Business Research Unit (BRU-IUL)

Universidade Europeia

Hospitality as a Tool for Service Improvement: A Hospital Case Study

Ana Sofia Almeida Lopes

Thesis special presented for the fulfilment of the degree of Doctor of

Tourism Management

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Resumo

Objetivos: A qualidade da prestação de serviços, os recursos humanos e as interações verbais são componentes fundamentais dos serviços, como por exemplo nos setores do turismo e saúde. O estudo da hospitalidade como instrumento para a melhoria dos serviços, em particular nos hospitais, é o principal objetivo desta investigação. Analisar a hospitalidade, o seu significado e, a importância do contéudo e nível de formalidade das interações verbais são, também, objetivos deste estudo.

Desenho da tese: Este estudo tem como base uma abordagem qualitativa que inclui observações presenciais e entrevistas.

Contribuição teórica: Este estudo contribui para o conhecimento teórico sobre a importância da hospitalidade nos hospitais. A presença de hospitalidade não depende somente da componente médica e dos fatores ambientes e físicos num hospital, mas também, da qualidade das interações verbais, isto é, do seu conteúdo e nível de formalidade.

Contribuição prática: Este estudo destaca a relação entre os hospitais e os hotéis ao nível das dimensões de hospitalidade e destaca a utilidade dos profissionais de saúde na implementação e desempenho da hospitalidade nomeadamente na forma de interagir com os pacientes.

Originalidade: Este estudo identifica novas temáticas que exploram a perspetiva dos profissionais de saúde sobre a hospitalidade; a influência das interações verbais; alerta para os pontos que necessitam ser abordados pela literatura e praticados pelos profissionais para melhorar a experiência dos pacientes; e a relação entre a hospitalidade nos hospitais e na hotelaria de uma forma social e não unicamente física.

Palavras-chave: Hospitalidade; hospitalidade nos hospitais; interações verbais; informalidade.

Abstract

Purpose: The quality of service delivery, human resources and verbal interactions are key components of service providers' success, including those in the tourism and health sectors. This study's main objective is to examine how hospitality functions as a tool for service improvement, especially in hospitals. The additional goals are to analyse hospitality, its meaning and the importance of verbal interactions' content and level of formality.

Design: The research was based on qualitative methods including participant observation and interviews.

Theoretical contributions: The results contribute to a deeper theoretical understanding of hospitality's significance in hospitals. Whether hospitality is present depends not only on hospitals' medical staff and facilities and environmental and physical factors but also on the quality of verbal interactions and, more specifically, their content and level of formality.

Practical contributions: The findings highlight both the parallels between hospitals and hotels in terms of hospitality dimensions and health professionals' central role in the implementation and performance of hospitality through the ways they interact with patients.

Originality: This study focused on new topics within hospitality by exploring health professionals' perspectives on this strategy and the effects of hospital staff's verbal interactions with patients. The results highlight the aspects that still need to be addressed by researchers and emphasised by health professionals to improve patients' experiences, as well as the similarities between hospitality in hospitals and hotels in terms of social rather than just physical dimensions.

Keywords: Hospitality; hospitality in hospitals; verbal interactions; informality.

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1. Introduction

1.1 Background

1.1.1 Tourism

Tourism is a complex phenomenon that includes varied services and comprises a set of activities and attractions offered by service providers to meet customers' needs and expectations, thereby creating value and benefits for them (Darbellay & Stock, 2012; Echtner & Jamal, 1997; Lovelock & Wright, 1999). Tourism services have specific characteristics: intangibility, inseparability, heterogeneity and perishability (Moeller, 2010; Reisinger, 2001; Taherdoost, Sahibuddin & Jalaliyoon, 2014; Vargo & Lusch, 2004).

1.1.1.1 Intangibility

Services are intangible, which means that they are not physical and cannot be physically owned since they cannot be observed, touched, heard or smelled before their acquisition (Fisk, Grove & John, 2008; Kotler, Hayes & Bloom, 2002; Reisinger, 2001; Taherdoost et al., 2014). Service providers must thus offer tangible representations of their services (Kotler et al., 2002).

1.1.1.2 Inseparability

Specific intrinsic conditions characterise services, for example, the simultaneous purchase and consumption of products. Providers, consumers and interactions between service providers and customers are also essential features, among other key components (Hill, 1999; Javalgi & Martin, 2007; Moeller, 2010).

1.1.1.3 Heterogeneity

Services vary from client to client. That is, services with identical characteristics can be provided in different ways since each individual is different and consumers make unique demands (Moeller, 2010; Reisinger, 2001; Taherdoost et al., 2014). On the one hand, this

heterogeneity facilitates customisation, personalisation and the provision of differentiated services to customers. On the other hand, heterogeneity makes establishing a single service and standardised performance and avoiding mistakes quite difficult (Reisinger, 2001). In addition, clients show great subjectivity when evaluating services (Fisk et al., 2008; Kotler et al., 2002).

1.1.1.4 Perishability

This characteristic means that services cannot be stored for future use. Therefore, if they are not utilised within a certain period, they cannot be preserved, returned or resold (Hoffman & Bateson, 2003; Järvinen & Lehtinen, 2004; Reisinger, 2001; Taherdoost et al., 2014; Vargo & Lusch, 2004). Beside these characteristics, services in tourism, as in any sector, require human resources (Baum, 2007, 2015) not only to create products, goods and activities but also to distribute them to clients directly or indirectly. Service providers are fundamental to service quality.

1.1.1.5 Human Resouces and Verbal Interactions

In tourism organisations, human resources are placed according to their function. Those working in the back office provide services unobserved by clients, but this staff's work influences the final result. Front-office workers are in direct contact with clients, so these staff members can probably be considered the strongest determinant of customers' perceptions of services (Kandampully & Suhartanto, 2000; Rao & Sahu, 2013; Watt, 2007).

When staff are in contact with clients, their interactions are the main vehicle of communication. Even non-verbal interactions, such as postures and gestures, and verbal interactions, as well as looking into people's eyes, influence customers' perceptions and generate value judgments of experiences (Gabott & Hogg, 2001; Islam & Kirillova, 2020; Kelly, Losekoot & Wright-StClair, 2016; Moon, Miao, Hanks & Line, 2019; Pinto et al., 2012; Roberts & Bucksey, 2007). Interactions' quality has thus become a key component of tourism-related service quality, which helps improve clients' experiences. Interactions' content and their level of formality condition relationships between providers and

customers. Given the importance of cultural, social, political, religious, gender and other issues, staff must adjust how they communicate and adapt services to take into account different contexts (Islam & Kirillova, 2020).

The necessary conditions for positive experiences are created by the relationships established between tourism service managers and their employees. These conditions are also shaped by providers' competence and the quality of the products offered and interactions between providers and clients, which thus contribute to customer loyalty (Berry, Carbone & Haeckel, 2002; Budianto, 2019; Stauss & Seidel, 2019). Hospitality is also a fundamental dimension of professionals' interactions with clients within service provision. Hospitality conditions and unites the previously mentioned elements (i.e. services, human resources and verbal interactions), which means that service management, professionals and interactions are connected in specific ways through hospitality (Garavan, 1997; Kaminakis, Karantinou, Koritos & Gounaris, 2019; Noe, Hollenbeck, Gerhart & Wright, 2017; Secchi, Roth & Verma, 2019).

In addition, tourism organisations' management must be oriented towards not only making a profit but also ensuring staff members' satisfaction. This condition is fundamental for these individuals to perform their functions in more positive ways (Borralha, 2018). When service providers base their work on hospitality, they also receive benefits. These include higher satisfaction with their job performance (i.e. workers can directly perceive the results of their efforts), better relationships with people (i.e. staff members, care providers and clients) and a sense of responsibility for their organisation's image (Quevedo, 2004). Thus, hospitality emerges as a dimension that makes positive interactions possible between all the actors in service provision and that contributes to a better workplace environment (Borralha, 2018).

1.1.2 Tourism and Hospitality

Although tourism can be defined in various ways, most researchers agree that tourism is to some extent fragmented. It comprises multiple spheres including, among others, transport, lodging, attractions, facilities, catering services and entertainment, as well as eating and drinking establishments (Chon & Maier, 2009; Lee & Yuan, 2018; Reisinger,

2013). Tourism is, as a result, a blend of services and products that different subsectors offer to tourists.

Hotels are one of the main tourism service providers. Currently, hotels invest not only in physical components (e.g. design, products and services) but also in personal components, which hotel managers have realised are a crucial element in their organisation's success. Hotels professionals receive guests and interact with a variety of people from different cultures and age groups, so employees' competence, as well as the way they receive, interact and welcome guests, has becoming key to improving hotel services.

These services range from reception to room service, from restaurant to breakfast service and from laundry service to concierge and security, so they involve many different professionals and their interactions with guests. Hospitality is thus vital to hotel service improvements (Rao & Sahu, 2013) as it can be used to support and develop different services (Lashley, 2000). Examining the quality of hotel services without measuring the presence of hospitality is now considered impossible (Rao & Sahu, 2013). The health sector similarly offers – and subdivides into – different services that are mostly quite specific and complex. In these two sectors, hospitality can also be understood as a fundamental factor in service quality.

1.1.3 Healthcare and Hospitality

The philosophy of hospitality is based on exchanges of services, products and goods and the way service providers receive and interact with customers. Thus, hospitality can be studied in varied contexts, including in healthcare provision (Bunkers, 2003; Dickson, Severt, Aiello & Noland, 2008; Gilje, 2004; Kelly et al., 2016). The health sector's competitiveness and supply chain have grown as the average life expectancy has risen. Patients have further become more demanding because their choices are currently more varied. In this setting, hospitality functions as an essential connection between healthcare services, professional caregivers and patients (Taylor & Edgard, 1996). In addition, hospitality's importance is magnified in healthcare contexts because caregivers treat and care for sick guests (Severt, Aiello, Elswick & Cyr, 2008).

However, because the concept of hospitality can have various meanings, researchers have experienced much difficulty understanding how hospitality can be applied in healthcare settings such as hospitals and which areas need to be included or which aspects are more important. Hospitality can be treated as an outcome (i.e. patients' response after healthcare services are provided) or as a process to be evaluated (i.e. the form in which services are provided) (Coulter, Fitzpatrick & Cornwell, 2009; Ottenbacher, Harrington & Parsa, 2009; Quader, 2009).

1.1.3.1 Human Resources and Verbal Interactions

In hospital settings, hospitality affects hospitals' everyday routines, and studies have shown that related aspects such as hospital conveniences and personal exchanges have an impact on how well patients' wishes and expectations about outcomes are satisfied (Kelly et al., 2016). Hospital experiences can be emotionally charged, so personal interactions are important to improving these experiences (Hartwell, Edwards & Symonds, 2006). Verbal interactions are the main means of communication, thus these interactions' content and level of formality and staff members' capacity for listening to patients are fundamental to building patients' trust and improving clients' experiences (Fleischer, Berg, Zimmermann, Wüste & Behrens, 2009; Rashid, 2009; Stanyon, Griffiths, Thomas & Gordon, 2016).

Healthcare professionals (e.g. doctors and nurses) are crucial because of not only their performance of medical services but also their interactions with patients. Hospitals' human resource managers need to encourage healthcare professionals and other front-office (e.g. reception) and back-office (e.g. cleaning and security) staff to implement hospitality strategies as this is also important to improving healthcare service quality (Berry et al., 2002; Cunningham et al., 2012). Service providers can significantly enhance the quality of patients' experiences by expressing positive attitudes. Patients' satisfaction levels are influenced by health professionals' emotional support and in-person interactions. However, the way that each patient gets pleasure from the same hospital experiences is always different since satisfaction has been shown not to be a universal phenomenon. The hospital staff's perceptions of patient satisfaction thus may or may not correspond to the reality of each situation (Hartwell et al., 2006).

Satisfaction is generated by both core services and peripheral features surrounding services. The resulting hospitality experiences are satisfactory only when all products and services' individual elements converge to create positive experiences (Hartwell et al., 2006). Taking into account patients' requests and desires appears to have become essential to any healthcare system's success. Consequently, health service providers have given increasing support to using patients' assessments and reports to supplement other ways of evaluating and checking healthcare quality (Cleary et al., 1991). Similar to hotels, hospitals include different services, human resources and multiple verbal interactions between different actors. This means that these three elements are connected and influenced by hospitality (Garavan, 1997; Kaminakis et al., 2019; Noe et al., 2017; Secchi et al., 2019), which contributes to better hospital experiences.

1.2 Purpose of Research

The present study's goal was to assess hospitality as a tool for service improvement. Hospitality is an important dimension of service provision in tourism and healthcare, but the literature reveals a gap in research contributing to a deeper understanding of hospitality in healthcare. Therefore, this study conducted a case study of a hospital setting to examine healthcare professionals' perceptions of hospitality's meaning and importance to service provision and the significance of verbal interactions – specifically in hospitals. The results help fill the gap left by the limited research on these topics and, more particularly, on healthcare professionals' perspectives on hospitality.

1.3 Relevance of Topic

Hospitality has already been investigated in hospital contexts. Prior studies have revealed that, besides healthcare's technical quality and clinical results, an essential characteristic of hospitals that affects patients' satisfaction is the quality of daily interactions in which a variety of individuals participate in different ways (Henke et al., 2018). Hospitality in hospitals thus contributes to satisfying human needs (Oliveira, Gomes, Racaneli, Velasquez & Lopes, 2013). However, few researchers have focused on the way hospitality is implemented and its current use as a practical resource in daily hospital operations. In addition, studies have neglected to examine the actual role played by

hospitality in hospitals and the significance of interactions between healthcare professionals and patients.

In addition, many researchers have concentrated on patients' experiences in hospital contexts and their perspectives on these (Ahlenius, Lindström & Vicent, 2017; Andaleeb, 2001; Cleary et al., 1991; Price et al., 2014; Richter & Muhlestein, 2017; Zaim, Bayyurt & Zaim, 2010), but the literature on health professionals' views is still incomplete (Turner, Eccles, Elvish, Simpson & Keady, 2017). Given that healthcare providers are essentially in charge of service quality, investigations are needed of the way these professionals interact with patients, these caregivers' experiences and their views regarding the importance of hospitality in hospitals. Finally, hospitality function as a tool for service improvement from a healthcare professional perspective is still underresearched.

Therefore, this study's results are expected to help not only hospital-related organisations but also other sectors such as tourism to achieve a deeper understanding. This includes how to use hospitality as way to improve services, which hospitality practices to adopt and how to ensure verbal interactions become the best vehicle for hospitality. This thesis is especially relevant because it focuses on a topic that is currently being explored and because parallels can be drawn with different contexts due to the hospitality concept's transferability.

1.4 Aims of Thesis

Although the concept of hospitality has been extensively studied in the hospitality and tourism industries, research on hospitality in the healthcare sector is still limited. The present study thus concentrated on understanding the importance of hospitality to service improvement and, more specifically, hospitality's presence and significance in hospitals, by examining hospital professionals' experiences and perceptions. Before the research could be conducted, the best way to address the following questions needed to be identified:

- RQ1: How is hospitality interpreted and experienced in hospitals by healthcare professionals?

- RQ2: How important are verbal interactions to hospitality in hospitals?
- RQ3: How important is hospitality as a tool for service improvement?

To define the research topic, the study's relevance and its main research questions, specific objectives had to be defined for each question. Regarding RQ1, the objectives were to examine hospitality' meaning and significance from healthcare professionals' perspective, as well as whether this strategy is perceived and interpreted in the same way by all individuals. To find out if hospitality has the same meaning for and importance to any sector, a comparison needed to be made between hospitality in tourism (i.e. hotels) and healthcare (i.e. hospitals). Hospitality's main components also had to be identified, including which can be implemented in hospitals. To achieve these objectives based specifically on healthcare professionals' perspectives, semi-structured interviews were conducted.

For the second research question (i.e. RQ2), the following objectives were delineated. The main types and contents of verbal interactions needed to be examined in inpatient hospital settings, along with the participants in these interactions. In addition, this research required developing an understanding of how informality is used as a hospitality strategy by hospital organisations. Finally, to evaluate verbal interactions between healthcare professionals and patients, data were collected using participant observation.

The objectives related to the third research question (i.e. RQ3) were defined. Hospitality was examined as an element of healthcare service assessments, especially its relationship with clients' satisfaction. Hospitality's importance to patients' experiences was investigated, as well as the significance of interactions in hospitals' daily operations. Further objectives were to determine the main participants and positive and negative factors that condition these interactions' quality. The final objective was to identify which improvements are needed to ensure better hospital experiences to allow conclusions to be drawn about the importance of hospitality as a tool for service improvement. To achieve the objectives proposed, semi-structured interviews were conducted.

1.5 Presentation of the Literature Review

This study started with a review of the literature on tourism as a multidimensional, complex phenomenon in order to explore its relationship with hospitality and the relevance of hospitality in other contexts such as healthcare. Next, the review focused on exploring the hospitality concept and its connection and importance to healthcare services, especially in hospitals, and the significance of verbal interactions as a way to transmit hospitality.

Subsequent analyses focused on how hospitality can be a tool for service improvement and implemented in practice and which practical resources can be adopted by other sectors. This part of the study concentrated on three elements: service provision, human resources and verbal interactions. The three elements are relevant in different sectors, including tourism and healthcare, and they are connected through hospitality (see Figure 1).

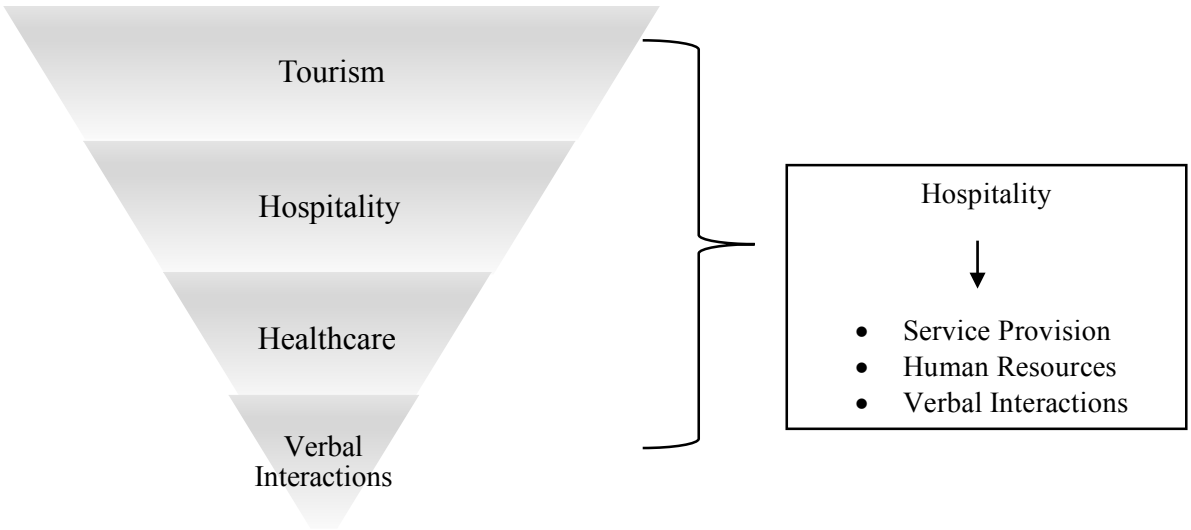

Figure 1. Presentation of the literature review

1.6 Organisation of Thesis

This thesis is organised into six major chapters. The first is the introduction, which is followed by two chapters discussing the general literature review and methodology applied, respectively. Chapter four details the results, while chapter five presents a discussion of the results. The last chapter offers the conclusions, including theoretical and practical implications, the study's limitations and suggestions for future research. The thesis ends with a bibliography and appendixes.

The above introduction identified tourism services' characteristics and the importance of human resources and provider-client interactions to services, with hospitality as the main link between them. In addition, the relationship between hospitality and healthcare was introduced. Because the health sector is also complex, diverse services are offered, and they have some points in common with tourism services. Next, the research's purpose was presented, as well as the research topic's relevance, the study's aims, a brief review of the literature and the thesis's sequence and organisation.

The following chapter covers the theoretical background, which includes a review of the relevant literature on tourism research. More specifically, the review covers the study of tourism as a multidimensional phenomenon, which is due to its economic, commercial, cultural and social dimensions. The discussion covers tourism's characteristics, service provision, human resources and verbal interactions, as well as this sector's relationship with hospitality. The chapter then reviews the hospitality concept as an important dimension of service provision in both tourism and healthcare, revealing a gap in researchers' understanding of hospitality in hospitals. The significance of hospitals' service provision, their human resources, the quality of verbal interactions and their connection with hospitality is also analysed.

The methodology chapter explains the reasons for using qualitative methods and a hospital setting to conduct the case study. This research focused on health professionals' perspectives on hospitality in hospital services and the daily routines of inpatient hospital healthcare. The study's context is presented with an explanation of the environment and details regarding the selection of the hospital and the authorisation process. This chapter further describes the data collection and content analysis methodologies. The data were

recorded via participant observation and semi-structured interviews over several months. Mixed content analyses of the data were carried out after 84 patients were observed, 241 interactions collected and various interviews recorded.

The results chapter covers the perspectives of health professionals on hospitality's meaning and importance in hospital contexts. The results include whether hospitality is perceived and interpreted in the same way by all participants and hospitality's relationship to services differs between sectors, in this case specifically in tourism (i.e. hotels) and healthcare (i.e. hospitals). Both sectors consist of varied services, providers, users and interactions. Other results are hospitality's main components and dimensions, as well as which can be implemented in hospitals. In addition, this chapter details the influence of verbal interactions' type, content and level of formality on patients' experiences, hospitality as part of healthcare service assessments and the importance of hospital experiences and verbal interactions. The final results include which improvements are needed to ensure better patient experiences, thereby revealing how hospitality can be used as a tool for service improvement.

The subsequent chapter presents a discussion of these results, while the final chapter offers the conclusions and discusses the findings' overall theoretical and practical implications for both academics and practitioners. This study's limitations are then detailed along with suggestions for future research.

2. Theoretical Background

2.1 Tourism as a Multidimensional Phenomenon

Tourism is a 'multisectoral industry and a truly multidisciplinary field of study' (Jafari, 2000, p. 585). Tourism is multisectoral because it includes different types of products (e.g. accommodations, food and beverages and transport) and services (e.g. hotels and travel agencies). Tourism not only conditions and influences other industries but is also influenced by them. Thus, research on this industry is a multidisciplinary field that has involved experts in different areas such as sociology, economics and psychology (Jafari & Ritchie, 1981). However, this industry is primarily given importance as a driver of

economic development (Sinclair, 1998; Tapper, 2001; Visser, 2019).

Because tourism is a multidimensional phenomenon, it is quite complex, presenting diverse services, products and individuals, and multifaceted, taking different forms and comprising varied areas (e.g. health tourism, religious tourism, ecotourism and business tourism). Tourism is also intangible because its services cannot be seen, used and experienced before they are acquired. For example, hotel rooms are only experienced during stays (Fisk et al., 2008; Kotler et al., 2002; Reisinger, 2001; Taherdoost et al., 2014). Furthermore, tourism is heterogeneous since its services are highly variable. That is, they change from client to client, making tourism a complex system dependent on tourists' subjective evaluations of services (Moeller, 2010; Reisinger, 2001; Silva, 2015; Taherdoost et al., 2014). Finally, tourism is perishable because its services, among other characteristics, cannot be stored for future use, so they must be consumed when produced. Namely, if hotels do not sell any of their rooms each day, their use cannot be stored for the next day, which means that empty hotel rooms do not generate profit (Hoffman & Bateson, 2003; Järvinen & Lehtinen, 2004; Reisinger, 2001; Taherdoost et al., 2014; Vargo & Lusch, 2004).

Tourism includes hospitality as an important dimension that influences its services. This concept is widely incorporated as a subarea of industries oriented towards services, such as tourism (Ariffin, Maghzi & Aziz, 2011). Tourism and hospitality providers are linked in stable patterns (Watson, 2008) since both industries centre their efforts around offering goods and services (Resinger, 2013).

The existing research on both hospitality and tourism shares various essential questions and concepts concerning the ways that hosts and guests relate to each other. These are power relationships because of provider-client interactions' dynamics. The concepts related to both hospitality and tourism have also been used to represent much wider social and cultural experiences and symbolic practices (Bell, 2009; Molz & Gibson, 2016; Wang, 2013).

Hospitality is necessarily one of tourism's basic components since the absence of hospitality compromises tourist destinations' sustainability. For hospitality to be

implemented successfully, tourists must understand and respect the cultural characteristics of the countries visited and their residents' customs (Besculides, Lee & McCormick, 2002; Doğan, 1989; Pizam & Jeong, 1996; Smith, 2012). Conversely, the interest and attention given by hosts to tourists' origins are also important so that they will feel accepted in their destination and that this process of sharing cultures can be positive.

However, the exchange process is jeopardised if the resident population is uncooperative and unreceptive and if tourists also fail to fulfil their duties, which leads to the breakdown of hospitality. Thus, all the actors involved need to realise hospitality's significance to tourists and host communities. Respect, understanding, acceptance and mutual tolerance strengthen communication skills and interpersonal relationships (Capocchi, Vallone, Pierotti & Amaduzzi, 2019; Martín, Martinez & Fernández, 2018).

In addition, service quality is crucial to achieving success in these areas. When guests are pleased with services, they will visit again and recommend service providers to others (Brochado & Rita, 2016). The best services will be those that, through hospitality, improve guests' wellbeing (Richie, Crouch & Hudson, 2001). Customer satisfaction and good quality services are much sought after by competing facilities within the hospitality industry (Paryani, Masoudi & Cudney, 2010). In general, the demand for tourism-related services has grown continuously, along with guests' desire for higher standards, which have increased competition between hospitality service providers.

In this context, key strategies known to promote companies' provision of services within the tourism sector have been implemented by providers in order to ensure high-level services and increase customer satisfaction (Dominici & Guzzo, 2010). Pleasing guests needs to be considered the minimum standard in tourism, so this industry's managers should take into account that their service quality depends on generating pleasurable emotions and memorable experiences (Brochado, Rita & Gameiro, 2015). Providing services and products alone is also no longer sufficient as experiences have become essential to guests' satisfaction. Generating and handling these events can be a challenging task particularly in terms of hospitality (Brochado et al., 2015).

Consumers categorise satisfactory experiences in four ways. The first is sensory – or physical – satisfaction, which arises from the pleasurable sensations felt during experiences. The second is social satisfaction, which occurs when consumers relate to others in positive ways. The third is emotions, which produce ideas, feelings or mental pictures. The last is intellectual satisfaction or consumers' capacity to understand experiences' intricate, enriched components (Dubé & Le Bel, 2003; Scott, Laws & Boksberger, 2009).

The experiences offered by tourism and hospitality can be viewed as dynamic, intricate systems within which hosts and guests interact through technical and service features (Checkland, 2000; Scott et al., 2009). Services can be defined as a combination of the actions occurring based on connections established between companies' staff, customers and other physical features, networks and/or structures. These aspects involve multiple service suppliers and potentially other customers, as the objective is to support routines clients find desirable (Brochado et al., 2015).

What guests hope to obtain from the services provided affects their post-purchase satisfaction, which makes satisfying guests with lower expectations easier than consumers with higher ones. Thus, understanding what guests wish for and want is essential (Wuest, 2001). Extraordinary service overall exceeds the quality and quantity expected by guests (Collier, Barnes, Abney & Pelletier, 2018; Pizam & Ellis, 1999; Wuest, 2001). Enjoyable surprises offered by hosts can increase customers' fulfilment, and their satisfaction levels will be higher. Guests whose expectations have been met or surpassed can be a bonus for businesses because these clients become excellent adverts (Collier et al., 2018; Wuest, 2001).

Torres and Kline (2006), among other authors, argue that customer satisfaction only shows that service provision was good, which does not imply that guests are enthusiastic about the provider. Highly pleased customers are both enthusiastic and likely to share positive opinions about services to other consumers. Delight with the services provided has been connected to results such as guest loyalty and firms' higher income, which can generate competitive advantages that other providers find hard to replicate (Crick & Spencer, 2011; Torres & Kline, 2006).

Crick and Spencer's (2011) study confirmed that the fulfilment of guests' needs is currently considered just a basic level of service provision. A variety of organisations providing hospitality services consider service quality to be the generation of emotional fulfilment and outstanding experiences. Different hospitality providers of standard services currently use the concept of experience to plan and improve services provided to visitors, guests and customers (Dickson et al., 2008; Pine & Gilmore, 1998). According to Hemmington (2007, p. 17), 'hospitality organisations that are able to capture this sense of theatre and generosity will gain competitive advantage[s] by providing their guests with experiences that are personal, memorable and add value to their lives.'

2.1.1 Hotel Service Provision

Research on hospitality in tourism has been expanding mainly in the hotel sector (Park, Phillips, Canter & Abbott, 2011; Suess & Mody, 2017). Hotel services have become one of the most visible faces of hospitality. Given the increased competition among hotels, guests can now choose their hotels' physical appearance, location and variety of services, as well as the way travellers are accommodated and received. Hotels currently bet not only on differences in the services offered but also on the quality of service provision.

