table 4.30 : Threshold values for goodness of fit measures.

MEASURE	THRESHOLD
Chi-Square/df (cmin/df)	<3 good; <5 Sometimes permissible
P- value for the model	>.05
CFI	>.95 Great; >.90 traditional; >.80 Sometimes permissible
GFI	>.95
AGFI	>.80
RMSEA	<.05 Good; .05-.10 moderate; >.10 Bad
SRMR	<0.09

In the first analysis, the model did not provide satisfactory values (GFI = 0.747; AGFI = 0.714; NFI = 0.853; IFI = 0.840; TLI = 0.887; CFI = 0.896; RMSEA = 0.064;

cmin/df=3,06). Hence, the factor loadings of the items are checked, and weak items are considered to be deleted. The analysis is continued by eliminating the items with low factor loadings one by one. The optimum solution is found when all the items under 0,6 factor loadings are deleted. 7 items are deleted (PRO5, TRU3, TRU6, TRU7, PUR3, WOM1, WOM2). In a questionnaire with 56 items, deleting 7 items does not cause a problem since the threshold of 20% is not exceeded (Kline, 2005). Hence, after eliminating the questions, the model fit demonstrated satisfactory values (GFI = 0.809; AGFI = 0.779; NFI = 0.897; IFI = 0.933; TLI = 0.925; CFI = 0.933; RMSEA = 0.057; SRMR=0.051). The cmin/df ratio of this model (cmin/df = 2.64) was less than 3, which is satisfactory according to Kline (2005). All standardized factor loadings were significant ($p < 0.001$) and all above 0.60, with majority being above 0.80 (Table 4.31).

Table 4.31 : Standardized regression weights of the dimensional model.

Item		Construct	Estimate
PRO1	<---	PROVIDER	,904
PRO2	<---	PROVIDER	,899
PRO3	<---	PROVIDER	,859
PRO4	<---	PROVIDER	,640
PERI1	<---	PERIPHERY	,811
PERI2	<---	PERIPHERY	,853
PERI3	<---	PERIPHERY	,969
PHY1	<---	PHYSICIAN	,880
PHY2	<---	PHYSICIAN	,990
PHY3	<---	PHYSICIAN	,993
PERS1	<---	PERSONNEL	,914
PERS2	<---	PERSONNEL	,984
PERS3	<---	PERSONNEL	,976
POW1	<---	POWER	,763
POW2	<---	POWER	,760
POW3	<---	POWER	,798
POW4	<---	POWER	,719
POW5	<---	POWER	,788
POW6	<---	POWER	,816
POW7	<---	POWER	,827
DET1	<---	DETAIL	,831
DET2	<---	DETAIL	,831
DET3	<---	DETAIL	,846
DET4	<---	DETAIL	,834
DET5	<---	DETAIL	,783
EFF1	<---	EFFECT	,801
EFF2	<---	EFFECT	,928
EFF3	<---	EFFECT	,785
TRU1	<---	TRUST	,856
TRU2R	<---	TRUST	,642
TRU4	<---	TRUST	,836
TRU5R	<---	TRUST	,609
TRU8R	<---	TRUST	,688
TRU9R	<---	TRUST	,629
PUR1	<---	PURCHASE	,837
PUR2	<---	PURCHASE	,940
PUR4	<---	PURCHASE	,881
INF1	<---	INFLUENCE	,824
INF2	<---	INFLUENCE	,834
INF3	<---	INFLUENCE	,710
INF4	<---	INFLUENCE	,655
KNOW1	<---	KNOWLEDGE	,800
KNOW2	<---	KNOWLEDGE	,972

Table 4.31 (continued) : Standardized regression weights of the dimensional model.

Item		Construct	Estimate
KNOW3	<---	KNOWLEDGE	,951
WOM3	<---	WM	,938
WOM4	<---	WM	,908
WOM5	<---	WM	,987
WOM6	<---	WM	,995

4.4.2 Common method bias

After eliminating the items, Harman's one factor test is employed for common method bias. In order to conduct the test, factor analysis is conducted with 1 fixed factor. The result reveals that 34,05% of the total variance is explained by one factor. Hence, no single factor accounted for the majority of the variance in the variables (Harman, 1976). Additionally, the correlation matrix of the constructs is examined and none of the correlations are found above 0.90, which is a critical threshold for common method bias (Pavlou et al., 2007). These two tests together provide that there is not a common method bias threat.

4.4.3 Convergent validity and discriminant validity

Convergent validity and discriminant validity are tested in order to assess the scales' fit to the model. Convergent validity measures if the items are theoretically accurate for the scale (Li, Liu, Xu, Heikkila, & van der Heijden, 2015). Composite reliability (CR) and average variance extracted (AVE) formulas are calculated (Fornell & Larcker, 1981) according to the formulas shown in the figures below (Figure 4.7 and Figure 4.8).

$$CR = \frac{(\sum_{i=1}^n \lambda_i)^2}{(\sum_{i=1}^n \lambda_i)^2 + (\sum_{i=1}^n \delta_i)}$$

Figure 4.7 : Composite reliability formula.

$$AVE = \frac{\sum \lambda_i^2}{\sum \lambda_i^2 + \sum_i \text{var}(\varepsilon_i)}$$

Figure 4.8 : Average variance extracted formula.

All of the AVE values of all factors are above 0.50, and CR values of all factors are above 0.80. Overall, the values reported in Table 4.32 provide evidence for convergent validity and internal consistency of measurement items (Hair et al., 2006).

Table 4.32 : Measurement values for factors.

Construct	Item	Mean	SD	Factor loading	AVE	α	Composite reliability (CR)
PRO	PRO1	5.57	1.6	0.90	0.70	0.88	0.90
	PRO2	5.65	1.53	0.90			
	PRO3	5.45	1.67	0.86			
	PRO4	4.62	1.95	0.64			
PERI	PERI1	5.11	1.77	0.81	0.78	0.91	0.91
	PERI2	4.66	1.83	0.85			
	PERI3	4.8	1.79	0.97			
PHY	PHY1	6	1.4	0.88	0.91	0.97	0.97
	PHY2	5.88	1.47	0.99			
	PHY3	5.85	1.48	0.99			
PERS	PERS1	5.64	1.52	0.91	0.92	0.97	0.97
	PERS2	5.56	1.57	0.98			
	PERS3	5.56	1.56	0.98			
POW	POW1	5.43	1.43	0.76	0.61	0.92	0.92
	POW2	5.43	1.46	0.76			
	POW3	5.16	1.5	0.80			
	POW4	5.1	1.7	0.72			
	POW5	5.29	1.54	0.79			
	POW6	5.38	1.53	0.82			
	POW7	5.26	1.66	0.83			
DET	DET1	4.56	2.1	0.83	0.68	0.91	0.91
	DET2	4.5	2.07	0.83			
	DET3	4.94	1.82	0.85			
	DET4	4.72	1.95	0.83			
	DET5	4.84	1.78	0.78			
EFF	EFF1	3.25	2.12	0.80	0.70	0.88	0.88
	EFF2	3.31	2.07	0.93			
	EFF3	3.71	1.9	0.79			
TRU	TRU1	5.41	1.88	0.86	0.52	0.86	0.87
	TRU2	5.17	2	0.64			
	TRU4	5.57	1.67	0.84			
	TRY5	5.11	2.07	0.61			
	TRU8	5.61	1.67	0.69			
PUR	TRU9	5.73	1.61	0.63	0.78	0.91	0.92
	PUR1	5.29	1.6	0.84			
	PUR2	5.01	1.75	0.94			
INF	PUR4	4.86	1.77	0.88	0.58	0.84	0.84
	INF1	3.82	2.19	0.82			
	INF2	4.21	2.13	0.83			
	INF3	3.18	2.11	0.71			

Table 4.32 (continued): Measurement values for factors.

Construct	Item	Mean	SD	Factor loading	AVE	α	Composite reliability (CR)
KNOW	INF4	4.12	2.14	0.66			
	KNOW1	3.16	2.19	0.80	0.83	0.93	0.94
	KNOW2	3.02	2.12	0.97			
WOM	KNOW3	3.08	2.12	0.95			
	WOM3	5.23	1.91	0.94	0.92	0.98	0.98
	WOM4	5.18	1.91	0.91			
	WOM5	5.21	1.93	0.99			
	WOM6	5.2	1.92	1.00			

All constructs are well performed for the average variance extracted values which are higher than squared correlations with other factors (Fornell and Larcker, 1981), providing evidence for discriminant validity (Table 4.33).

Table 4.33 : Discriminant validity.

	PRO	PERI	PHY	PERS	POW	DET	EFF	TRU	PUR	INF	KNOW	WOM
PRO	0.70											
PERI	0.47	0.78										
PHY	0.51	0.30	0.91									
PERS	0.43	0.28	0.41	0.92								
POW	0.02	0.02	0.01	0.01	0.61							
DET	0.01	0.03	0.01	0.00	0.51	0.68						
EFF	0.02	0.03	0.02	0.01	0.14	0.19	0.70					
TRU	0.52	0.39	0.34	0.20	0.03	0.03	0.01	0.52				
PUR	0.42	0.41	0.34	0.18	0.09	0.06	0.04	0.43	0.78			
INF	0.13	0.17	0.07	0.04	0.07	0.08	0.11	0.15	0.17	0.58		
KNOW	0.02	0.06	0.01	0.00	0.02	0.08	0.05	0.02	0.09	0.19	0.83	
WOM	0.57	0.43	0.42	0.32	0.05	0.04	0.02	0.51	0.52	0.18	0.06	0.92

Bolds are AVE, rest are squared correlations among constructs. PRO: Provider experience quality, PERI: Periphery experience quality, PHY: Physician interaction quality, PERS: Personnel interaction quality, POW: Power, DET: Detail, EFF: Effect, TRU: Trust, PUR: Purchase, INF: Information, KNOW: Knowledge, WOM: Word of mouth.

4.4.4 Path analysis

The path analysis is made without the moderator (MEM) in the dimensional model in order to test the direct and indirect effects. First, the measurement model fit measures are checked. The model fit values are found as acceptable (cmin/df=3.11; GFI= 0.846; AGFI=0.815; RFI=0.915; IFI=0.948; CFI=0.948; RMSEA=0,065). The direct effects are found significant except six of them: the effect of provider on WOM, the effect of

physician on influence and knowledge, and the effect of personnel on influence, knowledge, and purchase (Table 4.34).

Table 4.34 : Summary of the hypotheses.

Hypothesis	Result
H1a Provider experience quality has a positive effect on purchase	Supported
H1b Provider experience quality has a positive effect on knowledge	Supported
H1c Provider experience quality has a positive effect on influence	Supported
H2 Provider experience quality has a positive effect on WOM	Rejected
H3a Periphery experience quality has a positive effect on purchase	Supported
H3b Periphery experience quality has a positive effect on knowledge	Supported
H3c Periphery experience quality has a positive effect on influence	Supported
H4 Periphery experience quality has a positive effect on WOM	Rejected
H5a Physician interaction quality has a positive effect on purchase	Supported
H5b Physician interaction quality has a positive effect on knowledge	Rejected
H5c Physician interaction quality has a positive effect on influence	Rejected
H6 Physician interaction quality has a positive effect on WOM	Rejected
H7a Personnel interaction quality has a positive effect on purchase	Rejected
H7b Personnel interaction quality has a positive effect on knowledge	Rejected
H7c Personnel interaction quality has a positive effect on influence	Rejected
H8 Personnel interaction quality has a positive effect on WOM	Supported
H9a Provider experience quality has a positive effect on trust	Supported
H9b Periphery experience quality has a positive effect on trust	Supported
H9c Physician interaction quality has a positive effect on trust	Supported
H9d Personnel interaction quality has a positive effect on trust	Supported
H10a Purchase is positively affected by trust	Supported
H10b Knowledge is positively affected by trust	Supported
H10c Influence is positively affected by trust	Supported
H11 WOM is positively affected by trust	Supported
H12b Trust mediates the relationship between provider experience quality and knowledge.	Rejected
H12c Trust mediates the relationship between provider experience quality and influence.	Supported
H15b Trust mediates the relationship between periphery experience quality and knowledge.	Supported
H15c Trust mediates the relationship between periphery experience quality and influence.	Supported
H17b Trust mediates the relationship between physician interaction quality and knowledge.	Rejected
H17c Trust mediates the relationship between physician interaction quality and influence.	Rejected
H19b Trust mediates the relationship between personnel interaction quality and knowledge.	Rejected
H19c Trust mediates the relationship between personnel interaction quality and influence.	Rejected

Most of the effects of experience quality constructs on trust and engagement outcomes are found significant. The effect of provider experience quality on trust was found significantly positive ($\beta=0.781$, $p<0.001$). Additionally, provider experience quality was found to have a significant positive effect on influence ($\beta=0.427$, $p<0.01$), knowledge ($\beta=0.713$, $p<0.001$), and purchase ($\beta=0.282$, $p<0.01$). Periphery experience quality showed significantly positive performance on paths: trust on trust ($\beta=0.208$, $p<0.001$), influence ($\beta=0.342$, $p<0.001$), knowledge ($\beta=0.286$, $p<0.001$) and purchase ($\beta=0.295$, $p<0.001$). Physician interaction quality was found to have positive effects on trust ($\beta=0.096$, $p<0.05$) and purchase ($\beta=0.188$, $p<0.001$). Personnel interaction quality is found to have positive effect on trust ($\beta=0.199$, $p<0.001$), and positive effect on WOM ($\beta=0.164$, $p<0.001$). As hypothesized, trust has positive effects on influence ($\beta=0.638$, $p<0.001$), knowledge ($\beta=0.552$, $p<0.001$), purchase ($\beta=0.695$; $p<0.001$), and WOM ($\beta=0.650$, $p<0.001$).

4.4.5 Mediation analysis

Since some of the mediation relationships were the same as in the main model, additional analyses were conducted for this stage of the research. Only the mediation models with information and knowledge as outcomes were reported. PROCESS macro in SPSS suggested by Hayes (2013) was used to test mediation effects. For most of the models in Figure 4.9, the mediation was found as significant.

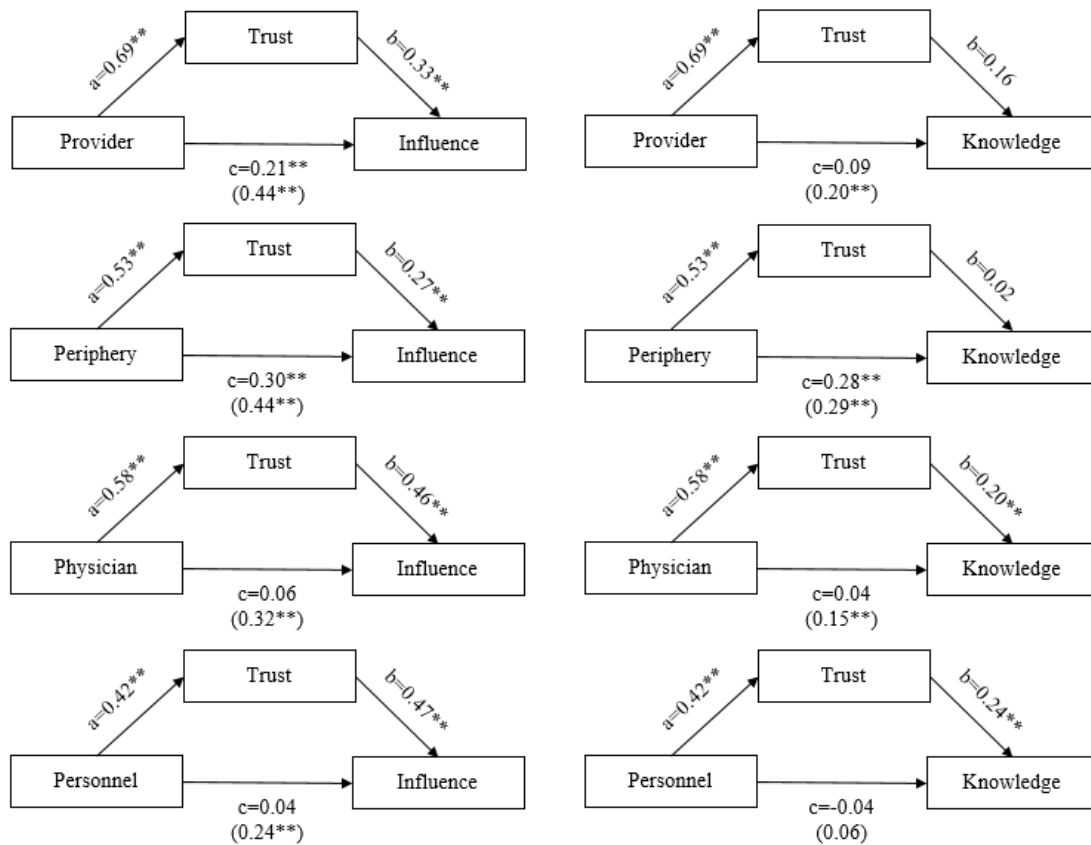


Figure 4.9 : Mediation analysis results – paths.

The effect of the provider experience quality on trust is positive and significant ($b = 0.69$, $p < 0.001$), but trust in turn does not exert a significant positive effect on knowledge ($b = 0.16$, $p > 0.001$). Further, the results using bootstrapping also indicate that the indirect effect of provider on the knowledge through trust ($b = 0.09$) is not significant, as the 95%, confidence interval $([-0.08; 0.26])$ contains 0. Thus, H12b is rejected.

The effect of the provider experience quality on trust is positive and significant ($b = 0.69$, $p < 0.001$), and trust in turn exerts a significant positive effect on influence ($b = 0.33$, $p < 0.001$). Further, the results using bootstrapping also indicate that the indirect effect of provider on the influence through trust ($b = 0.21$) is significant, as the 95%, confidence interval $([0.07; 0.35])$ does not contain 0. Thus, H12c is supported.

The effect of the periphery experience quality on trust is positive and significant ($b = 0.53$, $p < 0.001$), and trust in turn does not exert a significant positive effect on knowledge ($b = 0.02$, $p < 0.001$). Further, the results using bootstrapping also indicate that the indirect effect of periphery on the knowledge through trust ($b = 0.28$) is

significant, as the 95%, confidence interval ([0.15; 0.41]) does not contain 0. Thus, H15b is supported.

The effect of the periphery experience quality on trust is positive and significant ($b = 0.53$, $p < 0.001$), and trust in turn exerts a significant positive effect on influence ($b = 0.27$, $p < 0.001$). Further, the results using bootstrapping also indicate that the indirect effect of periphery on the influence through trust ($b = 0.30$) is significant, as the 95%, confidence interval ([0.19; 0.41]) does not contain 0. Thus, H15c is supported.

The effect of the physician interaction quality on trust is positive and significant ($b = 0.58$, $p < 0.001$), and trust in turn exerts a significant positive effect on knowledge ($b = 0.20$, $p < 0.001$). Further, the results using bootstrapping does not indicate that the indirect effect of periphery on the knowledge through trust ($b = 0.04$) is significant, as the 95%, confidence interval ([-0.12; 0.19]) contains 0. Thus, H17b is rejected.

The effect of the physician interaction quality on trust is positive and significant ($b = 0.58$, $p < 0.001$), and trust in turn exerts a significant positive effect on influence ($b = 0.46$, $p < 0.001$). Further, the results using bootstrapping does not indicate that the indirect effect of periphery on the influence through trust ($b = 0.06$) is significant, as the 95%, confidence interval ([-0.07; 0.18]) contains 0. Thus, H17c is rejected.

The effect of the personnel interaction quality on trust is positive and significant ($b = 0.42$, $p < 0.001$), and trust in turn exerts a significant positive effect on knowledge ($b = 0.24$, $p < 0.001$). Further, the results using bootstrapping does not indicate that the indirect effect of periphery on the knowledge through trust ($b = -0.04$) is significant, as the 95%, confidence interval ([-0.17; 0.09]) contains 0. Thus, H19b is rejected.

The effect of the personnel interaction quality on trust is positive and significant ($b = 0.42$, $p < 0.001$), and trust in turn exerts a significant positive effect on influence ($b = 0.47$, $p < 0.001$). Further, the results using bootstrapping does not indicate that the indirect effect of periphery on the influence through trust ($b = 0.04$) is significant, as the 95%, confidence interval ([-0.07; 0.14]) contains 0. Thus, H19c is rejected.

4.4.6 Moderated mediation analysis

The present study expects that the dimensions of autobiographical memory (power, detail, effect) moderates the indirect association between perceived experience quality (provider, periphery, physician, and personnel) and engagement outcomes (purchase, influence, knowledge and WOM). After the mediation analysis, moderated mediation analysis was conducted in order to test the hypotheses involving moderation effects by using PROCESS macro in SPSS suggested by Hayes (2013). Model 59 was used to measure the effects.

This study estimated the moderating effect of dimensions of autobiographical memory on: 1) the relationship between experience dimensions and engagement dimensions (path c); the relationship between experience dimensions and trust (path a); the relationship between trust and engagement dimensions (path b). Hence, a total of 144 paths were tested via 48 models. According to the results, moderated mediation was established for 21 relationships. The established ones can be seen on Table 4.35. The specifications of the all models were summarized in Table 4.36.

Table 4.35 : Established moderated mediations.

Y	X	W		
		POWER	DETAIL	EFFECT
WOM	Provider	Rejected	Supported	Supported
	Periphery	Rejected	Supported	Supported
	Physician	Rejected	Rejected	Supported
	Personnel	Supported	Supported	Supported
INFLUENCE	Provider	Rejected	Supported	Supported
	Periphery	Rejected	Supported	Supported
	Physician	Rejected	Rejected	Rejected
	Personnel	Rejected	Rejected	Rejected
PURCHASE	Provider	Rejected	Supported	Supported
	Periphery	Supported	Supported	Supported
	Physician	Rejected	Rejected	Rejected
	Personnel	Rejected	Rejected	Rejected
KNOWLEDGE	Provider	Rejected	Supported	Supported
	Periphery	Rejected	Supported	Supported
	Physician	Rejected	Rejected	Rejected
	Personnel	Rejected	Rejected	Rejected

Table 4.36 : Moderated mediation analysis results.

Y	X	Power			Detail			Effect		
		Path a	Path b	Path c	Path a	Path b	Path c	Path a	Path b	Path c
WOM	Provider	Non-sig.	Non-sig.	Non-sig.	Sig.	Non-sig.	Non-sig.	Sig.	Non-sig.	Non-sig.
	Periphery	Non-sig.	Non-sig.	Non-sig.	Sig.	Non-sig.	Non-sig.	Sig.	Non-sig.	Non-sig.
	Physician	Non-sig.	Non-sig.	Non-sig.	Non-sig.	Non-sig.	Sig.	Non-sig.	Sig.	Sig.
	Personnel	Non-sig.	Sig.	Sig.	Non-sig.	Sig.	Sig.	Non-sig.	Sig.	Sig.
INFLUENCE	Provider	Non-sig.	Non-sig.	Non-sig.	Sig.	Non-sig.	Non-sig.	Sig.	Non-sig.	Non-sig.
	Periphery	Non-sig.	Non-sig.	Non-sig.	Sig.	Non-sig.	Non-sig.	Sig.	Non-sig.	Non-sig.
	Physician	Non-sig.	Non-sig.	Non-sig.	Non-sig.	Non-sig.	Non-sig.	Non-sig.	Non-sig.	Non-sig.
	Personnel	Non-sig.	Non-sig.	Non-sig.	Non-sig.	Non-sig.	Sig.	Non-sig.	Non-sig.	Non-sig.
PURCHASE	Provider	Non-sig.	Non-sig.	Non-sig.	Sig.	Non-sig.	Non-sig.	Sig.	Non-sig.	Non-sig.
	Periphery	Non-sig.	Sig.	Sig.	Sig.	Non-sig.	Non-sig.	Sig.	Non-sig.	Non-sig.
	Physician	Non-sig.	Non-sig.	Non-sig.	Non-sig.	Non-sig.	Non-sig.	Non-sig.	Non-sig.	Non-sig.
	Personnel	Non-sig.	Non-sig.	Non-sig.	Non-sig.	Non-sig.	Non-sig.	Non-sig.	Non-sig.	Non-sig.
KNOWLEDGE	Provider	Non-sig.	Non-sig.	Non-sig.	Sig.	Non-sig.	Non-sig.	Sig.	Sig.	Sig.
	Periphery	Non-sig.	Non-sig.	Non-sig.	Sig.	Non-sig.	Non-sig.	Sig.	Non-sig.	Non-sig.
	Physician	Non-sig.	Non-sig.	Non-sig.	Non-sig.	Non-sig.	Non-sig.	Non-sig.	Non-sig.	Non-sig.
	Personnel	Non-sig.	Non-sig.	Non-sig.	Non-sig.	Non-sig.	Non-sig.	Non-sig.	Non-sig.	Non-sig.

