"CARE" in social media: perceptions of reputation in the healthcare sector

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Abstract

Purpose – Guided by the growing importance of social-mediated organisational communication, this study examines how communication professionals within healthcare organisations perceive and respond to the reputation impacts of social media on the organisation's reputation. Although the healthcare sector finds itself in the midst of a (continually) transforming landscape characterised by large amounts of digital health (mis) information and an empowered "patient-as-consumer", little is known about how professionals in this sector understand the changes and respond to them. Moreover, much extant scholarship on the topic is published in specialised health or medical journals and does not explicitly address the communication implications for healthcare organisations.

Design/methodology/approach – In-depth semi-structured interviews were conducted with communication professionals responsible for social media across eight hospitals in the Netherlands. The sample included two participants working as communication consultants/social media advisors for healthcare organisations. In all, 15 interviews were conducted.

Findings – Building on interviewee perspectives, the authors advance the CARE (Control, Access(ability), Responsive(ness) and Engagement) model of social-mediated communication, highlighting the dualistic characteristics of each dimension. This model is built upon a careful analysis of healthcare professional responses. In an always-on environment, understanding and managing the tensions within the authors' model may be decisive to the reputation implications of social media use.

Originality/value – Understanding the tensions within each dimension lends a more nuanced perspective on the potential impact(s) of social media as experienced by professionals in the field. In shifting away from a binary, either/or approach, the paper contributes to explicating the complexities of a pervasive phenomenon (i.e. social-mediated communication) and its multifaceted impacts on the healthcare sector.

Keywords Organisational communication, Healthcare, Netherlands, Paradox, Reputation, Social media

Paper type Research paper

Introduction

On Saturday, 29 January 2017, an 86-year-old man was injured in a car accident in Rotterdam, the Netherlands, and was taken to hospital (de Koning, 2017). Unfortunately, several mistakes were made in treating the man's injuries and his son complained about his treatment on social media. He indicated that he was prepared to sue the hospital for its negligence. This message was picked up by the newspaper *AD,* which forced the hospital to order an investigation into the incident. In another case, a University student sued Northwestern Memorial Hospital when a doctor took pictures of her receiving treatment for "extreme intoxication" and posted them on Facebook and Instagram (CBS, 2013). The student filed a lawsuit seeking US$1.5

million in damages in anticipation of the negative impact on her career prospects. In a wider critique of medical negligence and maltreatment, hashtags such as #DoctorsAreDickheads and #MyDoctorSaid signal a growing outpouring of patient complaints on social media (Vogel, 2019).

Such incidents are increasingly becoming more common in large part due to the rapid digitalisation of communication, especially via social media, which now also permeates the healthcare context. A report found that social media had fuelled a rise in complaints against doctors in the United Kingdom, nearly doubling from 5,168 in 2007 to 10,347 in 2012 (BBC, 2014). Whether the complaints reflected a deterioration of medical standards was unclear; however, two pertinent observations were made: *a changing patient profile* that is more aware and has higher expectations of their doctors, and the *role of negative press* on social media that could progressively "chip away" at the medical profession's reputation (BBC, 2014).

It is undeniable that in the last few years, the Internet and, in particular, social media have had a major impact on every industry. Social media are defined as "a group of Internet-based applications that build on the ideological and technological foundations of Web 2.0 and allow the creation and exchange of user generated content" (Kaplan and Haenlein, 2010, p. 61). Participation on social media by companies and organisations has been historically problematic when there was not a clear sense of strategic engagement for these organisations (see for instance, Fornier and Avery, 2011), highlighting a critical dimension (i.e. the lack of control) that is the centre point of conversations about the perceived impacts of social media.

The healthcare sector is not immune to these communication shifts. Building on the affordances of web 2.0, the concept of Health 2.0 is proposed as a participatory system of healthcare characterised by "active participation, with direct communication between patients, between professionals, and between patients and professionals" (RVZ, 2010). Fuelled by social media, developments in which "the patient is no longer a passive observer but an active participant in the healthcare process" (RVZ, 2010) have far-reaching implications which need to be examined in-depth.

As a result, there is a burgeoning body of research investigating the effects of social media on healthcare. However, much extant scholarship on the topic concerns itself with patients' or healthcare professionals' use of social media and/or the e-health communication between patient and provider. Few articles, if any, focus on the implications of social media for the reputation of healthcare organisations. Our study aims to fill this gap and examines how communication professionals within Dutch healthcare perceive and respond to the use of social media in their organisations. As a result of our analysis, we introduce a model of social media use that highlights the tensions and complexities that communication professionals must navigate as they seek to leverage social media for their respective organisations. Labelled *CARE – Control, Access(ibility), Responsive(ness) and Engagement* – the model lends a more nuanced perspective on the potential impact(s) of social media as experienced by professionals in the field. This is a timely endeavour because in spite of the organisational uptake of social media, digitalisation-led challenges (e.g. speed and volume of information, social media management, matching audiences and channels and big data) are successively named as the top three issues confronting communication professionals in Europe (European Communication Monitor, 2019), issues for which healthcare organisations are not exempt.