The hotel sector thus depends on offering quality services and products, competent employees and meaningful provider-client interactions. As a result, how hosts interact with guests has become a key element in the provision of quality services. The human factor is central to hospitality, and individuals are the essence of hotel businesses' services. This aspect has remained important regardless of technological developments given that the way in which guests are received in hotels deeply marks consumers' perceptions of these places upon arrival (Quevedo, 2004). Even the placement of items in rooms or the manner in which guests are greeted can generate a feeling of being in a home when individuals are away from home. The interaction of hotels' efforts to create a familiar, homelike setting with these businesses' need to be economically sustainable is what makes the hotel sector unique, as well as stimulating and exciting (Crick & Spencer, 2011; Pizam & Shani, 2009).

2.1.2 Hotel Human Resources

Individuals employed by hotels usually interact with people from different cultural backgrounds, whose views on service quality can be influenced by specific cultural aspects such as power distance (Crick & Spencer, 2011; Tsang & Ap, 2007). Studies of service quality have produced a consensus around the idea that guests are the final decision makers regarding the services provided (Crick & Spencer, 2011; Wuest, 2001). Therefore, the hospitality sector, especially hotels, involves a great deal of competition regarding offering service quality that results in customer satisfaction (Crick & Spencer, 2011; Parayani et al., 2010). Hotel guests' contentment is mainly based on hotels' quality services and products and the way clients are received. Mutual long-term guest-host relationships are essential given the largely positive connection found between guests' overall satisfaction and their likelihood to return to particular hotels (Ariffin et al., 2011).

Hotels must thus more accurately understand what guests actually want to obtain from their service experiences (Cetin & Dincer, 2014; Crick & Spencer, 2011). To prosper in their market, hotels need to not only attract more customers but also focus on keeping the existing ones by applying loyalty and customer satisfaction strategies. In this sector, customer satisfaction goes hand in hand with the service quality provided (Dominici & Guzzo, 2010), but service quality cannot be measured as a stationary goal because standards are constantly changing. The core of client-oriented service provision (i.e. hospitality) is the fulfilment of customers' expectations. Most research on hotels has shown that this sector is characterised by intense, rising competition regarding service quality and customer satisfaction (Crick & Spencer, 2011; Paryani et al., 2010).

Even though experts have concluded that meeting expectations generates satisfaction and that surpassing these produces pleasure, most studies of this topic have observed hospitality in only its most basic forms. Hotels provide many services over time, so these organisations need to prevent any failures in service provision. The possibility of these occurring is higher in hotels because of their greater volume of interactions. The service quality provided keeps on generating competitive advantages for these businesses since competitiveness has not decreased and the general public is travelling more and becoming more complex as clients. Individuals now expect to have a variety of options and

information available from individual hotels. Hotel managers who bet on hospitality as a tool for service improvement will gain additional advantages (Crick & Spencer, 2011).

2.1.3 Hotel Verbal Interactions

As previously mentioned, hotel services imply many interactions between hosts and guests and between service providers themselves. Hospitality is crucial in any area of hotels, from the front office to the back office. Hospitality starts with guests' arrival and their interactions with the concierge and continues with check-in and subsequent interactions with other employees. The latter's gestures and the way they receive and talk with clients are essential (Ariffin, Maghzi, Soon & Alam, 2018; Christou, Avloniti & Farmaki, 2019).

Different services' quality is crucial, including, among other features, hotels' design, hygiene, room service, restaurant food, security and many other services (e.g. check-in and check-out). However, physical services are not the only important component in guests' experiences as service personalisation, human resources' competence and verbal interactions' quality are also necessary elements of hospitality (Ariffin & Maghzi, 2012; Buhalis & Amaranggana 2015). The service quality and social environment provided through verbal interactions between all employees and clients contribute to better hotel services that are later reflected in the quality of guests' experiences (Bitner, Booms & Mohr, 1994; Christou et al., 2019).

2.2 Hospitality Concept

Hospitality is understood in different ways by various fields of research such as tourism, management and marketing. Previous studies have found that hospitality has been investigated from different viewpoints and to achieve varied objectives (Lynch, Molz, Mcintosh, Lugosi & Lashley, 2011; O'Gorman, 2007; Still, 2006). However, most studies of hospitality in service provision have sought to examine this concept's different dimensions (Lynch et al., 2011; O'Gorman, 2007; Still, 2006). These include physical environments (i.e. design and infrastructures) (e.g. Suess & Mody, 2017; Wu, Robson & Hollis, 2013) and amenities (i.e. prices, food, accommodations and security) (e.g. Crick

& Spencer, 2011; Dominici & Guzzo, 2010; Justesen, Gyimóthy & Mikkelsen, 2016). Other dimensions are customer satisfaction (e.g. Paryani et al., 2010; Severt et al., 2008) and social interactions (i.e. host-guest and service provider-client interactions) (e.g. Ariffin et al., 2011; Bell, 2009; Justesen et al., 2016; Lynch et al., 2011; Molz & Gibson, 2016; Severt et al., 2008).

Hospitality usually includes a vast spectrum of elements, such as accommodations, nourishment, leisure, protocols, travel and attractions. A quite broad conceptualisation is needed to facilitate analyses of hospitality activities in terms of social, commercial and private aspects (Lashley, 2000, 2011). The social aspect includes wider social contexts in which hospitality occurs (e.g. cultures and proximity levels) (Lashley, Lynch & Morrison, 2007). The commercial domain covers hospitality services as economic activities (e.g. travel and accommodation). The literature shows a growing interest in the study of hospitality in terms of more private aspects, namely, in its study and evaluation as a social phenomenon related to the establishment of personal relationships (Lashley, 2000, 2011).

Hospitality is defined similarly in academia and mainstream public discourse as related to the provision of food, beverages or accommodations. Defining hospitality this way – although useful at times – excludes part of its essence by narrowing the conceptual framework and hindering further rational options. Hospitality is thus often associated with commercial operations as it plays a fundamental role in boosting service provision's economic value, but this approach limits the role of personal interactions to commercial relationships (Kunwar, 2017; Lashley, 2011; Lynch et al., 2011; Ottenbacher et al., 2009).

To meet hospitality service standards, this concept's essential meaning needs to be understood more fully (Kunwar, 2017). The primary question to answer is what hospitality means, to which different answers have been given. These include 'receiving guests in a generous and cordial manner', 'creating a pleasant or nourishing environment', 'satisfying a guest's needs', 'anticipating a guest's desires' or 'generating a friendly and safe atmosphere' (Chon & Maier, 2009, p. 5). Another suggestion is 'friendly and welcoming behavior towards … guests' (Kunwar, 2017, p. 56). According to the *English Oxford Living Dictionaries* (n.d.), hospitality is defined as 'the friendly and generous reception and entertainment of guests, visitors, or strangers' (see

https://en.oxforddictionaries.com/definition/hospitality).

Determining hospitality's significance and importance has proved a challenge for many researchers in the fields of hospitality and tourism (e.g. Brotherton, 1999; Chon & Maier, 2009; Kunwar, 2017; Ottenbacher et al., 2009). The literature on hospitality shows that many scholars have studied this concept in recent years and that many researchers have contributed a growing number of evaluation instruments used to assess service quality, competitiveness and consumer expectations. Despite the plethora of research, key questions still remain unanswered, and they will likely continue without answers well into the future. While various definitions of hospitality are closely associated with the way guests are received and satisfied, a clear paradigm has not been defined for hospitality's significance and importance.

Given this lack of consensus among researchers, Jones (1996a, cited in Kunwar, 2017, pp. 6–7) argues that 'hospitality research exists more in form than in substance'. This has happened probably because hospitality is a subjective concept that is dependent on different contexts (e.g. cultural, social, economic, ethical, religious and political aspects). Various authors have also suggested that hospitality depends on complex relationships between those who engage in relevant acts and those who receive these acts through experiences (Kunwar, 2017; Lashley et al., 2007; Lugosi, 2008, 2009).

Hospitality can be further understood as a process involving the organisation of individuals who do not know each other, in cultural and social settings comprised of duties, obligations and morals (Lynch et al., 2011). This broad conceptualisation can also be used to explain the ways in which individuals behave towards other people (Crick & Spencer, 2011). Thus, a more useful way of looking at hospitality is as a process involving: hosts and guests as the main participants (Lynch et al., 2011).

Typically, hospitality comprises the act of involvement (i.e. welcoming behaviours), certain attitudes (i.e. allowing a free flow of expressions, opening a house door or letting an unknown person use one's space) and underlying social principles (Lynch, et al., 2011). Brotherton (1999) additionally specifies that hospitality is composed of three main relational exchanges. These are guest-host interactions, provider-receiver exchanges and

diverse features connected to the way in which hosts supply their guests with a sense of security and mental and physical wellbeing.

Establishing relationships or managing existing ones is, therefore, the essence of hospitality. Actions related to hospitality are present during host-guest interchanges of services, products and goods (Lashley, 2000; Selwyn, 2000). Hospitality is how institutions please and keep customers, going beyond their expectations and providing them with the best possible experiences (Chang & Teng, 2017; Kandampully, Zhang & Jaakkola, 2017; Rathore, 2017), which are achieved through personal interactions. These relationships are defined by hospitableness that, although initially shown by hosts to guests, can later become reciprocal (Brotherton, 1999; Paraschivescu, Cotârlet & Puiu, 2011; Severt et al., 2008).

Hospitality further comprises a welcoming attitude and atmosphere that ensure more than just outstanding services and memorable experiences (Severt et al., 2008). Hospitality as a transversal dimension is present across various domains and services in different sectors. It influences the service quality provided by employees and the different interactions they initiate. The presence of hospitality acts is important in day-to-day services (Kelly et al., 2016).

However, Taylor and Edgard (1996) argue that the scope of hospitality research must be defined more clearly in order to create a coherent theoretical framework that can more objectively reflect all functions and perceptions of hospitality. Researchers must, therefore, examine how service providers understand hospitality's meaning and importance and how hospitality is used as a tool for service improvement.

2.3 Healthcare: Hospitality in Hospitals

Hospitality has mainly been investigated in business contexts within the tourism and hospitality industry, for example, hotels, restaurants and transport (Dickson et al., 2008; Suess & Mody, 2017), but many insights can also be obtained from studying hospitality in different contexts not associated with these facilities. More specifically, hospitality needs to be studied within the health sector because its fundamental philosophy includes

the exchange of goods and services and interactions among service receivers and providers (Bunkers, 2003; Dickson et al., 2008; Gilje, 2004; Kelly et al., 2016). The literature on hospitality in healthcare contexts has been expanding, particularly regarding health tourism. Individuals have begun to engage in this type of tourism in places other than their own community, receiving treatments that do not exist in their region and/or country while simultaneously getting to know new places. Satisfying the need to get specific treatments and to visit new locations simultaneously reduces patients' stress on a mental and physical level.

Hospitality is important not only in health tourism but also as a part of routine healthcare services, so hospitality needs to be integrated into the relevant institutions' service philosophy. Hospitality has also been found to be relevant in different healthcare services (Bunkers, 2003; Gilje, 2004; Kelly et al., 2016). Hospitals are a prime example of organisations providing these services, which means that research on hospitality in hospitals has developed into an important topic in the literature. Nonetheless, the information available on this subject is still incomplete even though this field of study has grown in recent years.

Research on hospitality in hospitals has become crucial due to the growing importance patients give to the quality of their experiences in routine healthcare provision. According to Pizam (2007, p. 500), 'the difference between hospital and hospitality is "ity", but that "ity" can make a significant difference in the recovery and stay of hospital patients.'

Hospitals need to provide patients with a hospitable atmosphere when they are ill (Dickson et al., 2008). Given that life expectancy is higher and more individuals will potentially require medical care, social welfare systems and hospitals will have to meet new standards in healthcare provision. The general public, potential patients and competitors, for instance, are beginning to assess their satisfaction with hospitals through publicly accessible online reviews. Extremely positive results could come from this public information (DeMicco, 2017; Dickson et al., 2008). Based on related research, Bart and Tabone (1998) concluded that caretakers' conduct is positively influenced by institutions that line up their structures, practices, internal policies and processes with a clear mission (Bart & Tabone, 1998; Dickson et al., 2008).

Hospitals as organisations mainly focus on management procedures (Kelly et al., 2016; Wensing, Wollersheim & Grol, 2006), medical treatments (Walshe & Rundall, 2001) and clinical and financial results (Walshe & Rundall, 2001; Wensing et al., 2006). While hospital functions are necessarily related to and centred around clinical results (Porter & Lee, 2015), patients do not only evaluate their clinical results but instead assess and remember hospital experiences as a whole rather than as separate services (Kelly et al., 2016; Poksinska, Fialkowska-Filipek & Engström, 2017). The unique experiences of hospitals' 'guests' thus need to be examined because the quality of these experiences is often related to these clients' emotions, which can be intensified by illness, fear and other factors (Paraschivescu et al., 2011; Severt et al., 2008).

Various studies of patients' hospital experiences have paid attention to customer service in terms of service provision systems and service quality measured across a variety of structures and procedures (Ahlenius et al., 2017; Cleary et al., 1991; Price et al., 2014; Richter & Muhlestein, 2017; Zaim et al., 2010). Because of hospitality's importance to the proper management of routine hospital activities, researchers have also verified that various aspects play a part in shaping patients' expectations, namely, hospital amenities and interpersonal relationships (Kelly et al., 2016). Scholars have had some difficulty determining the exact role of expectations, experiences and satisfaction levels when these are used to measure clinicians or organisations' healthcare provision. Patients' viewpoints and questions are most likely affected by their previous experiences with healthcare services and by their understanding of the relationships and dependencies existing among providers. Nonetheless, the feedback obtained is essential to producing positive change (Coulter et al., 2009).

Research on hospital service quality has identified essential dimensions (Kelly et al., 2016; Shirzadi, Raeissi, Nasiripour & Tabibi, 2016): technical care, treatments and medications; hospital facilities' quality (i.e. reception and room design); and relationships between individuals. The latter personal connections are a non-medical aspect that is crucial to meeting patients' general expectations. Improving support service provision apparently requires enhancing patients' safety, care, health recovery and general comfort (Kelly et al., 2016; Suess & Mody, 2018). Hospitals' atmosphere is also regarded as crucial to patients' experiences. This has led some hospitals to adopt service design

strategies used by the hospitality industry to provide better services (Kelly et al., 2016; Shirzadi et al., 2016).

2.3.1 Hospital Service Provision

Even though some studies early on confirmed that other hospital services are provided besides medical treatments, hospital staff have viewed patients as clients only in recent decades. These individuals clearly have other needs and wishes that need to be fulfilled in addition to their health, illness or treatment (Quevedo, 2004). A parallel can thus be found between some tourism and healthcare services.

Managing hospitals as hotels is a relatively new research topic, but Sloan (as cited in Wu et al., 2013) considered options and searched for an innovative training programme for new hospital executives already at the beginning of the 1950s. The cited author concluded that a 'hospital in certain respects is a very specialised hotel'. Sloan (as cited in Wu et al., 2013) believed that hospital administrators could acquire much useful knowledge from hospitality firms' management perspectives.

Hotels seek to delight their guests as satisfying their needs is only a minimum standard (Dominici & Guzzo, 2010; Torres & Kline, 2006). This goal has led hotels to direct their efforts towards bettering products and management. Hospitals can learn from hotels' experiences, and patients, hospital staff and employees could greatly benefit from hospitals' adoption and application of hotel practices to enhance patients' satisfaction and endorsement (Zygourakis, Rolston, Treadway, Chang & Kliot, 2014).

When researchers have observed hospitals closely, a correspondence has been found between these and hotel settings. According to Severt et al. (2008), parallels have been detected in host-guest relationships within both organisations, and these providers have already been compared with regard to the types of services offered. The features in common include the 24-hour service availability of bedding, maintenance, security and nourishment. Another similarity is that, in both settings, various expected or unanticipated changes can occur (Tanner, 2011).

In addition, hotel and hospital staff must offer round-the-clock availability and welcome unknown individuals for diverse reasons, including friends and family members (Dickson et al., 2008). Other shared features of hotels and hospitals are that they assist clients who are knowledgeable and who demand good service and that both types of organisations consist of vast hierarchies with diverse responsibility levels. Hotels and hospitals' incomes are also connected to customers and/or patients' assessments. Despite the above similarities, few studies have compared hospitality in the hospital and hotel sectors (Zygourakis et al., 2014).

Hotels have benefited from many years of experience of applying management and market research, which has given their staff extensive practice in how to improve customer satisfaction. Contrary to hotels' long-term focus on guests and/or customers' experiences, hospitals are new to paying attention to patients' satisfaction (Zygourakis et al., 2014). Notably, in hospitals, patients are generally nervous and worried about their treatment. While they might be able to choose the place in which they will receive care, they may not voluntarily seek out that care. Medical treatment might be an unwelcome experience (Zygourakis et al., 2014).

In contrast, hotel guests choose their accommodations, and these individuals are mostly enthusiastic about being there, especially if they are travelling for leisure and not just for business. Hotels are generally selected prior to a stay. Hospitals are, in this respect, at a disadvantage compared to hotels since hospitals need to provide more services to guarantee patients' wellbeing (Zygourakis et al., 2014). Paraschivescu et al. (2011, p. 126) thus observe that 'the difference between a patient and a guest is not mutual, [since] a patient can be a guest, but a guest is not always a patient'.

Given the similarities between hospitals and hotels, practices and novel ideas generated in the hotel sector have over time been brought into healthcare in diverse ways (Shirzadi et al., 2016; Wu et al., 2013). When examining conventional hotels, researchers have been able to identify various practices that can be transferred to hospital settings. The most common are preadmission processes, welcome and check-in processes, patients' stay, discharge procedures, post-stay experiences, food and beverage provision and administrative processes (Quevedo, 2004; Zygourakis et al., 2014). Furthermore,

hospitals can adopt hotels' practices according to the dimensions discussed in the following subsections.

2.3.1.1 Tangible Dimensions and Space Attachment

Hotel guests consider different dimensions when evaluating the quality of hotel services: hygiene, price, location, security, personal services, places' general appeal, relaxation opportunities, service level, good image and reputation (Dominici & Guzzo, 2010). Researchers have found proof of hospital physical surroundings' growing importance, which enhance healing and determine consumer decisions (Shirzadi et al., 2016; Suess & Mody, 2017, 2018; Wu et al., 2013). The hotel industry's influence on healthcare service provision began with the incorporation of hotel-style facilities into hospitals, as well as supplying services similar to those provided in hotels. Some hospitals' design has been based on hotels to meet the patients and families' expectations and satisfy monetary and regulatory requirements (Shirzadi et al., 2016; Wu et al., 2013). This new guest service approach embodies the idea that, when hospitality is combined with healthcare, this affects not only the image projected by spaces and facilities but also the efficacy of processes and staff relationships (Suess & Mody, 2017).

Hospitals that have an atmosphere more closely related to hotels appear to retain their staff longer, and these facilities have higher levels of staff satisfaction than those reported by professionals working in less appealing hospitals (Wu et al., 2013). Essential aspects of the hospitality industry such as good quality food, dedicated employees and an enjoyable atmosphere play an important role in creating demand for hospitals (Shirzadi et al., 2016; Wu et al., 2013). Patients appreciate hotel-like characteristics including, among others, private and family-friendly rooms, views and meals brought in as if they are room service. These aspects are given a similar level of importance as hospitals' good name and status when patients make their choice of healthcare facilities (Wu et al., 2013).

2.3.1.2 Intangible Dimensions

Hotel staff's performance as hosts comprises three items – personalisation, comfort and a warm welcome (Ariffin et al., 2011; Ariffin & Maghzi, 2012) – with personalisation

being the most essential feature (Ariffin et al., 2011). Elements of the latter include establishing eye contact with guests and always addressing them with great respect (Ariffin et al., 2011). Hospitals' hospitality has also inspired applications of the concept of humanisation to the healthcare sector (Oliveira et al., 2013; Severt et al., 2008), resulting in a new image of hospitals as facilities that provide patients with comfort and safety and create a feeling of exclusivity. Humanisation in hospitality means patients are approached as healthcare customers who have special needs. Thus, healthcare institutions have implemented a conceptualisation of service provision that seeks to humanise services (Oliveira et al., 2013).

In practice, hospitality is shown by healthcare providers' attentiveness to the experiences patients talk about and the emotional links established between caregivers and clients (Kelly et al., 2016; O'Halloran, Worrall & Hickson, 2011). This is at times shown through small details such as a nod of the head or a look straight into someone's eyes (Kelly et al., 2016). These gestures can happen during medical routines, so adding these details does not require providers to invest more time. When the latter connect directly with patients by giving them attention, hospitals' users are more content than they would be otherwise, and this probably diminishes patients' calls for assistance (Kelly et al., 2016; O'Halloran et al., 2011). Healthcare providers (i.e. medical and support staff) need to understand the concept of true hospitality, which allows them to meet patients' needs better and treat them holistically – focusing on more than just their symptoms (Kelly et al., 2016).

2.3.1.3 Organisational System

The practice of hospital hospitality also requires specific resources to satisfy patients' needs and provides healthcare institutions with strategies that amplify service options in order to appeal to more potential customers (Oliveira et al., 2013). Hospital administrators are currently becoming more aware that patients are usually involved in the choice of their inpatient care hospital, so these managers are starting to treat patients as consumers. Healthcare services' quality relies on the combined effects of human components, processes and technology, as well as hospital staff's professional skills, qualities and hospitality practices (Paraschivescu et al., 2011).

The main ways in which patients evaluate healthcare provision has been sometimes investigated by measuring their satisfaction as clients (Coulter et al., 2009; Quader, 2009). The term hospitality usually has a multidimensional meaning, so no agreement has been reached on the areas comprising hospital hospitality or the most important aspects (Coulter et al., 2009; Ottenbacher et al., 2009). At times, hospitality is treated as a result (i.e. feedback regarding healthcare provision after treatment), and, at other times, hospitality is seen as a process to be measured (i.e. the way in which healthcare is provided).

Health status and cultural patterns can also affect patients' expectations. Researchers can find unravelling the influence of expectations, experiences and satisfaction difficult when these are utilised to assess clinicians or organisations providing healthcare. Users' perspectives and responses are probably influenced by their experiences during healthcare provision and their awareness of the relationships and/or dependencies among healthcare suppliers. Given that client feedback is essential to generate change, knowledgeable healthcare staff and representatives need to be involved in the process of planning service provision (Coulter et al., 2009).

Hospitals and hotels have in common the task of designing useful, profitable facilities that support these organisations' mission. However, when determining how to use resources to meet hospitality-oriented goals, hospitals cannot forget that their primary objective is to provide high-level clinical services (Wu et al., 2013).

2.3.2 Hospital Human Resources

Hospitality within hospital settings focuses on ensuring wellbeing, comfort and safety and providing support and quality care through staff who are polite and who ensure patients' security while attending to their healthcare. In addition, these professionals are responsible for accommodation, clothing, hygiene, the ambience, maintenance and nourishment. This thus comprises a transference of services provided in hotels to healthcare organisations and their professionals and facilities (Quevedo, 2004).

Hospitality can be provided or received in any place or situation (Tanner, 2011). In hospitals, what most influences patients' views on the hospitality offered is the staff, namely, whether these healthcare professionals or other employees interact with patients (Sofaer, Crofton, Goldstein, Hoy & Crabb, 2005; Tanner, 2011). According to Tanner (2011, p. 16), 'the future of the perception of hospitals is more dependent on the people rather than the facilities.' Researching hospitality in hospitals needs to focus on the individuals who are part of patients' hospitality experiences rather than just hospital facilities.

The hospital employees and managers need to take into account patients' expectations. The latter can serve as a starting point to help healthcare providers tailor the care delivered to meet each patient's needs. Understanding these users' expectations can play a crucial role in patients' active recovery if they think that their feelings are acknowledged, which allows these individuals to be kinder and more tranquil. Trust becomes the basis of interactions with patients from the moments preceding their arrival and throughout the entire hospitalisation process.

Healthcare providers can implement this approach after receiving training, thereby adding a new link to the service provision chain. The establishment of provider-client connections is the beginning of all patients' experiences (i.e. clinical or diagnostic) in hospital settings (Tanner, 2011). While providers' professional capacity is also critical, their ability to offer politeness, compassion and empathy is even more crucial to excellence in hospitality services (Logger, 2012). According to Zygourakis et al. (2014, p. 50), 'the foremost priority of hospitals is, and always should be, to improve patient health, but patient comfort and wellbeing should not be neglected along the way.'

2.4 Interactions in Service Provision

Services' structure depends on the configuration and subject matter of daily interactions. Interactions are characterised by the number and disposition of individuals within similar interactions. These range from dyads (i.e. two participants) and triads (i.e. a third element added to dyadic interactions) (Siltaloppi & Vargo, 2017) to networks (i.e. four or more elements and the links that connect these elements) (Li & Choi, 2009). Most previous

research on service has looked at individual-level variables that dictate the interaction quality strategies followed by service providers and variables that dictate customers' perception of those interaction strategies (e.g. Cronin, Brady & Hult, 2000; Crosby, Evans & Cowles, 1990). The social science literature overall supports this focus on dyads because these have been found to be the basic constituent of larger social structures that determine service providers' performance and shape customers' behaviours (Borgatti & Halgin, 2011; Brass, 2011; Yagil, 2001).

Prior research has also provided descriptions of organisational processes involving service providers in the hospitality industry, including descriptions offered by studies of providers' customer complaint strategies. However, these descriptions suggest that dyadic provider-customer interactions are only part of – and are perhaps not the most important – service interactions in hospitality organisations (Roggeveen, Tsiros & Grewal, 2012; Smith, Bolton & Wagner, 1999). Social science researchers have thus more recently advocated a focus on social structures larger than dyads to incorporate social processes that do not happen in dyads (Borgatti & Halgin, 2011; Brass, 2011; Solomon, Surprenant, Czepiel & Gutman, 1985).

Thus, although dyadic interactions are the most basic building blocks of social networks (Holma, 2004), dyads are not the only component currently under analysis (Brass, 2011). In some instances, dyads cannot be studied separately from the networks in which they are embedded (Hill & McGrath, 2008; Holma, 2004). Some researchers have, therefore, suggested that triads are the nuclear element of networks because triads allow scholars to examine the effect of a third actor on interactions between two individuals, which is not possible if researchers focus on isolated dyads (Siltaloppi & Vargo, 2017; Vedel, Holma & Havila, 2016). When a third person joins an interaction, this enables the creation of a majority (i.e. two individuals against one individual) and changes the focus from individuals to groups (Holma, 2004; Mena, Humphries & Choi, 2013).

To understand networks and detect the presence of indirect links and paths, researchers usually assume the existence of at least two links connecting three parties (i.e. triads) (Brass, 2011). This has led some authors to advocate that, as suggested previously, the triad is the most elementary structure within networks. The argument is that triads are the

main configuration that allows networks' social dynamics to materialise and unfold. Triads thus may provide a manageable but effective unit of analysis with which to understand the role of networks in interactions, including those between service providers and customers (Brass, 2011; Holma, 2004; Mena et al., 2013; Siltaloppi & Vargo, 2017). The movement away from studying dyads and towards examining triads is especially significant in research on service interactions. This approach has allowed researchers to include interactions involving more than two individuals (e.g. two providers interacting with one customer) (Holma, 2010).

Nonetheless, research on service provision, especially studies of hospitality, has mostly examined interactions in the context of dyads (e.g. Grönroos, 2008; Kim, Meija & Connolly, 2017). These have included host-guest (e.g. Connolly, 2000; Zygourakis et al., 2014), service provider-customer (e.g. Atwood & Morosan, 2015; Bove & Smith, 2006; Connolly, 2000; Yagil, 2001), manager-employee (e.g. Testa, 2002) and parent-child interactions (e.g. Siegenthaler & O'Dell, 2000). Recent studies have also begun highlighting the role of triadic interactions in service encounters, namely, the presence of intermediaries (e.g. employees, travel agencies or buyers) between service providers and clients (e.g. Andersson-Cederholm & Gyimóthy, 2010; Holma, 2010; Li & Choi, 2009; Sheehan, Ritchie & Hudson, 2007; Van Iwaarden & van der Valk, 2013; Wynstra, Spring & Schoenherr, 2015). Thus, the literature on service interactions (e.g. in hospitals and hotels) highlights dyads, but the effects of triadic interactions on clients' satisfaction needs more extensive study (see Table 1).