Sig.: significant

Non-sig.: non-significant

4.4.7 Results

The dimensional model tests the hypotheses considering the effects of experience on engagement dimensions of purchase, influence, and knowledge. Besides, the mediating effect of trust and moderated mediating effect of dimensions of autobiographical memory as power, effect, and detail are tested.

The significant relationships which are also included in the main model are found in dimensional model. The results of testing these hypotheses show some additional relationships to the main model results. First, the effects of experience quality on engagement dimensions of influence and knowledge are found significant for only provider and periphery. The dimensions of personnel and physician, which are mainly about the interaction and communication, are not found effective for influence and knowledge. The direct effect of trust is also found as significant for influence and knowledge. However, the mediating effect of trust is found significant for only provider-influence, periphery-knowledge, periphery-influence, physician-knowledge. Other relationships between experience quality and engagement dimensions are not found as significant. Contrary to the main model, autobiographical memory is found as an effective moderated mediation effect when it is included in the model with its sub-dimensions. The sub-dimension of effect influences most of the relationships. The non-significant ones are physician/personnel-trust-influence/knowledge/purchase. This means that the mediation effect of trust on the relationship between interaction experience quality dimensions and engagement dimensions are not affected by the importance of the experience. On the other hand, personnel-trust-WOM and periphery-trust-purchase relationship is always affected by all of the autobiographical memory dimensions. Power sub-dimension only affects the relationships of personnel-trust-WOM and periphery-trust-influence. Detail sub-dimension does not affect the relationships including personnel and physician but affects all the relationships including provider and periphery. The results of both models are evaluated in detail under the Discussion section.

5. DISCUSSION

The main purpose of this thesis was to investigate the relationship between patient experience and engagement, and the effect of autobiographical memory to this relationship. Since trust is a critical construct for health care services (Bova et al. 2006), the research also considers the effect of trust as a mediator between experience and engagement. Besides, as a novel approach, autobiographical memory with its dimensions was added to the research model in order to prospect its moderating effect on the aforementioned relationships. As a contribution to the field, conceptual model was built with both expert- and patient-centered approach by collecting firstly their opinions with a qualitative research. The qualitative study resulted in five patient experience dimensions: provider, periphery, physician, personnel, and patient. Since patient is not a dimension that the hospital can control, it was not included in the model as dependent variable. After shaping the research model with the guidance of qualitative study, the quantitative analyses were conducted to test the relationships. The research model which aspires to investigate the statistical significance of the relationships between experience quality dimensions, engagement, trust, and autobiographical memory. As some of the variables (engagement and autobiographical memory) have sub-dimensions, the conceptual model was tested under two different versions: a main model and a dimensional model. In main model, the dimensional constructs were taken as one construct each, and the analyses were made upon that approach. In dimensional model, each sub-dimension was taken as different constructs in the analyses. Thus, the results were reported for both versions of research model.

The results suggest that all of the dimensions of perceived experience quality have significant effect on purchase intention and trust to hospital, in line with the hypotheses. The effects on WOM, and other engagement dimensions of influence and knowledge were not found for physician and personnel experience quality. Besides, trust was found as a significant mediator for most of the relationships between experience quality and engagement regarding purchase, influence, knowledge and

WOM. The moderated mediation effect of autobiographical memory as a single construct was only found for physician and WOM relationship. However, when it is considered with its breakdowns, the results showed a different picture including various significant moderated mediation effects. These findings suggest that, in health care, in addition to experience quality in different dimensions, patient engagement could also be dependent upon autobiographical memory dimensions which addresses a memorable health care experience.

5.1 Theoretical Implications

Service design, as Varnali (2018) suggests, deals with identifying and regulating the parts of a complex customer journey in order to embody the customers in co-creating activities resulting from their experiences. Considering patients as customers of health care services (Levine, 2015), the service in such a complex experience system needs to be designed well. A strong healthcare system must exist in order to deliver quality and value to patients (Camgoz-Akdag and Zineldin, 2010) by seeing them as consumers. In this thesis, both the consumers and decision makers, providers, experts of health care market were interviewed for identifying the experience dimensions of a patient's journey. Although there are some previous studies in the literature which analyzed the perspectives of both sides (e.g. Andrade et al., 2012; Kennedy et al., 2011; Berry and Bendapudi, 2007), most studies reflect only the expert or provider side (e.g. Brauer et al. 2018; Bradley et al., 2006) or only the patient side (e.g. Otani et al. 2009; 2010; 2012; Babakus and Mangold, 1992). There are also some studies which are conceptually summarized the literature and listed patient experience dimensions (e.g. Klaus, 2018; Castro et al. 2016; Needham, 2012). This thesis contributed to the literature by providing a patient experience framework from a dual perspective of experts and patients. Besides, previous studies which collected patient opinions mainly focused on certain branches such as cancer (Deshwal and Bhuyan, 2018), weight control (e.g. Dellande et al., 2004), primary care (e.g. Brauer et al., 2018) or specific patient segments such as older adults (e.g. Bradley et al., 2006). This study comprehends a general approach to patient experience with its two-step qualitative research. Interviewing the experts in order to determine the patients who can give valuable insight is a novel approach to the literature and it can be evaluated as an assuring methodology for the following research steps.

The qualitative research of the study provided a 5-point framework for patient experience: provider, periphery, physician, personnel, and patient. Provider explains the perception of patients' about the hospital management, their expertise, and process management. A patient-centered approach to hospital management can provide higher quality of service which satisfies the patients with increasing expectations (Charmel and Frampton, 2008). The relationship between patient and provider is built upon patient's perceptions about functional service quality dimensions (Becker et al. 2008, Grönroos, 1984) which means the service beyond medical treatment. The expertise of the provider, which is defined as the capacity of holding a specialized skill or knowledge on a branch (Stewart, 1989) is also critical for patients when evaluating the experience. Patients seek for expert providers with high quality service in order to experience a good service. The patients who are more and more aware of competition in health care may be affected by the experience from the provider to have loyalty (Gaur et al. 2011). On the other hand, provider dimension addresses to the organizational characteristics which are affective on patient experience perception such as private or state insurance contract. In this sense, after quantitative research, comparing the questionnaire answers for different groups of hospitals which have insurance contract and of patients who use or do not use insurance in the hospital provided evidence that the existence and usage of the insurance affect experience quality perception, trust, and engagement outcomes. Hence, in parallel with social identity theory, it can be inferred that the existence of insurance may create a clue for hospital segment and patient profile in the patients' minds about and may affect the evaluation of the experience. According to the theory, a person may be supportive when he/she feels a belongingness of a group (Ashforth and Mael, 1989). Hence, patients' identifications with hospitals influence their attitudinal and behavioral outcomes (Cornwell and Coote, 2005; Lichtenstein et al., 2004). Addition to social identity, homophily which refers to the similarity between the patient and the provider may be effective. A similar patient profile may lead patients to care the hospital more attentively (Dellande et al., 2014) because of trust and respect (Simons et al. 1970).

The identification process is also affected by the environment in which the patient is being treated, thus, another concept arises as a critical issue in a hospital: periphery. Periphery can be explained as the ambiance of the health care organization. Including the physical appearance, the location, the crowd level, etc. The participants of the

qualitative research mentioned the environment as a critical issue for experiencing the service in a private hospital. Previous research suggest that the physical appearance of hospital rooms leads a better well-being for patients (Devlin and Arneill, 2003). Bitner (1990) suggests that reaching a high patient satisfaction in a hospital is mainly depends on the environment in which the service is provided. Comfort of waiting areas, hygiene, interior design of the facility are positively related to patient experience (Fottler et al., 2000). Atmospherics, defined by Kotler (1973), identifies the physical environment which affects consumers' purchase decision. In healthcare context, patients give importance to this criterion (Fottler et al., 2000) since their stressful situation is mainly influenced by the ambiance (Andrade and Devlin, 2015). Distraction theory (Shirey and Reynolds, 1988) and the theory of supportive design (Ulrich, 1991) suggest that patients can lower their anxiety level with the help of positive stimuli around. Positive distractions such as music, reading materials, a room full of happy and supportive people can reduce pain and help patients to deal with the disease easier (Berman et al., 2008).

Happy and supportive people deserve a distinct attention as distractors thanks to their contribution to the communication in the service setting. Communication is a part of service quality in the health-care (Al-assaf, 1999). People are critical in terms of the interaction between them and its influence on patient experience. In the context of this study, those effective people are the medical and administrative employee in this study. The interaction with the the medical staff has a great impact on healthcare consumption (Lee et al., 2012; John, 1996). According to the qualitative study results, patients consider the employee under two groups: physician and personnel. Personnel, as indicated earlier, includes the nurses and the administrative staff since participants agree on this grouping. Although the physician interaction may be thought as the most critical one, nurse is as important as the physician (Vinagre and Neves, 2008). The interaction with both physician and personnel is found as critical key points for patient experience. A patient-centered approach, which suggests a high interaction quality with patients and their families, will lead higher positive outcomes (Anderson et al., 2018), and can be effective for patient satisfaction in a nervous and stressful environment (Hutton and Richardson, 1995) by overcoming patient's negative feelings (Suess and Mody, 2018). Additionally, good relationships lead patients to become loyal to the hospital (Kessler and Mylod, 2011). For such a huge effect of the

interaction, even with the physician or the personnel, the employee engagement is critical for patient experience. Healthcare organizations should move beyond the basic trainings of frontline staff and intensify the employee engagement programs in order to create a patient experience culture and to provide high experience quality for the patients (Birkelien et al., 2017; Mazurenko et al., 2015; Needham, 2012). The employee should proactively seek for the opportunity of serving patients in parallel with their expectations (Fortenberry and McGoldrick, 2016). During the social interaction in the service encounter, all of the staff represent their own cultural background which is shaped by the organizational culture (John, 1996), thus, the health care organization should have a culture to support patient experience focus (Birkelien, 2017; Bonebrake and Ratchford, 2017).

The experience of a patient, naturally, depends on him/herself. Patient itself is found as a critical dimension for experience. It includes the treatment type (outpatient vs inpatient), the patient type (patient vs patient relative), and the treatment branch (internal disease, oncology, general surgery, etc.). John (1996) analyses the physician-patient encounter dramaturgically and finds that audience's (patient's) back region such as cultural values, patient expectations, past experience are effective on patient's experience quality perception as much as the actor's (physician's) region and setting (physical appearance). Considering the findings in the qualitative research, this study pays attention to patients in private hospitals. Hence, patient relatives are not in the scope of the research. However, it is estimated that the effect of being a patient relative in the same hospital and the question of "Did you visit the same hospital as a patient relative after your visit?" is asked in the survey. According to the results, periphery and personnel experience quality perception and trust is not found different in two groups (yes or no). A patient can shape the perception about periphery and personnel and build trust through the provider within his/her own experiences. Provider and physician may be changed after a visit as relative. This is reasonable since different communicative and managerial processes are experienced with different physician and in a different situation as patient relative as it is found in qualitative research. While conducting the interviews, patient relatives are observed as independent experience evaluators since their observations have different perspectives from the patients.

After qualitative research, the results of the quantitative study support the Reciprocal Action Theory (Gouldner, 1960) which suggests that people behave in turn of what they get. Consumers build a relationship between past experience and future behavior in a gratitude (Gouldner, 1960). In accordance with the theory and prior findings regarding that satisfaction leads to retention and willingness to recommend (Zeithaml et al., 1996), the results of this study suggest the positive effect on engagement outcomes can occur if the consumer perceived a high experience quality. This research shows that there is a positive relationship between some of the experience and engagement dimensions. Considering purchase intention, all of the experience quality dimensions (provider, periphery, physician, and personnel) have positive effect. When patients perceive a high experience quality, they are more likely to purchase from the same hospital when needed. For other engagement dimensions, the results show various outcomes. Influence, which addresses to the behavior of mentioning the provider in the conversations, and knowledge, which addresses to the behavior of giving feedback to the managers of the hospital are found as only affected by higher experience quality from provider and periphery. Since the main objective of the research is to find how experience affects the outcomes about the whole hospital, the insignificant effect of physician and personnel are reasonable. Although patients indicate that they can repurchase from the same hospital with high physician and personnel experience quality, they do not guarantee that they will recommend or mention the hospital in their conversations or refer the hospital to others.

Another significant result is found as the positive effects of experience quality dimensions on trust to the hospital. Trust is also a result of reciprocity evolving over time (Lynn-McHale and Deatricks, 2000). Positive experience quality perceptions from provider, periphery, physician and personnel trigger the feeling of trust to the hospital. The findings including personnel and physician effect on trust might be interpreted in the light of Hupcey and Miller (2006) suggestion that interpersonal trust and provider trust are positively associated. The effect of trust on engagement outcomes (purchase, knowledge, influence, and WOM) is also remarkable. If a patient trust to the hospital, all engagement outcomes are positively affected from that trust: the patient rebuys, refers, shares feedback, and puts the hospital into his/her own life conversations. Also, mediating effect of trust on experience quality-engagement outcome relationships. Most of the relations are found to be mediated by trust in parallel with the previous

literature (see Holt, 2018 for a conceptual review). Contrary to expectations, the paths to knowledge from provider and personnel and the paths to influence from physician and personnel are not found as mediated by trust.

Although recommendation is positively associated with satisfied patients (Grantino et al., 2013; Otani et al., 2010; Burke-Miller et al. 2006), in this study, WOM is not found as being affected by provider, physician and personnel experience quality. Only periphery can lead people to refer the hospital to others according to the results. This can be explained by the reasons why patients choose that hospital in the first place. If a patient chooses the hospital only for the physician, he/she cannot build a significant engagement relationship with the hospital. However, a high experience quality perception from periphery (the ambiance of the hospital) may result as a high willingness to recommend. Since the results of WOM behavior are very critical for the patients, personal involvement is really high for WOM (Ferguson et al., 2010). Hence, recommending a health care organization might be affected from various antecedents.

One of the main contributions of this thesis to the literature is the effect of autobiographical memory on the relationships between experience, trust and engagement. Although providing memorable experience is not considered as the main focus of the organizations (Gentile et al., 2007), its effects may be critical since people memorize the effects in their lives and make future decisions according to those memories. The moderated mediation analyses showed that when considered as a single construct, autobiographical memory only moderates the relationship between physician, trust, and WOM. As patients had better remember their experience, their effect between physician experience quality and WOM behavior is becoming stronger. Other relationships were not found as significant under the moderation of autobiographical memory. One possible explanation for the results can be that remembering a target event depends on the prior events experienced (Marsh and Roediger, 2012). Another possible explanation for the results might be the measurement methodology. Autobiographical memory as a single construct might not perform well as a moderator. The participants answered the questions with a generic memory, but the questions asked as a single incident (Means et al., 1989). In this sense, the analyses with the sub-dimensions of the construct gave more detailed significant relations. Effect, the level of importance of the memory in one's life, is found to affect

most of the relationships. In particular, the only relationships that effect did not moderate are personnel-physician and influence-knowledge-purchase. There is no effect whether the patients have the hospital experience as a huge impact in their lives when considering being engaged. However, WOM performed differently in this relationship. Effect is found as influential for all of the relationships between experience quality dimensions on WOM through trust. According to Polyanna Principle (Matlin and Stang, 1978), people tend to remember the positive memories (Yin et al., 2017). With the personal involvement to WOM in mind (Ferguson et al., 2010), people who have positive memories in hospital will recommend the hospital to others more under the effects of high experience quality from provider, periphery, physician, and personnel. On the other hand, power, the level of belief that the patient remembers his/her experience, does not moderate most of the relationships. Two of them are only moderated by power: personnel-WOM and periphery-purchase relationships through trust. One interesting results about those two relationships is that they are affected by all of the subdimensions of autobiographical memory. If an effective, powerfully memorable experience in detail can be created, patients are more likely recommend to the hospital according to their quality perception about personnel interaction; and more likely purchase according to their quality perception about periphery experience. Lastly, detail, the level of remembering the particular points of the experience such as setting, noise, physical appearance only moderates the relationships of provider and periphery. Since these two experience quality dimensions are related to the physical scene of the hospital experience, it is natural to find such a result. Personnel and physician relationships are not affected by detail.

This research contributed to the literature with its several significant relationships between experience, trust, and engagement. Besides, autobiographical memory is a novel construct for healthcare marketing and patient experience. The main effects and dimensional effects may open a new perspective to both marketing and healthcare literature. Additionally, considering patients as consumers will be a contribution to the transformative consumer research.

5.2 Managerial Implications

This study provides a guideline for managing private healthcare organizations in terms of patients, their experiences, and behaviors. First, considering patients as consumers

is a significantly new approach for healthcare marketing and management. Healthcare managers should be aware of that the ability to rationally decide which health service to purchase make patients empowered consumers in such a competitive market. Especially in private hospitals, this study reveals that patients are conscious of their power when buying a health service according to the results of the qualitative phase. When they are asked about their experiences in the hospital, they mention the service experience such as communication quality, physical appearance, waiting time, etc. instead of their medical treatment, medicines, or side effects of the treatment. This points a critical transformation for patients: they are aware of their power and the competition in the market. Different from the consumers of other markets, patients can be fragile. Their need for being treated as human being is more than the others. Hence, hospital managers should consider them as not only patients but also sensitive consumers with high expectations.

Treating patients as consumers requires a well-designed experience in the hospital. The results of the qualitative study indicate that five points are critical for patient experience: patient, provider, physician, personnel, and periphery. A health care organization should pay attention to the patient in terms of the treatment area, his/her relatives or personal needs. The approach of “There is no disease, there is the patient” should be a guide for all health care employee who are working for creating a healing environment for the patients. The differences between different groups of patient type, treatment type, insurance usage provide evidence for the necessity of customizing the experience. Further, as providers, the hospitals should create a well-managed process in the hospital. The patients indicate that they are aware of the managerial climate around their experience and evaluate the hospital in this direction. Along with this, periphery is also found as a critical point for patient experience. Patients pay attention to location, crowdedness, extra services, etc. while evaluating the experience in a certain hospital. Addition to these points, communication-focused keys are extracted: physician and personnel. The two different groups of employee affect patients’ experiences in terms of the interaction quality. The information flow, favorable behavior, helpfulness, etc. are the important behaviors of the employee. Hence, creating a culture focused on patient experience may help hospitals acquire new patients and retain their patients when needed.

A well-designed experience will lead several positive outcomes such as trust to hospital, repurchase when needed, recommend the hospital through word of mouth, provide feedback, or mentioning the hospital in daily conversations. In particular, high perceived experience quality in aforementioned key factors will lead high trust and in turn patients are more likely to contribute to the marketing activities of the organization with engagement behaviors. The results also show that a memorable experience may provide stronger relationships between some of the constructs. To illustrate, a memorable environment makes the provider and periphery effects on engagement outcomes stronger. Furthermore, the impact of the memory in the patient's life leads stronger relationships for most of the constructs. Hence, a hospital should create a well-designed, physically and mentally memorable and effective experience in order to have the patients engaged.

5.3 Limitations and Suggestions for Further Research

This study has some limitations in terms of methodology and complexity of the health care system. First, the measurement scales about customer experience may be specialized for health care context. The measurement tools should go further than the tools created for, for instance, consumer goods or hotel services. Further research should build and use a validated scale for patient experience in the light of both experts' and patients' perspectives for such research areas. Bitner's (1990) model of servicescape includes four dimensions: (1) atmospherics, (2) social factors, (3) physical design, and (4) layout and orientation. Although these dimensions seem to be applicable to all consumer behavior contexts (Suess and Mody, 2018), healthcare should have a specific approach because of its complex system.

One of the main limitations of this research is the lack of the information of the reasons why the patient chooses the hospital. Although the qualitative study provided insight about the preferences of the hospital, the quantitative study had to focus on the experience only inside the hospital. The process before entering the hospital is excluded because of being such a complex structure. However, some relationships such as experience-WOM might be understood by evaluating the process of deciding which hospital to choose. Some patients may choose the physician and do not like the hospital, or vice versa. Hence, this effect should be investigated in detail in further studies.

This study did not focus on specific branches and only conducted in private hospitals. Future studies should investigate whether a difference occurs between various branches and hospitals. The comparisons between surgery patients, kids, outpatients in state and private hospitals may provide valuable insight for the study area.

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APPENDICES

APPENDIX A: Survey

APPENDIX B: Selected patient experience studies

APPENDIX C: Common method bias analysis results for main model

APPENDIX D: Path analysis model for main model

APPENDIX E: PROCESS macro outputs of significant moderated mediation for main model

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APPENDIX I: Research Ethics Committee approval

APPENDIX A: Survey

Hasta Deneyimi Araştırması

İyi günler. Adım İstanbul Teknik Üniversitesi İşletme Mühendisliği Bölümü adına bir doktora tezi için araştırma yapıyoruz. Bu ankette, **özel hastanelerde** hastaların yaşadığı deneyim ile ilgili sorular yer almaktadır. **Soruları “en son özel hastane tecrübenizi” düşünerek cevaplamanız istenmektedir.** Kişisel bilgileriniz herhangi bir şekilde paylaşılmayacaktır. Akademik bir araştırmaya destek verdiğiniz için teşekkür ederiz.

1a) Lütfen yaşınızı söyleyiniz.

.....(18 yaşından küçük ise ankete son veriniz)

1b) Kendiniz için ne sıklıkla hastaneye gidersiniz?

1	Ayda en az bir kez
2	2-3 ayda bir kez
3	4-6 ayda bir kez
4	7-9 ayda bir kez
5	10-12 ayda bir kez
6	Yılda bir kezden daha seyrek

1c) Kendiniz için ne sıklıkla özel hastaneye gidersiniz?

1	Ayda en az bir kez
2	2-3 ayda bir kez
3	4-6 ayda bir kez
4	7-9 ayda bir kez
5	10-12 ayda bir kez
6	Yılda bir kezden daha seyrek (ANKETE SON VER)

2) En son ne zaman kendiniz için sağlık kontrolünüz/tedaviniz için özel bir hastaneye gittiniz?

.....

3) Hangi branşa gittiniz?

.....

4) Gittiğiniz özel hastanede tedavinizi ayakta mı gördünüz yatarak mı?

1	Ayakta
2	Yatarak

5)En son sađlık kontrolünüz/tedaviniz için gittiđiniz bu özel hastaneye kaçınıcı gidişiniz?

1	İlk gidişim
2	Daha önce bir veya birkaç kez daha gitmişim
3	Her zaman o hastaneye giderim

6) Daha sonra herhangi bir **hasta yakını olarak** aynı hastaneye gittiniz mi?

1	Evet
2	Hayır

Lütfen aşağıdaki soruları en son gittiđiniz ve yukarıda birimini belirttiđiniz özel hastane deneyiminizi düşünerek cevaplayınız.

7) Aşağıda **en son gittiđiniz** özel hastanede deneyiminizi ne kadar hatırladıđınızı ölçen ifadeler bulunmaktadır. Lütfen ifadelere ne kadar katıldıđınızı yandaki ölçeđi kullanarak belirtiniz.

(1-Kesinlikle katılmıyorum,..... 7-Kesinlikle katılıyorum).