Social media in healthcare organisations

As mentioned, research on social media use in the healthcare sector is on the rise; however, with some exception (e.g. Lim, 2016; McCarroll *et al.*, 2014), much of this scholarship is published in specialised health or medical journals (e.g. *Journal of Medical Internet Research; Telemedicine and e-Health*) and does not explicitly address the reputation implications for

healthcare organisations. For example, a longitudinal study of social media in 12 Western European hospitals reported a growing usage trend across the board (van de Belt *et al.*, 2012). Notably, the Netherlands and the United Kingdom reported the highest use of social media in the study while Facebook was the dominant network with a presence in all countries.

Beyond the numbers, some research examined how hospitals are using social media. A study of US hospitals (Richter *et al.*, 2014) found that although seven in ten hospitals used Facebook, the majority relied on an information dissemination strategy (e.g. patient education, announcing hospital and staff awards) rather than an engagement orientation (less than one-third). Similar results are echoed in Jiang (2019) research of "functional interactivity" features in Chinese hospitals' Sina Weibo (Chinese equivalent of Twitter) accounts whereby organisational disclosure and information dissemination were significantly more prominent than audience involvement.

Relative to the types of social networks and usage practices, less is known about why the healthcare sector is gravitating toward social media; in other words, understanding why social media are relevant to healthcare (Bermúdez-Tamayo *et al.*, 2013). Although the ubiquity of social media make this question seem redundant, it is important to have a clear purpose for social media use and be cognisant of the potential benefits and risks. As Keller *et al.* (2014) contend, "public discourse on [. . .] critical health topics continues to be influenced and sometimes shaped by discussions online from Twitter to Facebook", making it imperative for health professionals and organisations to make well-informed decisions about whether or not to be present in the social media space.

The transformational effect of digital technologies and innovations on healthcare services is unmistakable. Key among these will be the adoption of cloud services to improve data sharing between healthcare providers and increase computing capabilities associated with data processing (Report forthcoming). Another important development is the growth of virtual or telehealth solutions, which is driven by "informed and empowered consumers" who seek convenient and accessible information and are no longer passive targets for "push" solutions from business (Deloitte, 2019). Therefore, an examination of new communication technologies and their impacts on the healthcare sector is not only timely but may also facilitate a better understanding of the conditions that facilitate and constrain professional practices (e.g. Lim, 2016).

The importance of accessibility and transparency of health information is reinforced by Cordina and Greenberg (2020). Their survey-based study confirms the growing use of varied online sources (31% hospital or physician website; 37% social media or apps; 20% health insurer's website or app) to make healthcare decisions from choosing a primary care provider or pharmacy to assessing quality of a physician or facility. Crucially, 68% of survey respondents consider facility and provider reputation in deciding where to receive care, and negative online reviews are decisive to patient experience (45% of respondents reported looking for a different provider after reading such reviews). These findings mirror a shift toward participatory medicine (Health 2.0) that allows "physicians and patients to digitally connect and take an active role in managing health" (Lim, 2016, p. 966). This is connected to and seen to give unbridled access, via "the patient's voice" (Lim, 2016, p. 967), to peer feedback and experiences with healthcare providers that could potentially be input for improving the quality of care. From a strategic standpoint, Kotsenas *et al.* (2018) note that a digital presence can contribute to building the (organisation and/or individual) brand, expanding the organisation's reach and generating business (e.g. through word-of-mouth referrals). From a consumer perspective, having access to transparent (online) information affords them the possibility to make better healthcare decisions accounting for the provider's reputation, quality and cost of care (Cordina and Greenberg, 2020).

The Netherlands is no exception to the transforming "patient as consumer" profile. Depending on their insurance, patients are free to make decisions on where to go for care

(Vuijst, 2009). Research by the *Nederlandse Vereniging van Ziekenhuizen* [The Dutch Association of Hospitals] found that 25% of the patients will not automatically choose the closest hospital and between 65 and 90% prefer to opt for a specialised hospital (NVZ, 2011). Moreover, rankings of healthcare service providers are being published by newspapers and agencies based on preselected quality indicators and patient surveys. In 2013, the Internet had already become the main source for patients to find health-related information as well as way for patients to connect and communicate with healthcare providers. By then, nearly a third of the Dutch population used the Internet to find ratings of healthcare providers online (van de Belt *et al.*, 2013). On ZorgkaartNederland.nl, "the largest experience site for Dutch healthcare where people share their experiences with healthcare with each other" [translated from Dutch], there are nearly 700,000 ratings of healthcare providers. In addition, owing to the vast accumulation of health information online, patients have become more aware and critical of the possibilities offered by health professionals, thereby challenging the assumption of "the doctor knows best" and thus pressuring hospitals to adapt to this new market of empowered patient-consumer (e.g. Waeraas and Maor, 2015).

Clearly, the pervasiveness of social-mediated communication has its pros and cons, for example, the potential for misinformation, violation of (patient) privacy, and risk to professional image and reputation (Lim, 2016; Ventola, 2014). In light of the aforementioned digitalisation-led changes, it becomes imperative to examine how communication professionals in the healthcare sector address the impacts of these developments with a specific focus on organisational reputation.