Table 1. Selected studies: dyads and triads

Reference	Research Context	Research Method	Type of Interaction Studied
Siegenthaler and O'Dell (2000)	The United States, role of interdependence in dyadic family relationship and 123 students at two midsized universities (total 272) and their family members	Quantitative (survey)	Dyads (family member-family member: parent-child, sibling-sibling and husband-wife)
Yagil (2001)	Israel, variety of service organisations (i.e. banks, government offices, community health services and insurance companies)	Quantitative (survey)	Dyads (service provider-customer)

	and 115 service provider-customer dyads		
Testa (2002)	Cruise industry and 367 shipboards and shoreside managers from a large cruise line	Quantitative (survey)	Dyads (manager-employee)
Bove and Smith (2006)	Melbourne, Australia; hairdressing services; and 2,169 phone calls but only 341 questionnaires used	Quantitative (survey)	Dyads (female client-female hairstylist provider and same gender provider-customer)
Weber, Stöckli, Nübling and Langewitz (2007)	Switzerland, two-ward rounds in internal medicine and 90 interactions	Qualitative (observations)	Triads (patient-doctor-nurse)
Li and Choi (2009)	Literature review and service outsourcing	Qualitative (literature review)	Triads (buyer-supplier-buyer's customer)
Holma (2010)	Business travel management (i.e. two airline companies, a hotel chain, a travel agency and an industrial buyer) and 10 participants	Qualitative (in-depth interviews)	Triads (industrial buyer-travel agency-service supplier)
Siltaloppi and Vargo (2017)	Systematic literature review of studies of triads	Theoretical paper	Triads
Turabian, Minier-Rodriguez, Moreno-Ruiz, Rodriguez-Almonte and Cucho-Jove (2017)	Toledo, Spain; differences in verbal behaviour styles in consultations between patients' companions (i.e. triads) and without patients' companions (i.e. dyads); and 5 dyadic consultations and 7 triadic consultations	Qualitative (observations and interviews)	Dyads (patient-doctor) Triads (patient-companion-doctor)

Source: Author

2.4.1 Hospital Verbal Interactions

Healthcare processes are also based on interactions between patients and healthcare providers, which are seen as crucial to treatments' results (Hall, Ferreira, Maher, Latimer & Ferreira, 2016). The literature shows that positive connections between caregivers and care receivers substantially affect results by lessening the severity of symptoms and enhancing patients' general state of health and satisfaction with the services provided (Hall et al., 2016; Pinto et al., 2012). Quality care and efficiency are enhanced by effective communication, which is a skill crucial to caregivers' work (Mauksch, Dugdale, Dodson & Epstein, 2008; Pinto et al., 2012). To achieve this level of communication, patients and caregivers have to cooperate with each other and manage their interaction together (Pinto

et al., 2012; Street, Gordon & Haidet, 2007).

Non-verbal communication is just as important as spoken words since the way things are said and the manner in which ideas are expressed are interconnected and need to be taken into account simultaneously (Pinto et al., 2012; Roberts & Bucksey, 2007). The connections between clinicians and patients become stronger when communication styles enable the latter to take part in consultations through active listening and questions centred around relevant emotional matters (Pinto et al., 2012). Ways to improve patient-care provider interactions through effective communication can be learned through organisations' training programmes focused on improving the quality of the messages transmitted to clients and empowering patients to bring up their worries in consultations. However, one important question that remains unanswered is which content should caregivers consider essential to address in consultations in order to strengthen patient-provider relationships (Pinto et al., 2012).

While the literature has addressed other issues regarding patient-doctor relationships, more research is needed that focuses on other health professionals and their functions in hospital service provision (Hart, 1997). In nursing, studies have already confirmed the importance of good communication, especially during the first stages of patient-nurse interactions in which roles are made clear and standards and behavioural patterns are set (Roberts & Bucksey, 2007).

2.4.1.1 Verbal Interactions Between Doctors and Patients

Since doctors' tasks are mostly challenging and emotionally draining, these are associated with high levels of self-criticism and other personality traits related to workplace stress. An aggravating factor in this tendency is the lack of mutual support or opportunities to get and give feedback. Teamwork appears to lead to improvements in dealing with stress even though physicians' communication skills are not always strong. Various aspects of doctors' problems related to heavy workloads, high stress and non-adaptive responses to alterations in responsibilities have to be taken into account when training, selecting and socialising doctors (Edwards, Kornacki & Silversin, 2002).

Doctors are mostly trained to work with people rather than organisations, to take on responsibilities instead of delegating and to provide the best care to patients as opposed to making compromises in settings with limited resources. Medical practice is primarily based on the first three behaviours (Edwards et al., 2002). The above aspects generate increased rates of work-related stress and heavier workloads, so dealing with the effects of these behaviours is challenging. Notably, most of the training given and professional values passed on to doctors are oriented towards individual cases and situations rather than towards helping physicians integrate into large, complex organisations. Adequate training at this level is still missing, which contributes to these professionals feeling stressed and frustrated (Edwards et al., 2002).

Traditionally, patients have not been seen as active contributors to doctor-patient interactions mostly because of a hierarchical view of doctor-patient relationships. Research on this topic shows that most interactions end up being unilateral with patients not being encouraged to communicate their views. Patients take an active part in this by limiting how much they share their opinions, thus making doctors dominant in interactions and undermining efforts to achieve better communication and results. The latter are more feasible when healthcare staff ask patients to contribute (Major & Holmes, 2008).

When assessing healthcare quality, professionals can no longer solely take into account accurate diagnoses, adequate treatment and low mortality rates. Organisations dealing with healthcare need to go beyond a medical perspective and focus on the hospitalisation process from the patients' perspective (Weigl, Müller, Zupanc & Angerer, 2009; Wong et al., 2013). Researchers worldwide have found proof that healthcare is heavily affected by patients' positive views regarding their experiences. Good results are related to compliance with treatments and follow-up services, the provision of relevant medical information to patients and increased confidence and higher levels of fulfilment among providers, which trigger fewer complaints filed regarding healthcare organisations. The factor of staff fulfilment also benefits patients and generates a good working environment at the core of healthcare institutions (Wong et al., 2013).

Prior studies have verified that an essential value of medical care is effective interactions between patients and physicians that generate empathy and the communication of relevant knowledge. Physicians need to be in contact with their patients directly, and doctors have to have enough time to attend adequately to their patients' requests and worries. Overall, doctors' professional fulfilment is connected to the time they have available for dealing with patients (Weigl et al., 2009).

2.4.1.2 Verbal Interactions Between Nurses and Patients

Since hospital service performance cannot be uniform or homogenised, administrators may need to provide healthcare workers with additional training in service provision. Clients' perceptions of the service quality provided can alter rapidly, and consumers' perspectives on entire institutions can be influenced by just one caregiver (Tanner, 2011). In hospitals, basic support is provided by nurses. They should be able to complete diverse tasks during their shifts, for which nurses need good concentration and adequate time management because their skills are needed throughout different areas of the hospital (Tanner, 2011). Nurses play a vital role in hospitality management by increasing patients' satisfaction with treatments and speeding up healing processes (Paraschivescu et al., 2011; Patten, 1994; Severt et al., 2008).

Nurses' level of motivation, behaviour and even the care they provide patients can negatively affect users' experiences when these professionals are seen as having inadequate skills. This effect is important for hospitals because nurses are at the frontline, and their conduct reflects on the hospital itself as they spend the most time of any staff with patients. If users are not given quality time or enough time, this affects their perceptions of the institution overall even if the service quality is adequate (Tanner, 2011).

Three methods have been proposed to develop more positive interactions between patients and nurses and generate good experiences that go well beyond users' initial expectations. First, human resource managers can be trained to examine individuals applying for nursing jobs to verify if their personality can contribute to good nurse-patient relationships. Second, lectures on specific personality traits that lead to successful

relationships with clients can be introduced into nursing school programmes to raise nurses' self-awareness. Last, hospitals can also sponsor seminars on this subject that are specifically geared towards improving nurses' communication skills (Tanner, 2011).

Most previous research has concentrated on consultations between doctors and patients, while fewer studies have been conducted on types of nurse-patient communication on wards. Despite the well-publicised differences between these two types of professionals' interactions with patients, parallels exist that should be taken into account when studies are conducted. Both kinds of health professionals can encounter potentially nervous, worried patients, and doctors and nurses depend on effective communication to reach long-term goals regarding patients' wellbeing, compliance and memories of their stay (Major & Holmes, 2008).

2.4.1.3 Verbal Interactions Between Hospital Ambassadors and Patients

Hospital ambassadors have been portrayed by the literature as having a beneficial role within hospitals. These individuals serve non-clinical functions, delivering the personalised services patients expect while easing nurses' workload in this regard (Tanner, 2011). Efforts to introduce this role into hospitals have met with great success. Given predictions of continuous growth in technology's use in clinical areas, more time has to be available for nurses' education in and development of technical services. Hospitality can thus potentially become separate positions filled by specific professionals and centred around improving human interactions (Tanner, 2011).

The introduction of hospitality ambassadors would reduce nurses' workload and give patients more time with staff, thereby enhancing these clients' loyalty. O'Malley and Serpico-Thompson (1992) conducted observations of a hospital setting in which an ambassador was introduced. The ambassador could spend time with patients and their family and friends, leaving the clinical professionals to focus their attention on healthcare provision. This professional also proved useful in terms of supporting simple clinical procedures by functioning as a connection between hospital sections and, consequently, giving health professionals the chance to remain in their specific work areas (Tanner, 2011).

Dickson et al. (2008) suggest that this 'concierge position' should be occupied by an extremely personable, friendly and outgoing individual who needs to be able to communicate effectively and feel comfortable with approaching strangers. These hospital ambassadors can provide comfort and support to patients. This position requires a deep understanding of hospital contexts since the 'concierge' would have to prepare ahead of time regarding patients needs' and wishes in order to meet their expectations (Dickson et al., 2008).

This role has parallels in hotels, in which concierges, housekeepers and personnel working in hotel bars and restaurants make crucial contributions to guests' general wellbeing and positive experiences. Hospital personnel thus can play a part in the implementation of strategies to increase patient satisfaction, and, just like hotel employees, hospital staff should be trained to improve their level of customer service (Zygourakis et al., 2014).

2.5 Hospitality as an Element of Healthcare Service Assessments

Service standards have become more demanding, and the competition to meet them is currently quite fierce as a result of a surplus supply of services. In this context, hospitality has become a differentiating factor within the service sector. To respond to a growing demand for better service quality, some service providers in different areas have experimented with new ways of promoting hospitality (Kunwar, 2017). According to Crick and Spencer (2011), 'hospitality became a required response to new demands and consumers' prospects.'

Service and hospitality are two quite different concepts. While the first is the unilateral, technical provision of services in which providers define what to do and what standards to meet, the second is the way in which service delivery affects the individuals who receive the services. In the latter case, providers have to look at experiences from the clients' point of view (Kerfoot, 2009). To ensure a growing customer base, excellent treatment of customers during service experiences is needed. This approach has sparked on-going debates about hospitality in service provision, but hospitality is generally perceived as a significant change in attitude that can lead to service enrichment (Dickson

et al., 2008).

Effective services within the hospitality sector are achieved through understanding consumers. The results are clients' positive experiences, which are crucial in terms of value and fulfilment because they make guests interested in returning or extending their stay, as well as motivating them to endorse services to others (Lu, Berchoux, Marek & Chen, 2015; Nasution & Mavondo, 2008). The difference between customers' expectations regarding the services provided and the same clients' views on service providers' effective performance is what defines perceived service quality (Parasuraman, Zeithaml & Berry, 1985).

Thus, this definition sees service quality as customers' general assessment of specific services as dependent on these clients' ideas of how the services should be performed (Parasuraman et al., 1985). The main factors affecting service excellence are the passion shown by employees while providing services and doing their job, as well as staff members' honesty, reliability and capacity to deal with crisis situations (Lu et al., 2015). The service quality provided is a central aspect of customers' fulfilment and behavioural goals. According to various quantitative studies, service quality also allows providers to forecast customer satisfaction (Bitner et al., 1994; Cronin & Taylor, 1992; Lu et al., 2015; Ramseook-Munhurrun & Naidoo, 2011).

Satisfaction corresponds to specific perceptions of value customers attribute to certain aspects of the services provided. Positive perceptions allow clients to maintain a good relationship with the establishments in question (Lu et al., 2015; Wicks & Roethlein, 2009). Despite these clear findings, qualitative studies on customers' perceptions of service quality have revealed that providers fail to address the relevant aspects of clients' viewpoint when seeking to generate customer satisfaction (Lu et al., 2015).

With regard to healthcare services, the components of service quality include technical and functional quality (Lin, Xirasagar & Laditka, 2004; Zarei, Arab, Froushani, Rashidian & Tabatabaei, 2012). Technical quality refers to what services patients receive, while functional quality is the way these services are experienced (Srinivasan & Saravanan, 2015). While clinical outcomes are the focus of most hospital operations

(Porter & Lee, 2015), patients view their experiences more holistically and perceive the quality of the care received according to their own subjective understanding (Kelly et al., 2016; Poksinska et al., 2017). This is where hospitality fits in as the capacity to exceed patients' expectations by bringing in new forms of service provision.

Dagger, Sweeney and Johnson (2007) developed a multidimensional scale for measuring health service quality. The cited authors identified four primary dimensions of quality: technical, interpersonal, administrative and environment. These were further divided into subdimensions: outcomes, expertise, interactions, relationships, tangibles, timeliness, operations, support and atmosphere. Other research on hospital service quality has identified additional essential dimensions (Kelly et al., 2016; Shirzadi et al., 2016). These are technical care (i.e. organisational system), relationships between individuals (i.e. intangible dimensions), quality of hospital facilities (i.e. tangible dimensions) and atmosphere (i.e. space attachment).

Non-medical aspects are especially crucial to meeting patients' general expectations. Enhancing the provision of support services evidently requires increasing patients' safety, care, health recovery and general comfort (Kelly et al., 2016; Suess & Mody, 2018). Hospitals' atmosphere is also regarded as crucial to patients' experiences. This has led some hospitals to adopt the hospitality industry's service strategies to attract and support patients (Kelly et al., 2016; Shirzadi et al., 2016). Severt et al. (2008, p. 664) report that 'hospital[s] aim … to offer hospitality to patients on a par with the hospitality experience offered to hotel guests'.

2.5.1 Patients' Expectations of Experiences

Excellent healthcare service delivery needs to be based on a clear understanding of three aspects: clients' expectations, desires and needs. Expectations can be defined as patients' idealistic standards regarding healthcare, but expectations can also be grounded in past experiences in hospitals. Understanding patients' expectations is crucial to ensuring hospital staff and their administrators anticipate clients' needs. These professionals must meet the expectations of those receiving care, as well as their desires and needs, to ensure consistent success in this sector (Zarei et al., 2012).

An awareness of expectations can help nurses and doctors to supply the most personalised services possible to each client. Individualised services' success is enhanced by caretakers who understand patients' emotional state, thereby helping them to remain calm and civil and take an active part in their own recovery. Patients' trust can be strengthened by every part of the hospital prior to their arrival on wards and by key connections with staff made during stays. Health professionals with the right training are able to use these assets to integrate patients upon arrival as new links in the existing chain. This feeling of connection is the starting point of each positive experience patients have in hospital contexts (Tanner, 2011).

In order to surpass patients' expectations and ideals, new forms of hospitality need to be applied. Given that hospital environments are crucial to improving patients' experiences and healthcare, some hospitals have started adding services previously implemented only in the hospitality sector, such as some hospitality terms (i.e. check-in and check-out), rooms with a view, single rooms and the option of another bed for a family member. Improved healthcare provision allows patients to feel better and contributes to more effective health recovery processes (Kelly et al., 2016; Shirzadi et al., 2016).

The healthcare sector's competitiveness makes meeting patients' wishes and needs essential for healthcare organisations to succeed. A precise understanding of these desires and requirements is crucial to the delivery of excellent services.

2.5.2 Patients' Evaluations of Experiences

Hospitals are an important part of any healthcare system, and patients are aware of their role in the adequate provision of curative care, safety, knowledge and services. Hospital users' expectations are rising due to an increased number of alternatives and stronger competition, which encourage higher standards of service. In this context, hospitals need to require their staff to try continuously to improve their service delivery quality in order to achieve excellence (Srinivasan & Saravanan, 2015).

Hospitalisation facilitates the offer of different options in patients' healing process. Designating good patient care as excellent service improves healthcare given that this

focuses on bettering guests' experiences rather than only on improving service provision. This shift in emphasis is the optimal way to revitalise and stimulate healthcare services in hospitals, changing the narrative from services to patients' perspectives on services and thereby shifting the focus of discourse to clients' experiences. Viewing healthcare service situations through patients' eyes has become vital (Logger, 2012).

Hospitalisation experiences are the result of sensory elements (e.g. ambience, sensory stimulation, places and/or roles or signs and/or symbols). These experiences also involve human relationships that develop based on attitudes, professional behaviour, optimistic viewpoints, care providers and the processes producing patients' conduct, behaviour, presence and socialisation (Prebensen, Chen & Uysal, 2017; Walls, Okumus, Wang & Kwun, 2011).

Although clinical results are at the core of most hospital activities (Porter & Lee, 2015), non-clinical service provision is what most influences patients' perspectives on the healthcare provided, for example, rooms and bathrooms' hygiene and the giving and receiving of information. This significant impact means hospitals need to pay attention to their facilities' management. Following specific guidelines for filing, communicating and structuring information will give all patients access to the knowledge essential to their situation, namely, how to care for themselves and support their own recuperation process or make the most of rehabilitation or continued services (Makarem & Al-Amin, 2014).

The evaluation of healthcare services' quality involves not only monitoring specific aspects, such as clinical results, waiting time and quality of food, but also gaining an understanding of experiences' meaning. This knowledge can be gained by assessing patients' perceptions of waiting for care, eating in hospitals and dealing with hospital environments, as well as the quality of clients' interactions with and communications received from health professionals. Treatments' quality and context are also significant aspects that include whether all experiences meet patients' expectations (Pope, van Royen & Baker, 2002). Healthcare services' quality depends on all participants' perspectives: patients, providers, family and thus each member of society (Pope et al., 2002). Therefore, hospitals need to take into account that, besides excellent technical care, the quality of hospital conveniences, atmosphere and relationships between individuals are also central

to meeting patients' expectations and enhancing their experiences (e.g. Kelly et al., 2016; Lam, 2010; Shirzadi et al., 2016; Zarei et al., 2012). At this point, hospitality enters into the picture.

2.6 Research Summary

The present analysis of hospitality as a tool for service improvement began with the choice of a hospital setting as the study's focus because research on this topic is still limited. Given that parallels can be found between the tourism and healthcare sectors and that both comprise different types of service provision, human resources and interactions, the following research steps were followed. First, tourism was examined as a multidimensional phenomenon including the characteristics of tourism service provision, importance of human resources, verbal interactions and connection with hospitality. Second, the hospitality concept was studied to understand its importance not only in sectors such as tourism but also in healthcare. Last, an analysis was carried out of hospitality's importance in hospitals and the relationships between hospitals' service provision, healthcare professionals and verbal interactions and the ways these aspects are linked through hospitality.

Similarities were confirmed between tourism and healthcare services, showing that hospitals could greatly benefit from the adoption and application of hotels' practices as part of hospitals' routine operations. The present research also focused on examining the importance of verbal interactions in service provision, especially in hospitals. Finally, hospitality's usefulness as an element of healthcare service assessments was appraised, including paying attention to the importance of the quality of patients' hospitals experiences (see Figure 2).

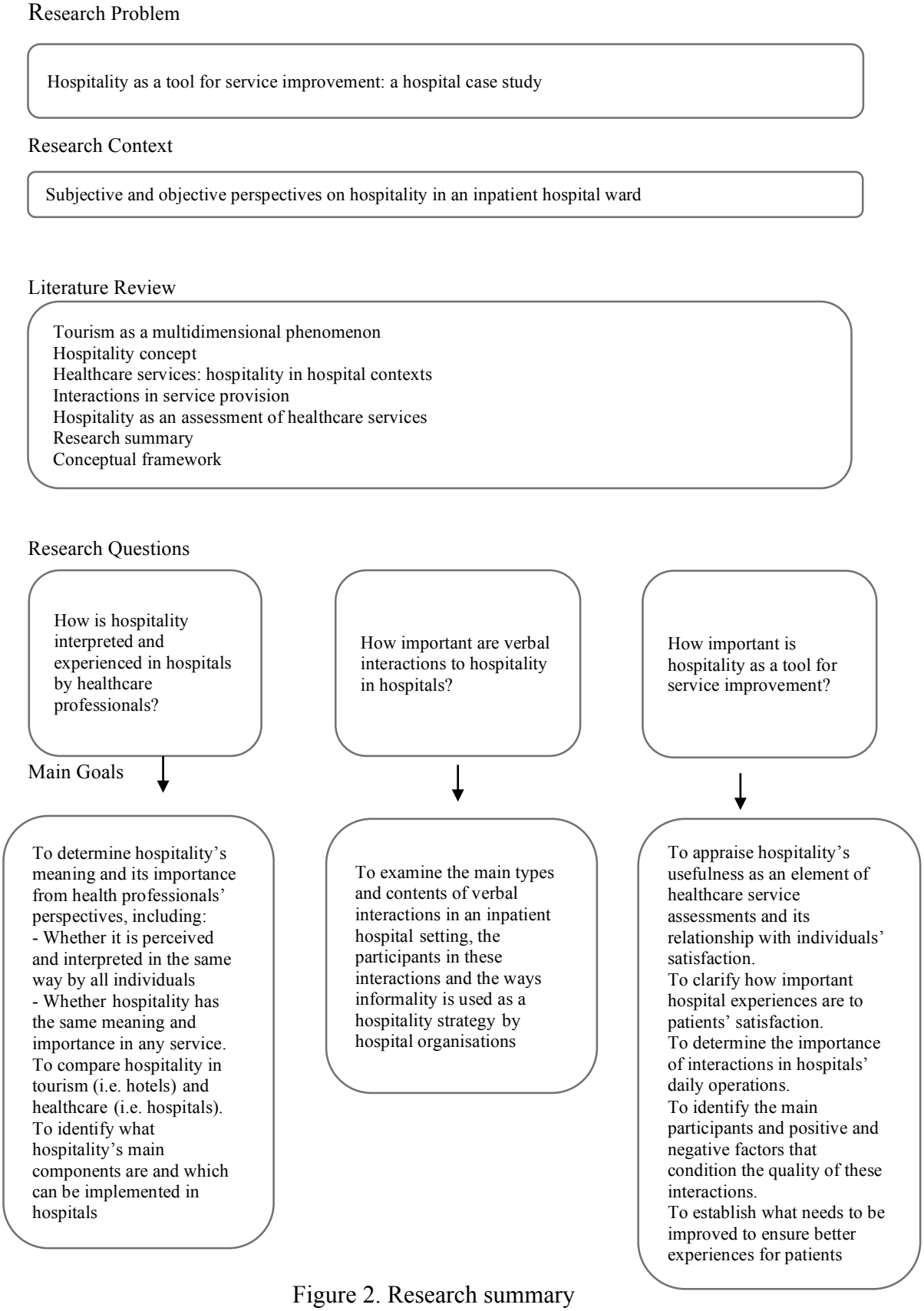

Figure 2. Research summary

2.7 Conceptual Framework

This study considered hospitality's utility as a tool for service improvement based on a hospital case study. To examine hospitality and its role in service improvement, three components and their relationships were considered: services provision, human resources and verbal interactions. These components are present in different sectors (e.g. tourism, healthcare, education and management) because service provision is dependent on human resources and verbal interactions between providers and receivers and between providers themselves. These components were evaluated, resulting in the verification of their interconnections through hospitality.

Services provision managers need to establish hospitality guidelines for their human resources in order to improve the quality of verbal interactions and thus the relationships these professionals develop with clients and/or users. These improvements increase client satisfaction. Ultimately, this strategy contributes to generating profit through services. Hospitality thus functions as a unifying element (see Figure 3).

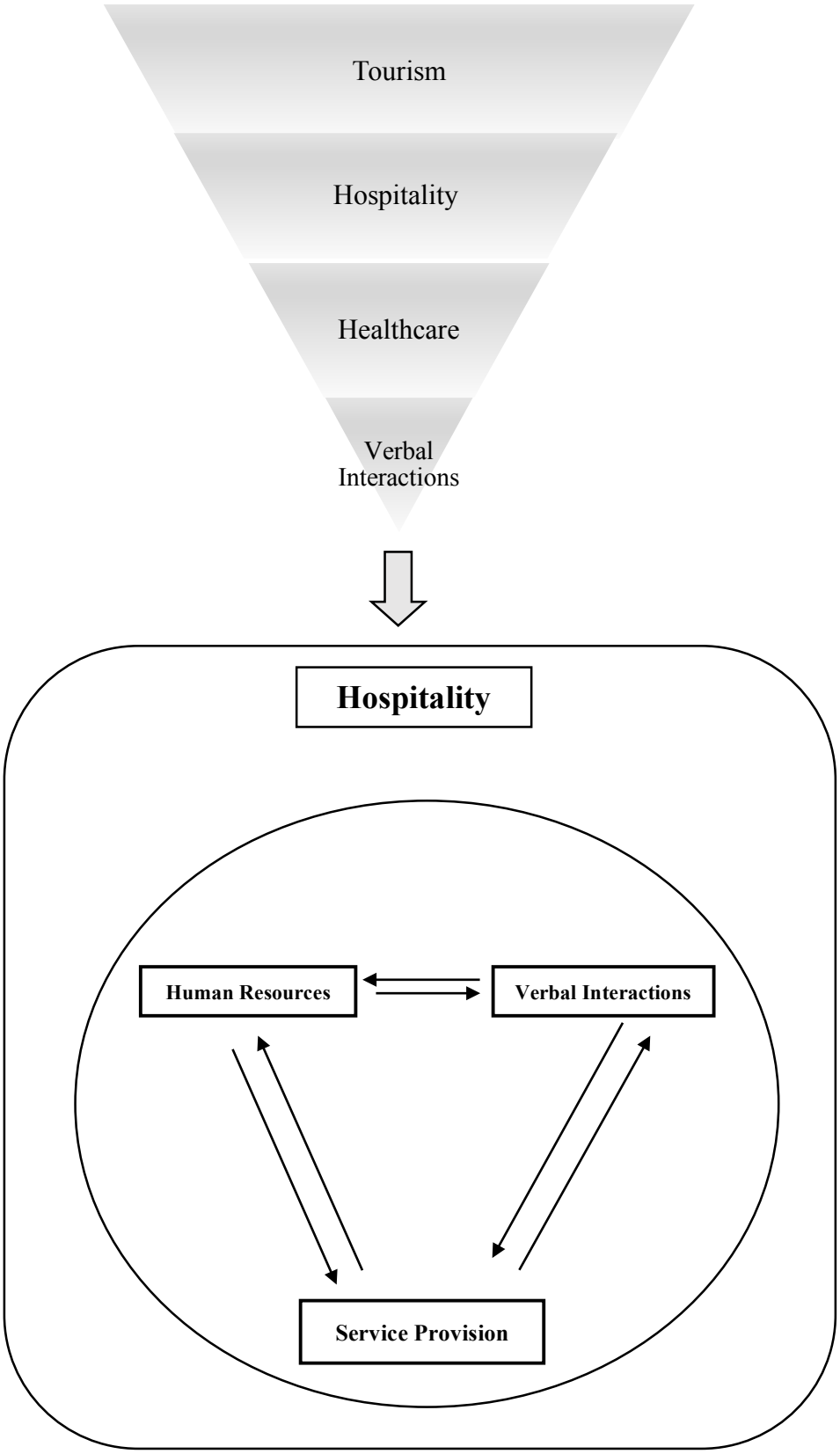

Figure 3. Conceptual framework

Source: Author

3. Methodology

3.1 Qualitative Analysis

Diverse fields of research such as anthropology, education and management use qualitative research methods. Healthcare studies have also favoured these methods (Arendt et al., 2012; Curry, Nembhard & Bradley, 2009; Sofaer, 2002), and they have been applied within the hospitality sector as well (Arendt et al., 2012; Kwortnik, 2003). Qualitative research has weaknesses and strengths, as does every research method (Babbie, 2017). Researchers have noted important differences between the wide range of studies based on statistical procedures and the less extensive research confined to qualitative methods (Correia, 2013). Qualitative methodology has often been classified as having less scientific value because the data collected are subjected to interpretation and the results are consequently shaped by researchers' biases. Findings based on these methods are also considered short-lived, and a greater distance is required between researchers and their object of study (Correia, 2013).

Nevertheless, researchers have successfully used qualitative methods to study phenomena and events in their natural settings, going directly to the social phenomena in question and observing their environments, attitudes and behaviours. The results contribute to a deeper understanding of the phenomena (Babbie, 2017). In addition, qualitative research methods allow researchers to examine the meaning people give to the phenomena in question and compare the findings with other scholars' interpretations.

