Abstract:

Telemedicine solutions are invading our daily life (applications, cabin …). The aim of this research is to have a better understanding of the acceptance of telemedicine cabins by young adults. A quantitative approach has been selected using the Theory of Acceptance Model (TAM), the Perceived Personalisation and Trusting Belief scales. A survey was administrated to students from different business schools and data were analysed using a Partial Least Approach. A sample of 158 students was collected. Findings highlight the key role of Trusting Beliefs on Perceived Personalization. In addition, results demonstrate that Perceived Ease of Use does not impact the Intention to Use Telemedicine cabin.

Keywords: Telemedicine, Smart Health, Acceptance, TAM

Résumé :

Les solutions de télémédecine envahissent notre quotidien (applications, cabine…). L'objectif de cette recherche est de mieux comprendre l'acceptabilité des cabines de télémédecine par les jeunes adultes. Le modèle de la théorie de l'acceptabilité (TAM), les échelles de personnalisation perçue et de confiance ont été mobilisés. Une étude quantitative a été réalisée auprès d'étudiants de différentes écoles de commerce et les données ont été analysées à l'aide d'une approche par les moindres carrés. (PLS). Un échantillon de 158 étudiants a été collecté. Les résultats mettent en avant le rôle clé de la confiance sur la personnalisation perçue et démontrent que la perception de facilité perçue n’affecte pas l’intention d’utiliser la cabine de télémédecine.