The (digital) reputation imperative and its implications for the healthcare sector

A classic definition of reputation deems it "a perceptual representation of a company's past actions and future prospects that describe the firm's overall appeal to all of its key constituents when compared to other leading rivals" (Fombrun, 1996, p. 36). In other words, reputation refers to "the perceptions by stakeholders of an organisation's ability to fulfil their expectations" (Fombrun and van Riel, 2007, p. 43). Reputations are a firm's most valuable intangible assets and likened to a "magnet" for stakeholder support, access to resources, alignment with strategic objectives, competitive differentiation, stakeholder support, trust and pride in an organisation and even a "buffer" in times of crisis (Fombrun and van Riel, 2007).

From a communication standpoint, reputations are fluid and dynamic, constituted through ongoing interactions between organisations and their stakeholders or among groups of stakeholders independent of the organisation (Ravasi *et al.*, 2018). Therefore, fully controlling or even managing reputation is an elusive goal (Aula and Heinonen, 2016), although organisations may, to some extent, influence reputation by how they behave, communicate and perform (Zarkada and Polydorou, 2014). The exponential growth of social media exacerbates the tension between control and reputation management as it changes how stakeholder evaluations are formed and disseminated in the public sphere. Etter *et al.* (2019) contend that new forms of uncontrolled interaction accompanied by real-time reach and a fragmented media environment challenge the homogeneity of evaluations that stakeholders make of organisations. Among the most significant developments, these authors highlight the shifts in communication flows (top-down to horizontal networks), audience roles (senders, receivers and co-producers with enhanced agency) and nature of content (emotional as opposed to "informational"; lower regard for "balance and accuracy") as fundamentally transforming the communication landscape, necessitating new approaches to the practice and research of digital reputation management (Etter *et al.*, 2019).

In an always-on environment, organisations of all kinds need to navigate the multitudinous possibilities – from unprecedented connectivity, engagement and

collaboration to heightened scrutiny, criticism and falsehoods, to name a few – that can
influence brand perceptions in the public sphere. Particularly since the General Data
Protection Regulation (GDPR) came into effect, awareness around personal data and privacy
has increased. While the responsibilities of healthcare organisations to their patients has
changed significantly, there are stronger consequences for breaches of privacy.
The reputation impact of privacy challenges is far-reaching affecting brand reputation,
financial performance and trust (Davis, 2019). Even the supposedly "mundane" efforts to
engage stakeholders on social media could pose reputation risks for healthcare organisations
given the "medico-legal" ramifications (e.g. Mishra, 2019, p. 505).

Healthcare organisations find themselves at a critical juncture. With the growing use of
online and social media to make healthcare decisions, providers face challenges to their
reputation (in case of bad reviews) and organisational sustainability (with a potential loss of
patients). However, these very developments also promise benefits for those that take the
lead in embracing changes and that ensure they are ahead of the curve. The healthcare
sector needs to take on board the idea that "companies that can provide greater value to
consumers will benefit from increased customer satisfaction" (Cordina and
Greenberg, 2020).

How, then, might communication professionals understand and manage social media use?

Method
For this study, semi-structured in-depth interviews were conducted with a purposive sample
of communication professionals employed at Dutch hospitals and/or working as
communication consultants for these organisations, advising them on social media
strategy (e.g. Bailey, 2007; Tracy, 2013). Participating hospitals were present on several
social media platforms (Facebook, Twitter or Instagram and/or YouTube) and included a link
to such platforms on their official website. Interviews were conducted with 15 professionals
holding such positions as "Head of Marketing and Communication" or "Advisor Online
Communication" and/or "Content Manager". Interviews lasted 60–90 min and yielded a total
of 326 pages of single-spaced data.

All interviews followed a semi-structured interview guide which included questions
related to the importance, relevance and use of social media; the perceived opportunities and
challenges of social media; and strategy to manage these affordances. Per interviewee
preference and comfort, all interviews were conducted in Dutch (one of the authors is a native
Dutch speaker) and transcribed verbatim, after which they were translated to English.
All participants signed informed consent forms. Each interview transcript was then
subjected to thematic analysis following the steps outlined by Braun and Clarke (2006):
familiarisation with data; generating initial codes; searching for themes; reviewing potential
themes; defining and naming themes; and producing this paper. The assessment of these
themes resulted in our model articulated further as "CARE". The concerns, opportunities and
interests of the interviewees became the basis for producing this model as well as a
framework to re-evaluate other quotes from our sample against.

In total, data for the study included interviews with 15 participants across eight hospitals
including one local hospital (Groene Hart Ziekenhuis), three specialised hospitals (Elisabeth
Tweesteden, Albert Schweitzer, Maxima Medisch Centrum) and four academic hospitals
(Erasmus MC, UMC Utrecht, Radboud UMC, VU MC Amsterdam). Academic hospitals are
commonly identified by the abbreviation of "UMC" (University Medical Centre or Universitair
Medisch Centrum) (see Table 1).