	<i>Son hastane deneyimimi düşündüğüm zaman...</i>							
a	...o deneyimi tekrar yaşıyormuş gibi hissediyorum.	1	2	3	4	5	6	7
b	...hastanede duyduğum sesleri aklıma getirebiliyorum.	1	2	3	4	5	6	7
c	...hastanede gördüklerimi aklıma getirebiliyorum.	1	2	3	4	5	6	7
d	...mekânsal düzeni hatırlayabiliyorum.	1	2	3	4	5	6	7
e	...o gün hissettiklerimi tekrar hissedebiliyorum.	1	2	3	4	5	6	7
f	...bu deneyimi yaşadığım yerdeki ortamı hatırlayabiliyorum.	1	2	3	4	5	6	7
g	...bu deneyimi kelimelerle tasvir edebilirim.	1	2	3	4	5	6	7
h	...o zamana tekrar gidiyorum ve dışarıdan gözlemleyen biri olarak değil tekrar yaşayan biri olarak orada bulunuyormuş gibi hissediyorum.	1	2	3	4	5	6	7
i	...bölük pörçük parçalar halinde sadece belirli sahneler olarak değil, kelimeler ve resimlerle zihnimde oluşan tutarlı bir hikaye olarak hatırlıyorum.	1	2	3	4	5	6	7
j	...tam da hatırladığım gibi gerçekleştiđine, hafızamın gerçekten yaşanmamış bir şeyler eklemediđine eminim.	1	2	3	4	5	6	7
k	...günün hangi saatinde olduđunu hatırlıyorum.	1	2	3	4	5	6	7
l	Bazen insanlar ne yaşadıklarını bilirler ama gerçekten hatırlayamazlar. Son hastane deneyimimi düşündüğümde, ne yaşadığımı bilmekten öte gerçekten hatırlıyorum.	1	2	3	4	5	6	7
m	Son hastane deneyimim benim için önemli çünkü hayatımda önemli bir dönüm noktasını temsil ediyor.	1	2	3	4	5	6	7
n	Son hastane deneyimimden sonra bu deneyim hakkında düşündüğüm oldu.	1	2	3	4	5	6	7
o	Son hastane deneyiminin hayatımda önemli bir yeri var çünkü bazı düşüncelerimi, davranışlarımı ve duygularımı farkedilir şekilde deđiştirdi.	1	2	3	4	5	6	7

8) Aşağıda en son gittiğiniz özel hastane deneyiminizi hatırladığınızda hissettiklerinizle ilgili bir ifade bulunmaktadır. Lütfen duygularınızın daha önce yaşadığınız başka bir deneyimle ne kadar eşleştiğini işaretleyiniz.

(1-daha önce yaşadığım olumsuz bir deneyimle aynıydı..... 7-daha önce yaşadığım olumlu bir deneyimle aynıydı)

Son hastane deneyimimi hatırladığımda, deneyim sırasındaki duygularım....	1	2	3	4	5	6	7

9) Aşağıda en son gittiğiniz özel hastaneye olan güveninizi ölçen ifadeler bulunmaktadır. Lütfen ifadelere ne kadar katıldığınızı yandaki ölçeği kullanarak belirtiniz.

(1-Kesinlikle katılmıyorum..... 7-Kesinlikle katılıyorum).

a	Gittiğim hastaneye verdiği sözü tutma konusunda güvenebilirsiniz.	1	2	3	4	5	6	7
b	Gittiğim hastaneyi bazı zamanlarda samimiyetsiz bulduğum olmuştur.	1	2	3	4	5	6	7
c	Gittiğim hastaneyle muhatap olurken tedbirli olmakta fayda olduğunu düşünüyorum.	1	2	3	4	5	6	7
d	Gittiğim hastane güvenilirdir.	1	2	3	4	5	6	7
e	Gittiğim hastane, almaktan kaçındığım bir sürü sağlık hizmetini bana gereksiz yere satmaya çalışıyor.	1	2	3	4	5	6	7
f	Gittiğim hastane, hastanın çıkarını kendi çıkarından önde tutar.	1	2	3	4	5	6	7
g	Gittiğim hastane de dahil olmak üzere bazı hastaneler istedikleri etkiyi yaratmak için gerçeği çarpıtırlar.	1	2	3	4	5	6	7
h	Gittiğim hastane dürüst değildir.	1	2	3	4	5	6	7
i	Gittiğim hastanede bazen vereceğim kararı etkileyecek kritik öneme sahip bilgilerin benimle paylaşılmadığından şüpheleniyorum.	1	2	3	4	5	6	7

10) Aşağıda en son gittiğiniz özel hastane deneyiminden sonra bu hastaneyle ilgili nasıl bir davranış sergilediğinizi belirten ifadeler bulunmaktadır. Lütfen ifadelere ne kadar katıldığınızı yandaki ölçeği kullanarak belirtiniz.

(1-Kesinlikle katılmıyorum..... 7-Kesinlikle katılıyorum)

a	Bu hastaneyle ilgili herhangi bir sosyal mecraada aktif olarak konuşmuyorum.	1	2	3	4	5	6	7
b	Bu hastaneyle ilgili deneyimimi anlatmayı seviyorum.	1	2	3	4	5	6	7
c	Bu hastanenin bana kazandırdıklarını başkalarıyla paylaşıyorum.	1	2	3	4	5	6	7
d	Kendimi bu hastanenin bir parçası gibi hissedirim ve mutlaka konuşmalarımda hastaneden bahsederim.	1	2	3	4	5	6	7
e	Hastane deneyimimi hastane yetkilileriyle paylaşıyorum.	1	2	3	4	5	6	7

f	Hastanenin performansını geliřtirmesi için hastaneye geri bildirim veririm.	1	2	3	4	5	6	7
g	Hastanenin yeni sunduđu hizmetleri ile ilgili önerilerimi sunarım.	1	2	3	4	5	6	7
h	Hastaneye yeni hizmetler geliřtirmeleri ile ilgili önerilerimi sunarım.	1	2	3	4	5	6	7
i	İhtiyacım olduđuunda bu hastaneden hizmet almaya devam ederim.	1	2	3	4	5	6	7
j	Bu hastaneden aldıđım hizmet beni memnun ediyor.	1	2	3	4	5	6	7
k	Bu hastaneden aldıđım hizmet, alınan paranın karřılıđını vermiyor.	1	2	3	4	5	6	7
l	Bu hastaneden hizmet almak beni mutlu ediyor.	1	2	3	4	5	6	7

11) Ařađıda en son gittiđiniz özel hastane deneyiminden sonra bu hastaneyi diđer insanlara nasıl anlattıđınızla ilgili ifadeler bulunmaktadır. Lütfen ifadelere ne kadar katıldıđınızı yandaki ölçeđi kullanarak belirtiniz.

(1-Kesinlikle katılmıyorum..... 7-Kesinlikle katılıyorum).

a	Başkalarına bu hastaneye gittiđimden bahsederim.	1	2	3	4	5	6	7
b	Diđer insanların benim bu hastaneye gittiđimi bildiđinden emin olurum.	1	2	3	4	5	6	7
c	Bu hastaneyi aileme öneririm.	1	2	3	4	5	6	7
d	Diđer insanlara bu hastaneyle ilgili olumlu şeyler anlatırım.	1	2	3	4	5	6	7
e	Bu hastaneyi tanıdıklarıma öneririm.	1	2	3	4	5	6	7
f	Bu hastaneyi yakın arkadaşlarıma öneririm.	1	2	3	4	5	6	7

12) Ařađıda en son gittiđiniz özel hastanedeki hekim ile ilgili yařadıđınız deneyimin kalitesine yönelik ifadeler bulunmaktadır. Lütfen ifadelere ne kadar katıldıđınızı yandaki ölçeđi kullanarak belirtiniz.

(1-Kesinlikle katılmıyorum, 7-Kesinlikle katılıyorum).

a	Muayene olduđum hekimle etkileřimim mükemmeldi.	1	2	3	4	5	6	7
b	Muayene olduđum hekimin hastalarıyla ilgilendiđini söyleyebilirim.	1	2	3	4	5	6	7
c	Muayene olduđum hekimin hastalarına özen gösterdiđine inanıyorum.	1	2	3	4	5	6	7

13) Aşağıda en son gittiğiniz özel hastanedeki çalışanlar (hemşireler ve idari personel) ile ilgili yaşadığınız deneyimin kalitesine yönelik ifadeler bulunmaktadır. Lütfen ifadelere ne kadar katıldığınızı yandaki ölçeği kullanarak belirtiniz.

(1-Kesinlikle katılmıyorum, 7-Kesinlikle katılıyorum).

a	Gittiğim hastanedeki personelle etkileşimim mükemmeldi.	1	2	3	4	5	6	7
b	Gittiğim hastanedeki personelin hastalarla ilgilendiğini söyleyebilirim.	1	2	3	4	5	6	7
c	Gittiğim hastanedeki personelin hastalarına özen gösterdiğine inanıyorum.	1	2	3	4	5	6	7

14) Aşağıda en son gittiğiniz özel hastanedeki ortam (fiziki görünüş, hastane içi ortamı vb.) ile ilgili yaşadığınız deneyimin kalitesini ölçen ifadeler bulunmaktadır. Lütfen ifadelere ne kadar katıldığınızı yandaki ölçeği kullanarak belirtiniz. (1-Kesinlikle katılmıyorum, 7-Kesinlikle katılıyorum).

a	Gittiğim hastanenin ortamının mükemmel bir deneyim sunduğunu söyleyebilirim.	1	2	3	4	5	6	7
b	Gittiğim hastanenin ortamının diğer hastanelerin ortamlarından daha iyi bir deneyim sunduğunu düşünüyorum.	1	2	3	4	5	6	7
c	Gittiğim hastanenin ortamının hasta deneyimi konusunda mükemmel olduğunu düşünüyorum.	1	2	3	4	5	6	7

15) Aşağıda en son gittiğiniz özel hastanede yaşadığınız deneyimin kalitesine yönelik ifadeler bulunmaktadır. Lütfen ifadelere ne kadar katıldığınızı yandaki ölçeği kullanarak belirtiniz.

(1-Kesinlikle katılmıyorum, 7-Kesinlikle katılıyorum)

a	Gittiğim hastanenin uzmanlığından eminim, ne yaptıklarını biliyorlar.	1	2	3	4	5	6	7
b	Gittiğim hastanede süreç çok kolaydı, her şeyle ilgilendiler.	1	2	3	4	5	6	7
c	Gittiğim hastanede benim yalnızca hastane işlemlerimle ilgilenmiyorlar, benim bütünüyle iyi olmama çalışıyorlar.	1	2	3	4	5	6	7
d	Gittiğim hastanede beni zaten tanıyorlar ve iyi hizmet ediyorlar, bu yüzden başka hastaneyi tercih etmek gibi bir düşüncem yok.	1	2	3	4	5	6	7
e	Gittiğim hastaneden bir kez hizmet aldıktan sonra tekrar gitmek çok kolay olur çünkü beni tanırılar.	1	2	3	4	5	6	7

16) Gittiğiniz özel hastanede devletin sağladığı sigorta geçerli miydi?

Evet	1
Hayır	2
Bilmiyorum	3

17) Gittiğiniz özel hastanede sigorta anlaşmanızı mı kullandınız yoksa ödemeyi kendiniz mi karşıladınız?

Özel sağlık sigortamı kullandım	1
Devletin sağladığı sağlık sigortamı kullandım	2
Ödemeyi kendim karşıladım	3

18) Lütfen cinsiyetinizi işaretleyiniz.

Kadın	1
Erkek	2

20) Lütfen en son mezun olduğunuz okula göre eğitim durumunuzu işaretleyiniz.

İlkokul ve altı	1
Ortaokul	2
Lise	3
Önlisans	4
Lisans	5
Lisansüstü	6

21) Lütfen gelir düzeyinizi işaretleyiniz.

3000 TL ve altı	1
3001 TL – 6000 TL	2
6001 TL – 9000 TL	3
9001 TL – 12000 TL	4
12001 TL- 15000 TL	5
15001 TL ve üzeri	6

APPENDIX B: Selected studies about patient experience

Table B.1: Selected studies about patient experience.

Author	Year	Journal	Title	Scope	Dimensions
Duggirala et al.	2008	Benchmarking: An International Journal	Patient-perceived dimensions of total quality service in healthcare	Total Quality Service in Healthcare	Infrastructure, personnel quality, process of clinical care, administrative procedures, safety indicators, overall experience of medical care, social responsibility
Birkelien, N. L.	2017	Journal of Healthcare Management	A Strategic Framework for Improving the Patient Experience in Hospitals	To improve the patient experience	Patient-provider communication, information transparency, patient engagement, accessibility to customers, empathetic hospital environment, quality outcomes maximizing value,
Deloitte	2016	-	-	Patient experience	Quality of doctors and clinical staff, information about the treatment, scheduling appointments, ease of scheduling an appointment, integration of medical records, appointment availability, ease of understanding the bill, ease of traveling to the facility, ease of accessing phone support, post-discharge follow-up, availability of appointments, availability of online and mobile capabilities, room furnishing
Fottler et al.	2000	Journal of Healthcare Management	Creating a Healing Environment: The Importance of Service Setting in the New Consumer-Oriented Healthcare System	Healing environment	Evaluate the current environment, providing a welcoming environment, designing the healthscape, creating a healing environment

Table B.1 (continued) : Selected studies about patient experience.

Author	Year	Journal	Title	Scope	Dimensions
Kennedy et al.	2011	Journal of Healthcare Management	A Roadmap for Improving Healthcare Service Quality	Service quality improvement	Solutions-focused, empathetic, reliable, valuing others, exceeding patient expectations
Berry and Bendapudi	2007	Journal of Service Research	Health Care: A Fertile Field for Service Research	Dissimilarities between health care and other services	Customers: reluctant, privacy-concerned, sick, reluctant, need "whole person" service, risky, stressed
Bonebrake	2017	Journal of Healthcare Management	One System's Approach to a Consistent Patient Experience	Implementation strategies to create a patient experience culture	Set common goals, deploy standard work, establish infrastructure to ensure spread, listen and respond to the voice of patients and their families
Brauer et al.	2017	Primary Health Care Research & Development	Development of a patient experience questionnaire to improve lifestyle services in primary care	Patient experience	Trust, general communication, first-contact accessibility, whole-person care, respectfulness
Deshwall and Bhuyan	2018	International Journal of Healthcare Management	Cancer patient service experience and satisfaction	Patient experience	Service environment experience, emotive experience, behavioral experience, comfort experience, social experience
Fortenberry and McGoldrick	2016	International Journal of Healthcare Management	Internal marketing: A pathway for healthcare facilities to improve the patient experience	Internal marketing implementations to improve patient experience	Program establishment, campaign implementation, campaign implementation, campaign evaluation
Mazurenko et al.	2015	Journal of Healthcare Management	What Determines the Surgical Patient Experience? Exploring the Patient, Clinical Staff, and Administration Perspectives	Surgical patient experience	Physical appearance, provider-patient relationship, interdisciplinary relationship, communication, technical infrastructure, patient preparation, family member experience, staff responsiveness, pain management, health outcomes, sanitization, staffing, patient dignity, hospitalists, food

Table B.1 (continued) : Selected studies about patient experience.

Author	Year	Journal	Title	Scope	Dimensions
Needham	2012	Journal of Healthcare Management	The Truth About Patient Experience: What We Can Learn from Other Industries, and How Three Ps Can Improve Health Outcomes, Strengthen Brands, and Delight Customers	Patient experience	Personalized medicine, partner with patients, empower employees
Otani et al.	2009; 2010; 2012	Journal of Healthcare Management	Patient Satisfaction: Focusing on Excellence	Patient satisfaction	Admission Process, nursing care, physician care, staff care, food, room

APPENDIX C : Harman's single factor test results for main model

Table C.1: Harman's single factor test results for main model.

Component	Total Variance Explained					
	Initial Eigenvalues			Extraction Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulative %
1	16,793	37,318	37,318	16,793	37,318	37,318
2	6,894	15,321	52,638			
3	2,190	4,867	57,506			
4	1,764	3,920	61,426			
5	1,609	3,576	65,002			
6	1,360	3,022	68,024			
7	1,159	2,575	70,599			
8	1,070	2,379	72,978			
9	,912	2,027	75,005			
10	,832	1,850	76,854			
11	,810	1,800	78,654			
12	,714	1,588	80,242			
13	,667	1,483	81,724			
14	,615	1,366	83,091			
15	,535	1,190	84,280			
16	,506	1,124	85,405			
17	,477	1,061	86,465			
18	,451	1,003	87,468			
19	,422	,939	88,407			
20	,402	,894	89,301			
21	,389	,863	90,164			
22	,379	,841	91,006			
23	,327	,728	91,733			
24	,314	,698	92,432			
25	,289	,642	93,074			
26	,278	,618	93,692			
27	,272	,604	94,296			
28	,262	,581	94,877			
29	,248	,550	95,428			
30	,241	,536	95,963			
31	,223	,495	96,459			
32	,210	,466	96,925			
33	,194	,431	97,356			
34	,176	,390	97,746			

Table C.1 (continued) : Harman's single factor test results for main model.

Component	Total Variance Explained					
	Total	Initial Eigenvalues		Extraction Sums of Squared Loadings		
		% of Variance	Cumulative %	Total	% of Variance	Cumulative %
35	,164	,364	98,110			
36	,150	,332	98,442			
37	,134	,297	98,740			
38	,124	,276	99,016			
39	,116	,259	99,275			
40	,101	,226	99,500			
41	,084	,187	99,687			
42	,077	,171	99,858			
43	,035	,078	99,936			
44	,016	,036	99,972			
45	,012	,028	100,000			

Extraction Method: Principal Component Analysis.

APPENDIX D : Path analysis model for main model

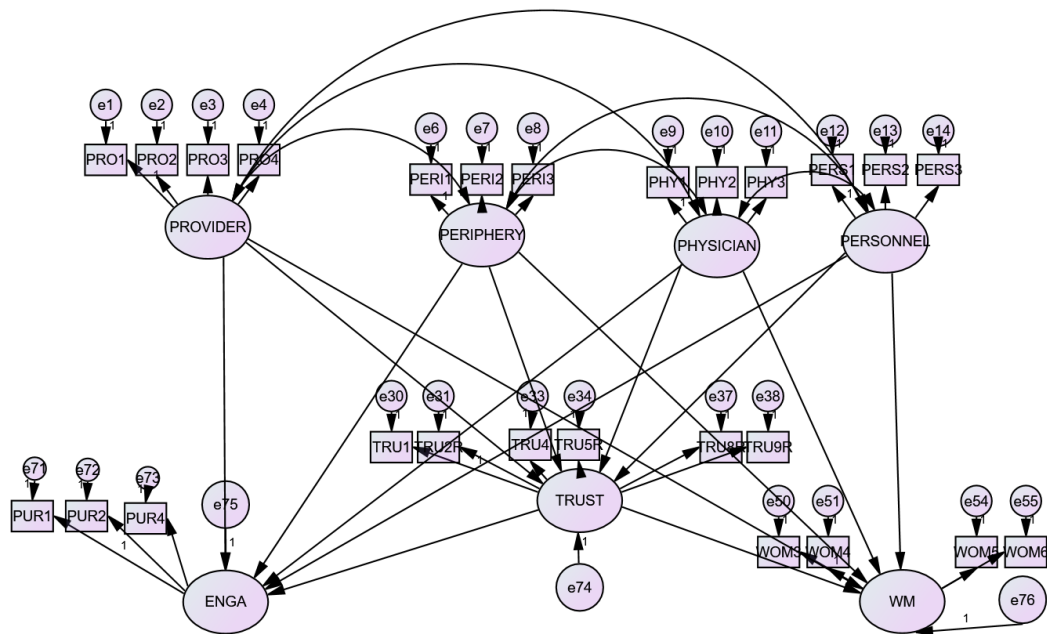


Figure D.1: Path analysis model for main model.

APPENDIX E : PROCESS macro output of significant moderated mediation for main model

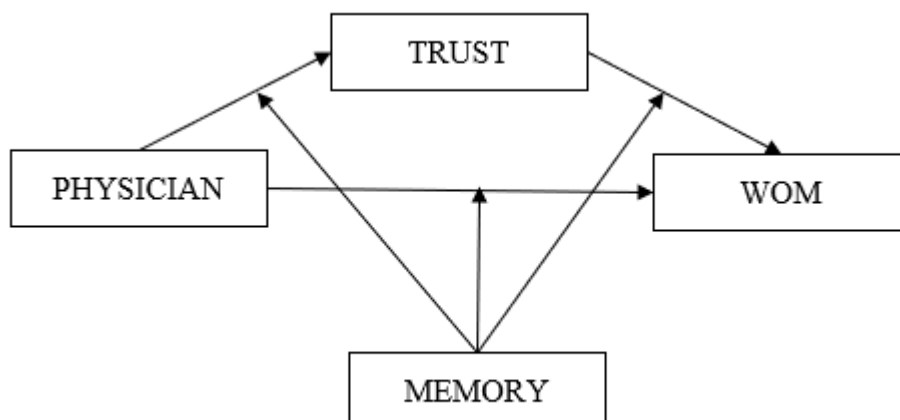


Figure E.1 : Hayes model of significant moderated mediation for main model.

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Run MATRIX procedure:

***** PROCESS Procedure for SPSS Version 3.3 *****

      Written by Andrew F. Hayes, Ph.D.      www.afhayes.com
      Documentation available in Hayes (2018). www.guilford.com/p/hayes3

*****

Model   : 59
Y       : WOM
X       : PHY
M       : TRU
W       : MEM

Sample
Size:   506
|
*****
OUTCOME VARIABLE:
TRU

Model Summary

      R      R-sq      MSE      F      df1      df2      p
      ,5911      ,3494      1,2857      89,8511      3,0000      502,0000      ,0000

Model

      coeff      se      t      p      LLCI      ULCI
constant      1,8672      ,9510      1,9634      ,0502      -,0013      3,7357
PHY            ,5185      ,1556      3,3327      ,0009      ,2128      ,8242
MEM            ,0450      ,1971      ,2282      ,8196      -,3423      ,4322
Int_1          ,0102      ,0317      ,3224      ,7473      -,0521      ,0726

Product terms key:
Int_1      :      PHY      x      MEM

Test(s) of highest order unconditional interaction(s):

      R2-chng      F      df1      df2      p
X*W            ,0001      ,1039      1,0000      502,0000      ,7473
  
```

```

*****
OUTCOME VARIABLE:
WOM

Model Summary
      R      R-sq      MSE      F      df1      df2      p
      ,7785      ,6061      1,3757      153,8858      5,0000      500,0000      ,0000

Model
      coeff      se      t      p      LLCI      ULCI
constant      -2,0970      1,0482      -2,0006      ,0460      -4,1564      -,0376
PHY      ,9150      ,2012      4,5479      ,0000      ,5197      1,3103
TRU      ,2287      ,1980      1,1547      ,2488      -,1604      ,6177
MEM      ,2161      ,2170      ,9959      ,3198      -,2102      ,6425
Int_1      -,0984      ,0413      -2,3842      ,0175      -,1796      -,0173
Int_2      ,0924      ,0405      2,2827      ,0229      ,0129      ,1719

Product terms key:
Int_1      :      PHY      x      MEM
Int_2      :      TRU      x      MEM

Test(s) of highest order unconditional interaction(s):
      R2-chng      F      df1      df2      p
X*W      ,0045      5,6844      1,0000      500,0000      ,0175
M*W      ,0041      5,2106      1,0000      500,0000      ,0229
-----
      Focal predict: PHY      (X)
      Mod var: MEM      (W)

Conditional effects of the focal predictor at values of the moderator(s):

      MEM      Effect      se      t      p      LLCI      ULCI
3,4667      ,5737      ,0698      8,2153      ,0000      ,4365      ,7110
4,8000      ,4425      ,0458      9,6677      ,0000      ,3526      ,5324
5,9920      ,3252      ,0688      4,7232      ,0000      ,1899      ,4604
-----
      Focal predict: TRU      (M)
      Mod var: MEM      (W)

Conditional effects of the focal predictor at values of the moderator(s):

      MEM      Effect      se      t      p      LLCI      ULCI
3,4667      ,5490      ,0697      7,8752      ,0000      ,4120      ,6860
4,8000      ,6722      ,0462      14,5501      ,0000      ,5815      ,7630
5,9920      ,7824      ,0681      11,4969      ,0000      ,6487      ,9161

***** DIRECT AND INDIRECT EFFECTS OF X ON Y *****

Conditional direct effect(s) of X on Y:
      MEM      Effect      se      t      p      LLCI      ULCI
3,4667      ,5737      ,0698      8,2153      ,0000      ,4365      ,7110
4,8000      ,4425      ,0458      9,6677      ,0000      ,3526      ,5324
5,9920      ,3252      ,0688      4,7232      ,0000      ,1899      ,4604

Conditional indirect effects of X on Y:

INDIRECT EFFECT:
PHY      ->      TRU      ->      WOM

      MEM      Effect      BootSE      BootLLCI      BootULCI
3,4667      ,3041      ,0619      ,1938      ,4332
4,8000      ,3816      ,0444      ,3005      ,4734
5,9920      ,4536      ,0729      ,3216      ,6033
-----

```

APPENDIX F: Harman's single factor test results for dimensional model

Table F. 1 : Harman's single factor test results for dimensional model.

Componen t	Total Variance Explained					
	Initial Eigenvalues			Extraction Sums of Squared Loadings		
	Total	% of Variance	Cumulative %	Total	% of Variance	Cumulat ive %
1	16,342	34,046	34,046	16,342	34,046	34,046
2	7,512	15,649	49,695			
3	3,319	6,915	56,610			
4	2,142	4,462	61,072			
5	1,717	3,576	64,649			
6	1,539	3,206	67,854			
7	1,289	2,686	70,540			
8	1,185	2,468	73,007			
9	1,036	2,158	75,166			
10	,994	2,071	77,237			
11	,737	1,535	78,772			
12	,709	1,477	80,249			
13	,641	1,335	81,584			
14	,591	1,231	82,816			
15	,565	1,177	83,992			
16	,524	1,091	85,084			
17	,487	1,014	86,098			
18	,445	,927	87,025			
19	,426	,886	87,912			
20	,395	,822	88,734			
21	,384	,800	89,534			
22	,370	,772	90,305			
23	,364	,758	91,064			
24	,329	,686	91,749			
25	,305	,636	92,386			
26	,285	,594	92,980			
27	,275	,574	93,553			
28	,273	,569	94,122			
29	,262	,545	94,667			
30	,250	,521	95,189			
31	,232	,484	95,673			
32	,221	,460	96,133			
33	,216	,450	96,583			
34	,206	,430	97,013			
35	,187	,390	97,402			

Table F. 1 (continued) : Harman's single factor test results for dimensional model.

Component	Total Variance Explained			Extraction Sums of Squared Loadings		
	Total	% of Variance	Initial Eigenvalues Cumulative %	Total	% of Variance	Cumulative %
36	,165	,343	97,746			
37	,159	,331	98,077			
38	,155	,322	98,399			
39	,134	,279	98,678			
40	,122	,255	98,933			
41	,117	,243	99,176			
42	,106	,222	99,398			
43	,087	,181	99,579			
44	,074	,155	99,733			
45	,065	,136	99,869			
46	,034	,071	99,940			
47	,016	,034	99,974			
48	,012	,026	100,000			
Extraction Method: Principal Component Analysis.						

APPENDIX G: Path analysis model for dimensional model

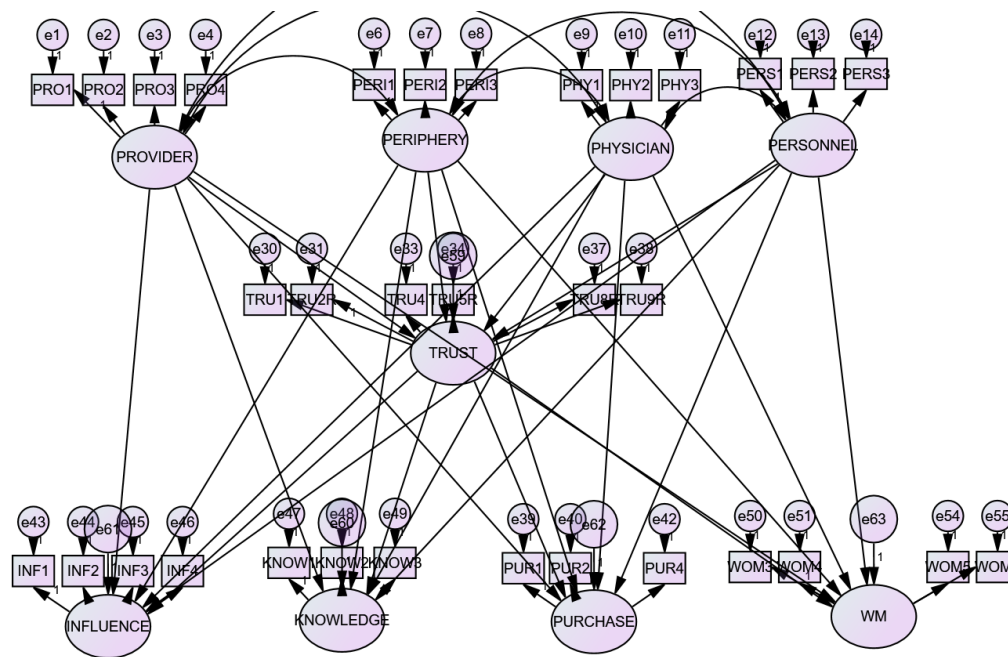


Figure G. 1 : Path analysis model for dimensional model.

APPENDIX H: PROCESS macro output of significant moderated mediations for main model

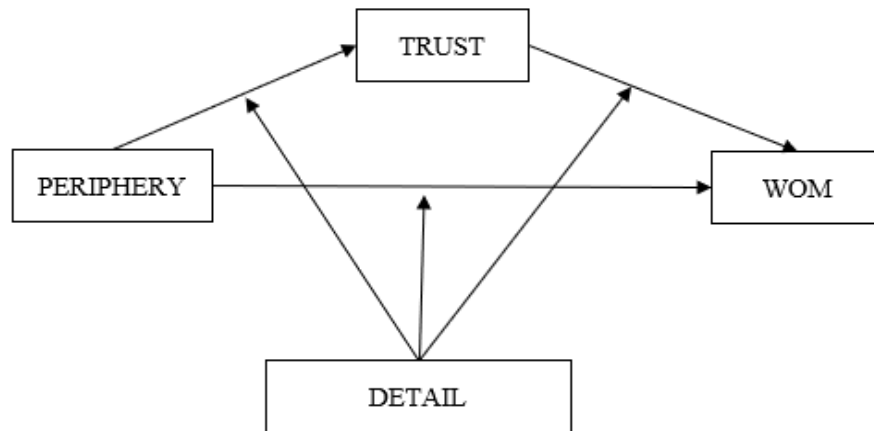


Figure H.1 : The Hayes model for the effect of detail on periphery-WOM relationship.

Run MATRIX procedure:

```

***** PROCESS Procedure for SPSS Version 3.3 *****

      Written by Andrew F. Hayes, Ph.D.      www.afhayes.com
Documentation available in Hayes (2018). www.guilford.com/p/hayes3

*****
Model   : 59
Y       : WOM
X       : PERI
M       : TRU
W       : DET

Sample
Size:   506

*****
OUTCOME VARIABLE:
TRU

Model Summary
      R      R-sq      MSE      F      df1      df2      p
      ,6319    ,3993    1,1871   111,2204   3,0000   502,0000   ,0000

Model
      coeff      se      t      p      LLCI      ULCI
constant    3,6608    ,4710    7,7724    ,0000    2,7354    4,5861
PERI         ,3275    ,0922    3,5512    ,0004    ,1463    ,5087
DET        -,1683    ,0980   -1,7166    ,0867   -,3608    ,0243
Int_1        ,0416    ,0185    2,2526    ,0247    ,0053    ,0779

Product terms key:
Int_1      :      PERI      x      DET

Test(s) of highest order unconditional interaction(s):
      R2-chng      F      df1      df2      p
X*W         ,0061    5,0744    1,0000   502,0000   ,0247

```

```

Focal predict: PERI      (X)
Mod var: DET            (W)

Conditional effects of the focal predictor at values of the moderator(s) :

      DET      Effect      se      t      p      LLCI      ULCI
2,8000      ,4441      ,0464      9,5637      ,0000      ,3529      ,5353
5,0000      ,5357      ,0304      17,6222      ,0000      ,4760      ,5954
6,6000      ,6023      ,0459      13,1287      ,0000      ,5122      ,6924

*****
OUTCOME VARIABLE:
WOM

Model Summary
      R      R-sq      MSE      F      df1      df2      p
,7681      ,5899      1,4323      143,8502      5,0000      500,0000      ,0000

Model
      coeff      se      t      p      LLCI      ULCI
constant      -,2593      ,6922      -,3745      ,7082      -1,6192      1,1007
PERI      ,5400      ,1248      4,3281      ,0000      ,2949      ,7852
TRU      ,4790      ,1496      3,2008      ,0015      ,1850      ,7729
DET      ,0046      ,1393      ,0333      ,9734      -,2691      ,2784
Int_1      -,0352      ,0259      -1,3590      ,1748      -,0861      ,0157
Int_2      ,0399      ,0303      1,3177      ,1882      -,0196      ,0995

Product terms key:
Int_1      :      PERI      x      DET
Int_2      :      TRU      x      DET

Test(s) of highest order unconditional interaction(s) :
      R2-chng      F      df1      df2      p
X*W      ,0015      1,8468      1,0000      500,0000      ,1748
M*W      ,0014      1,7363      1,0000      500,0000      ,1882

***** DIRECT AND INDIRECT EFFECTS OF X ON Y *****

Conditional direct effect(s) of X on Y:

      DET      Effect      se      t      p      LLCI      ULCI
2,8000      ,4415      ,0614      7,1875      ,0000      ,3208      ,5622
5,0000      ,3641      ,0434      8,3989      ,0000      ,2789      ,4493
6,6000      ,3078      ,0677      4,5497      ,0000      ,1749      ,4408

Conditional indirect effects of X on Y:

INDIRECT EFFECT:
PERI      ->      TRU      ->      WOM

      DET      Effect      BootSE      BootLLCI      BootULCI
2,8000      ,2624      ,0488      ,1692      ,3605
5,0000      ,3635      ,0376      ,2907      ,4378
6,6000      ,4472      ,0637      ,3217      ,5718
---

***** ANALYSIS NOTES AND ERRORS *****

Level of confidence for all confidence intervals in output:
95,0000

Number of bootstrap samples for percentile bootstrap confidence intervals:
5000

W values in conditional tables are the 16th, 50th, and 84th percentiles.

----- END MATRIX -----

```

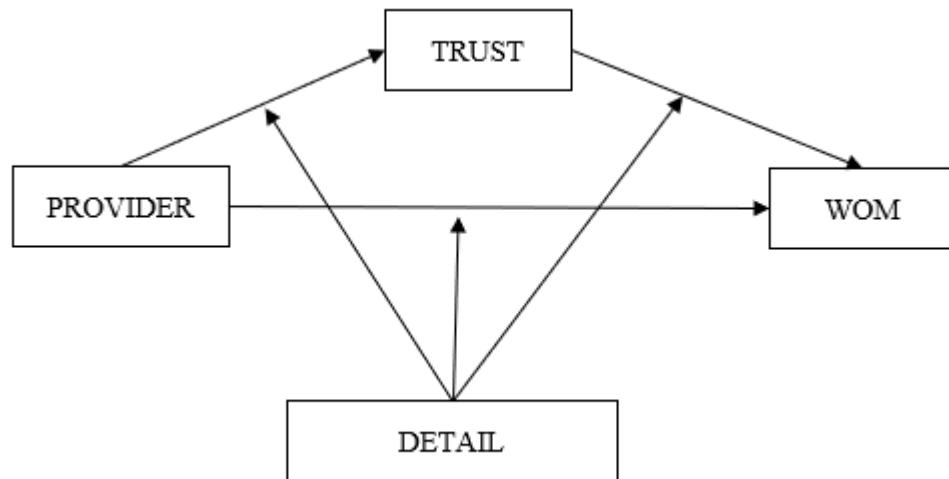


Figure H. 2 : The Hayes model for the effect of detail on provider-WOM relationship.

Run MATRIX procedure:

```

***** PROCESS Procedure for SPSS Version 3.3 *****

      Written by Andrew F. Hayes, Ph.D.      www.afhayes.com
Documentation available in Hayes (2018). www.guilford.com/p/hayes3

*****
Model   : 59
  Y     : WOM
  X     : PRO
  M     : TRU
  W     : DET

Sample
Size: 506

*****
OUTCOME VARIABLE:
  TRU

Model Summary
      R      R-sq      MSE      F      df1      df2      p
      ,7289      ,5312      ,9263  189,6375    3,0000    502,0000    ,0000

Model
      coeff      se      t      p      LLCI      ULCI
constant    2,4933    ,5593    4,4581    ,0000    1,3945    3,5921
PRO          ,4946    ,1000    4,9439    ,0000    ,2980    ,6911
DET         -,1426    ,1116   -1,2776    ,2020   -,3618    ,0767
Int_1        ,0387    ,0195    1,9780    ,0485    ,0003    ,0770

Product terms key:
Int_1      :      PRO      x      DET

Test(s) of highest order unconditional interaction(s):
      R2-chng      F      df1      df2      p
X*W      ,0037      3,9127    1,0000    502,0000    ,0485

```

```

-----
Focal predict: PRO      (X)
Mod var: DET           (W)

Conditional effects of the focal predictor at values of the moderator(s):

      DET      Effect      se      t      p      LLCI      ULCI
2,8000      ,6028      ,0504     11,9559      ,0000      ,5037      ,7019
5,0000      ,6878      ,0296     23,2363      ,0000      ,6297      ,7460
6,6000      ,7497      ,0446     16,8212      ,0000      ,6621      ,8372

*****
OUTCOME VARIABLE:
WOM

Model Summary
      R      R-sq      MSE      F      df1      df2      p
,7985      ,6376      1,2659     175,9127      5,0000     500,0000      ,0000

Model
      coeff      se      t      p      LLCI      ULCI
constant     -1,8471      ,7069     -2,6128      ,0093     -3,2361      -,4581
PRO           ,8326      ,1573      5,2939      ,0000      ,5236      1,1416
TRU           ,4022      ,1541      2,6103      ,0093      ,0995      ,7049
DET           ,2454      ,1400      1,7526      ,0803      -,0297      ,5205
Int_1         -,0440      ,0328     -1,3395      ,1810      -,1085      ,0205
Int_2         ,0151      ,0324      ,4657      ,6417      -,0486      ,0788

Product terms key:
Int_1 :      PRO      x      DET
Int_2 :      TRU      x      DET

Test(s) of highest order unconditional interaction(s):
      R2-chng      F      df1      df2      p
X*W      ,0013      1,7944      1,0000     500,0000      ,1810
M*W      ,0002      ,2168      1,0000     500,0000      ,6417

***** DIRECT AND INDIRECT EFFECTS OF X ON Y *****

Conditional direct effect(s) of X on Y:
      DET      Effect      se      t      p      LLCI      ULCI
2,8000      ,7094      ,0759      9,3424      ,0000      ,5602      ,8586
5,0000      ,6126      ,0523     11,7230      ,0000      ,5099      ,7152
6,6000      ,5422      ,0842      6,4419      ,0000      ,3768      ,7075

Conditional indirect effects of X on Y:

INDIRECT EFFECT:
PRO      ->      TRU      ->      WOM

      DET      Effect      BootSE      BootLLCI      BootULCI
2,8000      ,2679      ,0709      ,1408      ,4235
5,0000      ,3286      ,0432      ,2452      ,4164
6,6000      ,3763      ,0760      ,2285      ,5282
---

***** ANALYSIS NOTES AND ERRORS *****

Level of confidence for all confidence intervals in output:
95,0000

Number of bootstrap samples for percentile bootstrap confidence intervals:
5000

W values in conditional tables are the 16th, 50th, and 84th percentiles.

----- END MATRIX -----

```

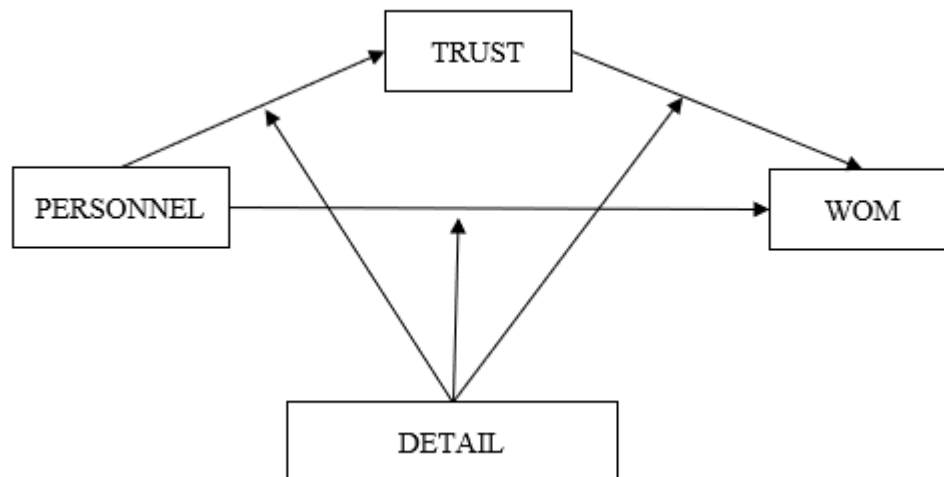


Figure H.3 : The Hayes model for the effect of detail on personnel-WOM relationship.

Run MATRIX procedure:

```

***** PROCESS Procedure for SPSS Version 3.3 *****

      Written by Andrew F. Hayes, Ph.D.      www.afhayes.com
Documentation available in Hayes (2018). www.guilford.com/p/hayes3

*****
Model   : 59
  Y     : WOM
  X     : PERS
  M     : TRU
  W     : DET

Sample
Size: 506

*****
OUTCOME VARIABLE:
  TRU

Model Summary
      R      R-sq      MSE      F      df1      df2      p
,4763    ,2269    1,5278    49,1022    3,0000    502,0000    ,0000

Model
      coeff      se      t      p      LLCI      ULCI
constant    2,5770    ,7376    3,4939    ,0005    1,1279    4,0261
PERS        ,4029    ,1248    3,2285    ,0013    ,1577    ,6480
DET         ,1131    ,1429    ,7912    ,4292    -,1677    ,3938
Int_1       ,0028    ,0239    ,1152    ,9083    -,0443    ,0498

Product terms key:
Int_1      :      PERS      x      DET

Test(s) of highest order unconditional interaction(s):
      R2-chng      F      df1      df2      p
X*W      ,0000    ,0133    1,0000    502,0000    ,9083

*****

```

OUTCOME VARIABLE:
WOM

Model Summary

R	R-sq	MSE	F	df1	df2	p
,7815	,6108	1,3594	156,9299	5,0000	500,0000	,0000

Model

	coeff	se	t	p	LLCI	ULCI
constant	-3,1137	,7986	-3,8989	,0001	-4,6828	-1,5447
PERS	,9270	,1302	7,1215	,0000	,6712	1,1827
TRU	,4743	,1314	3,6092	,0003	,2161	,7325
DET	,4229	,1567	2,6993	,0072	,1151	,7307
Int_1	-,1106	,0252	-4,3818	,0000	-,1602	-,0610
Int_2	,0572	,0261	2,1942	,0287	,0060	,1084

Product terms key:

Int_1	:	PERS	x	DET
Int_2	:	TRU	x	DET

Test(s) of highest order unconditional interaction(s):

	R2-chng	F	df1	df2	p
X*W	,0149	19,2003	1,0000	500,0000	,0000
M*W	,0037	4,8143	1,0000	500,0000	,0287

Focal predict: PERS (X)
Mod var: DET (W)

Conditional effects of the focal predictor at values of the moderator(s):

DET	Effect	se	t	p	LLCI	ULCI
2,8000	,6172	,0661	9,3321	,0000	,4873	,7472
5,0000	,3739	,0389	9,6208	,0000	,2975	,4502
6,6000	,1969	,0575	3,4265	,0007	,0840	,3098

Focal predict: TRU (M)
Mod var: DET (W)

Conditional effects of the focal predictor at values of the moderator(s):

DET	Effect	se	t	p	LLCI	ULCI
2,8000	,6344	,0665	9,5345	,0000	,5037	,7652
5,0000	,7602	,0425	17,8884	,0000	,6767	,8437
6,6000	,8517	,0635	13,4190	,0000	,7270	,9764

***** DIRECT AND INDIRECT EFFECTS OF X ON Y *****

Conditional direct effect(s) of X on Y:

DET	Effect	se	t	p	LLCI	ULCI
2,8000	,6172	,0661	9,3321	,0000	,4873	,7472
5,0000	,3739	,0389	9,6208	,0000	,2975	,4502
6,6000	,1969	,0575	3,4265	,0007	,0840	,3098

Conditional indirect effects of X on Y:

INDIRECT EFFECT:

PERS	->	TRU	->	WOM
DET	Effect	BootSE	BootLLCI	BootULCI
2,8000	,2605	,0543	,1626	,3752
5,0000	,3168	,0366	,2464	,3895
6,6000	,3586	,0640	,2344	,4860

***** ANALYSIS NOTES AND ERRORS *****

Level of confidence for all confidence intervals in output:
95,0000

Number of bootstrap samples for percentile bootstrap confidence intervals:
5000

W values in conditional tables are the 16th, 50th, and 84th percentiles.

----- END MATRIX -----

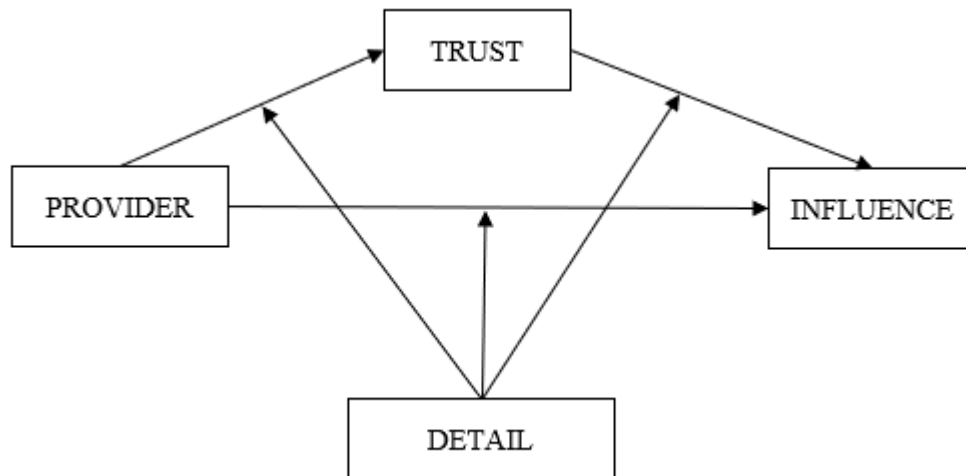


Figure H.4 : The Hayes model for the effect of detail on provider-influence relationship.

Run MATRIX procedure:

```

***** PROCESS Procedure for SPSS Version 3.3 *****

      Written by Andrew F. Hayes, Ph.D.      www.afhayes.com
      Documentation available in Hayes (2018). www.guilford.com/p/hayes3

*****
Model   : S9
  Y     : INF
  X     : PRO
  M     : TRU
  W     : DET

Sample
Size: 506

*****
OUTCOME VARIABLE:
  TRU

Model Summary
      R      R-sq      MSE      F      df1      df2      p
      ,7289      ,5312      ,9263    189,6375      3,0000     502,0000      ,0000

Model
      coeff      se      t      p      LLCI      ULCI
constant    2,4933      ,5593      4,4581      ,0000      1,3945      3,5921
PRO          ,4946      ,1000      4,9439      ,0000      ,2980      ,6911
DET         -,1426      ,1116     -1,2776      ,2020     -,3618      ,0767
Int_1        ,0387      ,0195      1,9780      ,0485      ,0003      ,0770

Product terms key:
Int_1      :      PRO      x      DET

Test(s) of highest order unconditional interaction(s):
      R2-chng      F      df1      df2      p
X*W          ,0037      3,9127      1,0000     502,0000      ,0485
-----

```

```

Focal predict: PRO      (X)
Mod var: DET           (W)

Conditional effects of the focal predictor at values of the moderator(s) :

      DET      Effect      se      t      p      LLCI      ULCI
2,8000      ,6028      ,0504     11,9559    ,0000      ,5037      ,7019
5,0000      ,6878      ,0296     23,2363    ,0000      ,6297      ,7460
6,6000      ,7497      ,0446     16,8212    ,0000      ,6621      ,8372

*****
OUTCOME VARIABLE:
INF

Model Summary
      R      R-sq      MSE      F      df1      df2      p
,4712      ,2220      2,4384     28,5383     5,0000     500,0000     ,0000

Model
      coeff      se      t      p      LLCI      ULCI
constant     -1,3403      ,9812     -1,3660      ,1725     -3,2681      ,5874
PRO           ,6079      ,2183      2,7849      ,0056      ,1790      1,0367
TRU          ,1445      ,2139      ,6757      ,4995     -,2757      ,5647
DET          ,5128      ,1943      2,6388      ,0086      ,1310      ,8946
Int_1        -,0846      ,0456     -1,8562      ,0640     -,1742      ,0049
Int_2         ,0339      ,0450      ,7535      ,4515     -,0545      ,1224

Product terms key:
Int_1 :      PRO      x      DET
Int_2 :      TRU      x      DET

Test(s) of highest order unconditional interaction(s) :
      R2-chng      F      df1      df2      p
X*W      ,0054      3,4455      1,0000     500,0000     ,0640
M*W      ,0009      ,5678      1,0000     500,0000     ,4515
-----
Focal predict: PRO      (X)
Mod var: DET           (W)

Conditional effects of the focal predictor at values of the moderator(s) :

      DET      Effect      se      t      p      LLCI      ULCI
2,8000      ,3709      ,1054      3,5198      ,0005      ,1639      ,5780
5,0000      ,1848      ,0725      2,5476      ,0111      ,0423      ,3273
6,6000      ,0494      ,1168      ,4226      ,6728     -,1801      ,2789

***** DIRECT AND INDIRECT EFFECTS OF X ON Y *****

Conditional direct effect(s) of X on Y:
      DET      Effect      se      t      p      LLCI      ULCI
2,8000      ,3709      ,1054      3,5198      ,0005      ,1639      ,5780
5,0000      ,1848      ,0725      2,5476      ,0111      ,0423      ,3273
6,6000      ,0494      ,1168      ,4226      ,6728     -,1801      ,2789

Conditional indirect effects of X on Y:

INDIRECT EFFECT:
PRO      ->      TRU      ->      INF

      DET      Effect      BootSE      BootLLCI      BootULCI
2,8000      ,1444      ,0699      ,0085      ,2867
5,0000      ,2161      ,0553      ,1069      ,3256
6,6000      ,2762      ,0957      ,0935      ,4644
---

***** ANALYSIS NOTES AND ERRORS *****

Level of confidence for all confidence intervals in output:
95,0000

Number of bootstrap samples for percentile bootstrap confidence intervals:
5000

W values in conditional tables are the 16th, 50th, and 84th percentiles.