Mots clés : Télémédecine, Santé connectée, Acceptabilité, TAM
INTRODUCTION

Healthcare is considered as a basic human need. However, due to the lack of infrastructure and insufficient qualified healthcare staff, many countries, and not only developing countries, are still deprived of quality healthcare services. To reduce these inequalities, the concept of e-health emerged. Lepore, Metallo, Schiavone and Landriani (2018) highlighted the role of technology use resulting on a positive change of the public healthcare sector (increase of flexibility, dynamic processes and consumer orientation). The information system is often perceived by users as the way to improve personal and managerial performance (Lepore et al., 2018). New technologies implementation emphasizes the need in the humanization of the physician-patient relationship because of the “technicalization” of medical science (Lega, Vendramini, Festa, Coscioni, 2018). Appio, Corso, Gastaldi and Martini (2014) studied the influence of digitalization in the clinical domain on performance improvement perceived both by physicians and patients — by operating efficiently (exploit) and, by adapting continuously (explore). Based on Wilson (2003), Telemedicine or e-health depends on innovative technologies such as telecommunication that will improve remote communication mainly between health care providers and their patients. E-health also implies the use of many technologies such as computers, mobile phones, web sites, applications to give access to health care providers and care workforce (DeLuca, Enmark, 2000). Pagliari et al. (2005) identified 36 definitions of e-health including the concept of telemedicine with six dimensions such as tele-pathology, tele-surgery, clinical reference laboratories, tele-homecare, tele-pharmacy and tele-consultation. Indeed, e-health refers to provided services using internet (Pagliari et al., 2005). Information and Communication Technology (ICT) in the Health domain includes three concepts: (1) telecare, (2) telehealth and (3) telemedicine. (1) Telecare, according to Barlow et al. (2006), implies the use of communications technology to provide health and social care directly to the user (patient) and limits the exchange of information solely between professionals. The well-known examples of telecare products are the user-triggered alarm button (sensors detecting automatically specific issues) and the lifestyle-monitoring which includes the measurement, collection and analysis of data in the user’s home. (2) Telehealth equipment is used as a tool in the management of health to reduce for example hospital admissions. Specific equipment in patients’ homes can be used to detect problems by measuring physiological indices such as blood pressure, oxygen saturations, and pulse. Connected devices combined with cloud computing will enable improvement in patient-centered practice and reduce costs due to enhanced sustainability (Papa, Mital, Pisano, Del Giudice, 2018). (3) Telemedicine or Teleconsultation, with interactive audiovisual exchanges and data communications, allows patients and physicians to save time, reduce costs and inconvenience of travelling (i.e. to hospital). The Teleconsultation is based on the collection and monitoring, in real time, of medical information provided to doctors or health professionals. Thus, it implies a remote diagnostic and treatment (Simon, 2016). The concept of Telemedicine, by recording and storing individual information: administrative and/or medical (Burt, Sisk, 2005), could increase efficiency of physicians (Chau, Hu, 2002), improve the quality of services provided to patients and decrease health costs (Kassirer, 2001). Nevertheless, Telemedicine, using Teleconsultation, is a clinical act and shouldn’t be considered as e-commerce (Simon, Lucas, 2014). According to Klaassen, et al. (2016), Telemedicine at home is a trending topic specially to control the
elderly or individuals with specific diseases such as cardiovascular or diabetes problems. Bice-Urbach and Kratochwill (2016) found that Teleconsultation can help teachers to solve social-emotional behavioural concerns within their class. From September 15th of 2018, medical consultations by videoconferences, using or not a Telemedicine cabin, are reimbursed at the same rate than a physical consultation by the French Health Insurance. The “Medical Office”, the “Consult Station”, the “Medical Teleconsultation Cabin”, the “Telemedical boost” or the “Telemedicine cabin” define the same concept based on an independent health check via telemetry. Main benefits of such solutions are to limit the mobility of patients or practitioners themselves in case of emergency response and reduce the waiting time to perform medical tests. Patients are connected to physicians who guide and advise them, the system collects data and proposes analysis. The connected medical booth is a revolution in medicine as the development of Telemedicine is critical to answer current and future challenges of the health system such as the difficulties to access to medical care in some areas suffering from a deficit of doctors or for some active and too busy population. Telemedicine cabin starts to be installed in Health centres, pharmacies, public places and even in working environment with the approvals of the Regional Health Agency (ARS), the National Union of complementary health insurance organizations (Unocam), and the National Commission for Informatics and Liberties (CNIL). Indeed, some companies such as Microsoft in France have already decided to propose to their employee’s a Telemedicine cabin at work. Individuals sometimes struggle to find an available date for medical consultation, proposing such services could simplify their daily life. Telemedicine cabins are equipped with measuring devices to control for example weight, blood pressure, the rate of saturation of your blood oxygen, temperature and devices to facilitate diagnostics such as stethoscope or fundus examination. Physician can test visual acuity, do hearing controls, electrocardiogram... About ten minutes are needed - half an hour for a more complete assessment, including auditory and visual tests. The results are instantly edited and retrieved using a personal and confidential code. Nevertheless, individuals could be scared by Teleconsultation using system that could record the conversation and implies confidential issue. Consequently, individuals will accept Teleconsultation only if they trust both the technology and the health care provider. Indeed, several technological issues could happen such as the loss of the signal, sound, and data (Bishop et al., 2002). Young adults (18-25 years old) are often considered as a population that consult more rarely when they have health issues (Deeks, Lombard, Michelmore, Teede, 2009; Devoe, Wallace, Fryer, 2009). Proposing a Telemedicine cabin inside universities or Business Schools could solve this problem. Even if, some researchers investigated the acceptance of telecare Health services (Suzari et al., 2017), the acceptance of patients and clinicians of Healthcare Telemedicine equipment (Kohnke et al., 2014), a gap on telemedicine cabins acceptance has been identified. The aim of this research is to have a better understanding on how new health technologies such as the Telemedicine cabin could improve the life of students and what could be their motivations to adopt or not this technology.

Our research aims to answer to the following questions:

R1: What is the potential impact of Perceived Personalization on the three dimensions of Trusting Beliefs ?
R2: What are the variables impacting Behavioral Intention to Use a Telemedicine cabin?

A survey was administered to students of different Business Schools in France. The article is organized as follows: First, the literature review on the constructs mobilized is presented followed by the hypotheses. Second, the methodology is explained, and sample analysed. Third, the findings are presented, and results are discussed highlighting the theoretical and managerial implications. Finally, limitations of the study and propositions for future researches are suggested.