Participant	Department/Role	Hospital/ Organisation	Hospital type	Location
1	Marketing and Communication	Erasmus MC and Sophia Children's Hospital	Academic	Rotterdam
2	Social Media, Finance and Staff	Erasmus MC	Academic	Rotterdam
3	Online Communication and Corporate Website	Erasmus MC	Academic	Rotterdam
4	Brand Manager	Erasmus MC	Academic	Rotterdam
5	Online Marketing and Communication	Het Groene Hart Ziekenhuis	Local	Gouda
6	Online Marketing and Communication	Het Groene Hart Ziekenhuis	Local	Gouda
7	Online Marketing	UMC Utrecht and Wilhelmina Children's Hospital	Academic	Utrecht
8	Communication	Maxima Medisch Centrum	Specialised	Eindhoven
9	Communications Department	Radboud UMC	Academic	Nijmegen
10	Communication	Albert Schweitzer Ziekenhuis	Specialised	Dordrecht
11	Communication and Media Relations	Albert Schweitzer Ziekenhuis	Specialised	Dordrecht
12	Online Communication	VUmc Amsterdam	Academic	Amsterdam
13	Online Communication; Media Relations	Elisabeth- TweeSteden Ziekenhuis (ETZs)	Specialised	Tilburg
14	Social Media	The Marketing Factory		Breda
15	Communication/Management Consulting	Regio+		Rotterdam

Table 1.
Participant profile

Results

Drawing on interviewee perspectives, our study offers a multidimensional perspective on social media use that juxtaposes benefits and risks, opportunities and challenges. We argue that instead of viewing these social-mediated affordances as dichotomous, scholars and practitioners need to understand and manage the tensions between the risks and benefits. Deriving from our study, we conceptualise the CARE model of social media use where each dimension – C (control), A (accessibility), R (responsiveness) and E (engagement) – is unpacked through the lens of paradoxes which permits an appreciation of both/and positions instead of the polarisation implicit in either/or approaches (e.g. Poole and van de Ven, 1989). Equally, how communication professionals balance and manage these tensions will shape (variable) organisational outcomes.
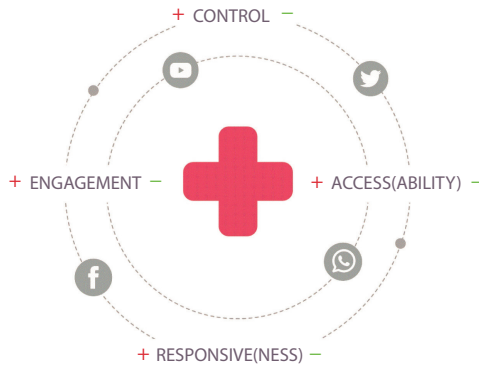

Figure 1.
A visual model of CARE

Source(s): Created by the authors

Control: The presumed loss of control resulting from social media use has been a centre point in much corporate communication research resting on the widely used model of transmission/one-way communication whereby organisational messages could be "decoded as intended" by passive receivers ultimately allowing organisations to shape stakeholder perceptions aka reputation (e.g. Argenti, 2006). Social media, and digital technology more broadly, have allegedly disrupted such control leading some to contend that organisational control was always an elusive idea and, if anything, brands now need to cede control to gain resonance with their audiences (Fournier and Avery, 2011).

Our interviewees offered more nuanced explanations of control noting that social media in fact allowed them to exercise control by circumventing media gatekeepers and directly reaching audiences, assessing the impact of their activities and tailoring communication efforts based on stakeholder reactions. Previously done through newsletters or print magazines, current digital formats allow hospitals not only a wider reach at low cost but also bypass media gatekeepers inverting the traditional "push" relationship and facilitating an interdependent one in which organisations are "able to influence the press through channels such as Twitter or Facebook [to publish certain stories]" (P15). Moreover, the ability to "easily check the sentiment on social media" is deemed important for ensuring that communication is relevant and useful, "so you quickly get insights into what's going on . . . [you can] address things well by providing particular information" (P7).

Likewise, interviewees viewed the potential to exercise control on internal stakeholders (aka employees) by instituting social media policies and guidelines to indicate "what affordances of social media are appropriate in the workplace" (Vaast and Kaganer, 2013, p. 81). Encouraging employees to speak for and on behalf of the organisation, however, highlights the paradox of employees as reputation agents, from being "untapped resources" whose creative expression can be strategically harnessed or "ticking time bombs" that pose significant reputation risk (Miles and Mangold, 2014, p. 401). The majority of participants attempt to navigate this double bind with formal policies noting that while employees are the "biggest brand ambassadors", it is too risky to not have a social media policy "to fall back on" (P12).

Nonetheless, too much control could be problematic, as it "may result in inauthentic brand communication and lead to a sense of alienation and resistance among employees" (Rokka *et al.*, 2014, p. 807). In line with this understanding, a small minority decried the overreliance on policies as a form of control, arguing that the unpredictability of social media requires quick thinking and rigid policies and protocols might make an organisation less responsive in a crisis: ". . .but so many things happen here. So nine out of ten times you cannot even imagine them. On the spot you will have to think of how to respond and manage it, who to contact" (P10).

Instead, these participants advocate for building trust in employees to do the right thing using their best judgement. The tension between control and autonomy was aptly summarised: "you cannot control it all, you can only educate them a little and hope everyone uses their common sense" (P13) (see Table 2).