----- END MATRIX -----

```

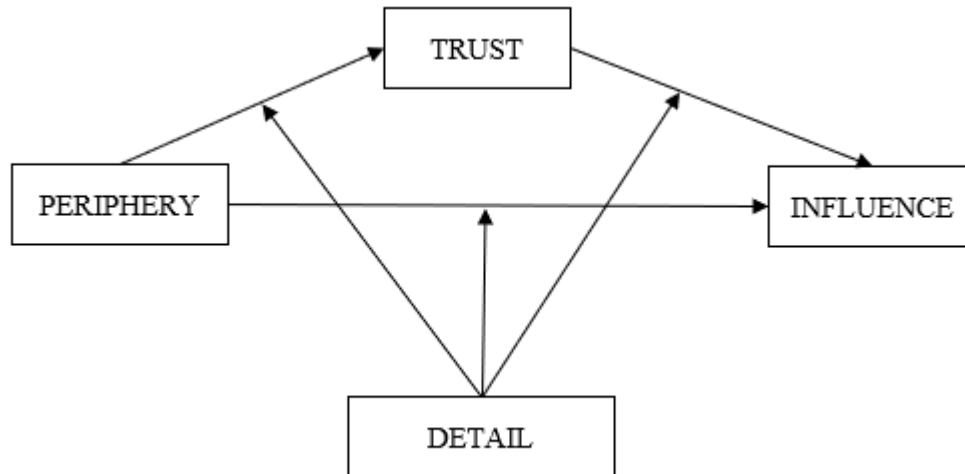


Figure H.5 : The Hayes model for the effect of detail on periphery-influence relationship.

```

Run MATRIX procedure:

***** PROCESS Procedure for SPSS Version 3.3 *****

      Written by Andrew F. Hayes, Ph.D.      www.afhayes.com
Documentation available in Hayes (2018). www.guilford.com/p/hayes3

*****
Model   : 59
Y       : INF
X       : PERI
M       : TRU
W       : DET

Sample
Size:   506

*****
OUTCOME VARIABLE:
TRU

Model Summary
      R      R-sq      MSE      F      df1      df2      p
      ,6319      ,3993      1,1871      111,2204      3,0000      502,0000      ,0000

Model
      coeff      se      t      p      LLCI      ULCI
constant      3,6608      ,4710      7,7724      ,0000      2,7354      4,5861
PERI           ,3275      ,0922      3,5512      ,0004      ,1463      ,5087
DET          -,1683      ,0980     -1,7166      ,0867     -,3608      ,0243
Int_1          ,0416      ,0185      2,2526      ,0247      ,0053      ,0779

Product terms key:
Int_1      :      PERI      x      DET

Test(s) of highest order unconditional interaction(s):
      R2-chng      F      df1      df2      p
X*W      ,0061      5,0744      1,0000      502,0000      ,0247
-----

```

```

Focal predict: PERI      (X)
Mod var: DET            (W)

Conditional effects of the focal predictor at values of the moderator(s):

      DET      Effect      se      t      p      LLCI      ULCI
2,8000      ,4441      ,0464      9,5637      ,0000      ,3529      ,5353
5,0000      ,5357      ,0304     17,6222      ,0000      ,4760      ,5954
6,6000      ,6023      ,0459     13,1287      ,0000      ,5122      ,6924

*****
OUTCOME VARIABLE:
INF

Model Summary
      R      R-sq      MSE      F      df1      df2      p
,4920      ,2421      2,3755     31,9421      5,0000     500,0000      ,0000

Model
      coeff      se      t      p      LLCI      ULCI
constant     -,5538      ,8914     -,6213      ,5347     -2,3052      1,1976
PERI          ,4888      ,1607      3,0415      ,0025      ,1730      ,8045
TRU          ,1866      ,1927      ,9681      ,3334     -,1920      ,5652
DET          ,3606      ,1794      2,0097      ,0450      ,0081      ,7131
Int_1        -,0481      ,0333     -1,4412      ,1501     -,1136      ,0175
Int_2         ,0163      ,0390      ,4183      ,6759     -,0603      ,0930

Product terms key:
Int_1 : PERI x DET
Int_2 : TRU x DET

Test(s) of highest order unconditional interaction(s):
      R2-chng      F      df1      df2      p
X*W      ,0031      2,0771      1,0000     500,0000      ,1501
M*W      ,0003      ,1749      1,0000     500,0000      ,6759

***** DIRECT AND INDIRECT EFFECTS OF X ON Y *****

Conditional direct effect(s) of X on Y:
      DET      Effect      se      t      p      LLCI      ULCI

***** DIRECT AND INDIRECT EFFECTS OF X ON Y *****

Conditional direct effect(s) of X on Y:
      DET      Effect      se      t      p      LLCI      ULCI
2,8000      ,3542      ,0791      4,4772      ,0000      ,1988      ,5096
5,0000      ,2485      ,0558      4,4504      ,0000      ,1388      ,3582
6,6000      ,1716      ,0871      1,9692      ,0495      ,0004      ,3428

Conditional indirect effects of X on Y:

INDIRECT EFFECT:
PERI -> TRU -> INF

      DET      Effect      BootSE      BootLLCI      BootULCI
2,8000      ,1032      ,0549      ,0030      ,2193
5,0000      ,1437      ,0427      ,0657      ,2313
6,6000      ,1773      ,0741      ,0440      ,3349
---

***** ANALYSIS NOTES AND ERRORS *****

Level of confidence for all confidence intervals in output:
95,0000

Number of bootstrap samples for percentile bootstrap confidence intervals:
5000

W values in conditional tables are the 16th, 50th, and 84th percentiles.

----- END MATRIX -----

```

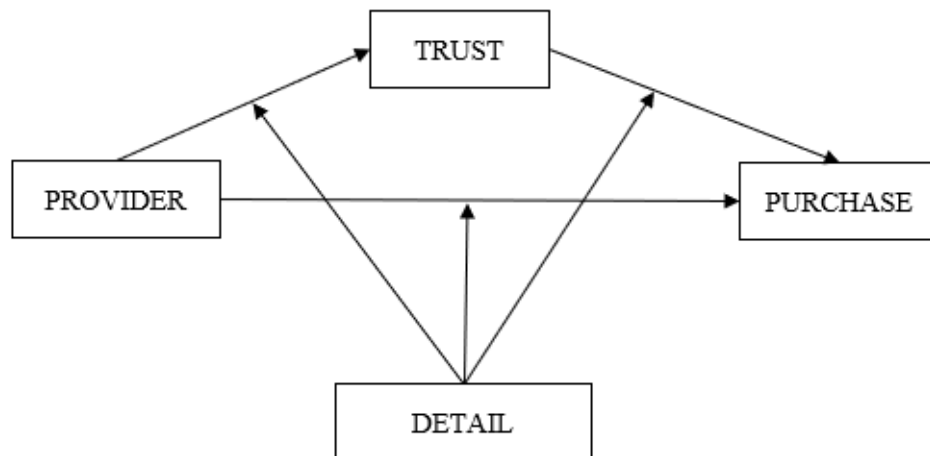


Figure H.6 : The Hayes model for the effect of detail on provider-purchase relationship.

```

Run MATRIX procedure:

***** PROCESS Procedure for SPSS Version 3.3 *****

      Written by Andrew F. Hayes, Ph.D.      www.afhayes.com
Documentation available in Hayes (2018). www.guilford.com/p/hayes3

*****
Model   : S9
  Y     : PUR
  X     : PRO
  M     : TRU
  W     : DET

Sample
Size:   506

*****
OUTCOME VARIABLE:
  TRU

Model Summary
      R      R-sq      MSE      F      df1      df2      p
      ,7289      ,5312      ,9263    189,6375     3,0000    502,0000      ,0000

Model
      coeff      se      t      p      LLCI      ULCI
constant    2,4933    ,5593    4,4581    ,0000     1,3945     3,5921
PRO          ,4946    ,1000    4,9439    ,0000     ,2980     ,6911
DET         -,1426    ,1116   -1,2776    ,2020    -,3618     ,0767
Int_1        ,0387    ,0195    1,9780    ,0485     ,0003     ,0770

Product terms key:
Int_1      :      PRO      x      DET

Test(s) of highest order unconditional interaction(s):
      R2-chng      F      df1      df2      p
X*W      ,0037      3,9127      1,0000    502,0000      ,0485
-----

```

```

Focal predict: PRO      (X)
Mod var: DET           (W)

Conditional effects of the focal predictor at values of the moderator(s) :

      DET      Effect      se      t      p      LLCI      ULCI
2,8000      ,6028      ,0504    11,9559    ,0000      ,5037      ,7019
5,0000      ,6878      ,0296    23,2363    ,0000      ,6297      ,7460
6,6000      ,7497      ,0446    16,8212    ,0000      ,6621      ,8372

*****
OUTCOME VARIABLE:
PUR

Model Summary
      R      R-sq      MSE      F      df1      df2      p
,7192      ,5172      1,2150    107,1386      5,0000    500,0000      ,0000

Model
      coeff      se      t      p      LLCI      ULCI
constant    -1,0448      ,6926    -1,5084      ,1321    -2,4055      ,3160
PRO          ,5882      ,1541      3,8175      ,0002      ,2855      ,8909
TRU          ,4198      ,1510      2,7807      ,0056      ,1232      ,7163
DET          ,3615      ,1372      2,6352      ,0087      ,0920      ,6310
Int_1       -,0389      ,0322    -1,2096      ,2270     -,1022      ,0243
Int_2       -,0012      ,0318     -,0370      ,9705     -,0636      ,0613

Product terms key:
Int_1      :      PRO      x      DET
Int_2      :      TRU      x      DET

Test(s) of highest order unconditional interaction(s):
      R2-chng      F      df1      df2      p
X*W      ,0014      1,4632      1,0000    500,0000      ,2270
M*W      ,0000      ,0014      1,0000    500,0000      ,9705

***** DIRECT AND INDIRECT EFFECTS OF X ON Y *****

Conditional direct effect(s) of X on Y:
      DET      Effect      se      t      p      LLCI      ULCI
2,8000      ,4792      ,0744      6,4417      ,0000      ,3330      ,6254
5,0000      ,3936      ,0512      7,6877      ,0000      ,2930      ,4941
6,6000      ,3313      ,0825      4,0176      ,0001      ,1693      ,4933

Conditional indirect effects of X on Y:

INDIRECT EFFECT:
PRO      ->      TRU      ->      PUR

      DET      Effect      BootSE      BootLLCI      BootULCI
2,8000      ,2510      ,0635      ,1345      ,3819
5,0000      ,2847      ,0440      ,1982      ,3712
6,6000      ,3089      ,0764      ,1559      ,4533
---

***** ANALYSIS NOTES AND ERRORS *****

Level of confidence for all confidence intervals in output:
95,0000

Number of bootstrap samples for percentile bootstrap confidence intervals:
5000

W values in conditional tables are the 16th, 50th, and 84th percentiles.

----- END MATRIX -----

```

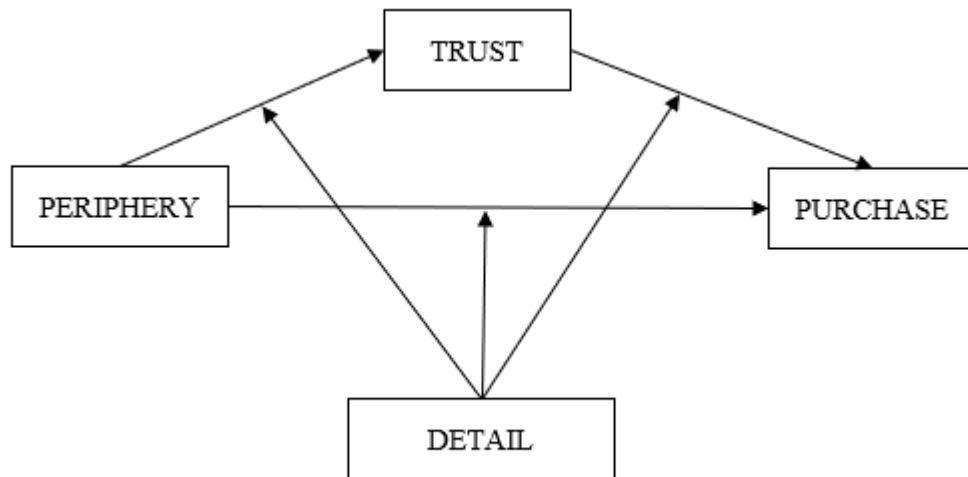


Figure H.7 : The Hayes model for the effect of detail on periphery-purchase relationship.

Run MATRIX procedure:

***** PROCESS Procedure for SPSS Version 3.3 *****

Written by Andrew F. Hayes, Ph.D. www.afhayes.com
Documentation available in Hayes (2018). www.guilford.com/p/hayes3

Model : S9
Y : PUR
X : PERI
M : TRU
W : DET

Sample
Size: 506

OUTCOME VARIABLE:
TRU

Model Summary	R	R-sq	MSE	F	df1	df2	p
	,6319	,3993	1,1871	111,2204	3,0000	502,0000	,0000

Model	coeff	se	t	p	LLCI	ULCI
constant	3,6608	,4710	7,7724	,0000	2,7354	4,5861
PERI	,3275	,0922	3,5512	,0004	,1463	,5087
DET	-,1683	,0980	-1,7166	,0867	-,3608	,0243
Int_1	,0416	,0185	2,2526	,0247	,0053	,0779

Product terms key:
Int_1 : PERI x DET

Test(s) of highest order unconditional interaction(s):	R2-chng	F	df1	df2	p
X*W	,0061	5,0744	1,0000	502,0000	,0247

```

Focal predict: PERI      (X)
Mod var: DET            (W)

Conditional effects of the focal predictor at values of the moderator(s) :

    DET      Effect      se      t      p      LLCI      ULCI
2,8000      ,4441      ,0464      9,5637      ,0000      ,3529      ,5353
5,0000      ,5357      ,0304     17,6222      ,0000      ,4760      ,5954
6,6000      ,6023      ,0459     13,1287      ,0000      ,5122      ,6924

*****
OUTCOME VARIABLE:
PUR

Model Summary

      R      R-sq      MSE      F      df1      df2      p
,7293      ,5319      1,1782     113,6082      5,0000     500,0000      ,0000

Model

      coeff      se      t      p      LLCI      ULCI
constant     -,0750      ,6278      -,1195      ,9049     -1,3084      1,1584
PERI          ,4755      ,1132      4,2016      ,0000      ,2531      ,6978
TRU          ,4245      ,1357      3,1281      ,0019      ,1579      ,6912
DET          ,1973      ,1264      1,5610      ,1192      -,0510      ,4455
Int_1        -,0263      ,0235     -1,1203      ,2631      -,0724      ,0198
Int_2         ,0076      ,0275      ,2757      ,7829      -,0464      ,0616

Product terms key:
Int_1 : PERI x DET
Int_2 : TRU x DET

Test(s) of highest order unconditional interaction(s):

      R2-chng      F      df1      df2      p
X*W      ,0012      1,2550      1,0000     500,0000      ,2631
M*W      ,0001      ,0760      1,0000     500,0000      ,7829

***** DIRECT AND INDIRECT EFFECTS OF X ON Y *****

Conditional direct effect(s) of X on Y:

    DET      Effect      se      t      p      LLCI      ULCI
2,8000      ,4018      ,0557      7,2123      ,0000      ,2924      ,5113
5,0000      ,3440      ,0393      8,7477      ,0000      ,2667      ,4212
6,6000      ,3019      ,0614      4,9193      ,0000      ,1813      ,4224

Conditional indirect effects of X on Y:

INDIRECT EFFECT:
PERI      ->      TRU      ->      PUR

      DET      Effect      BootSE      BootLLCI      BootULCI
2,8000      ,1980      ,0453      ,1136      ,2911
5,0000      ,2477      ,0346      ,1812      ,3163
6,6000      ,2858      ,0629      ,1635      ,4101
---

***** ANALYSIS NOTES AND ERRORS *****

Level of confidence for all confidence intervals in output:
95,0000

Number of bootstrap samples for percentile bootstrap confidence intervals:
5000

W values in conditional tables are the 16th, 50th, and 84th percentiles.

----- END MATRIX -----

```

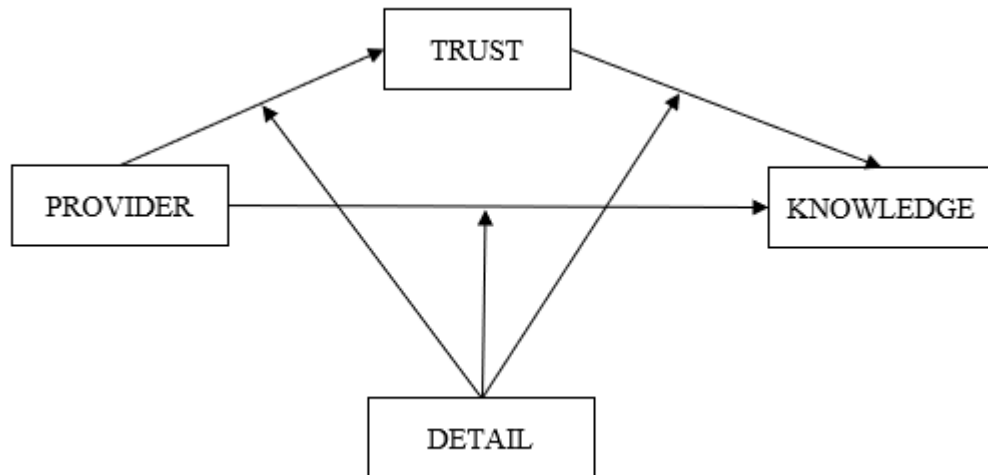


Figure H.8 : The Hayes model for the effect of detail on provider-knowledge relationship.

Run MATRIX procedure:

```

***** PROCESS Procedure for SPSS Version 3.3 *****

      Written by Andrew F. Hayes, Ph.D.      www.afhayes.com
Documentation available in Hayes (2018). www.guilford.com/p/hayes3

*****
Model   : 59
  Y     : KNOW
  X     : PRO
  M     : TRU
  W     : DET

Sample
Size:   506

*****
OUTCOME VARIABLE:
  TRU|

Model Summary
      R      R-sq      MSE      F      df1      df2      p
      ,7289      ,5312      ,9263    189,6375      3,0000    502,0000      ,0000

Model
      coeff      se      t      p      LLCI      ULCI
constant    2,4933    ,5593    4,4581    ,0000    1,3945    3,5921
PRO          ,4946    ,1000    4,9439    ,0000    ,2980    ,6911
DET         -,1426    ,1116   -1,2776    ,2020   -,3618    ,0767
Int_1        ,0387    ,0195    1,9780    ,0485    ,0003    ,0770

Product terms key:
Int_1      :      PRO      x      DET

Test(s) of highest order unconditional interaction(s):
      R2-chng      F      df1      df2      p
X*W      ,0037      3,9127      1,0000    502,0000      ,0485
-----
      Focal predict: PRO      (X)

```

```

Focal predict: PRO      (X)
Mod var: DET           (W)

Conditional effects of the focal predictor at values of the moderator(s):

      DET      Effect      se      t      p      LLCI      ULCI
2,8000      ,6028      ,0504     11,9559    ,0000      ,5037      ,7019
5,0000      ,6878      ,0296     23,2363    ,0000      ,6297      ,7460
6,6000      ,7497      ,0446     16,8212    ,0000      ,6621      ,8372

*****
OUTCOME VARIABLE:
KNOW

Model Summary
      R      R-sq      MSE      F      df1      df2      p
,3189      ,1017      3,6695     11,3191     5,0000     500,0000    ,0000

Model
      coeff      se      t      p      LLCI      ULCI
constant      ,9112     1,2037      ,7570      ,4494     -1,4536      3,2761
PRO            ,4407      ,2678      1,6460      ,1004      -,0853      ,9668
TRU           -,3167      ,2623     -1,2074      ,2279      -,8322      ,1987
DET            ,2458      ,2384      1,0311      ,3030      -,2226      ,7142
Int_1         -,0780      ,0559     -1,3942      ,1639      -,1879      ,0319
Int_2          ,0912      ,0552      1,6507      ,0994      -,0173      ,1997

Product terms key:
Int_1 :      PRO      x      DET
Int_2 :      TRU      x      DET

Test(s) of highest order unconditional interaction(s):
      R2-chng      F      df1      df2      p
X*W      ,0035      1,9437      1,0000     500,0000    ,1639
M*W      ,0049      2,7247      1,0000     500,0000    ,0994
-----

Focal predict: TRU      (M)
Mod var: DET           (W)

Conditional effects of the focal predictor at values of the moderator(s):

      DET      Effect      se      t      p      LLCI      ULCI
2,8000     -,0615      ,1280     -,4801      ,6314      -,3130      ,1901
5,0000      ,1391      ,0935      1,4870      ,1376      -,0447      ,3229
6,6000      ,2850      ,1474      1,9327      ,0538      -,0047      ,5747

***** DIRECT AND INDIRECT EFFECTS OF X ON Y *****

Conditional direct effect(s) of X on Y:
      DET      Effect      se      t      p      LLCI      ULCI
2,8000      ,2224      ,1293      1,7205      ,0860      -,0316      ,4764
5,0000      ,0509      ,0890      ,5719      ,5676      -,1239      ,2257
6,6000     -,0739      ,1433     -,5155      ,6064      -,3554      ,2077

Conditional indirect effects of X on Y:

INDIRECT EFFECT:
PRO      ->      TRU      ->      KNOW

      DET      Effect      BootSE      BootLLCI      BootULCI
2,8000     -,0371      ,0717      -,1738      ,1096
5,0000      ,0957      ,0678      -,0446      ,2224
6,6000      ,2136      ,1183      -,0248      ,4372
---

***** ANALYSIS NOTES AND ERRORS *****

Level of confidence for all confidence intervals in output:
95,0000

Number of bootstrap samples for percentile bootstrap confidence intervals:
5000

W values in conditional tables are the 16th, 50th, and 84th percentiles.