This type of methodology was selected for the present study to facilitate the development of a deeper understanding of how hospitality can be a tool for service improvement. Qualitative research was necessary to analyse the participants' perspectives and study the social environments these actors experience in hospitals. These methods comprise the continuous collection, organisation and analysis of material gathered from spoken and written words and observations (Babbie, 2017; Pope et al., 2002). Qualitative methodologies combine diverse data collection techniques (i.e. observation, interviews and textual and visual analyses). However, the most frequently used methods, especially in healthcare studies, are focus groups and interviews (Britten, 1999; Gill, Stewart,

Treasure & Chadwick, 2008; Legard, Keegan & Ward, 2003; Sofaer, 2002).

For many years, researchers argued that quality healthcare could only be ensured if accurate quantitative measures were developed (i.e. performance indicators) to identify problems and indicate the changes needed to improve healthcare services. This theoretical perspective has since been adjusted to include the use of qualitative measures based on the assumption that assessments of complex healthcare systems and services should also include some qualitative evaluations (Pope et al., 2002). Currently, the literature on healthcare reflects a strong awareness of the disparate effects of applying qualitative and quantitative methodology (Correia, 2013).

The use of different methods can be pertinent depending on particular situations and research questions. Sometimes a single method can be used, while, in other cases, a combination of methods should be selected (Pope et al., 2002). Finding the associations between qualitative methodologies, interactions' contexts and speakers' different discourses is one possible mechanism that can validate empirically the choice of qualitative methods. The inclusion of different qualitative methods is thus considered necessary to ensure more rigorous methodological standards.

Participant observations and semi-structured interviews were the methods selected for the present research. This choice was made because, on the one hand, observations without interviews do not fully capture the essence of or meaning behind observed attitudes. On the other hand, interviews without observations leave researchers completely dependent on interviewees' responses, which may not always be representative of real practices (Correia, 2013).

These methods were also chosen because they can provide both more details about participants' daily experiences of inpatient services and more opportunities to gain direct access to inpatient healthcare. The selected methods allow researchers to participate not as patients or health professionals but as independent outsiders not influenced by any specific aspect. In the present study, the time spent in the hospital was used to record details most often overlooked by the actors involved since, according to Kunwar (2017), 'understanding hospitality refers to the understanding of … dynamics in spaces of

hospitality.'

The current research was conducted in a hospital, which was treated as a case study. This approach was considered appropriate because the goal was to examine events and phenomena in their natural settings. Furthermore, case studies are useful in terms of analysing complex situations, such as hospitals, which comprise both physical and emotional conditions, different participants and many interactions (Douglas, 2010; Reis, 2013).

3.1.1 Qualitative Analysis: Observations

Observations of organisational settings, behaviours and interactions provide researchers with advantages because this method allows the observer to understand everyday behaviours, without depending solely on interviewees' versions (Bryman, 2016). Observations are increasingly used in studies of organisations and healthcare service provision (Pope et al., 2002). However, because the health sector involves ethical and privacy issues, observations of personal interactions in hospital rooms are not easy to conduct, so all recorded observations necessarily involve a process of gaining authorisation and following rules.

Observations need to be conducted in appropriate contexts (O'Halloran et al., 2011). In the present study, observations were based on the dimensions suggested by Spradley (1980): spaces, events and feelings. A higher level of objectivity can be achieved in observations by applying Correia's (2013) four strategies: distancing, routinisation, transparency and equidistance. The first strategy is developing detachment in relation to the object of study. The second strategy diminishes the subjectivity of researchers' interpretations of participants' interactions, as well as making the latter actors feel more comfortable. Observers also benefit from the repetition of processes as this facilitates explanations of events that may not make sense when observations begin. The third strategy requires the researcher to be objective and free of external influences, while the last strategy involves the observer remaining free from value judgments.

The observer effect can modify observations' results, so this was minimised in the current research by maintaining a physical distance and not communicating with patients and healthcare employees. Notably, in some instances, the natural course of healthcare processes made direct observations impossible.

3.1.2 Qualitative Analysis: Interviews

The primary reason for using interviews to conduct research is to discover individuals' stances, experiences and views on diverse issues. Within qualitative studies, this method is also valued as a way to develop a deeper understanding of social phenomena, which cannot be achieved by using quantitative methodology alone (Gill et al., 2008). Interviews in research can be divided into three categories: structured, semi-structured and unstructured. The first mainly comprises questions that are read aloud from a previously prepared list, with few or no variations and with no further follow-up questions after responses. Structured interviews can be used to clarify specific issues, and these interviews are simple and quick to conduct, although they are limited in terms of eliciting participants' full replies (Gill et al., 2008).

In contrast, unstructured interviews are not based on pre-defined theories or views and are executed with little or no previous preparation, so these interviews might last for many hours and require complex levels of participation (Gill et al., 2008). Semi-structured interviews merge various aspects from the other categories. This type of interview uses a set of essential questions previously prepared (i.e. the interview guide) to focus on specific areas, while simultaneously allowing the interviewer or interviewee some room to follow up on a specific response or to pursue a topic in greater detail (Bryman, 2016).

Healthcare studies have used the latter type more regularly than structured or unstructured interviews because it gives interviewees some guidance on which subjects to mention, which many researchers find useful. Given their higher degree of flexibility, semi-structured interviews give researchers the tools to discover information important to participants that might have not been previously considered relevant by the research team (Gill et al., 2008). The present research, therefore, used semi-structured interviews.

Sofaer (2002) argues that, to ensure interviews will collect relevant information, researchers must have enough background knowledge to know in which direction the questions need to proceed and what data is important to obtain from interviewees. Due to personal experience as a healthcare professional, the present researcher had knowledge about hospital environments and internal dynamics, so the connections between the interview and observation results could be more accurately interpreted. This background knowledge facilitated the development of a convergence between the data based on interviewees' interpretations and those gathered from social environments during observations.

3.2 Research Design

3.2.1 Data Collection

As healthcare sector research involves ethical and privacy issues, authorisation to interview and observe healthcare service provision can be difficult to obtain. From among the random group of hospitals selected, only one gave permission to conduct research, thus the data were collected in a private hospital located in a European capital. This hospital had at the time 127 beds, 47 medical consultation offices, 7 surgery blocks, 3 delivery rooms and an intensive care unit.

This hospital was thus selected after its administrators gave their authorisation to carry out observations and interviews. In the first phase, participant observation was conducted to provide a fuller understanding of the hospital's social environment, verbal interactions' importance and the ways hospitality is put into practice in hospitals' routine operations. In the second phase, semi-structured interviews were conducted to collect data on healthcare professionals' perspectives on hospitality's meaning and significance. The observations' results were analysed and compared with the interviewees' perceptions of how hospitality is important to service improvement.

3.2.1.1 Participant Observation

Participant observation is time consuming for researchers, and this method requires that the observer's presence is accepted by participants. In addition, researchers always have to be present to collect the data. Any invasion of hospitalised patients' space could be treated as hostile. Observations of patients who are emotionally and physically impaired and the recording of their verbal interactions and behaviours can be considered especially invasive. Health professionals can further consider observations of their work and interactions an evaluation of their competency, so researchers run the risk of possible rejection and even alterations in the way services are provided.

In the selected hospital, the administration authorised in-person observations of surgery inpatient services once or twice a week for several months. An inpatient setting was chosen because different patients stay in the hospital for a while, most of the time spending at least one night. In addition, inpatient care involves different providers and services (e.g. check-in, breakfast and check-out), as do other service sectors (e.g. hotels). Only observations of the morning shift were allowed, so all interactions were monitored in specific situations: the distribution of breakfast, clinicians' rounds and check-in and check-out procedures. Notably, even though data collection was subject to specific limited conditions, the shifts involving more interactions are the morning and afternoon shifts in the hospital in question.

During the observations, distance was maintained from the actors and no communication occurred with the patients and healthcare professionals to reduce the possible effects of embarrassment. Periodically, direct observations could not be conducted, for example, when doctors or nurses drew curtains around patients. The need for privacy had to be respected, yet the data collection could only proceed by taking a nearby position to listen to interactions. In various situations, observing and registering verbal interactions, however, could not take place, namely, when hygiene was involved (i.e. bathing and using toilets) and when private conversations arose between professionals and patients and/or relatives. In this way, all stakeholders' privacy and confidentiality were respected.

The participant observation phase ran from March to July 2016 and September to October 2016. The target population comprised patients and service providers (i.e. doctors, nurses and nursing auxiliaries) of the hospital's surgery inpatient services. Over these months, 84 patients were followed, and a total of 241 interactions were observed. The data collected on verbal interactions took into consideration the individual patients present at each moment of interaction. The unit of analysis was thus each patient and interactions involving him or her. The observations conducted in this hospital not only monitored verbal interactions between health professionals and patients but also sought to capture other elements and practices that could open up new perspectives on hospitality in the context of hospital dynamics.

3.2.1.2 Semi-structured Interviews

The interviews took place in the hospital between November and December 2016. The interview guide was created based on the need to question different stakeholders in order to get a broader picture of hospitality in hospitals. The guide established the questions' order and included the list of interviewees (Bell, Bryman & Harley, 2018; Jamshed, 2014). This guide was created to define the main questions, but some questions were modified during the interviews according to the answers given.

The interviews lasted between 20 and 80 minutes each, and they were conducted by the same researcher. Each session took place in different sections of the hospital, always in private. The interviews were completely confidential, and the interviewees agreed that they could be recorded after being informed that a full transcript of the audio records would be created. The interview guide included the following main sections (see Appendix A):

- Interviewees' career path, that is, their functions and the length of time they had been involved in hospital experiences
- Respondents' definition of hospitality as a service strategy to understand their perceptions of hospitality's meaning and importance in service provision
- Hospitality in different services, namely, the relationship between hospitality in hospitals and hotels to gather data on the interviewees' perceptions of the main

similarities and differences between hospitality's implementation in hotels and hospitals

- Hospitality's importance to hospitals and to the quality of patients' experiences
- Verbal interactions between service providers and users in hospital contexts, including the main participants in these interactions and the improvements needed to ensure better experiences.

The interviewees were selected based on their role in different hospital sectors and services in terms of hospitality implementation. The main objective was to understand the perceptions of health professionals (i.e. doctors and nurses), but other respondents were also selected (i.e. directors of clinical operations, directors of nursing and other hospital administrators). Table 2 below presents a brief description of the interviewees. The sample mainly consisted of healthcare professionals because they are essentially in charge of service quality. More importantly, patients' opinions and assessments of their hospital experiences with these professionals have been described in the relevant literature (Ahlenius et al., 2017; Andaleeb, 2001; Cleary et al., 1991; Price et al., 2014; Richter & Muhlestein, 2017; Zaim et al., 2010), whereas health professionals' views and experiences have not been adequately documented (Turner et al., 2017).

Table 2. Interviewees' profile

Position Held	**Function**	**Experience (Years)**
Clinical director	Gastroenterologist physician and director of clinical operations	8
General surgery physician	General surgery specialist	8
Orthopaedic physician	Orthopaedic assistant working mainly on knees and shoulders, but especially shoulders	14
Director of nursing	Nurse	8
Nurse in charge of inpatient surgical services	Nurse	8
Nurse coordinating inpatient surgical services	Nurse	8
Director of a hospital hospitality magazine	Hospital administrator	4

President of a hospital hospitality association	Hospital administrator specialising in hotel management and telephone switchboard operator	6
Manager of client and family support services	Hospital administrator	2

Source: Author

3.2.2 Data Treatment

The qualitative data analysis began with the transcription of interviews, field notes and observations. This process often involves handling a large, complex set of texts. Because researchers can rarely – or even do not necessarily need to – analyse all their data, a process of selection and coding is normally applied (Babbie, 2017; Leavy, 2017; Life, 1994). This qualitative analysis creates analytical categories and consequently explanations based on the textual data gathered. The results can be obtained directly from the data or with the help of a theoretical framework used when handling the data (Pope et al., 2002). Thus, the criteria for selecting key text fragments is based on the significance of statements or words and on the consistency and frequency with which they appear in the data collected (Leavy, 2017). These text fragments can then be transformed into concepts that may be closely related to the wording in the fragments or consist of full transcriptions of the relevant words (Life, 1994).

Since the early 1990s, qualitative data analysis programmes abound (Babbie, 2017; Corti & Gregory, 2011; MacMillan & Koenig, 2004; Mangabeira, Lee & Fielding, 2001). Although coding can be done manually, different software programmes (i.e. computer assisted qualitative data analysis software [CAQDAS]) have been created to help researchers organise and interpret data (Leavy, 2017). These programmes include, among others, Atlas.ti, MAXQDA, NVivo, Qualrus and HyperRESEARCH (Babbie, 2017; Corti & Gregory, 2011). Some programmes allow researchers to identify codes, concepts or portions of text, while others help investigators make theoretical links within the dataset. The most important function of all analytical software is to create categories and themes that facilitate the data analysis process (Pope et al., 2002).

3.2.2.1 Semi-structured Interview Analysis

The interview data were analysed using Leximancer software to facilitate the creation of analytical categories. According to Smith and Humphreys (2006 p. 262), 'Leximancer is a relatively new software for transforming lexical co-occurrence information from natural language into semantic patterns.' This programme can thus translate interview data from natural language into semantic patterns with minimal intervention from the researcher (Brochado, Stoleriu & Lupu, 2018; Lupu, Brochado & Stoleriu, 2017; Robinson, Kralj, Solnet, Goh & Callan, 2016; Wu et al., 2013).

Leximancer was chosen, rather than any other software, based on various authors who report, for example, that this software is more effective for research involving large quantities of data because Leximancer facilitates the coding process (Harwood, Gapp & Stewart, 2015; Penn-Edwards, 2010; Sotiriadou, Brouwers & Le, 2014). While some types of CAQDAS require at times manual handling of data, Leximancer facilitates completely automated analysis (Sotiriadou et al., 2014). In addition, other CAQDAS programmes produce visual representations of the results, but Leximancer goes beyond this to change the manner texts are processed by generating textual relationships. The researcher, in contrast to other software, only needs to understand the connections shown rather than having to define those relations (Angus, Rintel & Wiles, 2013).

Furthermore, Leximancer has emerged in the literature as software that particularly facilitates qualitative analysis due to the further advantages Leximancer offers compared with other CAQDAS programmes. It is a relatively simple, flexible software given that the data are easily introduced even without reading the instructions. The results are, as mentioned previously, provided with minimal manual intervention as opposed to some content analysis techniques in which the researcher must develop a list of codes before conducting analyses (Douglas, 2010). Consequently, the errors that can occur with manual coding are reduced, and the time lost is diminished (Douglas, 2010). Leximancer is flexible because the data can be adjusted if necessary and different types of analysis can be combined. Leximancer, therefore, enables a more objective, unbiased analysis of the data and produces the results quickly. Another advantage is the visual output generated, which facilitates observations, analyses and interpretations of the textual

content collected (Brochado, 2019; Douglas, 2010; Smith & Humphreys, 2006).

This software has been mainly used in social science research. For example, in tourism (Brochado & Brochado, 2019; Rodrigues, 2017; Tkaczynski, Rundle-hiele & Cretchley, 2015; Wu et al., 2013), Leximancer has been used to explore ecotourism satisfaction experiences (Lu & Stepchenkova, 2012) and examine tourists' shopping experiences (Wu et al., 2013). In addition, this software has been used in healthcare research (e.g. medical tourism) (Cretchley, Gallois, Chenery, & Smith, 2010; Rodrigues, 2017). For all the reasons presented above, Leximancer was chosen to conduct the analysis of the interview data collected in the present study.

3.2.2.1.1 Lexicographic Analysis

Leximancer functions as a lexicographic tool to scrutinise the contents of word-based documents, as well as presenting the data in frames (Rodrigues, 2017; Smith & Humphreys, 2006). This tool examines word association data to detect automatically groups of words that appear more frequently in the text, presenting them as probable key concepts (Rodrigues, 2017; Smith & Humphreys, 2006). Concepts are used in qualitative data analysis to identify important subjects by examining patterns and themes and observing related phenomena (Crofts & Bisman, 2010). Concepts in Leximancer are groups of words that commonly appear together throughout texts. These groups are assigned a specific weight depending on how often the groups' words appear together in sentences compared with how commonly they appear anywhere else in the texts analysed. These concepts' meaning is naturally derived from the surrounding text.

Concept seed words consist of the first item that conveys the concepts' meaning, so the definition of each concept includes one or more seeds. Leximancer generates lists of concepts containing similar content for additional examination and interpretation by researchers (Leximancer, 2016; Rodrigues, 2017). As soon as the software determines the set of concepts and the possible themes created, Lexminancer assigns concept codes to the corresponding text segments (Brochado, 2019; Tkaczynski et al., 2015). This qualitative analysis programme thus uses a quantitative approach that permits the association of words into concepts and the concepts into themes (Rodrigues, 2017).

After Leximancer completes this learning process and generates the list of concepts present in the texts and their interconnections, the results are presented as a concept map. This map visualises the automatic analysis of mathematical links between linguistic segments and the concepts connected to them (Cretchley, Rooney & Gallois, 2010; Leximancer, 2016; Rodrigues, 2017). Concept maps consist of two parts: (1) a visualisation of concepts and the connections among them and (2) report tabs to help the researcher read the concept map.

When the map is generated, the concepts are grouped into complex themes. Concepts appearing together within texts – often in the same section – are closely related to each other and thus have a tendency to group together on the map. The themes aid interpretation by bunching concepts into groups that are displayed as colourful spheres on the map (Leximancer, 2016). The most frequently used concepts and the most highly interrelated are represented by nodes, and the most highly interconnected themes that include the most frequent concepts are represented on the map as the biggest circles (Brochado, 2019; Campbell, Pitt, Parent & Berthon, 2011) (see Figure 4).

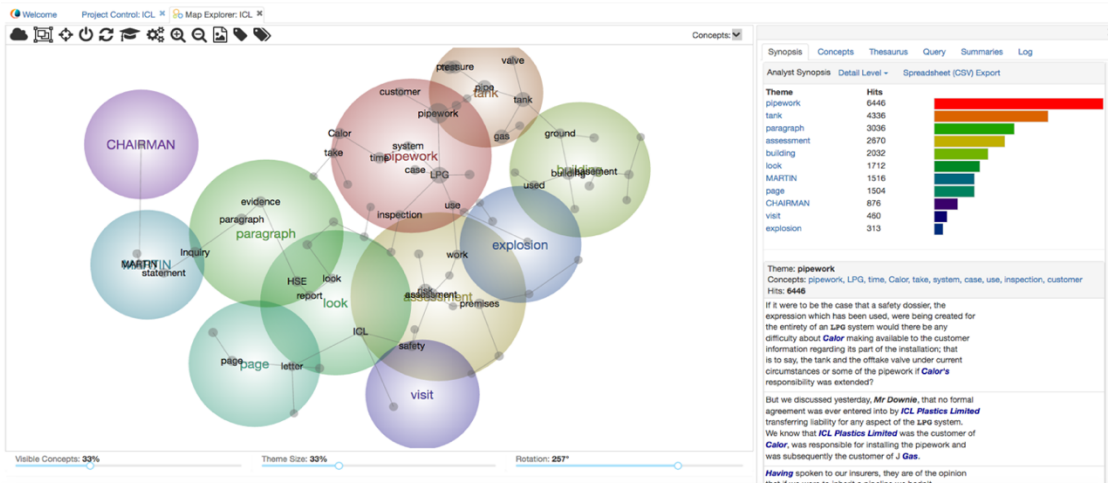

Figure 4. Example of Leximancer concept map and analyst synopsis panel

Source: Leximancer (2016, p.15)

Leximancer, therefore, approaches content analysis in two ways: conceptual and relational (Leximancer, 2016). In conceptual analysis, the data are evaluated in terms of concepts' presence and frequency (Leximancer, 2016). Relational analysis, in turn,

measures the relationships between each concept. Because Leximancer offers both approaches, it measures both concepts' occurrence and rate of incidences in texts and the way these concepts are correlated (Leximancer, 2016; Rodrigues, 2017).

In summary, depending on how often concepts appear together in the text, this software clusters them into themes (Rodrigues, 2017). Then, a concept map is created to help the researcher analyse the body of information in a graphical format. Simultaneously, statistical output and the results for the concepts in the text contribute to the researcher's ability to find deeper contextual associations (Rodrigues, 2017). Leximancer helps keep the researcher focused on significant items, draws attention to concepts' general context and meaning and guides the researcher away from potentially mistaken interpretations (Rodrigues, 2017).

3.2.2.1.2 Codification

Coding involves creating codes not through numerical analysis but through phrase analysis, which allows the researcher to pay more attention to the reasons behind interviewees' attitudes and word choices, as well as to context and consistency (Pope et al., 2002; Sofaer, 2002). In the present interview analysis, the results obtained from Leximancer were taken into consideration, and textual analysis and transcription of full phrases spoken by interviewees were used to refine the results and discussion.

Leximancer thus facilitated the analysis of hospitality as an element of healthcare service assessments and its importance to hospital experiences and the main actors in interactions with patients. In addition, this software produced results on hospitality's significance for service improvement in general and for hospitals in particular, indicating which improvements are needed to ensure better experiences. The database generated was organised on a Microsoft Word spreadsheet.

Eight key items were identified by this analysis to facilitate subsequent qualitative analyses. The items were hospitality, experiences (i.e. positive and negative factors), interactions between doctors and patients (i.e. positive and negative factors) and between nurses and patients (i.e. positive and negative factors) and the improvements needed. The main associated words mentioned by all participants were listed for each item.

3.2.2.2 Participant Observations Analysis

The analyses of the data gathered through participant observation was carried out by creating and interpreting codes and items. The data collected were recorded in a field book, including verbal communications, room numbers and patients in each room. The field notes also contained descriptions of physical spaces (i.e. rooms and corridors), activities at various moments during the morning shift (i.e. breakfast, rounds, family visitation and check-in and check-out processes) and the more unusual events observed. The dominant themes and verbal interactions among doctors, nurses, nursing auxiliaries and patients were recorded and qualified by type, content and formality in order to understand how hospitality is incorporated into practices.

3.2.2.2.1 Classification and Categorisation of Verbal Interactions

The database was organised on a Microsoft Excel spreadsheet, and a list of key items were created to facilitate data analyses. The correlations between these items and their frequency were examined to obtain more objective evidence of the results' validity. Four major items were defined: sequence, situation, type of interaction and content (see Figure 5).

Patient	Time slot	Sequence	Situation	Type of Interactions	Content
P1		1	Round	**dyad**	Clinic/Formal
P1		2	Check in	**tryad**	Clinic/Formal
P2		1	Round	**tryad**	Clinic/Formal
P2		1	Round	**dyad**	Clinic/Informal
P2		1	Round	**tryad**	Small Talk
P2		1	Round	**tryad**	Clinic/Formal
P2		2	Round	**dyad**	Accommodation/Formal
P2		3	Check out	**tryad**	Small Talk
P2		3	Check out	**dyad**	Clinic/Informal
P2		3	Check out	**tryad**	Clinic/Formal
	09h-12h				
P3		1	Check out	**dyad**	Small Talk
P3		2	Check out	**dyad**	Clinic/Informal
P4		1	Round	**dyad**	Accommodation/Formal
P5		1	Check out	**tryad**	Clinic/Formal
P6		1	Round	**tryad**	Clinic/Formal
P7		1	Round	**tryad**	Accommodation/Informal
P7		2	Round	**tryad**	Clinic/Informal
P7		3	Round	**tryad**	Clinic/Formal

Figure 5. Spreadsheet with classification and categorisation of interactions

Source: Author

The sequence defines the time frame in which each interaction was observed. The situation covers the different contexts of observations. As the observations took place during the morning shift, the possible situations to be observed were the time patients enter (i.e. check-in), the distribution of meals (i.e. breakfast), doctors and nurses' clinical rounds (i.e. rounds) and the time patients leave (i.e. check-out).

The type of interactions, in turn, shows the number of participants observed in each verbal interaction. Only dyads and triads were collected. Dyads were included because these are the simplest form of interaction and one of the policies of the hospital's inpatient services is to keep the number of people around patients small, thus enhancing the level of respect and privacy given to patients. Triads were recorded because, according to some authors (e.g. Holma, 2004; Mena et al., 2013; Patty & Penn, 2017; Siltaloppi & Vargo, 2017; Vedel et al., 2016), these are the simplest form of networks, and they can be representative of network interactions. Research on larger networks can involve other types of more in-depth analysis that was not within the present study's scope. In total, 156 dyads and 85 triads were recorded.

The content reflects the typology created to designate different verbal interactions. If verbal interactions' content was clinical, that is, if they were related to medical procedures and only possible in a health service context, the interactions were classified as 'clinical'. Each clinical interaction could be classified as formal or informal. The use of affective terms (e.g. 'my dear') were used to identify informal interactions.

Interactions often had a hospitality element so that they were related to activities that were not exclusively clinical and that could also be found in other contexts such as hotels (e.g. serving and/or eating breakfast, cleaning, taking baths and making beds). These interactions were classified as 'accommodation'. This type of interaction could also be formal or informal. When interactions' content was quite informal and ordinary – without being related to any of the two previous strands – the interactions were classified as 'small talk'. In this case, no differentiation was made between formal and informal because the informality of these interactions was already implicit (see Table 3).

Table 3. Some examples of verbal interactions observed and recorded in field notebook

Note: Conversations were translated into English.

Clinical	Formal	'I'm going to prepare the patient for surgery,' the nurse says. 'Great! Check his blood pressure,' the doctor responds.
	Informal	'Good morning, my dear!' 'Hello, Mrs Nurse!' 'Can I measure your blood pressure?' 'Sure!'
Accommodation	Formal	'Good morning!' the nursing auxiliary says. 'Hello …' 'Milk with coffee?' 'Oh … I don't want any,' the patient says. 'Would you like some tea?' 'Yes! Tea, please.'
	Informal	'Good morning. Nurse Daniel at your disposal!' the nurse says. 'Ha ha, good morning, my friend!' the patient responds.
Small Talk	n/a	'Oh … I meant to shave my beard, but I just took a shower!' 'You should shave, so it will look like you've been in a spa all these days!' the nurse responds. 'At a spa, no! I'm in a hotel! Ha ha,' the patient says with a smile.

Source: Author

This study conducted quantitative analysis of the observations to develop a typology of interactions. The methods used were frequency analysis, cross tabulation and perceptual map analysis. In addition, qualitative analysis was carried out to identify narrative descriptions associated with the main types of interactions.

3.3 Methodology Research Summary

The steps followed in qualitative analyses were based on Bryman's (2016) research (see Figure 6). In the first step, the research questions were defined as follows:

- How is hospitality interpreted and experienced in hospitals by healthcare

professionals?

- How important are verbal interactions to hospitality in hospitals?
- How important is hospitality as a tool for service improvement?

The second step was the selection of the main objectives, while the third was to achieve the defined objectives by collecting data through participant observation and then semi-structured interviews. In the fourth step, the data collected were analysed and interpreted. The last step was writing up the results and drawing conclusions.

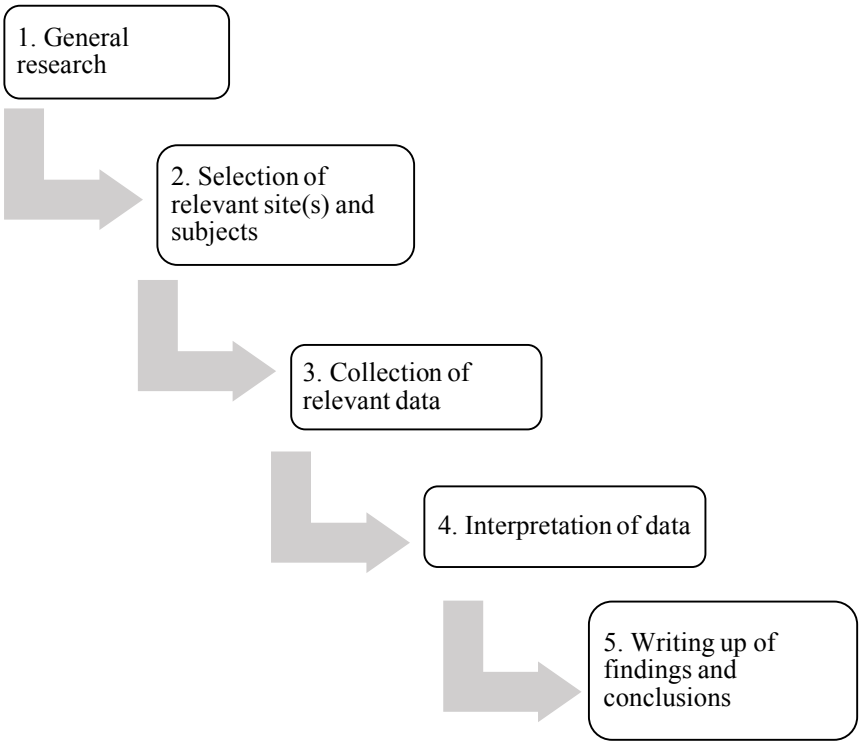

Figure 6. Main steps of qualitative research

Source: Adapted from Bryman (2016)

4. Results

4.1 The Healthcare Professionals' Perception of Hospitality

To answer the first research question (i.e. RQ1), how hospitality is interpreted and experienced in hospitals by healthcare professionals, semi-structured interviews were

conducted to gather objective evidence for analysis, thereby contributing to a better understanding of the nature of hospitality in hospital settings.