Access(ability): Interviewees view social media as affording a multi-directional communication flow between the hospital and the patient, permitting greater accessibility to the hospital and its services as well as facilitating knowledge exchange and conversation among other people, across horizontal networks. From this perspective, the patient (as consumer) feels that the hospital is more easily approachable on social media, which was regarded by interviewees as a clear advantage of having a social media presence.

Furthermore, it is easier to discuss medical topics considered more "complex" or taboo. An interviewee illustrated the case of special sessions/consultations with women regarding (pre-)menstrual symptoms or complaints organised by her hospital. Few women showed up to these sessions. Then the hospital did a session on Twitter with much success:

Dimension: Control		Illustrative quotes
Positive: Perceived control over communication (outcomes)	+ Bypassing media gatekeepers	[the press] will not pick up everything [published by the hospital]. You'll have to be lucky that they [the press] are just as interested in what you are doing as you are (P15)
	+ Assessing the impact of communication efforts	If you place an advertisement in such a newspaper [patient magazine or local newspaper] it is difficult to see what the effect was. While if you do this online [publish an advertisement or story] you can easily measure that effect (P14)
	+ Instituting governance mechanisms such as internal training and policies	I think it would be a risk if you did not have a social media policy because you have nothing to fall back on and mostly so you know what you are doing [. . .] and definitely for a serious organisation like a hospital (P12)
Negative: Perceived lack of control on reputation	− Challenges in employee alignment with organisational goals	Coincidently we have had to deal with employees grumbling about the organisation on Twitter a few times now (P9)
	− Multiplicity of actors that are involved	Yeah, but it is difficult to get 6,500 people pulling in the same direction (P13)
	− Limitations of governance mechanisms such as social media policies	If you set out too many rules for everything that could go wrong, people will stop thinking on their own and they will only follow these rules (P11)

Table 2.
Control

People said 'I did not dare to ask my question in public. . .but behind a computer screen people felt more safe and free, but in such a room [physical space] people did not want to talk about their (pre) menstrual symptoms or complaints but online the women did dare to ask their questions. (P14)

Stemming from the commonly invoked argument to "be where the stakeholders are", interviewees also envision long-term benefits by cultivating relationships with younger audiences. Two participants reported using social media to reach children or adolescents, for example, by experimenting with Snapchat, a social network popular among teens and millennials. Participants working at Academic Medical Centres emphasised their interest in reaching adolescents as a priority group that would constitute future medical students. In all, social media are seen as facilitators for new stakeholder relationships.

Like control, access comes with its challenges, notably the privacy associated with social media use. Legally, medical professionals are bound by rules of professional confidentiality and non-disclosure. However, reviews on the rating platform, Zorgkaart Nederland (2018) mentioned previously, reflect growing concerns with lack of privacy from sharing a room and/or rooms that cannot be locked to the lack of confidentiality in patient information in pharmacies (e.g. indiscreetly discussing medication and treatment in the presence of other patients in waiting). Besides, new complications of digital and mobile technologies additionally complicate existing offline problems.

The exponential growth of "social media photography" and short (YouTube) videos (Miller *et al.*, 2016), not to mention the popularity of selfies, was mentioned as a specific threat to patient privacy. At one hospital, for instance, visitors and patients who make a video without respecting the privacy of other patients can be addressed by hospital security, but

with the ease of using a mobile phone to film this has become increasingly more difficult to control. Another interviewee explained that although they do not prohibit taking selfies, they urge mindfulness: "please pay attention to the following rules: privacy of others, privacy of employees and do not disrupt your medical treatment" (P11) (see Table 3).

Responsive(ness): Relative to time invested in emails or phone calls, interviewees reported a growing use of social media channels both by patients (to ask questions of the hospital's staff) and by the hospital (to communicate with patients). Being responsive was not limited to positive sentiment; in fact, responding to negative messages or complaints received through social media was also perceived as a latent opportunity to engage with the online community even more by invoking them in resolving problems: ". . .And [uh] it will help you with your reputation especially if you can respond back with 'many thanks for your tip, you were right and we are now working on improving this'. . .fantastic opportunity" (P15). Thus, identifying and potentially addressing brewing issues or "paracrises" (Coombs and Holladay, 2012) is critical; left unaddressed, paracrises could escalate into full-fledged crises. A case in point is the Coronavirus crisis that went far beyond such a paracrisis and required healthcare professionals to significantly increase their public healthcare responsiveness through social media and other channels. While data for this study preceded this pandemic, more research into effective responsiveness of healthcare institutions (as well as the other elements of the CARE model) for crisis situations is needed.