----- END MATRIX -----

```

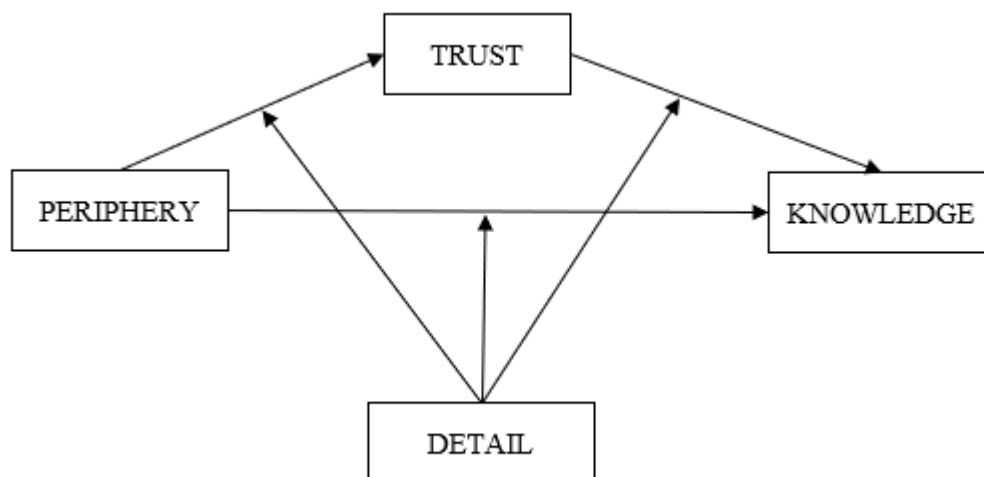


Figure H.9 : The Hayes model for the effect of detail on periphery-knowledge relationship.

Run MATRIX procedure:

***** PROCESS Procedure for SPSS Version 3.3 *****

Written by Andrew F. Hayes, Ph.D. www.afhayes.com
Documentation available in Hayes (2018). www.guilford.com/p/hayes3

Model : 59
Y : KNOW
X : PERI
M : TRU
W : DET

Sample
Size: 506

OUTCOME VARIABLE:
TRU

Model Summary	R	R-sq	MSE	F	df1	df2	p
	,6319	,3993	1,1871	111,2204	3,0000	502,0000	,0000

Model	coeff	se	t	p	LLCI	ULCI
constant	3,6608	,4710	7,7724	,0000	2,7354	4,5861
PERI	,3275	,0922	3,5512	,0004	,1463	,5087
DET	-,1683	,0980	-1,7166	,0867	-,3608	,0243
Int_1	,0416	,0185	2,2526	,0247	,0053	,0779

Product terms key:
Int_1 : PERI x DET

Test(s) of highest order unconditional interaction(s):	R2-chng	F	df1	df2	p
X*W	,0061	5,0744	1,0000	502,0000	,0247

Focal predict: PERI (X)
Mod var: DET (W)

Conditional effects of the focal predictor at values of the moderator(s):

DET	Effect	se	t	p	LLCI	ULCI
2,8000	,4441	,0464	9,5637	,0000	,3529	,5353
5,0000	,5357	,0304	17,6222	,0000	,4760	,5954
6,6000	,6023	,0459	13,1287	,0000	,5122	,6924

OUTCOME VARIABLE:

KNOW

Model Summary

R	R-sq	MSE	F	df1	df2	p
,3447	,1188	3,5997	13,4795	5,0000	500,0000	,0000

Model

	coeff	se	t	p	LLCI	ULCI
constant	1,4814	1,0973	1,3500	,1776	-,6745	3,6374
PERI	,2688	,1978	1,3590	,1748	-,1198	,6575
TRU	-,2047	,2372	-,8630	,3885	-,6708	,2613
DET	,1089	,2209	,4929	,6223	-,3251	,5428
Int_1	-,0073	,0410	-,1776	,8591	-,0879	,0734
Int_2	,0412	,0480	,8569	,3919	-,0532	,1355

Product terms key:

Int_1	:	PERI	x	DET
Int_2	:	TRU	x	DET

Test(s) of highest order unconditional interaction(s):

	R2-chng	F	df1	df2	p
X*W	,0001	,0315	1,0000	500,0000	,8591
M*W	,0013	,7342	1,0000	500,0000	,3919

***** DIRECT AND INDIRECT EFFECTS OF X ON Y *****

Conditional direct effect(s) of X on Y:

DET	Effect	se	t	p	LLCI	ULCI
2,8000	,2484	,0974	2,5509	,0110	,0571	,4398
5,0000	,2324	,0687	3,3811	,0008	,0973	,3674
6,6000	,2207	,1073	2,0577	,0401	,0100	,4315

Conditional indirect effects of X on Y:

INDIRECT EFFECT:

PERI -> TRU -> KNOW

DET	Effect	BootSE	BootLLCI	BootULCI
2,8000	-,0397	,0514	-,1401	,0620
5,0000	,0006	,0458	-,0898	,0898
6,6000	,0403	,0833	-,1221	,2026

***** ANALYSIS NOTES AND ERRORS *****

Level of confidence for all confidence intervals in output:

95,0000

Number of bootstrap samples for percentile bootstrap confidence intervals:

5000

W values in conditional tables are the 16th, 50th, and 84th percentiles.

----- END MATRIX -----

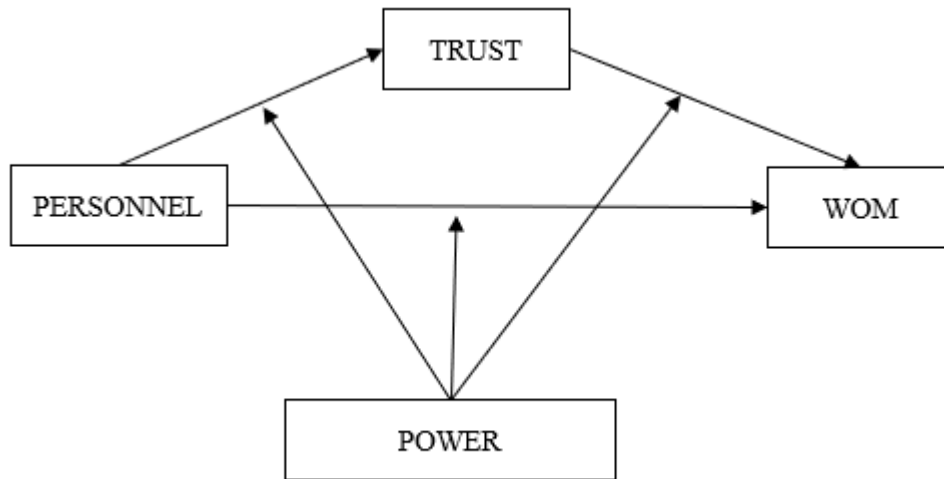


Figure H.10 : The Hayes model for the effect of power on personnel-WOM relationship.

Run MATRIX procedure:

```

***** PROCESS Procedure for SPSS Version 3.3 *****

      Written by Andrew F. Hayes, Ph.D.      www.afhayes.com
Documentation available in Hayes (2018). www.guilford.com/p/hayes3

*****
Model   : S9
  Y     : WOM
  X     : PERS
  M     : TRU
  W     : POW

Sample
Size:   506

*****
OUTCOME VARIABLE:
  TRU

Model Summary
      R      R-sq      MSE      F      df1      df2      p
      ,4706      ,2214      1,5385      47,5956      3,0000      502,0000      ,0000

Model
      coeff      se      t      p      LLCI      ULCI
constant      1,3606      ,9104      1,4944      ,1357      -,4281      3,1493
PERS           ,5942      ,1577      3,7687      ,0002      ,2844      ,9040
POW           ,3315      ,1645      2,0157      ,0444      ,0084      ,6547
Int_1         -,0337      ,0282     -1,1969      ,2319      -,0891      ,0216

Product terms key:
Int_1      :      PERS      x      POW

Test(s) of highest order unconditional interaction(s):
      R2-chng      F      df1      df2      p
X*W           ,0022      1,4327      1,0000      502,0000      ,2319

*****

```

OUTCOME VARIABLE:
WOM

Model Summary

R	R-sq	MSE	F	df1	df2	p
,7780	,6053	1,3786	153,3562	5,0000	500,0000	,0000

Model

	coeff	se	t	p	LLCI	ULCI
constant	-2,1944	1,0541	-2,0817	,0379	-4,2655	-,1233
PERS	,8785	,1733	5,0685	,0000	,5380	1,2191
TRU	,3128	,2027	1,5429	,1235	-,0855	,7111
POW	,2226	,1951	1,1414	,2543	-,1606	,6059
Int_1	-,0918	,0308	-2,9771	,0031	-,1524	-,0312
Int_2	,0805	,0371	2,1722	,0303	,0077	,1533

Product terms key:

Int_1	:	PERS	x	POW
Int_2	:	TRU	x	POW

Test(s) of highest order unconditional interaction(s):

	R2-chng	F	df1	df2	p
X*W	,0070	8,8633	1,0000	500,0000	,0031
M*W	,0037	4,7186	1,0000	500,0000	,0303

Focal predict: PERS (X)
Mod var: POW (W)

Conditional effects of the focal predictor at values of the moderator(s):

POW	Effect	se	t	p	LLCI	ULCI
4,1429	,4982	,0566	8,7964	,0000	,3869	,6095
5,4286	,3802	,0389	9,7657	,0000	,3037	,4567
6,5714	,2753	,0515	5,3474	,0000	,1741	,3764

Focal predict: TRU (M)
Mod var: POW (W)

Conditional effects of the focal predictor at values of the moderator(s):

Conditional effects of the focal predictor at values of the moderator(s):

POW	Effect	se	t	p	LLCI	ULCI
4,1429	,6464	,0615	10,5060	,0000	,5255	,7673
5,4286	,7499	,0424	17,7074	,0000	,6667	,8331
6,5714	,8419	,0619	13,5928	,0000	,7202	,9636

***** DIRECT AND INDIRECT EFFECTS OF X ON Y *****

Conditional direct effect(s) of X on Y:

POW	Effect	se	t	p	LLCI	ULCI
4,1429	,4982	,0566	8,7964	,0000	,3869	,6095
5,4286	,3802	,0389	9,7657	,0000	,3037	,4567
6,5714	,2753	,0515	5,3474	,0000	,1741	,3764

Conditional indirect effects of X on Y:

INDIRECT EFFECT:

PERS -> TRU -> WOM

POW	Effect	BootSE	BootLLCI	BootULCI
4,1429	,2938	,0507	,2045	,4032
5,4286	,3083	,0354	,2420	,3797
6,5714	,3137	,0515	,2159	,4175

***** ANALYSIS NOTES AND ERRORS *****

Level of confidence for all confidence intervals in output:
95,0000

Number of bootstrap samples for percentile bootstrap confidence intervals:
5000

W values in conditional tables are the 16th, 50th, and 84th percentiles.

----- END MATRIX -----

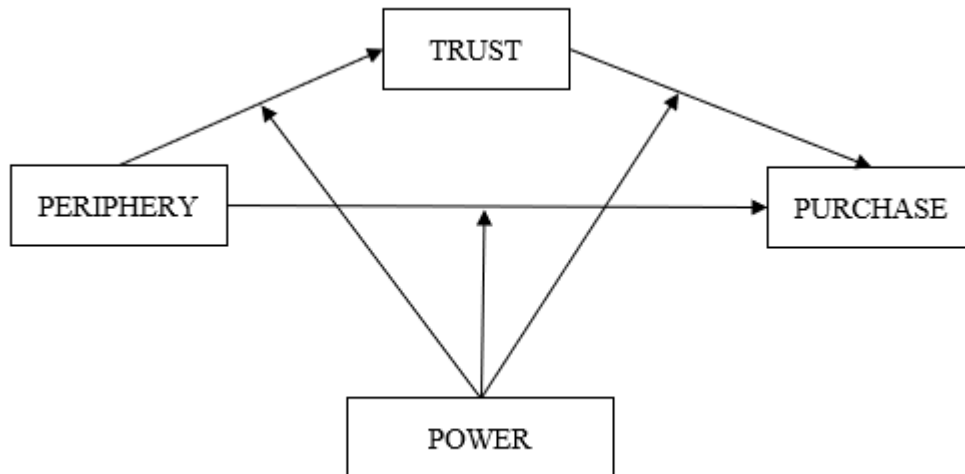


Figure H.11 : The Hayes model for the effect of power on periphery-purchase relationship.

Run MATRIX procedure:

```

***** PROCESS Procedure for SPSS Version 3.3 *****

      Written by Andrew F. Hayes, Ph.D.      www.afhayes.com
      Documentation available in Hayes (2018). www.guilford.com/p/hayes3

*****
Model   : 59
Y       : PUR
X       : PERI
M       : TRU
W       : POW

Sample
Size:   506

*****
OUTCOME VARIABLE:
TRU

Model Summary
      R      R-sq      MSE      F      df1      df2      p
      ,6293      ,3960      1,1936      109,7052      3,0000      502,0000      ,0000

Model|
      coeff      se      t      p      LLCI      ULCI
constant      2,1336      ,6780      3,1470      ,0017      ,8016      3,4656
PERI           ,5923      ,1318      4,4943      ,0000      ,3334      ,8512
POW           ,1432      ,1260      1,1368      ,2561      -,1043      ,3908
Int_1         -,0129      ,0240      -,5388      ,5903      -,0600      ,0342

Product terms key:
Int_1      :      PERI      x      POW

Test(s) of highest order unconditional interaction(s):
      R2-chng      F      df1      df2      p
X*W           ,0003      ,2903      1,0000      502,0000      ,5903

*****

```

OUTCOME VARIABLE:
PUR

Model Summary

R	R-sq	MSE	F	df1	df2	p
,7477	,5590	1,1098	126,7646	5,0000	500,0000	,0000

Model

	coeff	se	t	p	LLCI	ULCI
constant	1,1858	,8799	1,3477	,1784	-,5429	2,9145
PERI	,8008	,1608	4,9811	,0000	,4849	1,1167
TRU	-,2243	,1983	-1,1311	,2586	-,6139	,1653
POW	-,0531	,1644	-,3231	,7468	-,3761	,2699
Int_1	-,0830	,0292	-2,8428	,0047	-,1403	-,0256
Int_2	,1251	,0364	3,4389	,0006	,0536	,1966

Product terms key:

Int_1	:	PERI	x	POW
Int_2	:	TRU	x	POW

Test(s) of highest order unconditional interaction(s):

	R2-chng	F	df1	df2	p
X*W	,0071	8,0815	1,0000	500,0000	,0047
M*W	,0104	11,8257	1,0000	500,0000	,0006

Focal predict: PERI (X)
Mod var: POW (W)

Conditional effects of the focal predictor at values of the moderator(s):

POW	Effect	se	t	p	LLCI	ULCI
4,1429	,4572	,0511	8,9520	,0000	,3568	,5575
5,4286	,3505	,0366	9,5797	,0000	,2786	,4224
6,5714	,2557	,0507	5,0400	,0000	,1560	,3554

Focal predict: TRU (M)
Mod var: POW (W)

Conditional effects of the focal predictor at values of the moderator(s):

POW	Effect	se	t	p	LLCI	ULCI
4,1429	,2941	,0607	4,8436	,0000	,1748	,4134
5,4286	,4550	,0432	10,5265	,0000	,3700	,5399
6,5714	,5980	,0627	9,5431	,0000	,4748	,7211

***** DIRECT AND INDIRECT EFFECTS OF X ON Y *****

Conditional direct effect(s) of X on Y:

POW	Effect	se	t	p	LLCI	ULCI
4,1429	,4572	,0511	8,9520	,0000	,3568	,5575
5,4286	,3505	,0366	9,5797	,0000	,2786	,4224
6,5714	,2557	,0507	5,0400	,0000	,1560	,3554

Conditional indirect effects of X on Y:

INDIRECT EFFECT:

PERI -> TRU -> PUR

POW	Effect	BootSE	BootLLCI	BootULCI
4,1429	,1585	,0479	,0675	,2561
5,4286	,2376	,0314	,1778	,3011
6,5714	,3034	,0510	,2063	,4059

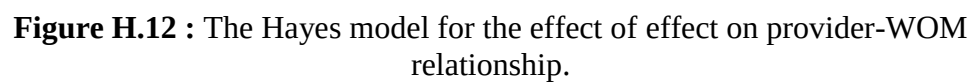
***** ANALYSIS NOTES AND ERRORS *****

Level of confidence for all confidence intervals in output:
95,0000

Number of bootstrap samples for percentile bootstrap confidence intervals:
5000

W values in conditional tables are the 16th, 50th, and 84th percentiles.

----- END MATRIX -----



```
***** PROCESS Procedure for SPSS Version 3.3 *****

      Written by Andrew F. Hayes, Ph.D.      www.afhayes.com
Documentation available in Hayes (2018). www.guilford.com/p/hayes3

*****
Model   : 59
Y       : WOM
X       : PRO
M       : TRU
W       : EFF

Sample
Size:   506

*****
OUTCOME VARIABLE:
      TRU

Model Summary

      R          R-sq      MSE          F          df1          df2          p
      ,7255      ,5264      ,9358      186,0010      3,0000      502,0000      ,0000

Model

      coeff      se      t      p      LLCI      ULCI
constant      2,5591      ,3563      7,1815      ,0000      1,8590      3,2592
PRO            ,5485      ,0645      8,5035      ,0000      ,4217      ,6752
EFF           -,2458      ,0965     -2,5464      ,0112     -,4355     -,0562
Int_1          ,0428      ,0168      2,5482      ,0111      ,0098      ,0758

Product terms key:
Int_1      :      PRO      x      EFF

Test(s) of highest order unconditional interaction(s):
      R2-chng      F      df1      df2      p
X*W      ,0061      6,4933      1,0000      502,0000      ,0111
```

```

| Focal predict: PRO      (X)
  Mod var: EFF      (W)

Conditional effects of the focal predictor at values of the moderator(s) :

      EFF      Effect      se      t      p      LLCI      ULCI
1,3333      ,6055      ,0458     13,2079      ,0000      ,5154      ,6956
3,3333      ,6911      ,0299     23,1284      ,0000      ,6324      ,7498
5,3333      ,7766      ,0440     17,6393      ,0000      ,6901      ,8631

*****
OUTCOME VARIABLE:
WOM

Model Summary

      R      R-sq      MSE      F      df1      df2      p
,7954      ,6327      1,2828     172,2599      5,0000     500,0000      ,0000

Model

      coeff      se      t      p      LLCI      ULCI
constant     -,5224      ,4875     -1,0716      ,2844     -1,4801      ,4354
PRO           ,6141      ,1017      6,0394      ,0000      ,4143      ,8139
TRU           ,4238      ,1116      3,7982      ,0002      ,2046      ,6430
EFF          -,0504      ,1291     -,3903      ,6965     -,3039      ,2032
Int_1        -,0003      ,0288     -,0094      ,9925     -,0568      ,0562
Int_2         ,0176      ,0313      ,5616      ,5746     -,0440      ,0792

Product terms key:
Int_1      :      PRO      x      EFF
Int_2      :      TRU      x      EFF

Test(s) of highest order unconditional interaction(s) :

      R2-chng      F      df1      df2      p
X*W      ,0000      ,0001      1,0000     500,0000      ,9925
M*W      ,0002      ,3154      1,0000     500,0000      ,5746

***** DIRECT AND INDIRECT EFFECTS OF X ON Y *****

Conditional direct effect(s) of X on Y:

      EFF      Effect      se      t      p      LLCI      ULCI
1,3333      ,6138      ,0709      8,6513      ,0000      ,4744      ,7531
3,3333      ,6132      ,0509     12,0505      ,0000      ,5132      ,7132
5,3333      ,6127      ,0823      7,4482      ,0000      ,4511      ,7743

Conditional indirect effects of X on Y:

INDIRECT EFFECT:
PRO      ->      TRU      ->      WOM

      EFF      Effect      BootSE      BootLLCI      BootULCI
1,3333      ,2708      ,0659      ,1508      ,4060
3,3333      ,3334      ,0457      ,2517      ,4286
5,3333      ,4020      ,0742      ,2673      ,5609
---

***** ANALYSIS NOTES AND ERRORS *****

Level of confidence for all confidence intervals in output:
95,0000

Number of bootstrap samples for percentile bootstrap confidence intervals:
5000

W values in conditional tables are the 16th, 50th, and 84th percentiles.

----- END MATRIX -----

```

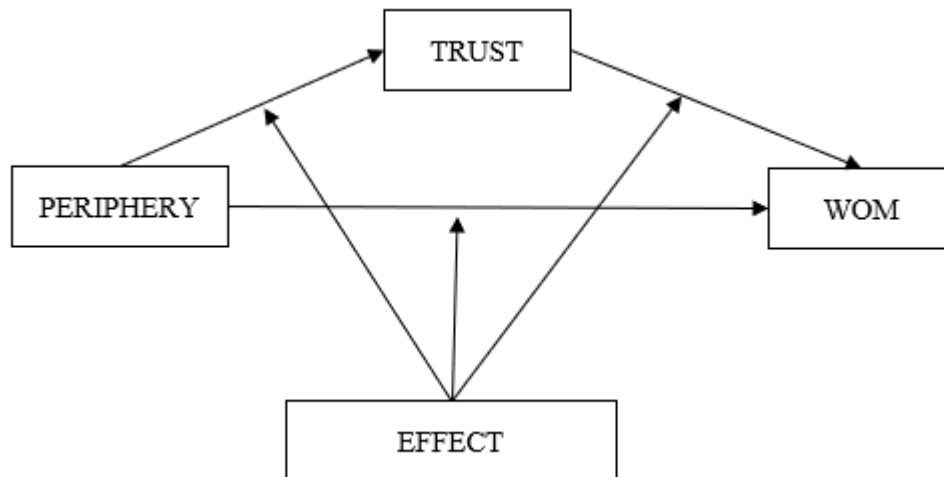


Figure H.13 : The Hayes model for the effect of effect on periphery-WOM relationship.

Run MATRIX procedure:

```

***** PROCESS Procedure for SPSS Version 3.3 *****

      Written by Andrew F. Hayes, Ph.D.      www.afhayes.com
Documentation available in Hayes (2018). www.guilford.com/p/hayes3

*****
Model   : 59
Y       : WOM
X       : PERI
M       : TRU
W       : EFF

Sample
Size:   506

*****
OUTCOME VARIABLE:
  TRU

Model Summary
      R      R-sq      MSE      F      df1      df2      p
      ,6329      ,4005      1,1846      111,8107      3,0000      502,0000      ,0000

Model
      coeff      se      t      p      LLCI      ULCI
constant      3,6354      ,3154      11,5263      ,0000      3,0157      4,2551
PERI           ,3784      ,0620      6,1021      ,0000      ,2566      ,5002
EFF          -,2429      ,0867      -2,8017      ,0053      -,4132      -,0726
Int_1         ,0461      ,0161      2,8545      ,0045      ,0144      ,0778

Product terms key:
Int_1      :      PERI      x      EFF

Test(s) of highest order unconditional interaction(s):
      R2-chng      F      df1      df2      p
X*W      ,0097      8,1483      1,0000      502,0000      ,0045
-----

```

```

Focal predict: PERI      (X)
Mod var: EFF      (W)

Conditional effects of the focal predictor at values of the moderator(s) :

      EFF      Effect      se      t      p      LLCI      ULCI
1,3333      ,4399      ,0444      9,9110      ,0000      ,3527      ,5271
3,3333      ,5320      ,0299      17,7993      ,0000      ,4733      ,5908
5,3333      ,6242      ,0436      14,3110      ,0000      ,5385      ,7099

*****
OUTCOME VARIABLE:
WOM

Model Summary

      R      R-sq      MSE      F      df1      df2      p
,7676      ,5893      1,4345      143,4752      5,0000      500,0000      ,0000

Model

      coeff      se      t      p      LLCI      ULCI
constant      ,0149      ,5025      ,0297      ,9763      -,9723      1,0021
PERI      ,3423      ,0812      4,2182      ,0000      ,1829      ,5018
TRU      ,6201      ,1042      5,9495      ,0000      ,4153      ,8248
EFF      -,0795      ,1333      -,5962      ,5513      -,3415      ,1825
Int_1      ,0107      ,0225      ,4732      ,6363      -,0336      ,0549
Int_2      ,0130      ,0287      ,4532      ,6506      -,0433      ,0693

Product terms key:
Int_1      :      PERI      x      EFF
Int_2      :      TRU      x      EFF

Test(s) of highest order unconditional interaction(s) :

      R2-chng      F      df1      df2      p
X*W      ,0002      ,2239      1,0000      500,0000      ,6363
M*W      ,0002      ,2054      1,0000      500,0000      ,6506

|***** DIRECT AND INDIRECT EFFECTS OF X ON Y *****

Conditional direct effect(s) of X on Y:

      EFF      Effect      se      t      p      LLCI      ULCI
1,3333      ,3566      ,0576      6,1908      ,0000      ,2434      ,4697
3,3333      ,3779      ,0424      8,9112      ,0000      ,2946      ,4612
5,3333      ,3992      ,0659      6,0588      ,0000      ,2698      ,5287

Conditional indirect effects of X on Y:

INDIRECT EFFECT:
PERI      ->      TRU      ->      WOM

      EFF      Effect      BootSE      BootLLCI      BootULCI
1,3333      ,2804      ,0516      ,1831      ,3861
3,3333      ,3529      ,0371      ,2799      ,4265
5,3333      ,4303      ,0589      ,3154      ,5435
---

***** ANALYSIS NOTES AND ERRORS *****

Level of confidence for all confidence intervals in output:
95,0000

Number of bootstrap samples for percentile bootstrap confidence intervals:
5000

W values in conditional tables are the 16th, 50th, and 84th percentiles.