The first step was to organise all the interviewees' answers according to the main objectives defined. The data were analysed using the interview transcripts. In the present study, the resulting transcripts' content was analysed using a mixed approach that combined quantitative and qualitative steps using Leximancer software. The analysis of interviews was biphasic, which meant that, first, quantitative analysis was done using Leximancer and, second, qualitative analysis was conducted comparing the results obtained through Leximancer with narratives in the interview transcripts. Leximancer generated a concept map that reproduces the most common themes and concepts found in the analysis, as well as the likelihood of these concepts appearing in the texts (see Figure 7).

According to the objectives previously defined, this section presents the results of the content analysis regarding: (1) the meaning of hospitality from health professionals' perspectives; (2) if hospitality is perceived and interpreted in the same way by all individuals; (3) if hospitality has the same meaning and importance in any service - comparison between hospitality in tourism (hotels) and healthcare (hospitals) and (4) the main components of hospitality and which can be implemented in hospitals.

(1) The Hospitality Meaning

Taken into account, the meaning of hospitality by seeking to understand hospital professionals' points of views, Leximancer presents the overall representation of the hospitality concept.

The main themes obtained from the Leximancer analysis are 'hospitality', 'patient', 'professionals', 'humanisation', 'service', 'needs', 'welcome' and 'communication' (see Figure 7).

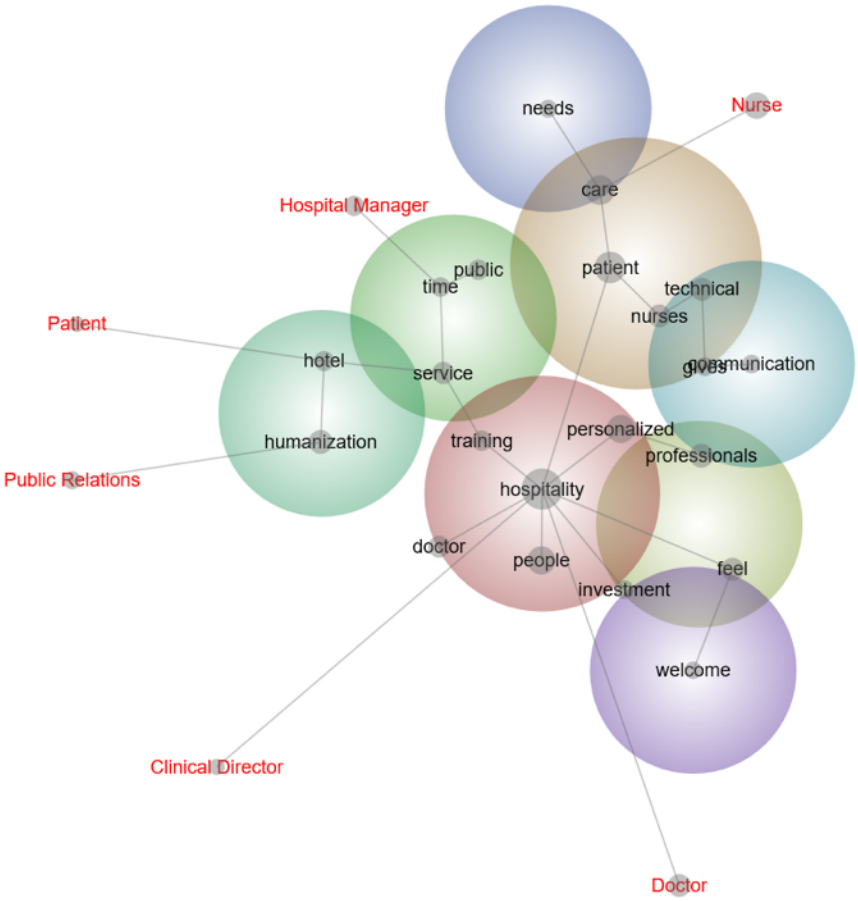

Figure 7. Concept map of hospitality from actors' point of view

Source: Author

1 Hospitality

The hospitality theme includes the concepts of 'hospitality' (relevance: 100%), 'people' (44%), 'person' (39%), 'doctor' (22%) and 'training' (11%). This is the most important theme, and it is linked with the themes of patients, service, professionals and welcome. The way services are provided by health professionals influence the presence of hospitality.

One nurse interviewed said:

> Hospitality can be the way you welcome [patients] ... If you pay attention when you walk here through the hospital, when you see a person looking around, trying

> to find out where she/he is and where she/he wants to go, and then you talk to them and ask, 'Can I help you?'… This is a form of hospitality.

A hospital administrator shared that 'taking care of a sick person in a hospital means people caring for people. This is hospitality.'

Interviewees associated hospitality with the way professionals treat people, highlighting that hospitality depends on the investment made in training professionals. A nurse stated, 'my training has always focused on the human aspect [of healthcare], ... [which is] also due to the school from which I graduated, where the human component is given great importance.'

A doctor in turn emphasised that:

> We have made an important investment in the training of everyone, and, when I speak of everyone, I mean from the auxiliaries to the doctors, and we also have made an attempt [to encourage hospitality], which I believe has been improved and achieved by greater proximity among all actors.

A hospital administrator explained that:

> We have a training programme that is from Disney. Every year, we have a refresher course of this training that has four modules. It was Walt Disney who developed this training for Disney employees, and we decided to apply it here. We brought in people from Disney at an early stage to train our team of human resource professionals to give this training, and every year we attend a refresher course and all the new staff members also go through this training. It has to do with the techniques of taking care of others, with knowing how to be in the clients' position [and] with time management [and] stress management, ... and, of course, we have adapted Disney's approach to a hospital context.

2 Patient

The patient theme includes the concepts of 'patient' (relevance: 58%), 'care' (47%), 'nurses' (19%), 'technical (aspects)' (19%), 'giv(ing)' (8%). An especially strong connection exists between this theme and the concept of care, which means that the health professionals interviewed believe that patients need to be the centre of attention. The nurses argued that besides technical aspects, the notion of caring is also important. These interviewees focused the most on paying attention to patients during their interviews, reiterating the importance of caring. One nurse stated:

> [Hospitality is] the way you take care of people. … The patients don't know how to evaluate technical aspects, I think. … The part of whether they feel cared for they know how to evaluate and know how to criticise. … This has to do with caring, with hospitality. We don't call it that. We call it caring, but I think it means the same thing ... [that is] caring for people by showing affection, by paying attention [and by] people feeling that they are the centre of attention.

Another nurse added more about the significant role of nurses in patients' healthcare:

> Doctors treat patients. Nurses take care of patients. Of course, surgeons operate on patients, [and] the patients want [that part to be] the best possible, but then all the follow-up is done by the nurses and also, of course, by the auxiliaries. This caring aspect affects the people who stay with us very much because – to remove their pain, to adjust their position, to worry if the patients are thirsty, if they are hungry, if they want to get up – this is our concern. [This is] besides all the more technical aspects … of the surgical procedures that are carried out in the hospital or even medical situations. For me, nurses are the personification of hospitality.

During the interviews, patients were also associated with the concept of hospitality in hotels and the importance of hospitals adopting some characteristics of hotels.

A doctor suggested:

> When I am patient, I think that, if there is an understanding, an adjustment, it is good to combine the two areas. I consider they [hospitals] should be, in some aspects, like a hotel because, if the clients are in a hospital and they are sleeping in the hall, this is bad and not hospitality. I think that, in hospitals, some things should be based on hotel business [strategies], with competent people … from the hotel sector. … In certain services, the organisation must be based on hotels.

However, the participant highlighted that human aspects are more important than physical aspects, namely, the importance of personalised service with humanisation. This interviewee said, 'hotels have some functions, and hospitals have others. In the sense of being settled in, it [hospitality] would be good. Now, the best thing for patients to do is to invest in doctors [and] nurses.' In addition, the interviewee felt that:

> [Hospitals need to] invest in training their professional staff because the important thing is not to be in a room with good paintings [and] good walls. What really matters is that I'm being well attended. People come to this hospital to be cured and get out of here as soon as possible. It is not about staying here [or] settling in to look at the walls [and] the beds. ... We want to be well taken care of [and] welcomed by attentive staff. For me, this is hospitality!

3 Professionals

This theme is linked with the concepts of 'professionals' (25%), 'feelings' (28%) and 'investment' (11%). This theme includes narratives that highlight the role of professionals in knowing how patients feel and how they should be treated. This depends, according to some interviewees, on the investment made not only in physical surroundings but also in the quality of technical procedures and professional training. A nurse interviewed said:

> The technical component in any hospital, from the outset, is based on the principles followed. The hospitality part may already be more or less assured because it is assumed that all the technicians working in a hospital have the

> necessary technical skills. The way the staff attend to the clients in a personalised way already varies from hospital to hospital and from professional to professional, and I think that we have to invest [in training] to make the difference.

Another nurse explained:

> When we say that our motto is 'know how to care', it has to do exactly with this, and we try in the hospital to take care of our patients and their families in the best way possible, so they come back and feel good, because the technical part, I believe, is assured by the universities, by each staff member's good practices.

A doctor affirmed that:

> From the arrival of people [patients] at the institution until their departure, there are always people [staff] with the maximum training. [This] … ensures not only a commitment to quality from a technical-professional point of view but also an effort to help the patients understand by all means possible that, at that moment, they are the most important thing that exists.

4 Humanisation

The humanisation theme includes the concepts of 'humanisation' (31%) and 'hotel' (14%). The interviewees highlighted the relationships between hotels, humanisation and hospitals. The participants argued that more important than offering hospital services based on hotels is to be inspired by the humanisation policy of hotels. A doctor who also functions as a clinical director emphasised that humanisation 'has to be a part [of our work] because hospitality is present not only in hotel-related services … [but also] the way doctors receive [patients, which] is very important.'

A nurse explained:

> [Hospitality is] the way the patients feel cared for, the technicians' concern for them and their family. The hotel industry, for example, can be very good, but, if

> the human aspects do not match people[’s needs, they] will not value the [hotels’] services as much. I think the key part is the attention paid to the patients.

This theme is also related to the concepts of ‘service’ and ‘time’. All the participants felt that humanisation in a hospital setting – the time spent with patients and the way the services are given (i.e. with hospitality) – means clients are ‘treated with humanity’, which is important for patients’ satisfaction and successful treatment. A doctor said, ‘the humanisation of care giving is part of hospitality.’ As previously noted, one nurse also emphasised humanisation, reporting that ‘my training has always focused on human aspects.’ One hospital administrator stated, ‘friendliness … is humanisation. This is hospitality. … If we can relate to our doctor, we will believe much more in the treatment. … The concept of hospitality aims to put into practice the desire to humanise [services].’

5 Service

The service theme contains the concepts of ‘service’(19%), ‘public’(14%) and ‘time’(11%). This theme is closely associated with the time spent with patients and the way health services can be similar to hotel services with regard to the relationships between hosts and guests. Service provision can also be influenced by training health professionals in how to improve these relationships. A hospital administrator highlighted that ‘the lack of hospitality negatively affects the provision of services. … The function of hotel managers is to create conditions so that other professionals themselves feel more easily motivated to perform their tasks well, so hospitals have to do the same.’ One nurse shared, ‘all the areas for us are important. All the connections between the auxiliaries, between the nurses, between medical procedures [and even] to hotels: everything is important to us.’

6 Needs

This theme is connected to the concept ‘needs’ (11%) and associated with ‘patient’ ‘care’. This is not only about technical aspects and physical needs but also emotional needs. A nurse pointed out that:

> Patients who come to a hospital and are going to be operated on or are ill – in crisis – they need support, … and we need to treat the patients as if they were our relatives [and] know how to take care of them [and] see beyond the disease.

One hospital administrator stated, hospitality 'is to exceed expectations and to think that patients have other needs than to be attended by the doctor. … [Hospitality] is also about being treated with humanity and as members of a civilised society.'

7 Welcome

The welcome theme includes the concept 'welcome' (8%), and this theme is linked with the concept 'feel'. Most participants argued that hospitality is associated with the feeling of being well received. A nurse said, 'hospitality can be the way we welcome patients.' A doctor who was also a clinical director shared, 'when I speak of hospitality, I think it is synonymous with being welcoming [and] hospitable. Hospitality is knowing how to welcome patients well [and] treat them well.' Another doctor explained, 'if patients … are being well treated in terms of technical procedures, but they don't feel welcome, they will become distrustful.'

8 Communication

The communication theme includes the concept 'communication' (8%). This theme is also linked with the concept 'technical' and strongly associated with the concepts of 'nurses' and 'patients', which means that the relationships between these two actors is defined by the way they communicate. One nurse reported that 'hospitality improves communication and, consequently, improves the rate of therapeutic success for clients and the nursing team'. Another nurse asserted, 'sometimes there are bad situations that happen not due to technical errors but due to a lack of communication.'

Some doctors also feel that information is the basis for treatments' success. The way health professionals communicate with patients defines the quality of patients' experiences. A doctor said:

> Patients have to feel that they are surrounded by competent people. Hospital professionals have to approach patients in a safe way [and] in a calm way, always answering every question the patients have without fear of [how they will take] the answer, because this will come across as insecurity. 'You don't answer because you don't know.' Professionals should not be afraid of communication, and then we have to be pleasant because, if we are not pleasant, we are contributing to the continuation of bad environments.

Another doctor stated:

> The most basic element is information. Patients have to know, at all times, what will happen. The worst thing for patients who are going to be hospitalised is the fear of the unknown, of being in a strange [situation] … where they will only be subjected to aggression. The patient comes in, is stung [and] intubated. … Knowing what's going to happen – when, why and for what – is essential. If patients know, they will feel better, and, besides being calmer [and] more confident, they will not feel so strange and so aggressive. Even if the information is negative, it is always best to communicate it.

(2) The perception and interpretation of hospitality: Comparison between different healthcare professionals

After an overall representation of hospitality, the next stage intended to understand if hospitality is perceived and interpreted in the same way by all the individuals. Therefore, the results were presented through the participants' representations of hospitality, grouping them according to their functions:

*9 Hospital Administrator**s***

Hospital administrators are more closely associated with the concepts of 'time' (50%), 'public' (40%), 'service' (29%) and 'humanisation' (27%). The time concept is especially strongly related to the concepts of public and humanisation (50%). A hospital administrator interviewed argued that time shared with patients is crucial to service

quality and hospitality. However, this participant reported that, in the public sector, some conditions – 'hundreds and thousands of civil servants' and 'lots of stress' – affect the quality of time with clients and 'present obstacles to providing true hospitality'. This interviewee also focused on the public concept, which is related to public hospitals, showing that some differences exist between the public and private sectors in terms of hospitality and humanisation.

This hospital administrator said:

> Humanisation is present, although we are aiming for it to be [even] more present in hospitals. I now think hospitality is something that is too broad ... in the sense that all hospital professionals must have a culture of hospitality. We [hospitals] cannot be just a sector providing [healthcare]. We must start really enjoying talking about hospitality. It must be [part of] hospital culture.

The interviewee went on to say, 'the concept of hospitality seeks to put into practice the desire to humanise.'

The participant also stated:

> This strategy [hospitality] is too ambitious especially for a public hospital, where the cases that flow into the public hospital all come from the most difficult backgrounds [and are] the most severe cases. ... I would venture to say that it is more difficult to implement hospitality in public hospitals than in private ones because things are more predictable in a private hospital. In a public hospital, all kinds of cases appear because we have the national health system. Serious and emergency cases all go to the public hospital, which does not mean that there are no serious cases in private hospitals, but they are more predictable.

10 Clinical Director

The clinical director interviewed focused on the concepts of 'welcome' (30%), 'hotel' (20%) and 'service' (14%). This participant perceived hospitality to be an act of

'welcoming' patients that is strongly associated with hotel services (concepts of hotel and service together = 33%). The interviewee also emphasised that the function of professionals is to implement hospitality based on the quality of services (concepts of hotel and doctor together = 100%; service and doctor together = 50%) 'because hospitality is not only in hotel-related services … but [also] in the way professionals receive [patients], which is very important'. The clinical director conveyed a more general view of management, arguing that hospitality exists due to the management of human resources by hired hospitality specialists and that this a business strategy that helps develop the hospital's brand to generate loyalty in its clients.

11 Doctors

Doctors are associated with the theme of hospitality, which is linked to the concepts of 'feel' (60%), 'investment' (50%), 'professionals' (44%) and 'people' (44%). These interviewees highlighted the importance of hospitality to ensuring patients' satisfaction, associating hospitality with hospital professionals' capacity to invest in and improve the quality of care not only in terms of technical and medical procedures but also in the way these providers care for patients' emotional needs.

One doctor said:

> The first tactic is the friendliness of those who receive them [patients] and then the swiftness with which processes happen. But, most of all, sometimes the process may not be efficient, but, if the personnel are sympathetic, the users accept this.

Another interviewee stated:

> In the healthcare industry, I think hospitality, above all, is to make patients feel well attended to [and] not feel lost in the middle of a [big] institution. The patients must feel that they always have the support they need.

A further doctor reported:

> On our side, we have made an important investment in training everyone, and, when I say everyone, I mean from the auxiliaries to the doctors, and we also have made an attempt, which I believe has led to improvements, to bring all actors closer together. From when people arrive at the institution until they leave, there are always people with the maximum level of training that ensures not only a commitment to quality from a technical-professional point of view but also an effort to make the [patients] understand by all means possible that, at that moment, they are the most important thing that exists.

Another physician said, 'patients have to feel that they are surrounded by competent people, and thus professionals have to approach patients in a safe way [and] in a calm way.'

12 Nurses

Nurses are related to the concepts of 'technical' (86%), 'needs' (75%), 'nurses' (71%), 'communication' (67%) and 'patients' (48%). Of all the professionals interviewed, these participants have a more ambiguous view of hospitality in hospitals' daily routines. These interviewees think that it must be present, and they most consistently point out the importance of patients' positive experiences through hospitality.

However, various nurses interviewed were the ones who most strongly underlined the need for professionals' technical competence, relegating hotel-related issues to second place. A nurse said, 'this [hotel-related services] is a component [but] not the main one! The main thing is the technical capabilities of the technicians, but the hotel [services] part is also important for the customers. It is important, but it is not the main point.' The nurses argued that the attention paid to patients, the quality of care and communication are some of the most important factors contributing to hospitality. As mentioned previously, one interviewee focused on the need to 'treat the patients as if they were our relatives, know how to take care of them [and] see beyond the disease'.

The nurses also underlined the importance of the nursing team and auxiliaries to providing hospitality because, according with these participants, they are always with the patients. According to these nurses, the main difference between hospitals and hotels is the vital significance of providing quality services in hospitals. In hospitals, professionals must take into account that clients are sick individuals. Healthcare providers cannot approach matters only from the customers' point of view and should watch out for pathological behaviours, so the providers' responsibility is greater.

(3) The Meaning and Importance of Hospitality in any Service and (4) The Main Components of Hospitality

The final two steps were grouped and analysed simultaneously: (3) if hospitality as the same meaning and importance in any service - comparison between hospitality in tourism (hotels) and healthcare (hospitals) and (4) the main components of hospitality and what can be implemented in hospitals.

According to the qualitative analysis of interview content, hospitality in some aspects is perceived in hospitals in the same way as in hotels. Four items were identified that reveal similarities and/or differences between hospitals and hotels: tangible dimensions, intangible dimensions, space attachment and organisational system. Each element was elucidated based on the interviewees' answers, which meant the four items became groups of sub-items (Appendix B).

13 Tangible Dimensions

The element of tangible dimensions was isolated to cover content about operational mechanisms, room cleaning and food quality. According to the analyses' results, some participants agreed that, in terms of operational mechanisms, some similarities exist between hospitals and hotels. A doctor said, 'what they have in common is food, cleaning [and] room service.' A hospital administrator asserted, '[in terms of] the management of beds and food, namely, maintenance, [and] also operational matters, it makes total sense to be based on the hotel industry.'

However, the interviewees suggested that some limits in hospitals are imposed by each patient. For example, another hospital administrator stated:

> In terms of services, namely, food, they [the staff] can't do much more because it depends on the type of patient. There are certain things that cannot be adopted because if we do, the hospital wouldn't exist anymore and would become a hotel. Good sense needs to be applied in this way. Only what can be adapted [from hotels] for use in hospitals should be done.

14 Intangible Dimensions

This item represents the emotional side of patients' experiences in hospitals and correlations with hotel experiences: experiences during stays, types of social interactions, clients' wellbeing and satisfaction and reasons for and perceptions of the time spent during stay. Regarding this element, some convergent and divergent points of view appeared. The interviewees shared the same view with the hospital administrator who said that 'the complementarity of the two areas is that they both welcome [clients and] provide accommodations, comfort, joy and simplification [of problems]. This is what they have in common.' A nurse said, 'the accommodation side of things must be similar.'

Nevertheless, the differences between hotels and hospitals should not be underestimated. These include the reasons for the clients' stay, causing one interviewee to argue that 'hospitals must have the opposite philosophy from hotels'. Another difference is the clients' perception of length of stay. As one doctor put it, 'patients want to stay for the shortest time possible in a hospital.'

15 Space Attachment

Hospitals' physical environments were frequently mentioned by the interviewees, namely, the physical support areas, management models and organisation of space.

A participant asserted that:

> There are some similarities between hotels and hospitals. There are aspects that are found in hotels that must be present in hospitals. The design of the hospital should have as a reference point the users, as in the case of hotels. The choice of location is very important for both: for hotels in terms of tourism and hospitals in terms of accessibility. Furthermore, the reception area should be comfortable and efficient both in a hotel and in a hospital. All the spaces should always be conducive to improving people's conditions.

However, most of the health professionals interviewed considered that, in the majority of hospitals, improving these aspects is not viable due to the limits imposed by service provision in hospitals. One doctor argued that 'the paediatrics area can't be equal to the geriatrics area, for example, so this is completely different from hotels where the areas are not differentiated'.

16 Organisational System

This item comprises the management strategies and adoption of practices and professional routines that, according with the interviewees, are or should be similar in hotels and hospitals. An administrator interviewed said, 'hotel services in hospitals can do two important things. One is meeting [the clients'] expectations, and the other is [generating] loyalty because they [hotels and hospitals] both depend on their regular customers.' Another interviewee suggested that 'hospitals and hotels work 24/7 all year and provide accommodations. In these aspects, we can think of a hospital as a hotel.'

However, differences were noted in the technical components of service provision and adoption of practices and professional routines. Most of the health professionals interviewed stated something similar to a nurse's opinion that 'it [the hospital] shouldn't only be based [on hospitality]. That's one component [but] not the main one! The main one is the technical capabilities of the technicians.' Another nurse argued, 'it's obvious that health is a very specific field, and our focus is and always will be taking care of our patients on a clinical level.' Still another nurse said, 'an excess of hotel services can

sometimes cause complications for all the clinical services.' In summary, the interviewees highlighted the main components of hospitality (tangible and intangible dimensions, space attachment and organisational system), the various similarities and differences between hospitality in hotels and hospitals and which hotel practices can be implemented in hospitals (see Table 4).

Table 4. Actors' point of view

Hospitality in hospitals and hotels	**Similarities**	**Differences**
Tangible Dimensions	Operational mechanisms such as cleaning services, room organisation and food quality	Limits imposed by different patients (e.g. type and variety of food)
Intangible Dimensions	Quality of experiences including types of social interactions, social environment and clients' wellbeing and satisfaction	Patients restricted by physical and emotional conditions Patients' completely different motivations for and perceptions of length of stay
Space Attachment	Physical support areas, organisation of space and management models	Divergent organisation of some hospital services (e.g. paediatric and geriatric areas)
Organisational System	Management strategies (i.e. business strategies and hiring of professionals specialising in hospitality) Adoption of hotel practices and professional routines	Limits imposed by hospital organisation Technical components of service provision and professional routines

Source: Author

4.2 The Importance of Verbal Interactions for Hospitality in Hospitals

The data collected from the participant observations were analysed to help the researcher to understand the hospital environment and the dynamics of the verbal interactions, answering to the second research question (RQ2): how verbal interactions are important for hospitality in hospitals. The results are presented according to the description of

interactions by type, situation and content and the analysed associations between these items (Appendix C).

17 Type of Interactions and Participants

As the services provided to the patients require privacy and confidentiality, interactions between a smaller number of participants (i.e. dyads) are the most numerous (64.7%). The observed interactions kept the patients as the central unit of analysis, so most dyadic interactions involved patients (82.6%). Notably, 55.8% of interactions are patient-nurse communication. Of the total remaining percentage of interactions (i.e. triads), the overwhelming majority occur in the presence of patients (96.4%), and patient-nurse-auxiliary interactions are the most frequent (32.9%). This high percentage reflects how much more time these two professionals spend with patients in inpatient services.

Table 5. Percentage of types and participants in interactions

Type of Interaction	Participants	Count	%
Dyad (64.7%)	P-P	1	0.6%
	P-D	24	15.4%
	P-N	87	55.8%
	P-A	15	9.6%
	P-Nut	1	0.6%
	P-F	1	0.6%
	D-N	16	10.3%
	D-F	1	0.6%
	N-F	2	1.4%
	N-A	8	5.1%
	Total	156	100.0%
Triad (35.3%)	P-P-D	1	1.2%
	P-P-N	15	17.6%
	P-P-A	4	4.7%
	P-D-D	2	2.4%
	P-D-N	18	20.9%
	P-D-A	2	2.4%
	P-D-Nut	2	2.4%
	P-D-F	2	2.4%
	P-N-F	4	4.7%
	P-N-A	28	32.9%
	P-A-F	1	1.2%

Triad (35.3%)	D-D-N	1	1.2%
	N-A-A	1	1.2%
	D-N-F	1	1.2%
	P-N-N	2	2.4%
	P-A-A	1	1.2%
	Total	85	100.0%

Notes: P = patient; D = doctor; N = nurse; A = nursing auxiliary; Nut = nutritionist; F = family.

Source: Author

18 Type of Interaction and Situation

The frequency of dyads and triads in each situation was verified during analysis. Most interactions occur during clinical rounds (73.9%), that is, at the time when health professionals visit patients to provide medical care. This result means that rounds – as medical and nursing acts – are the key moment in terms of quantitative measures of interactions in the daily routines of inpatient hospital services.

In addition, most of the interactions in which doctors are attending patients, whether dyadic or triadic interactions, occur during rounds (89.8%). Doctors usually visit patients once a day, but these short visits are specifically clinical and practical. Nurses are the health professionals who spend the most time doing their rounds, in which they assess vital signs and give medication, among other regular activities. In addition to these required rounds, mainly nurses go to rooms whenever patients or other health professionals call for assistance.

The percentage of triads is only higher than dyads during breakfast. The interactions at this time occur mainly (97.2%) between at least two of the following participants: patients, nursing auxiliaries and nurses. This high percentage is because the distribution of meals is the nursing auxiliaries' responsibility and the nurses verify medication.

Table 6. Percentage of dyads and triads in each situation

				Count	Valid %
Type	Dyad	**Situation**	Breakfast	19	12.2%
			Check in	6	3.8%
			Check out	14	9.0%
			Rounds	117	75.0%
	Triad	**Situation**	Breakfast	17	20.0%
			Check in	1	1.0%
			Check out	6	7.2%
			Rounds	61	71.8%

Source: Author

19 Type of Interaction and Content

A frequency analysis of each type of content (see Table 7) revealed that clinical interactions are the most common in the hospital in question (42.3% formal and 21.2% informal), followed by accommodation (both formal and informal) and small talk, as expected for the hospital context.

The frequency of different content in each type of dyad and triad was verified, along with the type of participants. Of the total number of formal clinical interactions, the most frequent are patient-nurse (53.4%), followed by patient-doctor (30.9%) and doctor-nurse (15.7%).

Table 7. Percentage of each content

Content	**Count**	**Valid %**
Formal Clinical	102	42.3%
Informal Clinical	51	21.2%
Formal Accommodation	44	18.3%
Informal Accommodation	31	12.9%
Small Talk	13	5.3%
Other	0	0.0%
Total	100	100%

Source: Author

Of the total number of informal clinical interactions, the majority were recorded as patient-nurse (54.9%) which is a more significant percentage than that of formal clinical interactions. A significant part of the interactions classified as 'accommodation' were patient-nurse (26.7%). However, the patient-auxiliary interactions (20.0%) are also significant since the nursing auxiliaries deal with room cleaning and breakfast delivery, which means they are involved in most acts of hospitality.

In formal accommodation interactions, the percentage of patient-nurse and patient-nurse-auxiliary interactions is curiously the same (26.7%). The most often observed small talk interactions are patient-nurse (38.5%). Informal accommodation and small talk interactions only occur when patients are present. However, small talk interactions are also noticeably absent when doctors and nurses are simultaneously present with patients.