Owing to the fast pace of change and dual professional responsibilities (only a third of the interviewees worked fulltime on social media), participants found themselves struggling to stay updated. Equally, expectations for a speedy response are often misplaced as several intermediate experts might have to be consulted especially when communicating medical content. Particularly for the academic hospitals, where research, education and patient care are three main pillars, it can be a race against time as "social media forces you to work quicker" (P6). How to respond is also context-dependent and adds to pressure of carefully thinking through the response so as to not aggravate the issue:

Dimension: Access(ability)		Illustrative quotes
Positive: Increased access to information and audience	+ To information; to target audience(s)	You can exchange knowledge in an easily accessible manner and also engage in conversation with people (P7)
	+ Access(ability) in terms of message/content comprehension	Subjects that are often somewhat more complex can be shown on a more accessible level (P12)
	+ Access to future generations	To make the younger community a little more aware of what is means to be healthy. So it has a more preventative aim. . . . to make them aware that it is good to stay fit and eat healthy (P1, P7)
Negative: Potential to cross boundaries	− Invasion of privacy and possible misuse by asking/posting sensitive information/videos/photos (e.g. the "selfie" culture)	. . .you cannot just participate in the conversation on social [media] because there is a lot of personal information. Yes, you are dealing with a disease of a patient. The patient does not want everything out in the open, but you do want to be empathetic and not too professional and bleak. So you'll have to find a middle ground (P2, P3)

Table 3.
Access(ability)

It is all really customised. So, it is important to not always react impulsively, yes think for more than 3 seconds. . . . but you have to realise the consequences of that message, you know. And what sort of language you will use and how you would interpret that sentence. (P13)

In addition to the issue of feasibility is the question of prioritising. The growing use of social media in their organisations prompted some to introspect on the core purpose of the healthcare institution. For example, an interviewee noted that reputation problems stemming from negligence in patient care and well-being would have more serious implications than what an organisation does (not do) on social media:

A few months ago, we had an IVF-disaster, which is way worse for your image, because it resulted in a very big group of patients who became victims. They did not know whether they would have a child from the man they thought they would. Yes, that is a lot worse. That is directly related to care giving. (P7).

Others concurred but shared examples consistent with the amplifying effect of social media as an "accessory in escalating crises" (Mei *et al.*, 2010, p. 143) such as the time a patient posted a picture on Twitter:

Like a lot of dust on the light cover [above the patient's head when they woke up from surgery]. So that patient took a picture of that and that was really horrible of course. This escalated on social media . . . that really was reputation damage for the organisation. . . . Yes 'is it a clean place?' that is essential for a hospital, hygiene. So that is then a reputation thing. (P2) (see Table 4).

Engagement: The final dimension in our model refers to engagement, arguably, the holy grail of social media practice and scholarship. The primacy of engagement via interactive, dialogic affordances of social media is well documented; in practice, however, much organisational (corporate and non-profit) research confirms the preponderance of broadcasting/information dissemination approaches, as opposed to engagement (e.g. Etter, 2014; Lovejoy *et al.*, 2012).

For our interviewees, engagement manifested in the ability to position the hospital as a caring institution, to "convey a warm impression. . .to show the human dimension of care"

Dimension: Responsive(ness)		Illustrative quotes
Positive: Opportunity to respond quickly	+ Ability to respond quickly	I notice it myself that if I need to talk to an organisation I use social media because if I email you often get an email back with "we will answer within two weeks." So I thought I'd try social media, and then you get an answer almost immediately, which is really nice. Yes, and I think that happens here too. We try to answer as quickly as possible (P9)
Negative: Alignment with core purpose may diverge	− Creates an always-on environment	Social media forces you to work quicker (P6)
	− "Forced innovation" that may contradict core purpose (providing quality healthcare)	I do not think hospitals are particular organisations that are on the frontline when it comes to innovation, well with medical innovation they are of course. But when it comes to communication and social media they are not necessarily, and we always are a little behind the curve even if you have a different target group, you still need to keep renewing. We do not want to be doing the same thing we did two years ago and want to keep things exciting (P12)

Table 4.
Responsive(ness)

(P6, P11) with a goal to "...eventually to have engagement on your brand" (P4). Participants explained that via social-mediated communication, massive organisations such as hospitals can be humanised and made less impersonal. The underlying driver, according to some, was that its institutional status made hospitals more distant, thereby limiting the connectedness with their audience. Social media were seen as a way to communicate the faces behind the hospital and alleviate perceptions of "a cumbersome organisation where all doors are closed and one you cannot come to easily" (P9).

Participants relayed the importance of storytelling as the pathway to dialogue and conversation. Another shared her vision for storytelling as facilitating dialogue:

> Well I would like to tell more stories and we will post that on all our social channels and then try to generate dialogue with our target group. So it is not only sending out messages, but also entering into discussions with our target groups. (P4).

Another narrated a poignant story about her hospital facilitating the journey of a terminally ill patient to visit his mother's grave in Morocco. Not only was the effort well received on social media but many employees expressed pride in their employer.

Coupled with greater engagement via dialogue comes the possibility of negative feedback, making it imperative for communication or social media professionals to have the know-how and guidance to respond in an appropriate manner to questions and complaints posted on social media. None of the participants in this study were authorised to answer medical questions posed on social media. Additionally, social media professionals were not authorised to (or able to – as they have no access to a patient's medical file) correct, dispute or provide nuance to, inaccurate messages posted by disgruntled patients or their family members.

A broader concern relates to the consequences of anonymity afforded by social-mediated engagement. On the one hand, social media are seen as empowering previously powerless groups or individuals; on the other, the anonymity affords them the possibility to distort information and spread falsehoods that bear serious reputation consequence. While acknowledging the need to understand the "sentiment behind the message", interviewees highlighted unequal power relationship that disadvantages the institution because "people always believe the patient" (P8). Combined with the inability to "defend" the brand, our interviewees highlight the unequal power equation that they are faced with on social media, particularly as engagement with a somewhat anonymous public is difficult to sustain.