----- END MATRIX -----

```

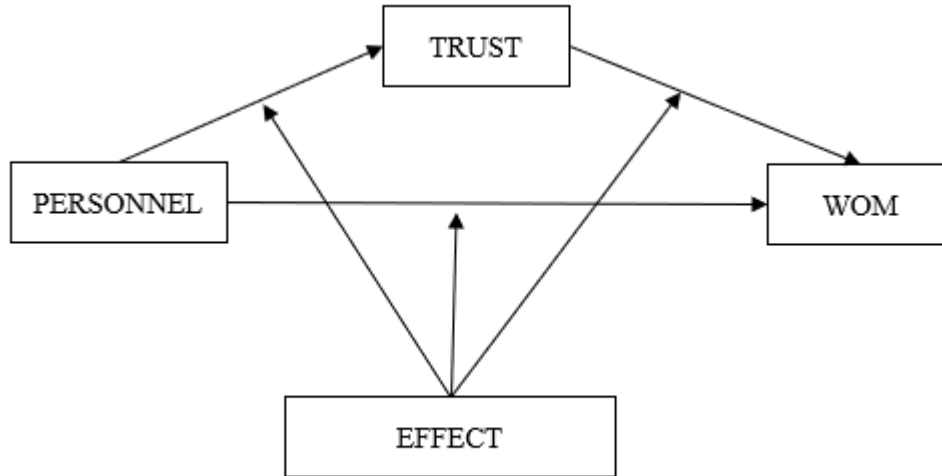


Figure H.14 : The Hayes model for the effect of effect on personnel-WOM relationship.

Run MATRIX procedure:

```

***** PROCESS Procedure for SPSS Version 3.3 *****

      Written by Andrew F. Hayes, Ph.D.      www.afhayes.com
Documentation available in Hayes (2018). www.guilford.com/p/hayes3

*****

Model   : 59
Y       : WOM
X       : PERS
M       : TRU
W       : EFF

Sample
Size:   506

*****
OUTCOME VARIABLE:
TRU

Model Summary
      R      R-sq      MSE      F      df1      df2      p
,4567    ,2086    1,5639    44,1031    3,0000    502,0000    ,0000

Model
      coeff      se      t      p      LLCI      ULCI
constant    3,3715    ,4529    7,4441    ,0000    2,4817    4,2613
PERS         ,3405    ,0785    4,3401    ,0000    ,1864    ,4947
EFF        -,0742    ,1178   -,6302    ,5289   -,3057    ,1572
Int_1        ,0214    ,0199    1,0719    ,2843   -,0178    ,0605

Product terms key:
Int_1      :      PERS      x      EFF

Test(s) of highest order unconditional interaction(s):
      R2-chng      F      df1      df2      p
X*W      ,0018    1,1490    1,0000    502,0000    ,2843
  
```

OUTCOME VARIABLE:

WOM

Model Summary

R	R-sq	MSE	F	df1	df2	p
,7744	,5997	1,3981	149,8180	5,0000	500,0000	,0000

Model

	coeff	se	t	p	LLCI	ULCI
constant	-1,2535	,5415	-2,3147	,0210	-2,3174	-,1895
PERS	,5555	,0822	6,7568	,0000	,3940	,7170
TRU	,5742	,0959	5,9858	,0000	,3857	,7626
EFF	,0683	,1413	,4835	,6290	-,2093	,3460
Int_1	-,0551	,0214	-2,5798	,0102	-,0971	-,0131
Int_2	,0566	,0255	2,2231	,0267	,0066	,1066

Product terms key:

Int_1	:	PERS	x	EFF
Int_2	:	TRU	x	EFF

Test(s) of highest order unconditional interaction(s):

	R2-chng	F	df1	df2	p
X*W	,0053	6,6553	1,0000	500,0000	,0102
M*W	,0040	4,9423	1,0000	500,0000	,0267

Focal predict: PERS (X)
Mod var: EFF (W)

Conditional effects of the focal predictor at values of the moderator(s):

EFF	Effect	se	t	p	LLCI	ULCI
1,3333	,4820	,0588	8,2004	,0000	,3665	,5975
3,3333	,3717	,0393	9,4640	,0000	,2945	,4489
5,3333	,2614	,0573	4,5620	,0000	,1488	,3740

Focal predict: TRU (M)
Mod var: EFF (W)

Conditional effects of the focal predictor at values of the moderator(s):

EFF	Effect	se	t	p	LLCI	ULCI
1,3333	,6496	,0671	9,6782	,0000	,5178	,7815
3,3333	,7628	,0422	18,0679	,0000	,6799	,8458
5,3333	,8760	,0651	13,4470	,0000	,7480	1,0040

***** DIRECT AND INDIRECT EFFECTS OF X ON Y *****

Conditional direct effect(s) of X on Y:

EFF	Effect	se	t	p	LLCI	ULCI
1,3333	,4820	,0588	8,2004	,0000	,3665	,5975
3,3333	,3717	,0393	9,4640	,0000	,2945	,4489
5,3333	,2614	,0573	4,5620	,0000	,1488	,3740

Conditional indirect effects of X on Y:

INDIRECT EFFECT:

PERS -> TRU -> WOM

EFF	Effect	BootSE	BootLLCI	BootULCI
1,3333	,2397	,0505	,1482	,3438
3,3333	,3141	,0352	,2480	,3830
5,3333	,3981	,0529	,2942	,5061

***** ANALYSIS NOTES AND ERRORS *****

Level of confidence for all confidence intervals in output:

95,0000

Number of bootstrap samples for percentile bootstrap confidence intervals:

5000

W values in conditional tables are the 16th, 50th, and 84th percentiles.

----- END MATRIX -----

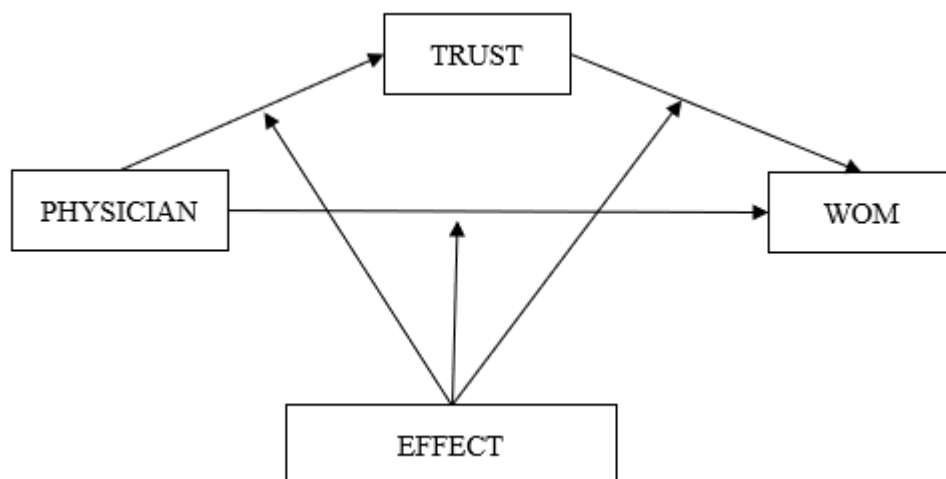


Figure H.15 : The Hayes model for the effect of effect on physician-WOM relationship.

Run MATRIX procedure:

```

***** PROCESS Procedure for SPSS Version 3.3 *****

      Written by Andrew F. Hayes, Ph.D.      www.afhayes.com
Documentation available in Hayes (2018). www.guilford.com/p/hayes3

*****
Model   : 59
  Y     : WOM
  X     : PHY
  M     : TRU
  W     : EFF

Sample
Size: 506

*****
OUTCOME VARIABLE:
  TRU

Model Summary
      R      R-sq      MSE      F      df1      df2      p
      ,5871      ,3447      1,2950      88,0124      3,0000      502,0000      ,0000

Model
      coeff      se      t      p      LLCI      ULCI
constant      2,7393      ,4693      5,8375      ,0000      1,8173      3,6612
PHY            ,4528      ,0772      5,8637      ,0000      ,3011      ,6045
EFF           -,2276      ,1309     -1,7390      ,0826     -,4848      ,0295
Int_1          ,0386      ,0208      1,8534      ,0644     -,0023      ,0795

Product terms key:
Int_1      :      PHY      x      EFF

Test(s) of highest order unconditional interaction(s):
      R2-chng      F      df1      df2      p
X*W      ,0045      3,4350      1,0000      502,0000      ,0644
-----

```

```

Focal predict: PHY      (X)
Mod var: EFF           (W)

Conditional effects of the focal predictor at values of the moderator(s):

      EFF      Effect      se      t      p      LLCI      ULCI
1,3333      ,5043      ,0543      9,2817      ,0000      ,3975      ,6110
3,3333      ,5815      ,0364     15,9554      ,0000      ,5099      ,6531
5,3333      ,6587      ,0564     11,6874      ,0000      ,5480      ,7695

*****
OUTCOME VARIABLE:
WOM

Model Summary

      R      R-sq      MSE      F      df1      df2      p
,7752      ,6010      1,3937     150,5958      5,0000     500,0000      ,0000

Model

      coeff      se      t      p      LLCI      ULCI
constant     -1,0594      ,5528     -1,9164      ,0559     -2,1454      ,0267
PHY           ,6117      ,0952      6,4277      ,0000      ,4248      ,7987
TRU           ,4558      ,1025      4,4481      ,0000      ,2545      ,6571
EFF          -0,0121      ,1503     -0,0802      ,9361     -0,3074      ,2833
Int_1         -0,0521      ,0261     -1,9912      ,0470     -0,1034     -0,0007
Int_2          ,0681      ,0270      2,5221      ,0120      ,0151      ,1212

Product terms key:
Int_1 :      PHY      x      EFF
Int_2 :      TRU      x      EFF

Test(s) of highest order unconditional interaction(s):

      R2-chng      F      df1      df2      p
X*W      ,0032      3,9647      1,0000     500,0000      ,0470
M*W      ,0051      6,3612      1,0000     500,0000      ,0120

-----
Focal predict: PHY      (X)
Mod var: EFF           (W)

Conditional effects of the focal predictor at values of the moderator(s):

      EFF      Effect      se      t      p      LLCI      ULCI
1,3333      ,5423      ,0669      8,1068      ,0000      ,4109      ,6738
3,3333      ,4382      ,0465      9,4346      ,0000      ,3470      ,5295
5,3333      ,3341      ,0728      4,5868      ,0000      ,1910      ,4773

-----
Focal predict: TRU      (M)
Mod var: EFF           (W)

Conditional effects of the focal predictor at values of the moderator(s):

      EFF      Effect      se      t      p      LLCI      ULCI
1,3333      ,5466      ,0722      7,5711      ,0000      ,4048      ,6884
3,3333      ,6828      ,0463     14,7408      ,0000      ,5918      ,7739
5,3333      ,8191      ,0701     11,6825      ,0000      ,6813      ,9568

***** DIRECT AND INDIRECT EFFECTS OF X ON Y *****
Conditional direct effect(s) of X on Y:

      EFF      Effect      se      t      p      LLCI      ULCI
1,3333      ,5423      ,0669      8,1068      ,0000      ,4109      ,6738
3,3333      ,4382      ,0465      9,4346      ,0000      ,3470      ,5295
5,3333      ,3341      ,0728      4,5868      ,0000      ,1910      ,4773

Conditional indirect effects of X on Y:

INDIRECT EFFECT:
PHY      ->      TRU      ->      WOM

      EFF      Effect      BootSE      BootLLCI      BootULCI
1,3333      ,2756      ,0611      ,1670      ,4103
3,3333      ,3971      ,0442      ,3155      ,4883
5,3333      ,5396      ,0791      ,3997      ,7116

---
***** ANALYSIS NOTES AND ERRORS *****

Level of confidence for all confidence intervals in output:
95,0000
Number of bootstrap samples for percentile bootstrap confidence intervals:
5000|
W values in conditional tables are the 16th, 50th, and 84th percentiles.
----- END MATRIX -----

```

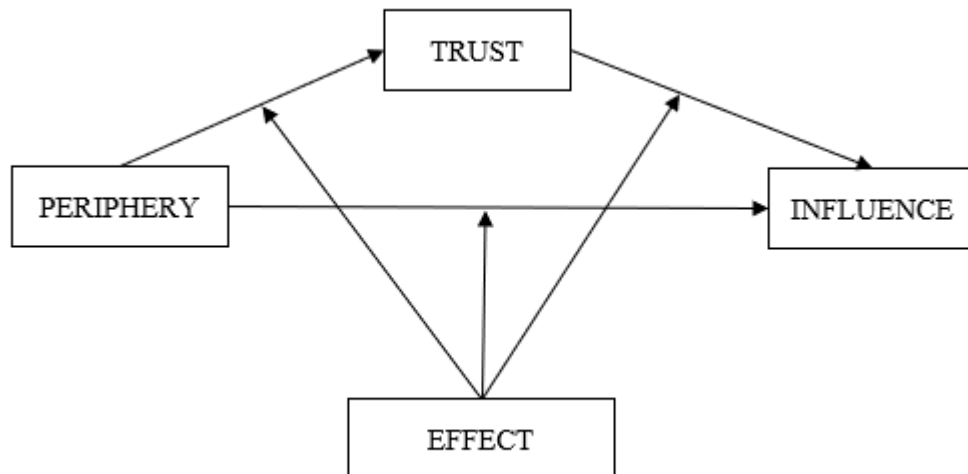


Figure H.16 : The Hayes model for the effect of effect on periphery-influence relationship.

Run MATRIX procedure:

```

***** PROCESS Procedure for SPSS Version 3.3 *****

      Written by Andrew F. Hayes, Ph.D.      www.afhayes.com
      Documentation available in Hayes (2018). www.guilford.com/p/hayes3

*****
Model   : 59
  Y     : INF
  X     : PHY
  M     : TRU
  W     : EFF

Sample
Size:   506

*****
OUTCOME VARIABLE:
  TRU

Model Summary
      R      R-sq      MSE      F      df1      df2      p
,5871    ,3447    1,2950    88,0124    3,0000    502,0000    ,0000

Model
      coeff      se      t      p      LLCI      ULCI
constant    2,7393    ,4693    5,8375    ,0000    1,8173    3,6612
PHY          ,4528    ,0772    5,8637    ,0000    ,3011    ,6045
EFF         -,2276    ,1309   -1,7390    ,0826   -,4848    ,0295
Int_1        ,0386    ,0208    1,8534    ,0644   -,0023    ,0795

Product terms key:
Int_1      :      PHY      x      EFF

Test(s) of highest order unconditional interaction(s):
      R2-chng      F      df1      df2      p
X*W      ,0045      3,4350      1,0000      502,0000      ,0644
-----

```

Focal predict: PHY (X)
Mod var: EFF (W)

Conditional effects of the focal predictor at values of the moderator(s):

EFF	Effect	se	t	p	LLCI	ULCI
1,3333	,5043	,0543	9,2817	,0000	,3975	,6110
3,3333	,5815	,0364	15,9554	,0000	,5099	,6531
5,3333	,6587	,0564	11,6874	,0000	,5480	,7695

OUTCOME VARIABLE:

INF

Model Summary

R	R-sq	MSE	F	df1	df2	p
,4873	,2375	2,3901	31,1400	5,0000	500,0000	,0000

Model

	coeff	se	t	p	LLCI	ULCI
constant	,4021	,7239	,5555	,5788	-1,0201	1,8243
PHY	,0487	,1246	,3907	,6962	-,1962	,2936
TRU	,4018	,1342	2,9947	,0029	,1382	,6655
EFF	,2820	,1969	1,4325	,1526	-,1048	,6689
Int_1	-,0145	,0342	-,4230	,6725	-,0817	,0528
Int_2	,0156	,0354	,4404	,6598	-,0539	,0851

Product terms key:

Int_1	:	PHY	x	EFF
Int_2	:	TRU	x	EFF

Test(s) of highest order unconditional interaction(s):

	R2-chng	F	df1	df2	p
X*W	,0003	,1789	1,0000	500,0000	,6725
M*W	,0003	,1939	1,0000	500,0000	,6598

|***** DIRECT AND INDIRECT EFFECTS OF X ON Y *****

Conditional direct effect(s) of X on Y:

EFF	Effect	se	t	p	LLCI	ULCI
1,3333	,0294	,0876	,3354	,7375	-,1427	,2015
3,3333	,0004	,0608	,0069	,9945	-,1191	,1199
5,3333	-,0285	,0954	-,2992	,7649	-,2160	,1589

Conditional indirect effects of X on Y:

INDIRECT EFFECT:

PHY -> TRU -> INF

EFF	Effect	BootSE	BootLLCI	BootULCI
1,3333	,2131	,0557	,1108	,3288
3,3333	,2639	,0431	,1835	,3528
5,3333	,3194	,0835	,1665	,4972

***** ANALYSIS NOTES AND ERRORS *****

Level of confidence for all confidence intervals in output:

95,0000

Number of bootstrap samples for percentile bootstrap confidence intervals:

5000

W values in conditional tables are the 16th, 50th, and 84th percentiles.

----- END MATRIX -----

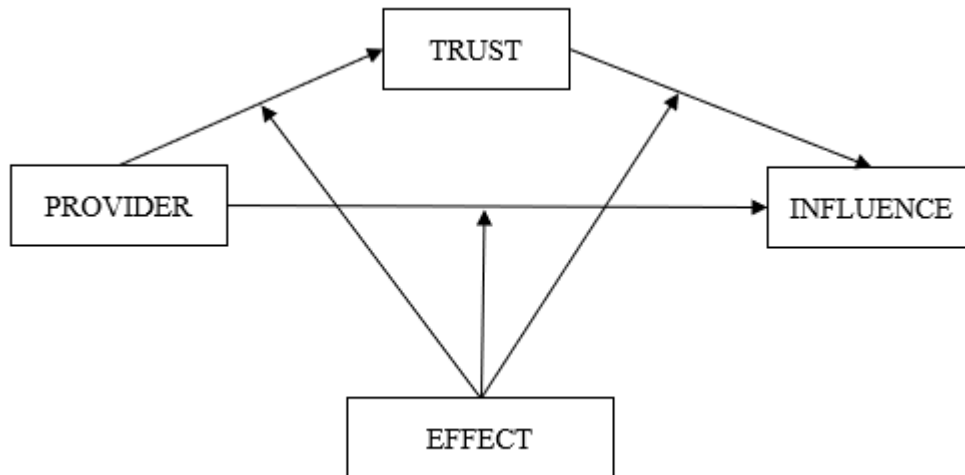


Figure H.17 : The Hayes model for the effect of effect on provider-influence relationship.

```

Run MATRIX procedure:

***** PROCESS Procedure for SPSS Version 3.3 *****

      Written by Andrew F. Hayes, Ph.D.      www.afhayes.com
  Documentation available in Hayes (2018). www.guilford.com/p/hayes3

*****
Model   : 59
  Y     : INF
  X     : PRO
  M     : TRU
  W     : EFF

Sample
Size: 506

*****
OUTCOME VARIABLE:
  TRU

Model Summary
      R      R-sq      MSE      F      df1      df2      p
      ,7255      ,5264      ,9358  186,0010      3,0000      502,0000      ,0000

Model
      coeff      se      t      p      LLCI      ULCI
constant    2,5591    ,3563    7,1815    ,0000    1,8590    3,2592
PRO          ,5485    ,0645    8,5035    ,0000    ,4217    ,6752
EFF         -,2458    ,0965   -2,5464    ,0112   -,4355   -,0562
Int_1        ,0428    ,0168    2,5482    ,0111    ,0098    ,0758

Product terms key:
Int_1      :      PRO      x      EFF

Test(s) of highest order unconditional interaction(s):
      R2-chng      F      df1      df2      p
X*W      ,0061      6,4933      1,0000      502,0000      ,0111
-----

```

```

Focal predict: PRO      (X)
Mod var: EFF           (W)

Conditional effects of the focal predictor at values of the moderator(s) :

      EFF      Effect      se      t      p      LLCI      ULCI
1,3333      ,6055      ,0458     13,2079      ,0000      ,5154      ,6956
3,3333      ,6911      ,0299     23,1284      ,0000      ,6324      ,7498
5,3333      ,7766      ,0440     17,6393      ,0000      ,6901      ,8631

*****
OUTCOME VARIABLE:
INF

Model Summary
      R      R-sq      MSE      F      df1      df2      p
,4996      ,2496      2,3520     33,2639      5,0000     500,0000      ,0000

Model
      coeff      se      t      p      LLCI      ULCI
constant      ,0324      ,6600      ,0492      ,9608     -1,2644      1,3293
PRO      ,3680      ,1377      2,6724      ,0078      ,0974      ,6385
TRU      ,1677      ,1511      1,1102      ,2675     -1,1291      ,4646
EFF      ,3331      ,1747      1,9064      ,0572     -1,0102      ,6764
Int_1      -,0699      ,0390     -1,7938      ,0734     -1,1464      ,0067
Int_2      ,0579      ,0424      1,3659      ,1726     -1,0254      ,1413

Product terms key:
Int_1      :      PRO      x      EFF
Int_2      :      TRU      x      EFF

Test(s) of highest order unconditional interaction(s):
      R2-chng      F      df1      df2      p
X*W      ,0048      3,2178      1,0000     500,0000      ,0734
M*W      ,0028      1,8656      1,0000     500,0000      ,1726

-----
Focal predict: PRO      (X)
Mod var: EFF           (W)

Conditional effects of the focal predictor at values of the moderator(s) :

      EFF      Effect      se      t      p      LLCI      ULCI
1,3333      ,2748      ,0961      2,8607      ,0044      ,0861      ,4635
3,3333      ,1350      ,0689      1,9600      ,0506     -1,0003      ,2704
5,3333     -,0047      ,1114     -,0422      ,9664     -1,2235      ,2141

***** DIRECT AND INDIRECT EFFECTS OF X ON Y *****

Conditional direct effect(s) of X on Y:
      EFF      Effect      se      t      p      LLCI      ULCI
1,3333      ,2748      ,0961      2,8607      ,0044      ,0861      ,4635
3,3333      ,1350      ,0689      1,9600      ,0506     -1,0003      ,2704
5,3333     -,0047      ,1114     -,0422      ,9664     -1,2235      ,2141

Conditional indirect effects of X on Y:

INDIRECT EFFECT:
PRO      ->      TRU      ->      INF

      EFF      Effect      BootSE      BootLLCI      BootULCI
1,3333      ,1483      ,0707      ,0067      ,2876
3,3333      ,2494      ,0536      ,1467      ,3581
5,3333      ,3703      ,1070      ,1718      ,5889
---

***** ANALYSIS NOTES AND ERRORS *****

Level of confidence for all confidence intervals in output:
95,0000

Number of bootstrap samples for percentile bootstrap confidence intervals:
5000

W values in conditional tables are the 16th, 50th, and 84th percentiles.

----- END MATRIX -----

```

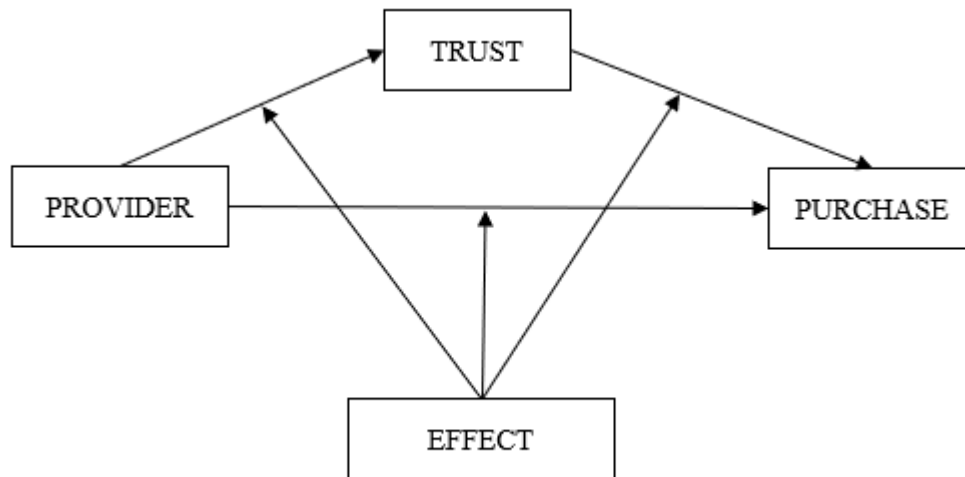


Figure H.18 : The Hayes model for the effect of effect on provider-purchase relationship.