An analysis of the data in Table 8 revealed that, of the 156 dyads, 69.2% were classified as 'formal and informal clinical'. The highest percentage of triads observed are also clinical (53.0%). The number of individuals present in interactions (i.e. dyads or triads) thus conditions the degree of formality, that is, whether interactions are formal or informal. The results in Table 8 show that, in interactions with greater informality (i.e. informal accommodation and small talk), the percentage of triads is higher than that of dyads. The presence of small talk interactions in this study's results for both dyads and triads indicates the significant presence of informal content in the hospital context.

Table 8. Percentage of dyads and triads for each content

				Count	**Valid %**
Type	Dyad	**Content**	Formal accommodation	26	16.7%
			Informal accommodation	14	9.0%
			Formal clinical	71	45.5%
			Informal clinical	37	23.7%
			Small talk	8	5.1%
			Formal accommodation	18	21.1%

Type	Triad	**Content**	Informal accommodation	17	20.0%
			Formal clinical	31	36.5%
			Informal clinical	14	16.5%
			Small talk	5	5.9%

Source: Author

20 Situation and Content

The results presented in Table 9 show that most of the interactions during rounds were classified as 'clinical' (70.8%), demonstrating once again that, during rounds and the associated medical and nursing activities, these interactions are naturally formal or informal clinical.

Regarding breakfast, most interactions were classified as 'accommodation' (75.0%) since this is the time when greater relaxation and more frequent acts of hospitality were verified.

Table 9. Percentage of different content in each situation

		Content				
		Formal Accommodation	Informal Accommodation	Formal Clinical	Informal Clinical	Small Talk
		Count %	Count %	Count %	Count %	Count %
Situation	Breakfast	17 47.2%	10 27.8%	2 5.6%	6 16.7%	1 2.7%
	Check in	2 28.6%	0 0.0%	3 42.9%	2 28.5%	0 0.0%
	Check out	4 20.0%	0 0.0%	10 50.0%	4 20.0%	2 10.0%
	Round	21 11.8%	21 11.8%	88 49.4%	38 21.4 %	10 5.6%

Source: Author

The results presented in Table 9 above also show that in check in interactions there are no instances of informal accommodation and small talk since in the majority of time, the health professionals and patients don't know each other and in this situation the

procedures of hospitalisation are explained to patients. In addition, the patients' personal and clinical data are conveyed, so the actors are less predisposed to feel at ease. At check out, contrasting content appears ranging from informal (i.e. small talk 10%) to formal (i.e. half the interactions observed were formal clinical).

The study's quantitative results were also confirmed through perceptual map analysis with some examples of interactions collected (see Figure 8). The distribution of the main categories (i.e. type, situation and content) and the degree of proximity between them were used to establish the levels of interactions and the ways they are related.

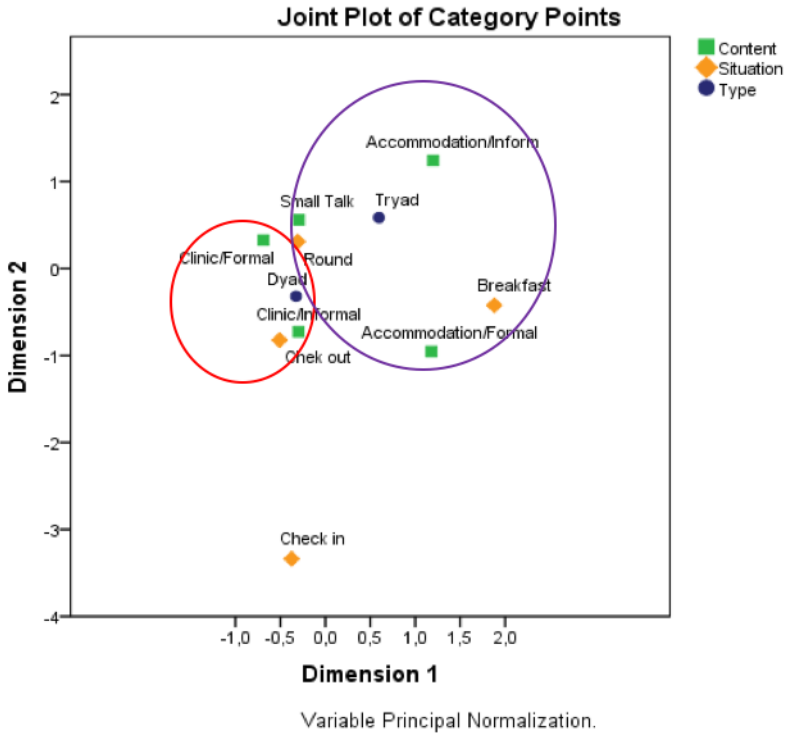

Figure 8. Perceptual map of dyads and triads

An analysis of the plot shown in Figure 8 revealed that dyadic interactions are more common during rounds and check out and that the contents are formal clinical (I) and informal clinical (II), as shown below:

(I) Formal clinical

- 'Good morning! How are you?' the nurse asks.
- 'The same,' the patient replies.

- ‘Let’s get you to your CAT scan. Then the doctor will look at it later.’
- ‘Good,’ replies the patient.

(II) Informal clinical

- ‘Good morning!’
- ‘Hello, doctor!’
- ‘How do you feel?’ …
- ‘When will I be discharged, doctor?’
- ‘You have to be patient, my dear.’

Triads are also present during rounds, but triads also appear during breakfast. In addition, triads’ content is more often quite informal than dyads, which means these can be classified as informal accommodation (III) and small talk (IV) interactions, as these examples show:

(IIIa) Informal accommodation

- ‘Excuse me. ... Good morning! So what can I get to drink here?!’ jokes the nurse.
- ‘Tea,’ replies the patient.
- ‘Very good. ... Eat some bread too,’ says the nurse.
- A nursing auxiliary enters. ‘Good morning, Mrs Germana!’
- ‘Hello!’
- ‘So, my dear, what surgery did you have?’ asks the nursing auxiliary.
- ‘Foot surgery!’
- ‘You’re going to be fine!’ says the nursing auxiliary.

(IIIb) Informal accommodation

- ‘Good morning, my dear! Here’s your breakfast. I know you like coffee,’ says the nursing auxiliary.
- ‘That’s absolutely right, good morning!’ replies the patient.
- The nurse comes in and says, ‘Good morning! How are my girls?’

(IV) Small talk

- ‘So tell me ... are you in favour of Brexit?’ asks the nurse.
- ‘Truthfully, I don’t think that’s going to happen. The British are going to stay in the European Union!’ replies Patient A.
- ‘And the national team, will they win?’ asks the nurse.
- ‘I sure hope so!’ replies Patient B.

As previously mentioned findings, identifying who are the main participants. The most common formal clinical interactions are patient-nurse (V), followed by patient-doctor and doctor-nurse (VI). Dyadic doctor-nurse interactions are exclusively clinical as no accommodation or small talk interactions were observed.

The most common informal clinical interactions are patient-nurse (VII), followed by patient-doctor (VIII). Informal clinical interactions between doctors and nurses are practically non-existent, revealing that these two actors, when alone with each other, rarely have informal interactions, as shown by the following examples:

(V) Formal clinical patient-nurse

- ‘Let’s get you to your CAT scan. Then the doctor will look at it later’ says the nurse.
- ‘Good,’ replies the patient.

(VI) Formal clinical doctor-nurse

- The nurse finds the surgeon on duty. ‘Good morning, doctor!’
- ‘Hello!’
- ‘I’m going to prep the patient for surgery!’
- ‘Great! Check the patient’s blood pressure,’ replies the surgeon.

(VII) Informal clinical patient-nurse

- ‘How do you feel? Are you dizzy?’
- ‘No.’
- ‘Very good, now let’s walk to the chair ... 1, 2, 3, now up!’ says the nurse helping the patient.

'That's wonderful! You can already get up!' says the nurse as she helps the patient sit down.

(VIII) Informal clinical patient-doctor

- 'Good morning!'
- 'Hello, doctor!'
- 'You are looking great!' says the doctor
- 'I need to go home. When will I be discharged, doctor?'
- 'You have to be patient, my dear.'

In the more predominant formal accommodation (IX) or informal accommodation (X) interactions, patients and nurses are present in both dyads and triads, while nursing auxiliaries are the other element most often present in triads.

When doctors are present in interactions with patients, non-clinical interactions are rarely observed, as shown by the absence of doctors in the following examples:

(IX) Formal accommodation

- 'Good morning!' says the nurse.
- 'Good morning,' says the nursing auxiliary holding a tray.
- 'Wow! So many people!' replies the patient.
- 'See?! We're all here to visit you! How have you been feeling?'

(X) Informal accommodation

- 'Good morning. Nurse Daniel at your service!' says the nurse.
- 'Good morning, my friend!' replies the patient.

The most common small talk interactions are patient-nurse (XI), followed by patient-patient-nurse (XII). These interactions are rarely patient-doctor.

(XI) Small talk patient-nurse

- 'Celebrate the saints' days?! No. ... In fact, I'm the one who's a saint for putting up with so many days in hospital!' says the patient.

- They laugh.
- ‘Don’t tell me you’ve been badly treated?!’ asks the nurse.
- ‘No! In fact, I’ve been treated like a king! Everyone has been wonderful!’ replies the patient.

(XII) Small talk patient-patient-nurse

- ‘So, tell me ... How is the weather, today? Rain or sun?’ asks the nurse.
- ‘Rain?! Truthfully, I think that’s not going to happen,’ replies Patient A.
- ‘I don’t think so,’ replies Patient B.

21 Sequences of Interactions

An analysis of the data shown in Table 10 revealed that a significant percentage of interactions that start with formal clinical content continue to follow this pattern (34.3%). Notably, when changes in content occur they are most commonly from formal clinical to formal accommodation (9.8%). Thus, after clinical interactions with a higher degree of formality, the contents of these interactions will either continue to be quite clinical, or hospitality is introduced to mitigate and facilitate the relative degree of formality always maintained in these interactions. Although not significant in number, small talk interactions (1.0%) can occur after moments of greater formality.

Table 10. Percentage of shifts from content (1) to content (2) in the same transaction

1 \ 2	Formal Clinical	Informal Clinical	Formal Accommodation	Informal Accommodation	Small Talk	No Sequence	Total
Formal Clinical	34.3%	2.9%	9.8%	2.9%	1.0%	49.1%	100%
Informal Clinical	13.7%	15.7%	5.9%	3.9%	7.8%	53.0%	
Formal Accom.	22.7%	15.9%	13.6%	0.0%	2.3%	45.5%	
Informal Accom.	6.5%	38.8%	3.2%	19.4%	12.9%	19.2%	
Small Talk	38.5%	61.5%	0.0%	0.0%	0.0%	0.0%	

Note: Accom = accommodation

The interactions that start as informal clinical stay that way (15.7%) or when they change in the most time change to formal clinical (13.7%). This indicates that informal clinical conversations are introduced to reduce patients' anxiety levels, after which the level of formality increases. Notably, when clinical interactions start as informal, the percentage of informal accommodation and small talk interactions increases compared to formal clinical.

When content changes occur, most formal accommodation interactions become formal clinical (22.7%) or informal clinical (15.9%) so that a degree of hospitality is often introduced before discussing clinical issues. In addition, a significant number of informal accommodation interactions become informal clinical (38.8%), thereby maintaining informality despite altering the content of the interactions.

In the interactions classified as 'accommodation', no changes were observed from formal to informal. This finding can be explained by how formal accommodation interactions do not indicate as significant a level of social distance between the actors as formal clinical interactions do. Nevertheless, shifts from informal to formal accommodation, although present, are relatively insignificant (3.2%).

This supports the conclusion that accommodation interactions – regardless of whether they are formal or informal – do not need to shift their degree of formality in order for the desired message to be transmitted. As previously mentioned, more informal verbal interactions can be observed in hospital settings, in this case by using hospitality (informal accommodation and small talk) before clinical content and thus creating a stronger connection between service providers and patients.

In small talk interactions, only shifts to formal clinical (38.5%) and informal clinical (61.5%) were recorded. This means that small talk conversations are used to 'break the ice' between health professionals and patients by bringing in conversation content from outside the hospital to reduce stress and gain the patients' trust. The introduction of this quite informal content before moving on to clinical content is extremely important in a hospital context because it allows patients to detach themselves from the immediate context, thereby facilitating more pleasant hospital experiences.

4.3 The Importance of Hospitality for the Services Improvement

Considering the results obtained from participant observations, in which, was revealed the importance of verbal interactions as a mean for hospitality, the last stage of semi-structured interviews was analysed to compare the results from researcher's observations with the health professionals' points of views.

Taken into account the third research question (RQ3.) how hospitality is important for services improvement, the results revealed the following points: (1) hospitality as an assessment element of healthcare services and its relation with individuals' satisfaction; (2) the importance of hospital experiences for patients' satisfaction; (3) the importance of interactions in hospitals' day-to-day operations; (4) the main participants and factors that condition the quality of these interactions and (5) what improvements are needed to better experiences.

(1) Hospitality as an Assessment Element of Healthcare Services

Hospitality was identified as a component of healthcare not assessed by patients' clinical standards. This means that, according to one interviewee:

> [Hospitality] is independent of the participants' physical state and independent from people's level of suffering. Thus, it [hospitality] is an area in which the human and technical investment points of view are based on larger amounts of evidence – separate from the difficulty, at times, of healing a person who's very sick and whose prognosis is uncertain.

All the individuals interviewed agreed that hospitality influences hospital users' satisfaction. One professional said, 'that's obvious. When a client is well treated – with hospitality, dignity and human caring – even small unfortunate failures are more likely to be forgiven.' Another interviewee stated simply, 'hospitality is excellence!'

Regardless, some of those interviewed felt that, in order to achieve an acceptable level of satisfaction, more investment needs to be made in certain sectors, namely, in human

resource and technical components. From the human resource point of view, more qualified health professionals experienced in dealing with hospitality are needed since hospital staff must know how best to welcome patients, inspire trust and humanise services. A hospital administrator said, 'everyone should be part of a culture of hospitality, so more training and investment is needed in this field.' Still another professional suggested, hospitals need to 'increase the number of human resources managers available to train the staff ... in how to communicate with patients, an issue that crosses all groups within organisations dealing with patients – from doctors to auxiliary personnel'.

From a technical point of view, factors such as the quality of food services and a clear well-defined network allow patients to feel comfortable with the surrounding space. Better facilities and design also have this effect. One doctor said, 'after following protocols, it's essential that patients feel that they've been well treated and that there have been no surprises. In hospital contexts, there shouldn't be any surprises so that there's no fear.'

(2) The Importance of Hospital Experiences for Patients' Satisfaction

The interviewees reported that, to assess the level of patients' satisfaction, the hospital analyses the users' experiences by conducting surveys and having 'ghost' clients use the inpatient services, even though they do not present any clinical symptoms. Therefore, during their stay, they can observe and assess their experiences, and, in the end, they write a report of the results, which is later used by the administration. Other evaluation tools are written and oral patient feedback and external assessments.

The interviewees also argued that the quality of experiences can be easily affected, that is, a certain moment or event in a section or a professional issue can condition the users' entire experience. One doctor said:

> All areas are important. For us, all levels from the auxiliaries to the nurses, from medical aspects to the hotel industry, everything is important to us. ... We have to keep in mind all of these because this set of areas is what creates people's

> perceptions of experiences in hospital. If one area is very good but the other is bad, personal experiences are affected. That is, if a person's experience in a consultation is bad, they might come here and see things with different eyes, so all areas are important.

All the professionals interviewed referred to patients' satisfaction with previous experiences as a determinant factor in choosing the same services again. The administrators considered these experiences as a whole important, but the clinical competence and empathy shown by professionals depend on the overall level of hospitals' organisation. These criteria contribute to not only patients' loyalty but also the loyalty of their entire family.

The doctors considered experiences and final results to be the main factors contributing to satisfaction, so matching patients' expectations is important. One physician asserted:

> Ah, it's the results, without a doubt! It's the subjective results. That is, they feel that they're treated well and that they had the results they were expecting – the same or better. This depends on the expectations that were created since they have to be realistic. That's why I say that the most important thing of all is information.

A nurse argued that, although some patients value the hotel aspects of hospitals, the most important is still the quality of the human components that define users' experiences:

> What ... differentiates it [users' level of satisfaction] is the experiences that patients end up having in their short or long period of hospitalisation and [experiences] with people with whom they entered into contact – doctors, nurses and auxiliaries. In some cases, there are people who place greater value on the hotel aspect, that is, if they have a beautiful, more comfortable room with less noise. [They care about] the fact that they didn't have to share [their room] with a stranger or that they had the opportunity to spend time with relatives. All this might vary somewhat, but the truth is that the human component is a very important generator of loyalty.

22 Patients' Experiences in Hospitals: Positive Factors

The interviewees identified positive and negative factors that affect patients' experiences. These factors were grouped in analyses according to the type of professional interviewed. The administrators and doctors felt that, the factors that make experiences positive are a warm welcome, proximity, friendliness and information. A hospital administrator said:

> For me, the basic factor is information. Patients have to know, at all times, what will happen. The worst for patients who will be hospitalised is the fear of the unknown. ... Even if the information is negative, it's always preferable to communicate it. ... Patients feel more confident when they know what's happening to them and why it's being done.

One doctor argued that, in a hospital environment in which patients can experience aggression, fear and ignorance, the more informed patients are the better their stay will be. This means that, if the same doctor always accompanies a patient and transmits complete information, that user's experience will be better:

> The most important thing for me is that patients know what's going to happen: when, why and what for? If patients know, they'll feel better, and, besides being calmer and more confident, they won't feel the environment as strange and aggressive.

Thus, the physicians were unanimous in believing that the information transmitted is more important than design and facilities since this is a way to differentiate services and create positive experiences through how professionals approach patients. One of these interviewees said:

> We think that from the perspective of people subjected to uncomfortable events, regardless if this is only a simple surgery or if the patient is very sick, a warm welcome is fundamental since it affects their entire stay. ... Also, the availability of the teams that take care of patients the most closely has an effect.

The other physician stated:

> I think the first factor is the friendliness of those who receive patients, and after this the most important is the smoothness of the process. Sometimes the process might not be smooth, but, if people are friendly, the patients will accept certain [difficult] situations more easily.

The nurses reported that the most important components are quality medical care and patient care. One nurse said, 'the medical aspect is very important and fundamental.' The second nurse emphasised that hospitality in tourism is different from hospitality in a hospital. He associated hospitality with hospitals' physical features and design, and he felt these are not so relevant as the most important factor is the human component. He said, 'the physical environment, for example, can be very good, but, if the human aspects do not match [this quality], people won't value it [hospitality] that much. I think the key factor is the attention paid to the patients.'

The other interviewee in this group argued that an organisational philosophy must be in place so that hospitality does not depend only on individual employees. They must all be involved. This professional stated:

> I think it has to do with people, with the humility of employees, with the attitude of employees and above all with the organisation's philosophy because, if there's no such philosophy, it's not one or another staff member that can effectively make a difference. This philosophy has to exist and start at the top and move downward and has to be followed across the entire organisation.

23 Patients' Experiences in Hospitals: Negative Factors

The negative factors mentioned by the interviewees can also be grouped according to different types of professionals. The administrators reported that a negative factor is related to users' high expectations. This professional said, 'I think expectations are very high, and this is a major obstacle.'

However, the doctors referred too few professionals and a lack of information as the most important factors. One doctor argued:

> Administrative aspects, the number of patients, the lack of administrative staff to respond to the [users'] needs [and] the lack of support staff can be factors compromising all of this [patients' experiences] because there's not enough time to pay attention to people as much as we should.

The doctors also highlighted the dense bureaucracy that affects the speed of processes. One interviewee said, 'bureaucracy exists because it's a hospital. It deals with insurance companies, entities and authorisation requests from insurers and this makes things harder for us.'

The nurses, for the most part, emphasised that poor quality of communication can be an obstacle. However, the most significant factors they mentioned were, first, the large turnover of patients who, fortunately, are only in the hospital for a short time, which does not allow the staff to develop stronger affective connections. Second, the nurses highlighted that the number of patients who are each nurse's responsibility affects the quality of the time they can be available to each patient. One of the nurses also emphasised that patients sometimes have 'prejudices ... regarding health professionals.

24 Patients' Experiences in Public and Private Healthcare Services

Given that, the professionals interviewed made comparisons between the public and private sector, a further question was directed at the entire sample focusing on the main differentiating factors between those two sectors. The administrators believe that no difference exists in terms of competence at the professional level. However, they see some differences in organisation and structure. The private sector is more concerned about training professionals since patients in this sector are more demanding as they are paying for the services.

Another aspect taken into account by private hospital administrators is the conceptualisation and valuation of their brand because these hospitals must create a brand

that retains their clients. Thus, private hospitals need to have the best and most qualified health professionals. An administrator stated:

> There is one circumstance that is discussed at a management level. The [private] sector cannot forget that we're in an open market and that people come because of good doctors. They come because of good teams, but they also come for the brand image. So, when there's a tendency that's already caused by the brand image, the latter has to be maintained carefully, and that is why the [hospital's] professionals must be good. They must be good, [so] we always want the best professionals in the world and surrounding areas.

The great majority of physicians did not make a strong distinction between the private and public sector, as they considered the pressures in both sectors to be similar. Some interviewees reported that the conditions offered in the two sectors are not that different since the professionals' function in the same way in both of types of hospitals. However, the doctors suggested that public hospitals have a higher number of patients, so patient-doctor interactions end up suffering changes. Not only are public sector professionals more exhausted, but also patients end up waiting longer to be treated. A doctor said:

> In terms of [treatment of] the same [medical] conditions, I would say [there's] no [difference]. But if I'm in the emergency room and the patient has already been waiting for 13 hours in terrible pain, the moment in which he or she enters the office, the patient isn't in the same state of mind as he or she would be if I could have seen the patient sooner. Therefore, for the same [medical] conditions, the treatment will be the same. The problem is that [hospital] conditions change from one place to another, and this may result in different interactions.

The other doctor stated:

> It's different to have appointments with 15 patients or with 35 [in a day]. I don't have the time or willingness to treat them in the same way. I don't think people change the way they treat users. I think the conditions are just different. There are different contexts.

The nurses believed that, in terms of professional competence, no differences exist between public and private hospitals since interviewees said that professionals often work in both sectors. One shared:

> Regarding the professional competence, I don't think there should be differences. We must be the same professionals whether in the private or in public sector. We have colleagues working in both areas, and I think their ability doesn't change because they're working in one institution or another.

The other nurse said, 'external conditions, environmental factors, everything else may be different, but the relationships and the way I work doesn't change.' The interviewee also stated that certain external constraints (i.e. environmental and organisational) influence the way professionals behave:

> The message that's transmitted by the hierarchy – both directly from the administration or via the sensitivity [to patients' needs] the hospital transmits to its professionals – is that, if excellent care is to be given in private hospitals to the patients, it's the staff's responsibility to render good services. [They must] create the least complicated or more pleasant experiences possible – although the term 'pleasant' is difficult to use when we talk of illness. Perhaps, in the public sector, this message isn't as strong, and, if it doesn't reach enough professionals, this can lead to inadequate care [of patients].

The nurses were also the only health professionals interviewed who admitted that pressures in the private sector are greater than in the public sector. One nurse felt that the private sector entails stronger pressures due to how much more easily staff members can be dismissed:

> Let's say that the person is the same, but, probably because of what the private hospital requires, it can dismiss this employee more easily, which influences this person. Each person knows that, in the public hospital, many steps need to be taken in disciplinary processes, so it takes something very serious to dismiss a professional.

In general, the interviewees mentioned in more indirect ways that significant differences exist in relation to interactions, namely, that the public sector involves a heavier workload and thus that the attention paid to patients cannot be the same. An interviewee reported:

> There's an overloading of services in public hospitals, and people are under more stress because they have to care for a greater number of patients. This is the case with doctors, nurses and auxiliaries. In order to get everywhere they need to be, they pay less attention to the clients.

(3) The Importance of Interactions in Hospitals, and (4) The Main Participants and the Positive and Negative Factors in these Interactions

No consensus appeared in the interview data in relation to the importance given to interactions between service providers and users, as well as who are the main actors in these interactions. The administrators tended to highlight the nurses, followed by the auxiliaries, as the main actors in inpatient services because these professionals spend the most time in the company of users, so they are the ones who interact most with patients. A hospital administrator said:

> Close proximity and care are provided by the nursing team, which also includes auxiliaries, operations assistants and everyone who is front office staff. The ability of the front office personnel to solve problems, [answer] questions [and overcome] difficulties and take these tasks on as their responsibility ... [– in essence] to take them [concerns] out of the family and patients' hands and mind – is fundamental.

Doctors prefer to emphasise the importance of all professionals, especially since high quality interactions are possible not only with users but also among professionals if messages are conveyed in positive ways. One physician stated, 'I think there have to be interactions between everyone because positive ... or negative reinforcement can occur among all stakeholders.' The other doctor affirmed:

> Nurses spend more time with patients. They can reassure them more, they forward information [and] they know how to work with different doctors. It's important that doctor-nurse partnerships exist. Patients put more hope in doctors because they're the ones who makes the diagnosis and apply the therapy. Now, the other professionals also have to work in a team and contribute to it. Everything can contribute to positive or negative reinforcement, so I cannot highlight anyone. I think everything has to work well.

In addition to emphasising the role of doctors, nurses and auxiliaries, another doctor stipulated that, 'in inpatient services, there are three important types of professionals: doctors, nurses and auxiliaries.'

The nurses gave special emphasis to nurses and auxiliaries' work, since these are the professionals in contact with patients for more time. One nurse stated:

> There are two very crucial areas here. The nurses, since they are 24 hours a day with patients, are the professional group that has a greater responsibility in terms of the image that patients create, as well as the auxiliary personnel who provide important support even in quite clinical areas. However, the nurses ... determine treatments 24 hours a day.

The second nurse interviewed said:

> Nurses are always one step ahead since they spend 24 hours with patients, but this is obvious. Doctors spend the time that's necessary [with patients], but nurses are always there. In terms of hospitality, it's the nurses and auxiliaries who are there longer. ... Hospitality comes through them.

25 Doctor-Patient Interactions: Positive Factors

The administrators and doctors showed a consensus regarding the determining factors in doctor-patient interactions. Although all members of these groups emphasised the clinical component (i.e. technical competence), the first words used when responding to this

question were related to the more emotional and personality sides of doctors, such as the ability to inspire trust and convey competence and empathy. An interviewee stated, 'for me, doctor-patient relationships have something that is fundamental and that is unique to this profession, that is, trust.' Another interviewee affirmed that 'there has to be empathy to establish a relationship of trust.'

In contrast, the nurses highlighted the physicians' medical and technical competence and experience, leaving the more emotional elements to nurses. One interviewee said:

> I think patients looking for a doctor first choose a hospital based on the technical aspects. In terms of nurses, [the patients focus on] ... their [nurses'] empathic aspects, which are of greater importance, although the empathic part of doctors' work is also very important, but I think that, when they [patients] choose [their doctor], it's not because of this.

However, the nurses did not dismiss the importance of the time available to interact with patients, as well as the human aspects of services. A nurse predicted, 'it's inevitable that doctors' technical and clinical knowledge [and] experience will remain essential, but soon I believe humanisation will be [equally] important.' The other nurse stated, 'technical knowledge is fundamental, but we cannot restrict ourselves to this alone. The way doctors heal patients – in human or non-human ways – makes warmth also fundamental.'

26 Doctor-Patient Interactions: Negative Factors

Regarding the negative factors that may affect interactions, most interviewees tended to highlight a lack of trust, breakdowns in communication and relationships and empathic components that can detract from more positive aspects. The majority of interviewees argued that the most important part for patients is clinical services, but, for doctors and nurses, this part does not depend only on them but also on other biological factors that are often not out of their control. An interviewee said:

> When I speak of hospitality, I speak of a circle. It's clear that the medical aspect is fundamental, but it's also the most fallible from the point of view of certainties

> because, although we're always hopeful that this [medical problems] can be resolved, sometimes things don't go the way we want.

Another professional suggested that 'there's an indicator that cannot be quantified because it's difficult to quantify exactly what it is, namely, when a failure is merely biological, meaning that it has nothing to do with any bad practices.' A further interviewee stated, 'doctors may be very good doctors on a technical level, but, if they can't establish the empathetic part of relationships with clients, then they [physicians] fail.' Still another professional expressed the opinion that:

> If something fails in terms of a technical component, this can have serious consequences for patients, so it's critical. Regardless, in some cases, this potential failure is inevitable, and, if patients are warned in advance and there's a humanisation of care, the consequences can be mitigated.

27 Nurse-Patient Interactions: Positive Factors

Overall, respondents felt that the positive factors in nurse-patient relationships are quite similar to doctor-patient interactions: competence, trust and empathy. However, all interviewees emphasised that nurses have some responsibility in the way they approach patients because, in inpatient services, nurses spend more time with clients. One doctor said:

> We can excuse another doctor who's serious [about doing a good job] but who doesn't have much empathy if he's competent, whereas, in the case of nurses, there's a closer relationship to the patients so it's essential that the nurses show empathy.