However, practitioners may take the opportunity *not* to engage. While they should know the risks of not mitigating negative comments, some practitioners are and more should be aware that these engagements on social media are fleeting and transient but simultaneously timeless and preserved. This struggle relates to a recognition that what is important at present may not be on the agenda tomorrow (see Table 5).

Implications and discussion

This exploratory study examined how healthcare organisations perceive the (reputational) opportunities and challenges of social media for their praxis. Participant perspectives shed light on how hospitals must simultaneously navigate the use of social media from a strategic perspective. Based on our participants' perspectives, we advance the CARE model, highlighting four tensions that communication professionals must balance and manage in order to be able to shape (variable) organisational outcomes.

Currently, there are no models of social-mediated communication in peer-reviewed outlets that respond to this challenge. Two models that are tangentially related are the SPIN model (Mills, 2012) and Technology Acceptance Model (TAM) (Davis, 2019), which has been adjusted to fit the assessment of social media adoption. The SPIN model focusses on the how to create viral content and does not provide insight into the challenges that social media

Dimension: Engagement		Illustrative quotes
Positive: Shaping the connection with the audience	+ Humanising the brand through storytelling and dialogue	The reason for profiling, so you are more visible as an organisation is to attract patients (P11)
	+ Fleeting	it [social media] is fleeting, so on that day and maybe the next two days it might be hot topic. And afterwards it might still simmer a little, but if there is something positive the next day, you'll be viewed positively in the news. That is something to keep in mind: that [social media] are fleeting, tomorrow people might all forget it again, as it were (P13)
Negative: Managing negative feedback constructively	− Lack of knowledge/resources/ decision-making power	I even find it a challenge to just point people in the right direction. . . . I always feel responsible when I get those sort of messages, and think "oh no, it is my job to ensure this person will hear something from us" (P9)
	− Challenge in correcting mis(perceptions); negative criticism/feedback	People always believe the patient (P8)
	− Unequal power equation	. . .you can just hurl a lot of things very easily into the world. I cannot do anything about that, but I do wonder if that is a good thing? All those "klokkenluiders" [someone who publishes something that might damage the reputation of the organisation] (. . .) sometimes you're happy with them as it can bring about improvement. On the other hand, the sentiment that is conveyed is rather simplistic (P7)

Table 5.
Engagement

experts are facing. TAM and its variations (see e.g. Raunier *et al.*, 2014) tend to focus more on the acceptance and use of new technology, but do not address actual or successful use of social media (by individuals). This approach also has limited applications to assess the challenges communication professionals face on social media, both in general and in healthcare organisations.

The CARE model has developed with a focus on actual practices by practitioners and moves away from such understandings of social-mediated communication that tend towards either/or choices or acceptance levels. Our model instead underlines how social media both increase and decrease the tensions for the dimensions control, access(ability), responsive(ness) and engagement. In doing so, the CARE model provides a comprehensive perspective of social media use by healthcare organisations and its practical implications for reputation management. Our model is unique in the sense that currently no models have been found in peer-reviewed journals that describe social-mediated communication and involve the associated practical challenges that social media professionals face.

We believe our results can offer an initial framework for interpretation and analysis in other areas but have critical application in the healthcare sector. As explicated in the results section, each dimension of the CARE model presents organisations with competing tensions that need to be simultaneously navigated. Particularly for two of the four dimensions, that is, Control and Engagement, the results challenge the polarised positions (negative and positive

respectively) which are accorded to these dimensions in most scholarship. As explicated before, participant experiences suggest that the perceived loss of control over "official" messaging co-exists with a sense of control that comes from circumventing media gatekeepers and getting the organisational voice out. Similarly, the potential to institute guidelines for employee behaviour provides a semblance of control over the multiplicity of voices that may speak on behalf of the organisation. However, the mere presence of a social media policy does not make an organisation immune to potential risks. O'Connor *et al.* (2016) concur that for policies to be effective, they have to be enforced and embedded in the organisation through appropriate employee communication and training.

Likewise, humanising a hospital or healthcare organisation presents trade-offs in terms of knowhow, expertise and decision-making abilities to effectively engage or respond to the challenges of engagement. The promise of access(ability) – of and to information, audiences and new stakeholder groups – demands finding a middle ground, given that some of the topics regarding specific medical conditions are personal and private to the patient. This makes it difficult to respond to patients who share their story online and safeguard their privacy. Finally, organisational responsive(ness) is deemed critical in maintaining (online) relations particularly in the face of a negative situation such as consumer complaints (e.g. Einwiller and Steinel, 2015). Although responsiveness can enhance positive perceptions of an organisation, healthcare professionals in our study noted the challenge of not only being behind the innovation curve but also questioning whether social media fit with the goals of delivering quality healthcare. Collectively, the model affirms the paradoxical manifestations of CARE dimensions and validates the need to foreground field experiences in social media research.