```

Run MATRIX procedure:

***** PROCESS Procedure for SPSS Version 3.3 *****

      Written by Andrew F. Hayes, Ph.D.      www.afhayes.com
Documentation available in Hayes (2018). www.guilford.com/p/hayes3

*****
Model   : 59
  Y     : PUR
  X     : PRO
  M     : TRU
  W     : EFF

Sample
Size:   506

*****
OUTCOME VARIABLE:
  TRU

Model Summary
      R      R-sq      MSE      F      df1      df2      p
      ,7255      ,5264      ,9358  186,0010      3,0000      502,0000      ,0000

Model
      coeff      se      t      p      LLCI      ULCI
constant    2,5591      ,3563      7,1815      ,0000      1,8590      3,2592
PRO          ,5485      ,0645      8,5035      ,0000      ,4217      ,6752
EFF         -,2458      ,0965     -2,5464      ,0112     -,4355     -,0562
Int_1        ,0428      ,0168      2,5482      ,0111      ,0098      ,0758

Product terms key:
Int_1      :      PRO      x      EFF

Test(s) of highest order unconditional interaction(s):
      R2-chng      F      df1      df2      p
X*W      ,0061      6,4933      1,0000      502,0000      ,0111
-----

```

```

Focal predict: PRO      (X)
Mod var: EFF      (W)

Conditional effects of the focal predictor at values of the moderator(s):

      EFF      Effect      se      t      p      LLCI      ULCI
1,3333      ,6055      ,0458     13,2079      ,0000      ,5154      ,6956
3,3333      ,6911      ,0299     23,1284      ,0000      ,6324      ,7498
5,3333      ,7766      ,0440     17,6393      ,0000      ,6901      ,8631

*****
OUTCOME VARIABLE:
PUR

Model Summary

      R      R-sq      MSE      F      df1      df2      p
,7085      ,5019     1,2536    100,7678     5,0000    500,0000      ,0000

Model

      coeff      se      t      p      LLCI      ULCI
constant      ,1967      ,4819      ,4082      ,6833      -,7500      1,1435
PRO      ,3541      ,1005      3,5229      ,0005      ,1566      ,5516
TRU      ,4945      ,1103      4,4836      ,0000      ,2778      ,7112
EFF      ,1272      ,1276      ,9974      ,3191      -,1234      ,3779
Int_1      ,0098      ,0284      ,3439      ,7311      -,0461      ,0656
Int_2      -,0177      ,0310      -,5708      ,5684      -,0785      ,0432

Product terms key:
Int_1      :      PRO      x      EFF
Int_2      :      TRU      x      EFF

Test(s) of highest order unconditional interaction(s):

      R2-chng      F      df1      df2      p
X*W      ,0001      ,1183      1,0000      500,0000      ,7311
M*W      ,0003      ,3258      1,0000      500,0000      ,5684

***** DIRECT AND INDIRECT EFFECTS OF X ON Y *****

Conditional direct effect(s) of X on Y:

      EFF      Effect      se      t      p      LLCI      ULCI
1,3333      ,3672      ,0701      5,2355      ,0000      ,2294      ,5049
3,3333      ,3867      ,0503      7,6878      ,0000      ,2879      ,4856
5,3333      ,4063      ,0813      4,9964      ,0000      ,2465      ,5660

Conditional indirect effects of X on Y:

INDIRECT EFFECT:
PRO      ->      TRU      ->      PUR

      EFF      Effect      BootSE      BootLLCI      BootULCI
1,3333      ,2852      ,0656      ,1681      ,4228
3,3333      ,3010      ,0434      ,2166      ,3880
5,3333      ,3108      ,0759      ,1640      ,4596
---

***** ANALYSIS NOTES AND ERRORS *****

Level of confidence for all confidence intervals in output:
95,0000

Number of bootstrap samples for percentile bootstrap confidence intervals:
5000

W values in conditional tables are the 16th, 50th, and 84th percentiles.

----- END MATRIX -----

```

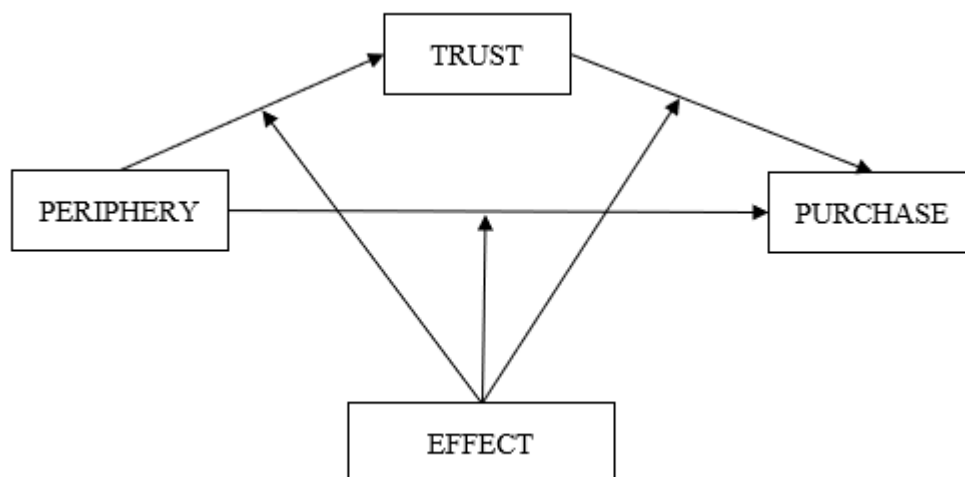


Figure H.19 : The Hayes model for the effect of effect on periphery-purchase relationship.

```

Run MATRIX procedure:

***** PROCESS Procedure for SPSS Version 3.3 *****

      Written by Andrew F. Hayes, Ph.D.      www.afhayes.com
Documentation available in Hayes (2018). www.guilford.com/p/hayes3

*****
Model   : 59
  Y     : PUR
  X     : PERI
  M     : TRU
  W     : EFF

Sample
Size: 506

*****
OUTCOME VARIABLE:
  TRU

Model Summary
      R      R-sq      MSE      F      df1      df2      p
      ,6329      ,4005      1,1846      111,8107      3,0000      502,0000      ,0000

Model
      coeff      se      t      p      LLCI      ULCI
constant      3,6354      ,3154      11,5263      ,0000      3,0157      4,2551
PERI           ,3784      ,0620      6,1021      ,0000      ,2566      ,5002
EFF           -,2429      ,0867      -2,8017      ,0053      -,4132      -,0726
Int_1          ,0461      ,0161      2,8545      ,0045      ,0144      ,0778

Product terms key:
Int_1      :      PERI      x      EFF

Test(s) of highest order unconditional interaction(s):
      R2-chng      F      df1      df2      p
X*W      ,0097      8,1483      1,0000      502,0000      ,0045
-----

```

```

| Focal predict: PERI      (X)
  Mod var: EFF            (W)

Conditional effects of the focal predictor at values of the moderator(s):

      EFF      Effect      se      t      p      LLCI      ULCI
1,3333      ,4399      ,0444      9,9110      ,0000      ,3527      ,5271
3,3333      ,5320      ,0299     17,7993      ,0000      ,4733      ,5908
5,3333      ,6242      ,0436     14,3110      ,0000      ,5385      ,7099

*****
OUTCOME VARIABLE:
PUR

Model Summary

      R      R-sq      MSE      F      df1      df2      p
,7244      ,5248      1,1959     110,4403      5,0000     500,0000      ,0000

Model

      coeff      se      t      p      LLCI      ULCI
constant      ,2948      ,4588      ,6426      ,5208      -,6066      1,1962
PERI           ,3851      ,0741      5,1968      ,0000      ,2395      ,5307
TRU            ,4866      ,0952      5,1130      ,0000      ,2996      ,6735
EFF            ,1450      ,1217      1,1911      ,2342      -,0942      ,3842
Int_1          -,0092      ,0206     -,4449      ,6566      -,0496      ,0313
Int_2          -,0051      ,0262     -,1945      ,8459      -,0565      ,0463

Product terms key:
Int_1 : PERI x EFF
Int_2 : TRU x EFF

Test(s) of highest order unconditional interaction(s):

      R2-chng      F      df1      df2      p
X*W      ,0002      ,1979      1,0000     500,0000      ,6566
M*W      ,0000      ,0378      1,0000     500,0000      ,8459

***** DIRECT AND INDIRECT EFFECTS OF X ON Y *****

Conditional direct effect(s) of X on Y:

      EFF      Effect      se      t      p      LLCI      ULCI
1,3333      ,3729      ,0526      7,0908      ,0000      ,2696      ,4762
3,3333      ,3546      ,0387      9,1579      ,0000      ,2785      ,4307
5,3333      ,3363      ,0602      5,5896      ,0000      ,2181      ,4545

Conditional indirect effects of X on Y:

INDIRECT EFFECT:
PERI      ->      TRU      ->      PUR

      EFF      Effect      BootSE      BootLLCI      BootULCI
1,3333      ,2110      ,0458      ,1311      ,3089
3,3333      ,2498      ,0337      ,1857      ,3181
5,3333      ,2868      ,0612      ,1608      ,4021
---
```

***** ANALYSIS NOTES AND ERRORS *****

Level of confidence for all confidence intervals in output:
95,0000

Number of bootstrap samples for percentile bootstrap confidence intervals:
5000

W values in conditional tables are the 16th, 50th, and 84th percentiles.

----- END MATRIX -----

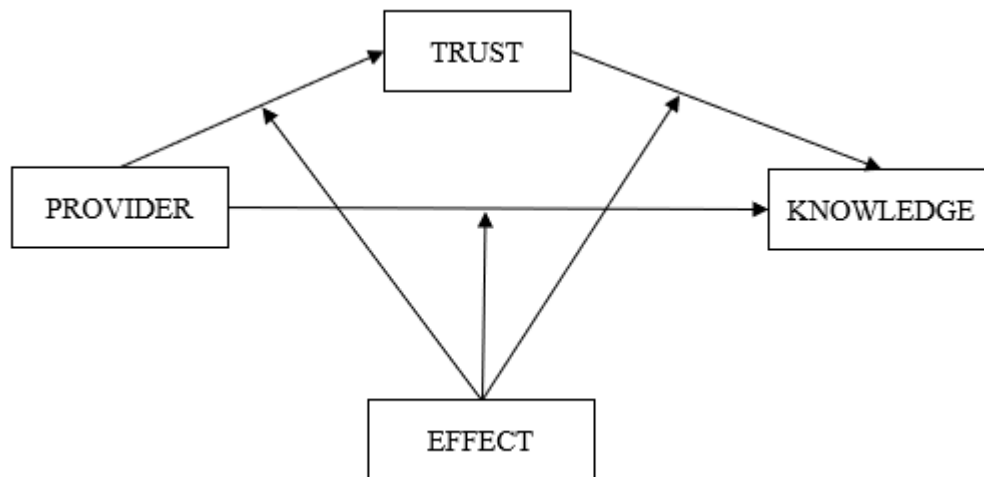


Figure H.20 : The Hayes model for the effect of effect on provider-knowledge relationship.

Run MATRIX procedure:

```

***** PROCESS Procedure for SPSS Version 3.3 *****

      Written by Andrew F. Hayes, Ph.D.      www.afhayes.com
Documentation available in Hayes (2018). www.guilford.com/p/hayes3

*****

Model   : 59
Y       : PUR
X       : PRO
M       : TRU
W       : EFF

Sample
Size:   506

*****
OUTCOME VARIABLE:
TRU

Model Summary
      R      R-sq      MSE      F      df1      df2      p
      ,7255      ,5264      ,9358  186,0010    3,0000   502,0000    ,0000

Model
      coeff      se      t      p      LLCI      ULCI
constant  2,5591    ,3563    7,1815    ,0000    1,8590    3,2592
PRO        ,5485    ,0645    8,5035    ,0000      ,4217    ,6752
EFF       -,2458    ,0965   -2,5464    ,0112   -,4355   -,0562
Int_1      ,0428    ,0168    2,5482    ,0111    ,0098    ,0758

Product terms key:
Int_1      :      PRO      x      EFF

Test(s) of highest order unconditional interaction(s):
      R2-chng      F      df1      df2      p
X*W      ,0061    6,4933    1,0000   502,0000    ,0111
-----

```

```

| Focal predict: PRO      (X)
  Mod var: EFF           (W)

Conditional effects of the focal predictor at values of the moderator(s) :

      EFF      Effect      se      t      p      LLCI      ULCI
1,3333      ,6055      ,0458     13,2079      ,0000      ,5154      ,6956
3,3333      ,6911      ,0299     23,1284      ,0000      ,6324      ,7498
5,3333      ,7766      ,0440     17,6393      ,0000      ,6901      ,8631

*****
OUTCOME VARIABLE:
PUR

Model Summary

      R      R-sq      MSE      F      df1      df2      p
,7085      ,5019     1,2536    100,7678     5,0000    500,0000      ,0000

Model

      coeff      se      t      p      LLCI      ULCI
constant      ,1967      ,4819      ,4082      ,6833     -,7500     1,1435
PRO            ,3541      ,1005      3,5229      ,0005      ,1566      ,5516
TRU            ,4945      ,1103      4,4836      ,0000      ,2778      ,7112
EFF            ,1272      ,1276      ,9974      ,3191     -,1234      ,3779
Int_1          ,0098      ,0284      ,3439      ,7311     -,0461      ,0656
Int_2         -,0177      ,0310     -,5708      ,5684     -,0785      ,0432

Product terms key:
Int_1      :      PRO      x      EFF
Int_2      :      TRU      x      EFF

Test(s) of highest order unconditional interaction(s) :

      R2-chng      F      df1      df2      p
X*W      ,0001      ,1183     1,0000    500,0000      ,7311
M*W      ,0003      ,3258     1,0000    500,0000      ,5684

***** DIRECT AND INDIRECT EFFECTS OF X ON Y *****

Conditional direct effect(s) of X on Y:

      EFF      Effect      se      t      p      LLCI      ULCI
1,3333      ,3672      ,0701     5,2355      ,0000      ,2294      ,5049
3,3333      ,3867      ,0503     7,6878      ,0000      ,2879      ,4856
5,3333      ,4063      ,0813     4,9964      ,0000      ,2465      ,5660

Conditional indirect effects of X on Y:

INDIRECT EFFECT:
PRO      ->      TRU      ->      PUR

      EFF      Effect      BootSE      BootLLCI      BootULCI
1,3333      ,2852      ,0656      ,1681      ,4228
3,3333      ,3010      ,0434      ,2166      ,3880
5,3333      ,3108      ,0759      ,1640      ,4596
---

***** ANALYSIS NOTES AND ERRORS *****

Level of confidence for all confidence intervals in output:
95,0000

Number of bootstrap samples for percentile bootstrap confidence intervals:
5000

W values in conditional tables are the 16th, 50th, and 84th percentiles.

----- END MATRIX -----

```

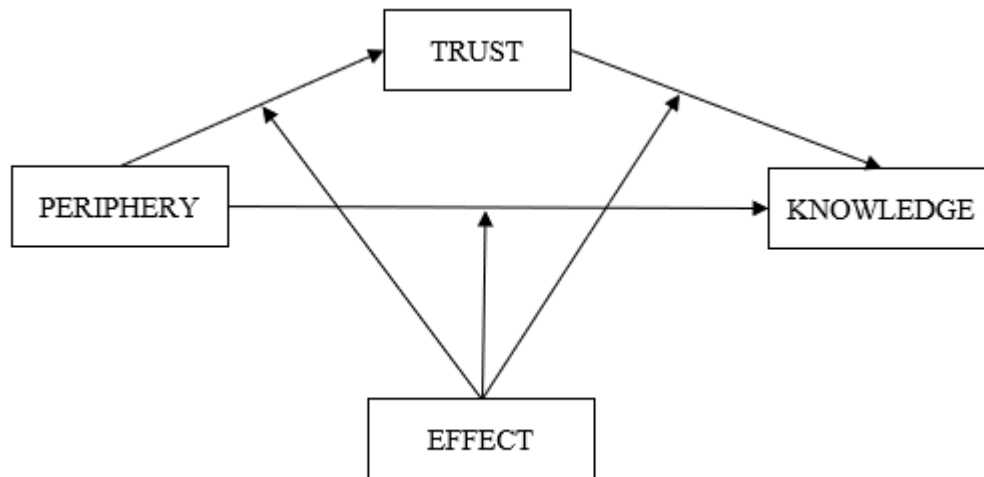


Figure H.21 : The Hayes model for the effect of effect on periphery-knowledge relationship.

Run MATRIX procedure:

```

***** PROCESS Procedure for SPSS Version 3.3 *****

      Written by Andrew F. Hayes, Ph.D.      www.afhayes.com
      Documentation available in Hayes (2018). www.guilford.com/p/hayes3

*****
Model   : 59
  Y     : KNOW
  X     : PERI
  M     : TRU
  W     : EFF

Sample
Size:  506

*****
OUTCOME VARIABLE:
  TRU

Model Summary
      R      R-sq      MSE      F      df1      df2      p
      ,6329      ,4005      1,1846      111,8107      3,0000      502,0000      ,0000

Model
      coeff      se      t      p      LLCI      ULCI
constant      3,6354      ,3154      11,5263      ,0000      3,0157      4,2551
PERI           ,3784      ,0620      6,1021      ,0000      ,2566      ,5002
EFF           -,2429      ,0867      -2,8017      ,0053      -,4132      -,0726
Int_1          ,0461      ,0161      2,8545      ,0045      ,0144      ,0778

Product terms key:
Int_1      :      PERI      x      EFF

Test(s) of highest order unconditional interaction(s):
      R2-chng      F      df1      df2      p
X*W           ,0097      8,1483      1,0000      502,0000      ,0045
-----

```

Focal predict: PERI (X)
Mod var: EFF (W)

Conditional effects of the focal predictor at values of the moderator(s):

EFF	Effect	se	t	p	LLCI	ULCI
1,3333	,4399	,0444	9,9110	,0000	,3527	,5271
3,3333	,5320	,0299	17,7993	,0000	,4733	,5908
5,3333	,6242	,0436	14,3110	,0000	,5385	,7099

OUTCOME VARIABLE:

KNOW

Model Summary

R	R-sq	MSE	F	df1	df2	p
,3050	,0930	3,7050	10,2535	5,0000	500,0000	,0000

Model

	coeff	se	t	p	LLCI	ULCI
constant	1,3200	,8075	1,6346	,1028	-,2666	2,9065
PERI	,3217	,1304	2,4664	,0140	,0654	,5779
TRU	-,0928	,1675	-,5543	,5796	-,4219	,2362
EFF	,1430	,2143	,6674	,5048	-,2780	,5640
Int_1	-,0285	,0362	-,7879	,4311	-,0997	,0426
Int_2	,0376	,0461	,8167	,4145	-,0529	,1281

Product terms key:

Int_1	:	PERI	x	EFF
Int_2	:	TRU	x	EFF

Test(s) of highest order unconditional interaction(s):

	R2-chng	F	df1	df2	p
X*W	,0011	,6207	1,0000	500,0000	,4311
M*W	,0012	,6670	1,0000	500,0000	,4145

|***** DIRECT AND INDIRECT EFFECTS OF X ON Y *****

Conditional direct effect(s) of X on Y:

EFF	Effect	se	t	p	LLCI	ULCI
1,3333	,2836	,0926	3,0644	,0023	,1018	,4655
3,3333	,2266	,0681	3,3247	,0010	,0927	,3605
5,3333	,1695	,1059	1,6009	,1100	-,0385	,3776

Conditional indirect effects of X on Y:

INDIRECT EFFECT:

PERI -> TRU -> KNOW

EFF	Effect	BootSE	BootLLCI	BootULCI
1,3333	-,0188	,0503	-,1178	,0809
3,3333	,0173	,0447	-,0697	,1048
5,3333	,0673	,0947	-,1228	,2460

***** ANALYSIS NOTES AND ERRORS *****

Level of confidence for all confidence intervals in output:

95,0000

Number of bootstrap samples for percentile bootstrap confidence intervals:

5000

W values in conditional tables are the 16th, 50th, and 84th percentiles.

----- END MATRIX -----

APPENDIX I: Research Ethics Committee approval

İSTANBUL TEKNİK ÜNİVERSİTESİ
SOSYAL VE BEŞERİ BİLİMLER İNSAN DENEYLERİ ETİK KURULU
DEĞERLENDİRME SONUCU

PROJE NUMARASI: 73

TARİH: 28.05.2018

1.	Projenin Adı ve Yürütücüsü: Sağlık sektöründe müşteri katılımının müşteri deneyimi açısından incelenmesi – Prof. Dr. Şebnem Burnaz
2.	Projenin Amacı (azami 100 kelime) : Bu araştırmanın amacı, müşteri deneyimi kalitesi, taahhüt, güven ve müşteri katılımı arasındaki ilişkiye yeni bir yaklaşım sağlamaktır. Araştırma soruları "Hastane deneyiminin kritik temas noktaları nelerdir?", "Deneyim kalitesi, katılımı nasıl etkiler?" ve "Hangi faktörler, deneyim ve katılım arasındaki ilişkiye aracılık eder?"dir. Bu araştırmanın literatüre üç alanda katkısı olmaktadır: (1) Nitel aşama ile deneyim kalitesindeki kritik temas noktalarını belirlenecektir, (2) Müşteri deneyimi ve müşteri katılımı ilişkisi literatür için yeni bir yaklaşım olacaktır ve (3) Karmaşıklık teorisi ışığındaki nicel analiz, tüketicilerin doğrusal olmayan davranışlarına ulaşmayı sağlayacaktır.
3.	Projenin Yöntemi (azami 100 kelime) : Proje, iki aşamadan oluşmaktadır. İlk aşamada katılımcılarla derinlemesine görüşme yapılacak ve daha sonraki aşamada anket çalışmasına geçilecektir.

~~X~~ Proje değerlendirilmiş ve etik açıdan uygun BULUNMUŞTUR.
γ Proje değerlendirilmiş ve etik açıdan uygun BULUNMAMIŞTIR.

AA ee M. 12.05.18

Proje Adı ve Yürütücüsü:

TARİH: 28.05.2018

Sağlık sektöründe müspet katılımların müspet deneyimi açısından incelenmesi
Prof. Dr. Şehinur Bursalı


Prof. Dr. Şehinur BURSALI
İstanbul Teknik Üniversitesi
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EDUCATION :

- **B.Sc.** : 2012, Istanbul Technical University, Faculty of Management, Department of Industrial Engineering
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PROFESSIONAL EXPERIENCE AND REWARDS:

- 2013- present : Research assistant in Istanbul Bilgi University, Faculty of Communication
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- 2015 : Finalist for the EDCOM Best Graduate Thesis Award
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PUBLICATIONS, PRESENTATIONS AND PATENTS ON THE THESIS:

- **Ozcelik, A. B. & Burnaz, S. (2019).** Customer Experience Quality Dimensions In Health Care: Perspectives Of Industry Experts. *Journal of Management, Marketing, and Logistics*, in press.
- **Ozcelik, A. B. & Burnaz, S. (2019).** Sadece Müşteri mi Deneyim Yaşar? Hasta Deneyimine 5P Yaklaşımı. *Harvard Business Review Türkiye*, Mayıs, 102-107.
- **Ozcelik, A. B. (2018).** Hatırlanabilir Deneyim Yaratmak. Doctoral Colloquim, 23rd Marketing Congress, 27-29 June, 2018, Kocaeli, Turkey. *Best dissertation proposal award.

OTHER PUBLICATIONS, PRESENTATIONS AND PATENTS:

- Kazazoglu-Sahin, G., **Ozcelik, A. B. & Burnaz, S. (2019).** Competitive Deviance from Ethicality: A Focus on Online Settings. In (Eds.) Ipek Altinbasak Farina and Sebnem Burnaz. *Ethics, Social Responsibility and Sustainability in Marketing*, Springer: Singapore.

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- Ceylan, C. & **Ozcelik, A.B.** (2016) “A Circular Approach to SERVQUAL and HOLSAT: An Implementation Suggestion”. *Journal of Hotel and Business Management*, 5(1), doi: 10.4172/2169-0286.1000125