LITERATURE REVIEW AND HYPOTHESIS

Central concept of our research model is Intention to Use the technology. Several frameworks and models have been developed to explain the Intention to Use technology, such as the Theory of Reasoned Action (Fishbein, Ajzen, 1975), the Theory of Planned Behavior (Ajzen, 1985), the Technology Acceptance Model (TAM) and TAM2 (Davis, 1985; Venkatesh, Davis, 2000), and the Unified Theory of Acceptance and Use of Technology (UTAUT) and UTAUT2 (Venkatesh, et al., 2003; Venkatesh et al., 2012). Several factors could impact the Intention to Use such as Perceived Ease of Use and Perceived Usefulness (Davis, 1985). Intention to Use can also be impacted by personal traits such as Perceived Personalization leading individual to reject or to adopt technology. In addition, with the development of internet, people are more and more concerned about their personal data, thus, Trust is regarded as a key influencer of technology use. This study proposes to analyze the acceptance of Telemedicine cabins by students if installed in their campus.

Technology Acceptance Model (TAM)

TAM, developed by Davis (1985) to highlight the factors explaining the acceptance of new technologies, is often used to analyze the Intention to Use information systems. Using behavioral intention as the dependent variable, instead of actual usage, is particularly useful to measure the acceptance of technological systems at an early stage (Chau, Hu, 2002; Sheppard et al., 1988; Wu et al., 2008). In the present study, the technological context (acceptance of Telemedicine cabins) clearly point to an early stage of IT implementation justifying the choice of TAM. Factors that influence on technology acceptance for healthcare professionals and patients may differ (Gücin, Berk, 2015). Therefore, three variables of TAM were mobilized: Intention to Use (ITU), Perceived Ease of Use (PEOU) and Perceived Usefulness (PU).

Perceived Ease of Use (PEOU)

PEOU is defined as the degree to which an individual perceives he can use a product or service without specific mental or physical efforts (Davis, 1989; Venkatesh, Davis, 2000). Therefore, PEOU is a key indicator of Intention to Use specially in case of new technologies using internet such as Internet of Things (Chuah et al., 2016; Baudier, Ammi, 2019), mobile phone (Kabbiri et al., 2017) or healthcare solution (Pai, Huang, 2011; Sun et al., 2013). In addition, PEOU could impact PU and several researchers analysed it in the context of the acceptance of new technologies in the healthcare domain (Wu et al. 2008; Hung, Ku, Chien, 2012; Lanseng,
Andreassen, 2007; Liu, Yu, 2017; Baudier, Ammi, 2019). In other words, greater ease of use of the Telemedicine service suggests that it is more useful for users (Rho, Choi, Lee, 2014).

So, we postulate:

**H1:** PEOU has a positive, direct and significant on PU (H1)

**H3:** PEOU has a positive, direct and significant on ITU (H3).

**Perceived Usefulness (PU)**

PU, key for the acceptance of Telemedicine service, is defined by the degree to which a patient considers that by using a product he could enhance his performances (Davis, 1989) by satisfying, increasing efficiency, lowering costs and by improving quality and safety of care. For the purpose of this research, PU is redefined because performance is regarded from the side of the user/patient, so we define PU as the degree to which the patient believes that using of this technology (Telemedicine) will improve his health. Several studies (Venkatesh, Davis, 2000; Wamba et al., 2017) confirmed the impact of PU on ITU especially in the case of new technologies such as Smartphone’s acceptability (Kabbiri et al., 2017), or IoT (Mital et al., 2017) such as smartwatches (Chuah et al., 2016). In e-health studies the definition of usefulness is used broadly (Pai, Huang, 2011, Gücin, Berk, 2015) especially in the health context, such as e-health (Pulidindi et al., 2016) or Telemedicine solutions (Sun et al., 2013).

So, we postulate:

**H2:** PU has a positive, direct and significant on ITU

**Trusting Beliefs (TB)**

The use of digital technology in communication (e.g., Telemedicine) increases the level of uncertainty (McKnight, Choudhury, Kacmar, 2002; Pavlou 2003; Suh, Han, 2003). The construct of Trust applicable to technology adoption theories emerged in researches of e-commerce, when the user is placed into the situation of disclosure of private information. Gefen (2000) pointed out the importance of Trust and its influence on behavioral intention, and dependency of Trust on context (Gefen, 2000). Several authors have discussed the consideration of Trust and risk factors to explain the individual acceptance of online or digital systems including eHealth applications and health information systems (Chau, Hu, 2002; Tung et al., 2008, Yuan et al., 2015; Alazzam, et al., 2016). In research related to technology acceptance, Trust has been conceptualized as a Trusting Belief (Gefen, 2000; McKnight, Chervany, 2002; McKnight et al., 2002), defined as belief that allows users to willingly become vulnerable to technology providers after having taken the providers’ characteristics into consideration (Pavlou, 2003). Trusting Belief is a multidimensional concept, incorporating Competence (TBC), Integrity (TBI), and Benevolence (TBB) (McKnight et al., 2002; Akter et al., 2011; Istepanian et al., 2006). Nevertheless, the three dimensions must be studied separately (McKnight et al., 2002; Schlosser et al., 2006). Competence refers to the providers’ ability to perform effectively and Integrity refers to providers’ honesty in fulfilling their promises (McKnight et al. 2002). The Benevolence belief measures the level of care of the physicians for their patient and if they act in the employee’s interest. Thus, Trusting Belief is key for the acceptance of new technologies impacting the Behavioural Intention to Use by reducing uncertainty (Nicolaou, McKnight,2006).

Thus, we hypothesize the following:

**H4:** Benevolence has a direct, positive and significant impact on ITU.

**H5:** Integrity has a direct, positive and significant impact on ITU.
**H6: Competence has a direct, positive and significant impact on ITU.**

**Perceived Personalization**

In this research, Trusting Beliefs refer to the patients’ perceptions that the providers of Telemedicine services are trustworthy and would offer personalized services that prove beneficial to users. In the Telemedicine context, Personalization refers to the customization and recommendation of health services according to specific patients and their diseases. Thus, Personalization is imperative in the provision of Telemedicine services. Many studies have shown that Personalization is a key factor for providers (Schafer et al., 2001; Sutanto et al., 2013). The more personalized the product or service is, the stronger is the likelihood of satisfying consumers’ needs, and thus, the consumers are more likely to use it (Komiak, Benbasat 2006; Ho, Bodoff, 2014). Perceived Personalization can reduce Privacy Concerns and impact positively on Intention to Use the services of Telemedicine. Previous studies on Personalization have also highlighted the linkage between Personalization and Trust (Lee, 2005). By using Telemedicine services patients face the situation of data disclosure to enable these services. Nevertheless, as more are these services personalized as stronger is the trust of the patients in the quality of service. We propose:

*H7: Perceived Personalization positively, directly and significantly affects Benevolence*

*H8: Perceived personalization positively, directly and significantly affects Integrity*

*H9: Perceived personalization positively, directly and significantly affects Competence*

*Figure 1* - Research model

**METHODOLOGY**
The research model, in Figure 1, was built using the TAM (Davis et al., 1989), the Trusting Beliefs (McKnight, Nicolaou, 2006) and Perceived Personalization scales (Komiak and Benbasat 2006). A quantitative approach was selected using a five-point Likert scale. A survey was administered to students from different Business schools and data analysed using a Partial Least Approach. A sample of 158 responses were collected and analysed using SmartPLS3. Sample’s characteristics analysis confirms a high proportion of female (77%) compared to male (23%). Our gender breakdown is consistent with previous studies done on health or wellness topics (Waldron 1988, Baudier et al., 2018). All respondents were students studying in a business school, 88 percent were below 23 years old living in Paris (34%) or Paris Area (66%) in their parents’ home (47%).

RESULTS

Outer model

The reliability of the model was checked by verifying that all the variables’ loadings, the Alpha’s Cronbach and the composite reliability were above the recommended threshold of 0.7 (Table A.1). The convergent validity was verified by making sure that the Average Variance Extracted (AVE) of each variable wasn’t below 0.5 (Table A.1). Finally, the discriminant validity was confirmed by analysing that the cross loading of each indicator didn’t load higher on other constructs and in table A.2 that the Square root of the AVE were superior to the correlations of this construct with other constructs (Fornell, Larcker, 1981). Results confirm the validity and reliability of our outer model. Finally, the quality of the model was validated by the Goodness-of-Fit index at 0.54.