Additionally, the model offers some big picture reflections with implications for reputation in the health sector. As stakeholders increasingly expect transparent healthcare information (e.g. Cordina and Greenberg, 2020), the power equation shifts in favour of the patient, who, as we have found, now holds a better informed and empowered position compared to the past. However, when voicing patient complaints online, especially when these are false, they "force organisations to respond to the beliefs or new expectations that it propagates" (Aula and Heinonen, 2016, p. 145). This in turn can lead to a mismatch or misunderstanding of expectations and opinions. Because organisations "are easily stigmatized as manipulators" (Aula and Heinonen, 2016, p. 148), it can be difficult to respond to negativity on social media. Therefore, by monitoring social media conversations about the organisation, negative sentiment or possible reputation risk can be intercepted.

For healthcare organisations, ethical issues of privacy and anonymity constitute a particularly serious challenge to establishing and maintaining trustworthy relationships between healthcare providers and patients. The conundrum between being transparent and compliant means that even storytelling needs to be undertaken within the norms of professional medical practice without compromising patient privacy or confidentiality. Conversations about privacy and anonymity also raise the question of "power" and control whereby patients are able to share (personal, positive and/or negative) information online but hospitals and their social media representatives are limited by rules and regulations. This creates an unequal playing field, limiting hospitals' ability to respond well and provide more context to a situation that may have been presented unfairly, thereby amplifying the reputation risk.

Such an imbalance is exacerbated due to the privacy-sensitive nature of health data (in context of the GDPR). In light of a participant's comment that "people always believe the patient", we find a hint of a dynamic that resembles of the underdog against the big corporation (Zourrig and El Hedhli, 2018). Such an imbalanced power equation may apply to a wider range of organisations and sectors, and so the CARE model is likely to have useful applications beyond healthcare.

An interesting finding, worthy of further exploration, relates to the potential of branding hospitals and healthcare organisations on social media. At one level, this approach is attuned

to the previously discussed shifts towards a patient-as-consumer profile and a competitive healthcare landscape characterised by heightened (media) scrutiny of medical practice and demand for transparency. However, it is equally illustrative of the everyday communication practices in which hospitals engage in "doing branding" (Vasquez *et al.*, 2013). By attending to the communication dynamics, we can appreciate the negotiated and diffuse processes of branding in which, for better or worse, patients, employees and the organisation are all able to shape and define the brand.

Related to branding is another paradox – on the one hand, healthcare organisations are (seen as) brands competing for attention and "customers"; on the other, their primary goal is to deliver quality healthcare. In characterising their organisations as "brands", participants reflect a keen awareness of business developments in the healthcare sector, that is, greater competition and more choice for the consumer. However, this demonstrates the challenges previously outlined in how such brand can engage the wider public on social media as participants who were "uninvited" (Fournier and Avery, 2011). Part of this is to focus on connected online communities often referred to as "brand communities". These may positively contribute to enhancing brand trust and loyalty (Laroche *et al.*, 2012). Given that brand loyalty closely relates to attitudinal perspectives of consumers (Zheng *et al.*, 2015), it is also relevant to an organisation's overall reputation. Arguably, branding and healthcare provision are no longer mutually exclusive, especially in the digital age. Still, more research is necessary to ascertain the reputation damage in case of lapses in caregiving relative to brand challenges in the social media domain.

The CARE model is based on qualitative, exploratory research using a small data set, which presents several limitations in terms of generalisability and validity. Although the use of qualitative methods permits a foregrounding of participant perspectives, a larger data set as well as the implementation of some quantitative methods would allow for more generalisation and permit testability. The model itself may also vary in applicability across different healthcare contexts. For example, the applicability in places where patients cannot choose their healthcare provider limits the generalisability of this Dutch experience. Future research may examine whether and how the dimensions of CARE manifest in other contexts.

Despite these limitations, the CARE model provides a valuable contribution for media and communication scholars in search of a deeper understanding of the impacts of social-mediated communication in the healthcare sector. Our focus on paradoxes allows us to move away from the either/or and instead adopt a perspective of both/and. This results in a more insightful and sophisticated view on what is considered a ubiquitous phenomenon, and in doing so, we establish the significance of the CARE model. Future research may examine the applicability of this model to other organisational domains. The issues highlighted in this study will no doubt take on greater import in the post Coronavirus era, as public health will remain a crucial issue more broadly, and healthcare organisations will continue to work through the paradoxical problems and possibilities outlined in our CARE model. While our research preceded the COVID-19 pandemic, our model begins to highlight the interplay of organisational identity and culture in defining the possibilities for social media use.

Few studies have investigated the role of culture in shaping social media use in organisations (e.g. see Rokka *et al.*, 2014), and examples from industry are scattered between open, collaborative cultures that encourage participation to those at the other end of the continuum. The culture of openness no doubt comes with its own paradox as it can often be counter-intuitive to organisational interests (Macnamara and Zerfass, 2012), manifested, for example, in the tension between controlling and encouraging employee voice on social media. Being aware of these tensions is indeed critical to identifying a strategic approach that works best for each organisation. In foregrounding these tensions, we hope have shown that the CARE model offers a grounded approach, situated in the practical realities and experiences of professionals and goes beyond the presumed dichotomies of risks and benefits.

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