The nurses themselves warned of the need for them to function as a fundamental participant in relationships with patients. One nurse reported:

> Patients evaluate everything, the [staff's] attitude, posture [and] form of communication. ... This evaluation also results from interactions, and it's in these

> that the therapeutic relationships between nurses and patients are created, which allows nurses to have patients' condition under control with respect to the intended treatments.

The administrators re-emphasised the relationship between nursing and hospitality. One interviewee from this group stated, maintaining 'closeness, touching, perceiving that you're in pain, helping you lie down, helping you get up, helping you put food in your mouth, all these things are much more the responsibility of the nursing team'. Another administrator said, 'when we speak of hospitality, this is [due to] nursing, [as well as the efforts of] operations assistants and front office employees.'

28 Nurse-Patient Interactions: Negative Factors

Regarding negative aspects, the interviewees highlighted the absence of the above-mentioned positive factors. The respondents also mentioned the lack of technical competence and empathy, in addition to burnout.

(5) The Improvements Needed for Better Experiences

The interviewees were asked about the aspects needing improvement to better the quality of patients' experiences. Their responses highlighted enhancing interactions and meeting patients' needs as the factors determining users' satisfaction and their choice of specific hospitals as a point of reference.

29 Interactions

During the course of the interviews, some of the most frequently discussed issues regarding what should be improved were the lack of interactions between health professionals and patients and a paucity of information that often affects treatments and builds mistrust, as well as patients' deep-seated fears. The lack of interactions and informations can elevate patients' expectations and, when results are not as expected, lead to patients' dissatisfaction and the discrediting of health professionals from the users' perspective.

Despite this problem, the interviewees focused mostly on identifying factors that do not allow interactions to be at their best. These factors are professionals' overly heavy workloads, which mean they cannot find the time to talk to patients, and the existence of a large number of professionals who are not part of the hospital staff, which implies that uniform standards cannot be implemented. Other factors are the need to create teams that include other professionals who can assist doctors and nurses and to provide better working conditions so that professionals feel motivated to communicate with patients in the best way possible. An interviewee reported:

> Technicians, if they have good working conditions, are more satisfied and are likely to do a better job because nurses and doctors are different from other workers in general. When someone isn't satisfied at work, this will most probably affect the quality of their work.

Notably, most professionals considered the need for training and information to be the two factors that most determine the quality of interactions. One respondent stated:

> Professionals must be aware that the results of their work depend on what the patients know and the information they have. As long as people [the staff] aren't careful [and] they aren't aware of this issue, they won't feel obliged to transmit as much information.

Another interviewee said, 'we improve our results if we improve [the level of] patient information by doing exactly the same procedure each time.' A further interviewee suggested, 'we should be as open as possible and try to start giving the details of what's going to happen early on to lower [patients'] expectations. ... Uncertainty and insecurity are the worst feelings that can be triggered.'

30 Patients' needs

Doctors thought that one of the factors that can be improved to satisfy patients' needs is time. One physician said, the most significant factor is 'essentially time to look at things

with attention. ... On our side, I think we lack the time and mental availability to dedicate to and analyse each case calmly.' The second doctor emphasised that collective institutional standards are needed to ensure practices are adapted uniformly. 'Institutional control promotes universal standards for everyone. We're all supposed to work well, but I think there should be some general rules regarding the information that should be given.'

One nurse emphasised the importance of each professional as individuals. 'I think these professionals themselves need, more and more, to have more confidence in procedures [and] in the care they provide, and this naturally comes through continuous training.' The other nurse focused primarily on the need for better working conditions, which can then be reflected in the way professionals deal with patients:

> [Regarding if] they [the staff] have better working conditions, they don't have them today! Nurses, for example, or auxiliaries – to have a minimally acceptable salary or to meet their needs – have to work in at least two places, and this doesn't improve the services provided. It's not the same to work 8 hours as it is to work 16, 32 or 42 hours in a row.

Other professionals highlighted the lack of means not only on an emotional level but also at the organisational level. An interviewee stated, 'there's a need for showing more empathy with clients, reducing the bureaucracy involved in processes [and providing] more training.' Another interviewee said:

> At the equipment level, even though the patients don't realise it, the staff lacks essentials both in the kitchen and in other areas, so [resolving] this [problem] could improve the quality of services. Training people is very important, [so] we should invest more in training [staff] in hospitality. For hospitality to be part of hospitals' dominant culture, there's still a lot of work to do.

An additional professional similarly reported, 'there's hospitality. There are those who care about it, but there's still much to be done. In terms of their infrastructure, some hospitals are very old, and this can affect the quality of services.' A final interviewee pointed out that 'the sick is the 'reason d'être' of hospitals.'

Table 11. Spreadsheet of main words in interviewees' answers for each item

Hospitality	**Experiences (Positive)**	**Experiences (Negative)**	**Doctor-Patient Interactions (Positive)**	**Doctor-Patient Interactions (Negative)**	**Nurse-Patient Interactions (Positive)**	**Nurse-Patient Interactions (Negative)**	**Improvements**
Welcome	Welcome, proximity	High expectations	Confidence	Burnout	Confidence	Burnout	More time
Dignity	Organisational philosophy	Too few professionals	Technical competence	Breach of trust	Technical competence	Absence of empathy	Better primary healthcare services
Humanisation	Hospitality professional in care teams	Lack of information	Empathy	Security breaches	Empathy	Technical components	Promotion of hospitality standards
Human resource investment; professional qualifications	Friendliness, humility	Negative clinical outcomes	Information	Loss of relationships	Attitude	N/A	More safety in procedures
Technical investment	Information	Discrimination	Communication	Clinical complications	Accommodation	N/A	Less pressure on professionals
Food	Hotel management	Lack of communication	Experience	Negative clinical results	Structure of communication	N/A	Continued professional training
Well-defined circuits	Medical component	High patient turnover	Humanisation	Bad interactions	Interactions	N/A	Less bureaucracy
Confidence	Human components	Number of patients	Cordiality	Lack of empathy	Humanisation	N/A	More empathy
Less waiting time	Attention to patients	Lack of organisation, bureaucracy	Clinical knowledge	High expectations	Security	N/A	Better infrastructure, more equipment

Source: Author

5. Discussion

According to the participating healthcare professionals' perspectives, hospitality is based on receiving, welcoming and treating individuals in the best way possible, including the humanisation of services, for which training is necessary. Respondents said, for example, 'hospitality can be the way you welcome [patients]', 'the concept of hospitality seeks to put into practice the desire to humanise' and 'we have invested in training everyone.' These results are in accordance with what has previously been mentioned by various

authors. For instance, Chon and Maier (2009, p. 5) write, '[h]ospitality means receiving guests in a generous and cordial manner.' Oliveira et al. (2013) and Severt et al. (2008) state that the implementation of hospitality is what brought the human component into the healthcare services provision.

The results on the ways hospital actors perceive and interpret hospitality reveal divergent opinions. The administration looks at hospitality as an investment through the training of all professionals ranging from doctors and nurses to auxiliary staff and other hospital employees because hospitality depends on these professionals. These results are in accordance with Sofaer et al. (2005) and Tanner's (2011) findings, which include that what most influences patients' perceptions of hospitality is all staff members.

Although the doctors reported that they view patients primarily as ill individuals who need treatment, the physicians interviewed also consider hospitality important. They asserted that it is related to the way they show they care about people and make them feel welcome (e.g. 'hospitality, above all, is to make patients feel well taken care of'). Nurses perceive hospitality as the way they take care of patients' needs, which means that the patients are the main focus of services and everything revolves around them. This includes technical procedures, the time nurses spend on patient care and the way they communicate with patients, making all these aspects part of hospitality (e.g. 'doctors treat patients; nurses take care of patients,' and 'nurses are the personification of hospitality').

If hospitality has the same meaning and importance in any service, the interviewees' answers can provide insights into the relationship between hospitality in hospitals and hotels. Four items were identified that reveal similarities and or/differences between these two sectors: tangible dimensions, intangible dimensions, space attachment and organisational system. Regarding tangible dimensions, the interviewees asserted that operational mechanisms, such as cleaning services, rooms and food quality, should be similar. One staff member said, 'the management of beds and food, namely, maintenance and also operational matters: it makes total sense for them to be based on the hotel industry.'

This result is in accordance with various researchers who argue that essential aspects of the hospitality industry should exist in hospitals. These need to include, among others, good quality food, enjoyable environments, hotel-like characteristics (e.g. private, family-friendly rooms and meals treated like room service) and hospitals' good name and status (Shirzadi et al., 2016; Wu et al., 2013). However, healthcare imposes limits according to each patient's different needs. For example, the type of food has to follow rules related to patients' pathology diagnosis. Wu et al. (2013) state that hospitals cannot forget that their main objective is to provide high quality clinical services.

The intangible dimensions most interviewees see as similarities between hospitality in hospitals and hotels are the quality of users' experiences and their satisfaction, social interactions' quality and emotional and social environments. According to various authors, hospitality is shown in practice by healthcare providers' attentiveness to what patients say about their experiences and by the emotional links established between staff and clients (Kelly et al., 2016; O'Halloran et al., 2011). Ensuring that users feel welcome and pursuing their wellbeing are two goals any service provider needs to achieve. However, in hospitals, clients are affected by their physical and emotional conditions and users' motivations and perception of time are different from hotel guests (e.g. 'the patients want to stay the shortest time possible in a hospital'). According to Zygourakis et al. (2014), patients are generally nervous and worried, and, while they might be able to choose the place in which they will receive care, they may not voluntarily seek out that care.

Regarding physical environments (i.e. space attachment), the interviewees said that some physical support areas (e.g. reception check-in and check-out) could benefit from space organisation and management models similar to hotels. Sloan (as cited in Wu et al., 2013) stated at the beginning of the 1950s that a 'hospital in certain respects is a very specialised hotel'. This idea has also been discussed in the more recent literature since practices and new ideas generated in the hotel sector have been brought into healthcare in diverse ways (Shirzadi et al., 2016; Wu et al., 2013). However, some hospital services need to be modified because they involve different clients (e.g. 'the paediatrics area can't be the same as the geriatric, for example, so this is different from hotels where the areas are not differentiated').

Hospitals' organisational system present parallels in terms of the implementation of management strategies similar to those used by hotels, for example, hiring professionals who are specialists in hospitality and adopting hotel professionals' practices and routines. In addition, healthcare professionals could benefit from incorporating hospitality practices and routines related to those found in hotels. According to Zygourakis et al. (2014), all participants in hospital contexts could profit from applications of hotel practices.

However, the interviewees asserted that the most important aspects of hospital services are patient care and clinical results (e.g. 'our focus is and always will be to take care of our patients on a clinical level'). Respondents argued that an excess of hotel services in hospitals can cause complications. For instance, nurses reported that one patient in each room is usually more difficult for them to control than all the other patients. These healthcare providers feel that the main difference between hospitals and hotels is the vital importance of quality service delivery (i.e. technical competence) in hospitals.

In this context, professionals must take into account that clients are ill, so providers cannot understand matters only from customers' point of view. Hospital staff also need to pay attention to patients' health complications, so these employees' responsibility is greater. Wu et al. (2013) observe that hospitals and hotels share the task of running purpose-built, profitable facilities that support these organisations' mission. However, hospital staff must determine how to assign resources to achieve hospitality-oriented goals without forgetting that their main objective is to provide crucial clinical services.

In summary, the interview data analysis revealed that the main components of hospitality in the context of hospitals include organisation factors and patients' experiences. Within organisation, three dimensions were identified. The first is organisational system since hospitality can be encouraged by upper management through their supervision of health professionals in terms of technical care provision qualifications. This strategy could involve hiring hospitality specialists who can introduce all the mechanisms necessary to implement hospitality in hospitals. The other two elements of organisation are tangible dimensions (i.e. the type of facilities) and space attachment (i.e. the hospital's environment).

The component of patients' experiences is related to intangible dimensions including emotions, wellbeing and satisfaction. These elements depend on not only organisational system but also the quality of interactions between service providers and patients (i.e. the ways doctors and nurses relate to and communicate with clients). Thus, the convergence between organisation factors and experiences facilitates using hospitality in hospital settings.

The present findings also cover the essential dimensions defined by prior research on hospital service quality (Kelly et al., 2016; Shirzadi et al., 2016). These are technical care (i.e. organisational system), hospital facilities' quality (i.e. tangible dimensions), atmosphere (i.e. space attachment) and relationships between individuals (i.e. intangible dimensions). The non-medical aspects are the most crucial to meeting patients' general expectations.

Verbal interactions' importance was analysed based on data collected during observations of daily routines involving inpatient surgery services, including descriptions of the structure of verbal interactions between participants. The results included the number of participants (i.e. dyads and triads), the content (i.e. clinical, accommodation and small talk) and the degree of formality (i.e. formal and informal). The first objective was thus to identify the main types of interactions in the selected inpatient hospital setting and the participants in these interactions.

The main findings in relation to the type of interactions (i.e. number of participants) reveal that dyadic interactions are the most common. This could be because, on the one hand, they are the simplest form of interaction (Borgatti & Halgin, 2011; Brass, 2011; Yagil, 2001). On the other hand, services provided to clients in hospital contexts require greater privacy and confidentiality, so the dominant form of interactions involves the fewest participants.

Doctor-patient interactions have been the main focus of previous research on hospital interactions (Pilnick, Hindmarsh & Gill, 2009). The present study's results confirm that dyads are the predominant form of interaction, but, more specifically, patient-nurse dyads

are the most common. Given the hospital setting in question, this finding is unsurprising. According to Weber et al. (2007), nurses are constantly present in the daily routines of inpatient services as these professionals make the rounds to each room and assess patients' vital signs, as well as engaging in other patient-related activities.

The hospital's routines under study frequently include multidisciplinary teams involved in inpatient services (i.e. doctors, nurses and nursing auxiliaries), so interactions between three (i.e. triads) or more actors (i.e. networks) are naturally also present. Besides dyads, only triads were analysed because some researchers have found that triads are the nuclear element of networks (e.g. Holma, 2004; Mena et al., 2013; Siltaloppi & Vargo, 2017; Vedel et al., 2016). When a third person joins an interaction, they change the focus from individuals to groups (Holma, 2004; Mena et al., 2013), which means the results can be extrapolated from triads to networks. The current study's results show that the most common triads are patient-nurse-auxiliary, followed by patient-doctor-nurse. This finding reflects that nurses and auxiliaries spend more time with patients.

Given how important interactions' content and level of formality are to hospitality, the results indicate that, in hospital environments, the most common content is clinical and that formal interactions are the most representative. These findings are in accordance with previous studies that have established that formal interactions are the main means of communication in hospitals (e.g. Kitson, Athlin, Elliott & Cant, 2014; Nugus et al., 2017). Nonetheless, the present research also confirmed the presence of informal accommodation and small talk interactions. This finding emphasises that, in contexts traditionally associated with formality such as hospitals, interactions reinforcing informality are another hospitality strategy used.

The highest percentage of formal clinical interactions was verified during patient-nurse interactions, followed by patient-doctor dyads. Besides formal interactions during patient-nurse dyads, informal interactions were also verified between these two actors. The highest percentage of informal interactions occurred in triads, which is related to how triadic interactions occur more often between patients and both nurses and nursing auxiliaries, who spend more time with patients. Kraut, Fish, Root and Chalfonte (1990) observe that, if actors interact several times a day, communication will naturally become

less formal (Kraut et al., 1990). In addition, whenever nurses and nursing auxiliaries interact, they are more informal because, despite performing services and fulfilling responsibilities of enormous importance, these professionals are not primarily responsible for final medical decisions. These healthcare providers thus feel more comfortable with being informal with patients. According to Kandlousi, Ali and Abdollahi (2010), hierarchical rules and procedures determine the degree of formality, so, when these restraints are removed, communication becomes more informal. As a result, nurses and nursing auxiliaries play a key role in hospitality in hospitals.

Finally, the highest percentage of dyads and triads occurred during rounds. Rounds tend more towards formal clinical interactions because these visits are associated with clinical services that entail greater responsibility. In check-out interactions, the participants know each other better, so they use more informal speech (i.e. small talk). The percentage of triads verified during breakfast is considerable, given that patients, nurses and auxiliaries, are more frequently present. The analysis of informality in interactions revealed that, in hospitals, professionals sometimes introduce quite informal content (i.e. informal accommodation or small talk) before moving on to clinical content and more formal speech patterns. This pattern is important because patients can disconnect themselves from the immediate context, diminishing stress levels and negative emotions and facilitating more pleasant hospital experiences.

Hospitality's significance as a tool for service improvement was defined as the third research question. An analysis was thus conducted of interviewees' perceptions of different domains. These areas included hospitality as an element of healthcare service assessment, hospitality's relationship with individuals' satisfaction and the importance of hospital experiences to users' satisfaction. Other domains were the significance of interactions in hospitals' routine operations, the main participants, positive and negative factors that condition these interactions' quality and improvements needed to ensure better experiences for patients.

The main findings in relation to how hospitality can be included as part of healthcare service evaluations reveal that all the professionals emphasised that hospitality is an important factor in hospitals (e.g. 'hospitality is excellence'). The interviewees called for

more qualified professionals with expertise in hospitality and more training for healthcare professionals to help them know how to receive patients, transmit confidence and humanise services. For example, one interviewee said, 'everyone should be part of a culture of hospitality, so more training and investment are needed in this field.'

However, a slight divergence in opinions was found. The hospital administrators – especially the clinical director interviewed – described a more general management perspective. These professionals argued in favour of fostering hospitality through human resource management including hiring hospitality specialists and implementing their services as a business strategy. This result is in accordance with the literature, which reports that hospital administrators are starting to treat patients as consumers and these managers are currently becoming more aware that patients are usually involved in choosing their hospital (Paraschivescu et al., 2011).

The doctors interviewed agreed that hospitality must exist in hospitals and that it is important in this context. These professionals associate hospitality with the staffs' capacity for improving the quality of care not only on a technical and medical level but also through services' human component.

Among all the interviewees, nurses stand out as having a more ambiguous view of hospitality in daily hospital routines. These participants believe that it must be present, and they emphasise the importance of creating positive experiences through hospitality. Nonetheless, nurses think that hospitality can only be implemented up to a certain point so that it does not affect the quality of medical services. In addition, most nurses interviewed highlighted the vital role of professionals' technical competence and the need for excellent healthcare provision, relegating some hospitality practices to second place. For instance, a nurse asserted, 'this [hospitality] is a component, but not the main one! The main thing is the technicians' technical capability.'

Regarding the importance of patients' experiences, their quality determines the level of client satisfaction (e.g. 'all areas are important for us. … If one is very good but the other is bad, personal experiences are affected'). These results are also in accordance with the existing literature. Evaluations of health service quality must monitor more than just

technical aspects, such as clinical results, waiting time and quality of food, since accurate assessments also require understanding patients' perceptions of experiences. This process includes evaluating patients' experiences and treatments' quality and context, as well as whether these experiences overall meet patients' expectations (Pope et al., 2002).

In regard to positive factors that improve the quality of users' experiences, administrators and doctors mentioned organisational aspects. In particular, they emphasised the human component of welcoming and ensuring the staff's proximity, friendliness and transmission of information (e.g. 'the basis factor is information' and 'patients have to know, at all times, what will happen'). The nurses, in turn, reported that the most important components are medical care and the attention paid to each patient.

In general, the interviewees asserted that an organisational philosophy must be present since hospitality cannot be provided by one employee alone. The entire staff must be involved. One respondent said, 'it's not one or another staff member that can affectively make the difference. This philosophy has to exist and start at the top and move downward and has to be followed across the entire organisation.'

The administrators believe that one of the most significant negative factors is users' high expectations and standards. The doctors felt the shortage of professionals and a lack of information were more important. The nurses, for the most part, emphasised poor quality communication as a serious obstacle. Overall, the most prominent factors mentioned were the large turnover of patients, which means that staff have no time to create stronger affective connections, and the number of patients who are assigned to each professional. The latter affects the staff's availability for quality time with each user. The dense bureaucracy slowing down procedures was also mentioned by many participants.

Although this study did not focus on the differences between public and private hospitals, the interviewees brought up this topic. The respondents argued that professionals' technical competence does not vary significantly between the public and private sector because staff members often work in both sectors. However, some differences were suggested in terms of organisation and structure. The administrators asserted that, in private hospitals, patients impose more stringent requirements and thus professionals'

training in hospitality is particularly important. The doctors reported more pressure put on professionals in the public sector, yet the nurses – despite asserting that they have more patients in public hospitals – affirmed that the private sector's hierarchy puts more pressure on professionals as their users' demands are greater. These results are in line with some authors' findings (e.g. Basu, Andrews, Kishore, Panjabi & Stuckler, 2012; Srinivasan & Saravanan, 2015), including that public and private hospitals provide the same types of services but the level of hospitality could be different.

This study's findings highlight the importance of interactions in hospitals, the main participants and the factors that affect these interactions positively and negatively. Although the professionals most frequently investigated in prior research have been doctors, the present results show that other professionals are also important to hospitality in hospitals, especially nurses and nursing auxiliaries. In general, the interviewees consider that all professionals are important, but nurses are the key element of hospitality in hospitals.

Regarding the positive and negative factors that affect the quality of doctor-patient and nurse-patient interactions, the results can be grouped by professionals' primary functions. The administrators and doctors interviewed revealed a consensus on the determinant factors of doctor-patient interactions. Although all respondents emphasised technical competence, emotional components were also seen as an essential part of interactions. These findings are already present in the existing literature. To assess healthcare quality, hospitals must take into account more than precise diagnoses, adequate treatment and low mortality rates. Organisations dealing with healthcare need to go beyond a purely medical perspective and focus on hospitalisation processes from patients' points of view (Weigl et al., 2009; Wong et al., 2013).

Most nurses interviewed agreed that the key factors are doctors' competence and patients' experiences and that the more emotional aspects of services are relegated to nurses (e.g. 'patients looking for a doctor … [make choices] based on technical aspects'). The nurses acknowledged the importance of the time available to deal with patients and the humanisation of healthcare. In addition, analyses of the interviews verified that an essential element of medical care is effective interactions between patients and doctors,

which include knowledgeable communication and empathy. Doctors need to be in contact with their patients directly and have enough time to respond adequately to their patients' requests and worries. According to Weigl et al. (2009), doctors' professional fulfilment is also connected to the time they have available for speaking to patients.

Concerning the negative factors potentially influencing doctor-patient interactions, most interviewees highlighted breaches of trust and a lack of communication and empathy as aspects that might undermine patients' experiences. The existing literature reports that patients have not traditionally been seen as important contributors to interactions, so most consultations end up being unilateral, with patients not being encouraged to communicate their views (Major & Holmes, 2008). Interactions between nurses and patients, in general, are affected by positive factors similar to those of interactions with doctors: competence, trust and empathy. Nevertheless, all respondents emphasised that nurses have significant responsibility in terms of how they address patients given that, in inpatient services, nurses spend more time with patients. The administrators further stressed the relationship between nurses and hospitality since these professionals are the main drivers of hospitality.

The nurses also drew attention to how they are a crucial element in relationships with patients. These results are matched by those in the extant literature on the hospital sector, confirming that basic support is provided by nurses. Tanner (2011) found that nurses are in the frontlines of interactions with users and these professionals' conduct reflects directly on hospitals' brand because nurses spend the most time with patients. These healthcare providers play a primary role in hospitality by increasing patients' satisfaction with their therapy and ensuring quicker healing processes (Paraschivescu et al., 2011; Patten, 1994; Severt et al., 2008).

The aspects needing improvement highlighted by interviewees include enhancing the quality of interactions and meeting patients' needs. In relation to interactions' quality, the respondents suggested more and better information is needed and sometimes better work conditions must be present so hospital staff can feel motivated to communicate. An interviewee said, 'when someone is not satisfied at work, this will most probably affect the quality of their work.' Some of the most important improvements needed are the time

spent and empathy offered, better primary healthcare services, the use of standard hospitality practices, better work conditions, less bureaucracy, more professional training on hospitality and better infrastructure. Satisfying patients' needs is crucial for better experiences for patients. As previously mentioned, the fulfilment of guests' needs is considered just the basic level of service provision (Crick and Spencer, 2011).

6. Conclusion

Hospitality has been studied as a dimension that crosses into various sectors, so it has been defined in different ways and from varied perspectives. Hospitality's meaning has been associated with the way service providers receive and welcome customers and commercial exchanges between providers and clients, thereby connecting this phenomenon to commercial contexts and excluding others. The literature on hospitality has been closely linked to specific services and areas, such as tourism. The latter is among those industries that have expanded significantly in recent decades, and hospitality is crucial to improvements in tourism services' quality.

This concept has also been studied in other contexts, but the literature has paid far less attention to the importance of hospitality in healthcare services. Hospitality in healthcare can and must be studied because, healthcare contexts also involve exchanges of goods, products and services, as well as interactions between different types of actors. In addition, hospitality's importance in these contexts is greater due to healthcare users' emotional and physical condition.

Despite the differences between healthcare and tourism, hospitality can serve as a metaphorical bridge between the two sectors. The literature on hospitality in healthcare has recently expanded, especially in terms of health tourism. Tourists travel to other places not only in search of treatments unavailable in their country or community but also to experience other places. These individuals may need treatment for specific health problems or just rest and relaxation, and the discovery of new destinations contributes to reducing the stress related to health tourists' psychological and/or physical conditions. Hospitality, however, is also a necessary part of daily routine healthcare services, so it

has to be part of every healthcare organisations' philosophy, which provides the motivation to study how hospitality can be best applied to this sector.

The current research thus focused on gaining a deeper understanding of hospitality as a tool for service improvement, based on a hospital case study. The reasons behind the choice of a hospital rather than another health service provider included that few studies of hospitality's meaning and importance in hospitals have been conducted. In addition, hospitality is an even more significant determinant in hospitals because their clients are individuals whose emotional and physical conditions can affect their experiences' quality. The specific research setting chosen was inpatient services because this is the most similar to hotel services. That is, patients stay for longer periods and have meals, and family and friends visit the rooms, ensuring that multiple verbal interactions take place between different actors.

The quality of patients' experiences in hospitals has gained greater weight in the delivery of routine healthcare services, so this study sought to examine more closely the importance of hospitality in hospitals as a tool to improve service quality. Hospitality in this context has been commonly associated with physical components, but hospitality in hospitals goes far beyond that. Social components that depend on the quality of daily interactions are also an important means of offering hospitality.

The present study began with a literature review to provide a general overview of tourism as a multidimensional phenomenon and its relationship with hospitality, as well as how the hospitality concept can be applied in other contexts, especially in healthcare services. To examine hospitality and its influence on hospital service improvement, three components and their connections were considered: service provision, human resources and verbal interactions. Service provision is dependent on human resources, and verbal interactions between providers and receivers and between providers themselves are crucial elements of service quality.

This study, therefore, addressed three research questions:

- How do health professionals interpret and experience hospitality in hospitals?

- How important are verbal interactions to hospitality in hospitals?
- How significant is hospitality as a tool for service improvement?

The results obtained in answer to the first research question show that all the professionals interviewed see hospitality as the way individuals receive and treat other people. Hospitality is thus one way of encouraging the wellbeing through specific mechanisms. The health professionals interviewed agree that hospitality influences the supply of quality services resulting in users' satisfaction. However, these respondents' perspectives revealed some divergences. Hospital administrators have a more commercial view of hospitality, while healthcare service providers believe that hospitality is a way to care for patients and humanise services, without diminishing the importance of medical procedures.

Given the importance of hospitality in tourism services and the similarities between hotel and hospital services, this study was able to confirm healthcare professionals' awareness of this issue. The results indicate that hospital services' organisation can be based on strategies hotels have developed to implement hospitality. However, all the interviewees made a clear distinction between these two contexts. The administrators and nurses' perspectives proved to be the most different. Hospital managers have a more generalised view of hospitality management as developing their hospital's brand and encouraging client loyalty. Nurses, in contrast, argue that hospitals' main function is to ensure their staff's technical competence, relegating hotel-related hospitality practices to second place.

The hospital professionals interviewed thus concede the possibility of thinking of hospitals as hotels in relation to the type of facilities (i.e. reception areas and rooms) and the ways staff act as hosts and communicate with users. Despite these similarities, interviewees feel these aspects cannot be dissociated from the idea that hospital users are a different type of guest deeply affected by health problems. The reasons that clients seek out hospitals are also different from the motivations behind these individuals' search for other service providers such as hotels.

The two main components of hospitality in hospital contexts are organisation factors, which include three dimensions (i.e. organisational system, tangible dimensions and space attachment), and experiences (i.e. intangible dimensions). The results highlight that hospitality in hospital settings is present in technical aspects (i.e. organisational system), types of facilities (i.e. tangible dimensions) and physical environments (i.e. space attachment). In addition, hospitality is expressed through professionals' interactions with patients and the way a welcoming atmosphere is created (i.e. intangible dimensions).