Inner model

Figure 3- Research model with results

The R², f² and Q² of the constructs were analyzed to test the inner research model. The relationships between variables were verified by controlling that the Path Coefficients (β) were above 0.200, the t-values >1.96 and p-values <0.05 (Figure 3). The R² at 0.476 showed that
the model explains 47.6 per cent of Perceived Usefulness determined by Perceived Ease of Use, confirmed by the size effects $f^2$ at 0.910 considered as huge (Cohen, 1988). Therefore, H1 is validated. Perceived Usefulness and Competence explained 51.5 per cent of Intention to Use, with a biggest size effect of Perceived Usefulness (0.229). Nevertheless, Perceived Ease of Use, Benevolence and Integrity do not impact Intention to Use. Thus, hypotheses H2 and H6 are validated and H3, H4 and H5 rejected. Perceived Personalization directly and significantly impacts the three variables of the Trusting Beliefs concept explaining Benevolence ($R^2=0.269$), Integrity ($R^2=0.213$) and Competence ($R^2=0.394$) confirmed by size effects of Benevolence ($f^2=0.368$), Integrity ($f^2=0.271$) and Competence ($f^2=0.651$). Therefore, H7, H8 and H9 are validated. The blindfolding procedure was used to test the predictive relevance of the model by analyzing that the Stone-Geisser’s $Q^2$ were all above 0 (Tenenhaus, Esposito, Chatelin, Lauro, 2005). The quality of the model was verified by controlling that (1) Standardized Root Mean Square Residual (SRMSR) was below 0.1 (0.068), Normed Fit Index (NFI) closed to 1 (0.767) and the RMS Theta (Root Mean Square) closed to 0 (0.182). In addition, the Goodness of Fit index (GOF) at 0.53 also confirms the quality of the model.

Finally, six hypotheses are validated, and three rejected (Table 1).

<table>
<thead>
<tr>
<th>Construct</th>
<th>Predictor variable</th>
<th>$R^2$</th>
<th>$f^2$</th>
<th>Path Coef</th>
<th>T Value</th>
<th>P Value</th>
<th>$Q^2$</th>
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<td>13.950</td>
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</table>

Table 1 - Outer model

DISCUSSION

This study aimed to find the potential impact of Perceiced Personalization on Trusting Beliefs and factors impacting Behavioral Intention to Use a Telemedecine cabin. Results are aligned with previous researches confirming the impact of PEOU on PU (Pai et al., 2011, Moores, 2012; Holden et al., 2010; Rho et al, 2014; Papa, Mital, Pisano, Del Giudice, 2018). Several
researchers in Healthcare field, found a direct effect of PU and PEOU on Intention to Use. Indeed, Pai and Huang (2011) confirmed that users’ behavioral Intention to Use healthcare information systems is impacted by PU. Study confirmed by Holden et al. (2010) who found that the relationship was significant for health IT use, suggesting that to promote use and acceptance of health IT solution individuals must perceived it as useful. Papa, Mital, Pisano and Del Giudice (2018) confirmed the PU and PEOU effects on the Intention to Use healthcare smart wearable in India. MacVaugh and Schiavone (2010) discuss three levels of technology adoption: micro level or behavior of single user, meso level or behavior of community, and macro level or features of industry. Individual adoption depends on the extent to which new technology meets the significant technological, social, and/or learning conditions encouraging its adoption i.e. it is easy to adopt; and the extent to which new technology is considered useful in the individual domain, community domain and/or industry/market domain; i.e. it is useful (MacVaugh, Schiavone, 2010). Finally, Moores (2012) discussed PU as the dominant factor of acceptance, because information system should provide the expected features to support users. Thus, our findings confirmed the strong impact of PU on Intention to Use a Telemedicine cabin. Nevertheless, most of the studies also highlighted the effect of PEOU on technology acceptance and our result is unexpected. Indeed, the impact of PEOU on ITU is not direct and significant therefore the hypothesis is rejected. Usually, PEOU is a strong predictor of Intention to Use (Pai, Huang, 2011). Nevertheless, Holden et al. (2010) found that the relationship between PEOU and Intention to Use was significant in only seven of thirteen tests performed. One of the explanation of weak effect of PEOU suggests the dependence of this construct to the users’ experience with IT (Chismar, Wiley-Patton, 2002; Barker, van Schaik, Simpson, Corbett, 2003), time and practice with technologies (Wu et al., 2008; Han, Mustonen, Seppänen, Kallio, 2005). Moores (2012), as well, discussed the moderating effect of experience on PEOU. The respondent’s profile, high educated students, could explained the reason why PEOU was rejected. Findings highlight the strong impact of Perceived Personalization on Trusting Beliefs. So, the fact that patients consider that physicians, even remotely, could understand and answer their needs as a direct impact on Trusting Beliefs. Indeed, this perception of personalization services (McKnight et al. 2002) will directly impact the beliefs of Benevolence (Act in the interest of the patient), Integrity (Be honest and sincere) and Competence (Is an expert, good knowledge). Guo et al. (2015), by analyzing the privacy–personalization paradox in the acceptance of mHealth services, found the role of Trust as a mediator of the relationship between Perceived Personalization and Privacy concerns on behavior intention. Thus, Perceived Personalization would influence consumer behavior intention through Trust, indicating that Trust can balance the Personalization paradox. Moreover, effects of Personalization on Trust are stronger for young people (Guo et al., 2015), that is highly in line with our research, where the respondents are students. On the other hand, the impact of Trusting Beliefs dimensions on ITU was partially supported. Benevolence and Integrity as Trusting Beliefs shown no effect on Intention to Use Telemedicine. Other studies reported similar results. Egea and Gonzalez (2011) argued the weak prediction effect of Trust for Intention to Use. The absence of significant effects of institutional Trust on Intention to Use is consistent with Suh and Han’s (2003) work, where Trust was more strongly related to Attitude than to Intention to Use online services. Therefore, the key concern of young patients is the belief of Competence as this dimension will be critical for the adoption of the Telemedicine cabin.
CONCLUSION AND LIMITS

The findings of the research are contributing in both – theory and practice. First, the Trusting Belief impacts, considered as a multidimensional concept, depends on technology. Thus, all dimension of Trusting Belief must be studied separately. Second, our research question aimed to examine the impact of Perceived Personalisation on Trusting Beliefs, as far as we know not studied in the past, and our findings confirmed this impact. Third, our findings argued that PEOU do not impact Intention to Use a Telemedicine cabin. The acceptance of Telemedicine in general and particularly the medical cabins is critical for French Hospital public reform as such equipment could help individuals to access to a physician or a medical specialist including in medical desert areas (Simon, 2016). Teleconsultation could have a huge impact on the urgency department of the hospital by reducing the number of people waiting for a doctor and could reduce some medical expenses such as ambulance transportations for patients (Stowe and Harding, 2010) and travelling cost for clinicians (Krupinski et al., 2004). This is the reason why the French government has decided to reimburse the cost when using the telemedicine cabin.

To allow a large diffusion of these eHealth services, it is necessary to develop an appropriate design and content of these services: the services must be understandable by health professionals and private users; relevant and trustworthy to reach a wide variety of users regardless their age, ethnicity, educational attainment and socioeconomic status; adapted with the day-to-day life; and respectful of the feelings of Privacy Concern and Benevolence Belief. Thus, Healthcare professionals should promote the benefits of such cabin to targeted population explaining how usefulness and straightforward to use it is. Companies should capitalize on the growing interest of e-health. Even if this study makes significant contributions to the question of Telemedicine adoption and use, there are several limitations that give us further opportunities to research. There are several factors not discussed that may influence Intention to Use Telemedicine, for example, (a) Perceived Risks and Privacy concerns, because both are related to Trust when using Telemedicine cabin; (b) Self-Efficacy and Personal Innovativeness, additional variables explaining paradox of Personalization. In addition, only several business schools were selected as samples to develop and test the model. We could extend the study to other types of school (Universities, Engineering school…). In addition, future research can test the model on other population, for example digital immigrants.
REFERENCE


DAVIS, F. D. (1985), A technology acceptance model for empirically testing new end-user information systems: Theory and results (Doctoral dissertation, Massachusetts Institute of Technology).


FISHBEIN M. & AJZEN, I. (1975), Belief, attitude, intention, and behavior: An introduction to theory and research. Addison-Wesley, Boston


APPENDIX

<table>
<thead>
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<th>Cronbach's Alpha</th>
<th>Composite Reliability</th>
<th>AVE</th>
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*Table A.1-

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<th>INT</th>
<th>ITU</th>
<th>PEOU</th>
<th>PP</th>
<th>PU</th>
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*Table A.2-*