The convergence between healthcare service organisation and patients' experiences makes hospitality possible in hospital settings. Thus, hospitality is presented to and detected by patients through technical competence in healthcare procedures, hospitals' projection of an image as a welcoming environment and service provision characterised by high-quality interactions.

In terms of the second research question about the importance of verbal interactions to hospitality in hospitals, the most predominant type of interaction is dyad involving patients and nurses. Most dyad and triad interactions have in common the presence of two participants: patients (i.e. the focus of observations) and nurses (i.e. the professionals spending the most time with patients). In triads, the most common third participant is nursing auxiliaries.

Another objective was to understand how informality in interactions is used as a hospitality strategy by hospital professionals. The findings indicate that the most common content of interactions is clinical information and that formal interactions are more common in hospital environments. However, informal interactions were also observed, thereby highlighting that, in contexts traditionally associated with formality such as hospitals, interactions reinforcing informality can also be used as a hospitality strategy. Patients can feel more relaxed and disconnect more easily from their beliefs about the negative, heavy environment normally associated with hospitals.

Based on the data collected, the highest percentage of informal interactions occur in triads. This finding reflects how triadic interactions occur more often between patients, nurses and nursing auxiliaries, who spend more time with patients. In triads, the addition

of doctors or nursing auxiliaries to patient-nurse interactions modifies the content such that doctors are involved in more clinical and formal interactions and nursing auxiliaries participate in more informal accommodation interactions.

The third research question focused on a deeper understanding of how important hospitality is as a tool for service improvement, in this case in hospitals. The results reveal that hospitality encourages the provision of quality services, ensures clients' satisfaction and welfare and contributes to hospital users' trust and loyalty. The staff's medical competence, nurses' empathy and sense of caring and patients' comfort are the most important factors promoting positive hospital experiences. However, the biggest obstacle in the way of quality experiences is a lack of communication and information exchanges leading to potential medical malpractice.

Interactions' quality was also analysed, revealing that, while doctors and nurses are especially important to these interactions, all healthcare professionals play vital roles. Hospital staff members thus need more training to improve the level of hospitality in hospitals' daily routines. Nurses are, nonetheless, considered to be primarily responsible for hospitality, and they are seen as the personification of hospitality. They use more informal content in verbal interactions, and nurses, along with nursing auxiliaries, spend more time with patients in hospital rooms. Nurses are, however, responsible for executing crucial clinical procedures, which nursing auxiliaries are not. The interviewees made a compelling case for bringing hospitality specialists into hospitals to help healthcare professionals implement the best hospitality practices possible.

Patients' experiences are negatively affected by the absence of interactions combined with a failure to transmit accurate information – whether positive or negative news. When results are unexpected, patients feel dissatisfied and tend to discredit the health professionals involved. The interviewees also suggested that other factors can reduce interactions' quality. These include overworked staff, which makes taking time to talk to patients impossible and the lack of teams that include other professionals who can help doctors and nurses. A further negative factor is a failure to create and maintain the best working conditions so that professionals feel motivated to initiate positive interactions

with patients. If the above factors are reversed, healthcare practitioners believe that hospitality practices can become more prevalent and patients' experiences more positive.

In summary, this study achieved the objectives initially proposed, thereby demonstrating how the existing research on hospitality and tourism can be used to open new doors for hospitality's application in other contexts. The parallels between hospitality in tourism and healthcare or, more precisely, between hospitality in hotels and hospitals show a convergence of relevant elements that means hospitality can be replicated in healthcare services. Although hotels and hospitals are two sectors in which most services have different clients and objectives, these industries share the objective of satisfying their users' needs. The present analysis of the relationships between service provision, providers' human resources and their verbal interactions in hospitals revealed that these elements are interconnected through hospitality (see Figure 9).

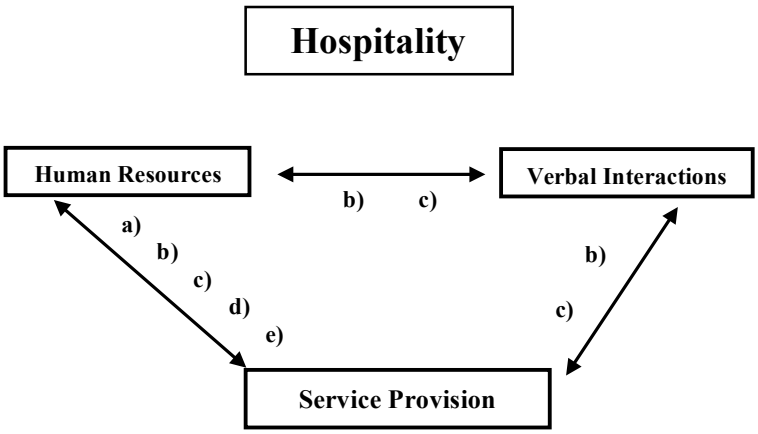

Figure 9. Summary of results

The results include:

a) The type and quality of services provided by professionals influence the level of hospitality offered
b) Services' technical aspect and human component are necessary parts of hospitality
c) Participants' roles and the informality present in verbal interactions function as vehicles for increased hospitality in services

d) Human resource management and the adoption of practices from other sectors are important for service improvement
e) Hospital administrations need to invest in training their professional staff and using hospitality professionals.

Therefore, hospitality acts as a unifying element for three key components (service provision, human resources and verbal interactions), which means that managers of hospital service provision must establish hospitality guidelines for their employees. These standards will improve verbal interactions' quality and these professionals' relationships with clients and/or users, ensuring their satisfaction and ultimately increasing profits generated by services. Hospitality can be seen as a tool for healthcare and other services' improvement given that the majority of services are provided by staff members and through verbal interactions.

6.1 Summary of Major Findings

This study's results clarify hospitality's meaning from healthcare professionals' point of view, as well as their current use of hospitality in practice during daily routines and the actual role played by hospitality in hospitals. This is a context often viewed as emotionally heavy and negative by users. The interviewees' perception of hospitality's meaning is in accordance with what has been written in the existing literature. That is, hospitality is the way hosts receive, welcome and interact with guests.

However, the present findings also include that the importance and perception of hospitality in hospitals depend on various factors and contexts. This study confirmed that hospitality is a quite significant element of hospitals' staff and patients' experiences, but each group of professionals interviewed offered divergent opinions about hospitality's main domains. Administrators argue that hospitality is dependent on organisational components. Doctors associate hospitality with emotional aspects, while nurses assert that hospitality is more dependent on technical components.

In addition, the way hospitality is established in practice during hospitals' basic routines were verified by the data gathered on daily verbal interactions between healthcare

professionals and patients. Hospitality can be used by everyone at any time in hospital contexts without heavy physical and monetary investment. Hospitality depends solely on health professionals' special effort to deliver quality healthcare services in association with the most effective verbal interactions. Informality in conversations diminishes the social distance between healthcare professionals and patients, thereby contributing to a better ambience.

Hospital administrators must also create the stable work conditions necessary for healthcare professionals to establish hospitality-based relationships with patients. These conditions translate into not only professionals' increased confidence but also the successful management of patients' expectations and improved experiences. Thus, hospitality should be understood as having more than just monetary value because humanisation needs to be the focal point of hospitality in hospitals.

According to the interviewees and the relevant literature, hospitality professionals must be incorporated into healthcare services so that these experts can help healthcare professionals respond adequately to problems and can expand the staff's hospitality training opportunities. In this way, the staff and their interactions with patients could become the best vehicles for promoting this service strategy. Healthcare education programmes can also offer curricular units in hospitality so that, from the outset, a culture of hospitality is created among future health professionals.

This research on hospitality in healthcare services revealed that hospitals clearly have room for service provision using hospitality mechanisms. In this context, hospitality needs to be seen as more than just good service and instead as an essential part of any organisation's service provision. The present study made only a single foray into investigating hospitality as a tool for service improvement and a preliminary attempt to understand this concept's importance in a specific healthcare setting, based on a hospital case study.

Other researchers need to join in further research on hospitality in hospitals and in other contexts, ensuring deeper analysis of this crucial topic. This study's choice of hospitals as a context for hospitality research and analysis of verbal interactions as a basic

component of hospitality practices sets a precedent for similar hospitality research in other contexts, services and formats. The research was conducted as part of the field of hospitality to achieve the objectives proposed, as well as to expand the existing literature's scope.

6.2 Theoretical Contributions

This study's results contribute to the scarce literature on hospitality in hospitals and to a deeper understanding of what hospitality's role is and how it is incorporated in practice in hospitals' daily operations. Previous studies have focused on management procedures (Kelly et al., 2016; Wensing et al., 2006) and medical components (e.g. Walshe & Rundall, 2001) as unique determinant factors in the use of hospitality in healthcare, and researchers have advocated offering hospitality through hospitals' physical design and infrastructure (e.g. Shirzadi et al., 2016; Suess & Mody, 2017, 2018; Wu et al., 2013). The present study, however, found that the main components of hospitality in hospitals include organisation factors, which comprise three dimensions (i.e. organisational system, space attachment and tangible dimensions), and patients' experiences (i.e. intangible dimensions). In addition, this research's findings contribute to a better understanding of how important verbal interactions are to hospitality.

The results highlight the need for investigations of triads made up of two service providers and one client. The findings also confirm that successful hospitality strategies in hospital settings do not depend solely on clinical results (i.e. medical treatments) and physical environments but also on verbal interactions' patterns. Overall, the most significant elements are who the participants are and how informal content is used during conversations as a hospitality strategy. The findings include more evidence that interactions' degree of formality is related to the number of participants and, most of all, with the kind of participants. Dyads are more clinical and formal, and triads are more informal. Doctors' presence makes interactions more clinical and formal, and nurses and/or nursing auxiliaries shift communication towards more informal interactions.

Given healthcare providers' importance to services and experiences' quality in hospitals and the limited literature on their perspective on hospitality's significance in hospitals,

this exploratory research's findings contribute to a fuller understanding of this topic. The results include what can be done to improve patients' experiences. Healthcare professionals' clinical competency, correct diagnoses, medical procedures and final clinical outcomes are crucial, but the results provide more evidence that services' emotional side is key to hospitality. The humanisation of services and ways professionals welcome, interact and communicate with patients are also crucial to meeting patients' needs and improving their experiences. Hospitals thus should emphasise every health professionals' responsibility to ensure a more informal environment that reduces users' stress and anxiety levels.

In summary, the theoretical findings include further proof that the organisation of services within hospitals can contribute to implementing some hospitality practices. The results provide deeper insights into how two different sectors (i.e. healthcare and tourism) use of hospitality shows points of convergence. In addition, hospitality should be seen as providing more than just quality services and as essential to hospitals' service provision. Evidently, hospitals have room for service delivery using hospitality. However, this strategy must be implemented while keeping in mind that hospital patients are a different type of guest with special needs and emphasising the significance of medical and clinical aspects that are – and always will be – the most important services in hospitals.

These findings add to the growing body of literature on hospitality in hospitals by contributing to a fuller understanding of hospitality as a tool for hospital service improvement. Further studies of hospitality need, nonetheless, to be conducted not only in hospitals but also in many other areas of the service sector. The results presented also confirm the value of using qualitative data to explore new areas of hospitality in hospital research. Finally, the present findings strengthen the empirical evidence for hospitality in hospitals and support the validity of integrating new topics within a broader conceptual framework.

6.3 Practical Implications

The results discussed in this thesis have additional managerial implications. Medical procedures' quality, professionals' competence and management procedures (i.e.

organisational system), as well as physical environments (i.e. space attachment) and types of facilities (i.e. tangible dimensions), are not the only dimensions that affect hospitality. The quality of personal interactions between service providers and patients (i.e. intangible dimensions) are also essential. Hospitality is, therefore, the result of a combination of excellent organisation with quality experiences.

This research confirmed that the various groups of health professionals interviewed perceive hospitality differently, but they all contribute to implementing hospitality. The findings on these professionals' perspectives facilitate further reflection on each staff member's role in healthcare service delivery in terms of not only technical competence but also quality interactions between staff and patients. These results should help healthcare professionals and administrators understand more clearly that the way they deal with services' human component influences patients' experiences in hospital rooms.

This study's findings also contribute to a fuller understanding of verbal interactions' function in healthcare service delivery and of the ways that informality is used in daily verbal interactions in hospitals and that hospitality and informality can be connected in the same healthcare procedures. Thus, the results highlight the practical implementation of informal interactions in hospitals' daily operations, thereby contributing to hospital service providers' greater awareness of how informality is a strategically important dimension of hospitality. Hospitality in hospital settings can also be developed further by hospitality specialists who can assist health professionals and provide them with training in more hospitality skills. In addition, hospitals should form alliances with higher education institutions to promote new curricula focused on hospitality.

These practical implications could help healthcare service providers and professionals to understand which practices can be adopted by hospitals. More specifically, staff members can learn how to use informality as a hospitality strategy. This informality is a way to interact with clients in more human ways, personalising interactions according to clients' different backgrounds (e.g. cultural, political, ethical and religious aspects).

6.4 Limitations and Suggestions for Future Research

The researcher is a healthcare professional familiar with the associated restrictions in hospital contexts, which greatly facilitated data collection, but gathering data in hospitals is always a challenge due to the ethical and privacy issues created by healthcare. The authorisation process and participants' receptiveness and acceptance of a strange person's presence in hospitals' daily routines present significant challenges. Any unknown person in hospital rooms conducting interviews and, above all, observing and collecting information on verbal interactions can be seen as hostile.

Thus, this study suffered from some limitations. The number of interviewees was relatively small and only included specific types of professionals. The results, therefore, do not necessarily capture other healthcare professionals' perceptions. The interviews collected data only on some topics within hospitality, so the data may not cover all hospitality domains.

Future research could benefit from conducting more interviews with actors from different services and hospitals, including both private and public ones, followed by a comparative study. A comparison between healthcare professionals and patients' perceptions is also needed to understand how hospitals' different functions and emotional and physical conditions can modify individuals' perspectives on hospitality. Another aspect that could yield interesting results would be an inter-country study analysing perspectives on hospitality among professionals and patients from different cultures.

In addition to the limitations on interviews, this research only included observations conducted at one hospital and of one specific type of service (i.e. inpatient post-surgery care). Participant observation could only take place during the morning shift, so data could not be collected on the remaining routines in patients' daily lives in this hospital setting. Further research on this topic could benefit from all-day observations of more than one hospital and more participants to produce even more interesting results.

Besides dyadic interactions, only triads were analysed, and interactions between patients and their families necessarily took place in private. Previous studies have highlighted the

need to analyse both dyads and triads, but future studies could also perform full network analyses of interactions in different hospital contexts. This study ultimately analysed just three components and their dynamics (i.e. human resources, verbal interactions and service provision), verifying that hospitality is a unifying element between them. However, more research is needed to understand hospitality's dynamics and dependent variables on all levels.

The present findings open up significant new lines of research. The results make clear that hospitality in hospitals needs to be understood in greater depth through patients' viewpoints, and comparisons are needed between different areas and services. Conducting similar research in diverse countries and cultures may also be worthwhile since hospitality depends on different dimensions in each context. In addition, more studies are needed on whether hospitality in hospitals can be considered a separate field of research and what challenges arise from the ethical issues surrounding hospitality in healthcare. Further analysis could be carried out of interactions in different hospital contexts and stakeholder networks.

Another motivation for additional research is to understand hospitality's dynamics by examining different forms of hospitality as tools for service improvement. Finally, future studies could focus on how to identify new forms of medical tourism grounded in hospitality, leading to a more extensive transfer of new forms of hospitality from one sector to another one. In summary, researchers may want to consider the following suggestions for future studies:

- Analysis of patients' perspective on hospitality, including how these individuals understand and evaluate this concept, whether they think that hospitality contributes to their recuperation and whether hospitality improves interactions with healthcare professionals
- A comparison between healthcare professionals and patients' perspectives on hospitality
- Comparisons between inpatient and outpatient services since experiences last longer in inpatient services and involve contact between different healthcare professionals and patients

- A comparison between hospitality in public and private hospitals, including whether managers and health professionals' perceptions and behaviours are similar in both sectors
- Inter-country studies of hospitality in hospitals involving different countries and cultures and the way location influences hospitality's implementation
- Research on hospitality versus healthcare ethical issues, namely, how hospitality can exist without triggering ethical issues and crossing significant limits
- A deeper study of hospitality as a bridge between tourism and healthcare services, including the influence of tourism practices on healthcare services
- Studies of how the adoption and implementation of hospitality practices, used in healthcare services, by the tourism sector influence the latter industry
- A comparison of the type, content and level of formality of verbal interactions between hotel professionals (e.g. receptionists, concierges and room service employees) and guests
- Research on hospitality and its influence on medical tourism.

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Appendixes

Appendix A. Interview Guide

My name is Sofia Lopes, I have a Master's Degree in Dentistry and I am PhD student in Tourism Management at ISCTE and Universidade Europeia.
My research aims to study hospitality as an instrument for services improvement, using the hospital as case study.
Thank you for the availability of this interview. I inform you that it will be confidential and I would like to know if I have authorisation to record it?

I - Interviewees' course:
- How long have you been working in this hospital?
- What is your current role?

II - Definition of hospitality from the point of view of strategy and service provision:
- Do you know the concept of hospitality?
- For you, what is hospitality?
- How does hospitality relate to the technical part of medical care? (is it important? is it compatible?)
- Hospitality is part of the strategy of this hospital? (If so, in what way?)
- Does hospitality influence the provision of services? (If so, in what way?)

III - Hospitality in different services:
- In your opinion, hospitality is viewed and has the same meaning and importance in any service?
- For example, should the organisation of services in a hospital be based on hotels?
- Do you believe we can think of a hospital as a hotel? Why?

IV - Importance of Hospitality for Hospitals and Users:

- Do you consider that a service that cares about hospitality influences user's satisfaction?
- Does the hospital care about the users' experiences? Why?
- What are the factors that most contribute to making this experience a positive one?
- Do you consider that there are obstacles that affect the quality of this experience? (If yes, which ones?)
- How do you check the users' perceptions about the quality of the service provided in this hospital?
-Do you consider that there are differences between a patient and a client? (If yes, which ones? If not, why?)

IV- Importance of Hospitality for Hospitals and Users (Cont.):

- In your opinion, who uses the services of this hospital is treated as a patient, client or both?
- In your opinion, what hospitality criteria can be validated and implemented to improve user satisfaction?
- For you, what are the factors that influence the users' decision to return to enjoy the same services?

V - Interactions between service providers and users:

- Who are the main players in the interactions between health professionals and users?
- For you, what are the most important aspects of the doctor / patient relationship?
- What are the most important aspects in the nurse / patient relationship?
- What are the reasons that may negatively influence physician / user interactions?
- What are the reasons that can negatively influence the nurse / user interactions?
- In your opinion, how can hospitals improve the communication between users and health professionals?
- What can be done to enable health professionals to meet all users' needs?
- Which are the improvements needed for better experiences?
- Finally, do you advise this hospital to a family member or a friend? Which are the main reasons?

Appendix B. Hospitality Dimensions

Tangible Dimensions[1]					
Similarities			Differences		
Author	Description	Narrative	Author	Description	Narrative
D1	Cleaning, food, rooms	'What they have in common is the food, the cleaning, the bed, the rest is different.'	GS	Limits imposed by each different patient (type and quality of food)	'In terms of services, namely food, they can't do much more because it depends on the type of patient. There are certain things that cannot be adapted because if we do, hospital doesn't exist more and become a hotel, must exist good sense in that way. Only what can be adapted for hospitals should be done.'
N3	Food, rooms	'Well, in the typical hotel management field, I think so. Better food, better rooms and better bathrooms! I think that both in private hospitals and in recent public hospitals this part is well defended (...) in terms of physical structure and very good hotel management, for example has single or double rooms '	P1	Mechanisms of operation	'In public hospitals, it is almost all through external companies, and I know that sometimes the food wasn't enough to all the patients and often it was cold.'
GS	Mechanisms of operation, cleaning, food, rooms	'The management of beds and food, namely the maintenance, also in the operative part it makes all the sense to be based in the hotel industry.'			
P1	Mechanisms of operation, food	'The food made in the own hospitals is much better than the food that is made by outside companies. I know that having a kitchen in the hospital itself is very expensive (...) but the result is much better (...)'			

Intangible Dimensions[2]					
Similarities			Differences		
Author	Description	Narrative	Author	Description	Narrative
D2	Experience of the stay, well-being, satisfaction	'In terms of facilities?! This is so… in a private environment is easier for the patient, because the patient feels more at home doesn't lose so many references, he is not so disoriented with a family member presented (...)'	D1	Reason and perception of the time of permanence	'The hospital must have an opposite philosophy than a hotel. The hospital must have to do the possible to stay people the shortest time. Patients want to stay the shortest time possible in a hospital'
A	Experience of the stay, well-being, satisfaction	The complementarity of the two segments that is give welcome, accommodation, comfort, joy and simplification, this is common ... '	A	The patients are conditioned due to their physical and mental condition because they have a pathology	'so I think it's so demanding because customers here are sick ... so here we still have to add the disease.'
N1	Experience of the stay, satisfaction	but the hotel aspects in a hospital are also important for the customer (...) Nowadays, customers value the hotel part a lot and in terms of hospitality the convergence between these two areas, the customer feels more satisfied (....) They are more satisfied with the same care but with a better hospital hospitality, if we can provide this, then for sure!'			
N2	Types of social interactions	'The accommodation side, yes. I think that afterwards there is an important aspect ... The first contact is very important'			

GS	Environment, satisfaction	'the important is that the client doesn't feel so much the hospital environment, in terms of colors, decoration ...'			
HH1	Experience of the stay, satisfaction	'It is essential that there exist a good, reception environment...'			

Space Attachment[3]

Similarities			Differences		
Author	Description	Narrative	Author	Description	Narrative
D1	Physical support area	'and of course, there is a support area that will be shared by hospitals and hotels'	D1	Management models and organisation of space	'the pediatric's area can't be equal to the geriatric's area for example, so this is completely different from hotels where the areas are not differentiated'
N1	Physical support area	'For example, we have different hotels' service in the hospital, we have different services that have already suffered changes and we feel that the customers are more satisfied.'			
N3	Organisation of space	'It is evident that in a hotel everybody wants to be in their single room (...)'			
GS	Management models, organisation of space	'Infrastructures we already walked to that. In relation to the facilities we have tried to be seen as a hotel (...)'			
HH1	Physical support area, management models, organisation of space	'There are some similarities between hotels and hospitals. There are aspects that are found in hotels that must be present in hospitals. From the design of			

		the hospital that should have as reference the patient, in the case of hotels the guests. The choice of location is very important for both: in a hotel in terms of tourism and in a hospital in terms of accessibility, e.g. the reception area should be comfortable and efficient both in a hotel and in a hospital, all the space should always be for improving the conditions of people (...)			
P1	Management models and organisation of space	'This room is an example, now they have to maintain it, if it is necessary to renew they have to do it, they can't stop doing maintenance but of course that is expensive.'			

Organisational System[4]

Similarities			Differences		
Author	Description	Narrative	Author	Description	Narrative
A	Management strategies (hiring professionals specialised in hospitality)	'much similar to the entire hotel mechanism, in such a way that our Public Relations Manager came from the hotel industry ...'	D2	Limits imposed by hospital organisation	'but this is in an ideal world, nowadays it's still not very viable ...'
A	Management strategies (economic strategies)	'The hotel service in hospitals has two important things: one is to pleasing expectations and the other is loyalty, because they also depend of their usual customers ...'	N1	Technical component of service provision	'It shouldn't be based. That's a component, not the main one! The main one is the technical capacity of the technicians (...) Hospitality is important but it is not fundamental.'

A	Management strategies	'(...)related to organisation(...)'	N2	Technical component of service provision	'It's obvious that health is a very specific field and our focus will always have to be the care we give to the client from a clinical and nursing point of view, this will always be our focus ...'
N	Adoption of practices and professional routines	'we can get new knowledge from other services whether it's hospitality or aviation, and why I am speaking in aviation?! In check-lists, namely, in the form of ensuring and confirming second time, if there are no mistakes if there aren't exchanges and hospitals don't have less responsibility (...) The confirmation if in terms of rooms everything is fine, the presentation, cleanliness, feeling that things are well and ready to receive the new patient, and in terms of what they invest in the relationship with the customer in terms of friendliness, etc.'	N2	Adoption of practices and professional routines	'but we have different situations, for example in surgery inpatient service or in pediatric service (…)'
H1	Management strategies	'hospitals and hotels work 24/7 every year and give accommodation. In these aspects, we can think in a hospital as a hotel.'	N3	Adoption of practices and professional routines	'There are clinical situations that the individual room is an obstacle! (...) critical patient that needs space that allow us greater vigilance and in a service where I have everything in individual rooms I can't have a closely observation. The excess of hotel services can sometimes complicate.'

Appendix C. Participant Obervations

Note: some examples of verbal interactions collected

Patient	Sequence	Situation	Type of Interactions	Descriptions	**Patient**	**Doctor**	**Nurse**	**Assistant**
P1	1	Round	dyad	Clinic/Formal	0	1	1	0
P1	2	Check in	triad	Clinic/Formal	1	1	1	0
P2	1	Round	triad	Clinic/Formal	2	0	1	0
P2	1	Round	dyad	Clinic/Informal	1	0	1	0
P2	1	Round	triad	Small Talk	2	0	1	0
P2	1	Round	triad	Clinic/Formal	1	1	1	0
P2	2	Round	dyad	Accommodation/ Formal	0	0	1	1
P2	3	Check out	triad	Small Talk	2	0	1	0
P2	3	Check out	dyad	Clinic/Informal	1	1	0	0
P2	3	Check out	triad	Clinic/Formal	1	1	1	0
P3	1	Check out	dyad	Small Talk	1	0	1	0
P3	2	Check out	dyad	Clinic/Informal	1	0	1	0
P4	1	Round	dyad	Accommodation/ Formal	1	0	1	0
P5	1	Check out	triad	Clinic/Formal	2	0	1	0
P6	1	Round	triad	Clinic/Formal	2	0	1	0
P7	1	Round	triad	Accommodation/ Informal	2	0	1	0
P7	2	Round	triad	Clinic/Informal	1	0	2	0
P7	3	Round	triad	Clinic/Formal	2	0	1	0
P8	1	Round	dyad	Clinic/Formal	1	0	1	0
P9	1	Round	dyad	Clinic/Formal	1	0	1	0
P10	1	Round	dyad	Clinic/Informal	1	0	1	0
P10	1	Round	triad	Clinic/Informal	1	1	1	0
P11	1	Round	triad	Clinic/Formal	1	1	1	0
P11	1	Round	dyad	Clinic/Formal	0	1	1	0
P11	1	Round	triad	Clinic/Formal	1	1	1	0
P11	1	Round	dyad	Clinic/Formal	0	1	1	0
P12	1	Round	dyad	Clinic/Formal	1	0	1	0

P13	1	Round	triad	Clinic/Formal	1	0	2	0
P13	2	Round	triad	Clinic/Formal	1	2	0	0
P13	2	Round	triad	Clinic/Formal	0	2	1	0
P14	1	Breakfast	triad	Accommodation/ Informal	2	0	0	1
P14	2	Breakfast	dyad	Small Talk	2	0	0	0
P14	3	Round	dyad	Clinic/Informal	1	0	1	0
P15	1	Breakfast	triad	Accommodation/ Formal	2	0	0	1
P15	2	Round	triad	Clinic/Informal	2	0	1	0
P15	2	Round	dyad	Clinic/Informal	1	0	1	0
P15	3	Breakfast	triad	Accommodation/ Formal	1	0	1	1
P15	3	Breakfast	triad	Clinic/Informal	1	0	1	1
P16	1	Breakfast	dyad	Accommodation/ Informal	1	0	0	1
P16	2	Round	triad	Accommodation/ Informal	1	0	1	1
P17	1	Breakfast	dyad	Accommodation/ Formal	1	0	0	1
P18	1	Round	dyad	Clinic/Formal	1	0	1	0
P18	1	Round	dyad	Clinic/Formal	1	0	1	0
P18	2	Round	triad	Clinic/Informal	1	0	2	0
P19	1	Check out	dyad	Clinic/Formal	1	0	1	0
P20	1	Round	dyad	Clinic/Formal	1	0	1	0
P21	1	Round	dyad	Clinic/Formal	1	1	0	0
P21	1	Round	triad	Clinic/Formal	1	1	1	0
P21	1	Round	dyad	Clinic/Formal	0	1	1	0
P22	1	Round	dyad	Clinic/Informal	1	0	1	0
P23	1	Round	dyad	Clinic/Formal	1	0	1	0
P23	1	Round	triad	Clinic/Formal	1	1	1	0
P23	2	Check out	dyad	Clinic/Formal	1	0	1	0
P24	2	Check out	dyad	Accommodation/ Formal	1	0	1	0