

***The Meaning of Patient Satisfaction:
Re-assessing a Qualitative
Psychological Research Methodology***

***A thesis submitted to the University of Sheffield in partial fulfilment of the
requirements of the degree of Doctor of Philosophy***

By

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June 2002

Acknowledgements

This study could not have been written without the considerable help and support of many people. Firstly, thanks must go to all the participants who generously agreed to take part in this research. Without their time and co-operation this study would not exist. I can only express my deepest gratitude to my supervisors Professor Paula Nicolson and Dr Jennifer Burr for their unfailing support over the span of the study, not only in practical terms, but also in constant encouragement and for having faith in me. I would also like to thank many friends, particularly Sue Ward, Caroline O’Keeffe, Alan Brennan and Daniel Hind. Their constant encouragement and support spurred me on and kept me going. Also, a special thank you to Jane French whom I owe a great debt of gratitude. I am also grateful to Jenny Powell and Louise Hall offering their administrative and technical assistance. Finally I would like to thank Dave Collins, for his help, suggestions, enthusiasm and love.

‘The function of research is not necessarily to map and conquer the world but to sophisticate the beholding of it.’

(Stake, 1995:43)

Abstract

In a move towards a more informed understanding of the concept of satisfaction, this study aims to explore how thirty dermatology patients describe what it means to be satisfied with their healthcare. This was undertaken by adopting a qualitative research approach, using an in-depth semi-structured interview methodology. It was conducted within the context of a randomised controlled trial of telemedicine in dermatology (RCT). A secondary aim was to evaluate the extent to which the methodological approach of the study (interpretative phenomenological analysis) was successful in eliciting such descriptions. The findings reveal patient satisfaction as being a complex and fluid construct underpinned by a range of values, beliefs, attitudes and experiences. Individual participant descriptions of satisfaction emphasise the importance of 1) receiving a diagnosis treatment and cure, 2) minimum waiting time for appointments and treatment 3) the need to receive adequate information and explanations 4) receiving individualised personal care and 5) the need for participants to feel as though they were being taken seriously and 6) the importance of practitioner characteristics/good communication. Perhaps the most significant observation was the sequential nature of satisfaction, which was defined, redefined and re-evaluated by participants throughout the interview process. This study also identified a continuum of satisfaction across patients' definitions of being 'satisfied' as opposed to 'very satisfied' with healthcare. The method of data analysis (interpretative phenomenological analysis-IPA) was a useful approach to guide the analysis identifying and exploring themes relevant to eliciting the meaning of satisfaction. However, limitations to this methodology were apparent

over the course of the study, and alternative methodology, *contextualised interpretative phenomenological analysis* has been postulated. It is suggested that the journey for a definitive notion of patient satisfaction, can only be meaningfully directed by accepting some form of refinement of phenomenological methods as a means of adding sophistication to existing quantitative studies.

List of Publications arising from this study

Collins K, Nicolson P, & Bowns I (2000), Patient Satisfaction in Telemedicine, *Health Informatics Journal*, vol. 6 ,no.2, pp. 81-85.

Collins K, Nicolson P, Bowns I, Walters S. (2000), General Practitioners Perceptions of Telemedicine in Dermatology. *Journal of Telemedicine & Telecare*, vol. 6, no.1, pp.50-53.

Collins K, & Nicolson P (2002), The Meaning of Patient Satisfaction: Re-assessing Qualitative Approaches in Health Psychology. *Journal of Health Psychology*, vol.7, no.5, pp. 615-629.

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PREFACE

My interest in researching patient satisfaction arose both from a professional background as a former nurse, and from consolidated experiences as a health researcher. As a nurse I was aware of research findings which suggested high levels of patient satisfaction within the National Health Service, but was sceptical of such findings and, at a purely intuitive level, not convinced that 'all was well' [from the patients perspective]. Informal personal accounts and experiences that I received from patients often incorporated both elements of satisfaction and dissatisfaction, but it was clear that these patients were unwilling to voice their overt 'dissatisfaction' at a more formal level.

More recently, working as a health services researcher, I began to become increasingly frustrated with what seemed to be uncritical acceptance, within the literature, of high patient satisfaction rates resulting from quantitative patient satisfaction surveys. Results such as '98% of patients reported being satisfied with their care' appeared meaningless, and to some extent misguided, in light of my previous experiences as a nurse, and although, I held the view that such results were able to establish generalised patterns of satisfaction, my hunch was that such data failed to acknowledge the complexities of patient experiences. As a result I began to question the usefulness of patient satisfaction surveys (Collins, 1999; Collins et al, 1997; 2000a; 2000b). From reviewing the patient satisfaction literature (as part of other research projects) it became increasingly evident, that although there was a vast amount of studies that had reported 'patient satisfaction', relatively few studies had attempted to define the term. Indeed, there appeared to an unspoken assumption of the existence of a universally

accepted notion or 'taken for granted' notion of patient satisfaction. This naturally led me to question whether or not researchers were accurately gauging patients experience of satisfaction; therefore, at the centre of this study I present the fundamental question: what does satisfaction actually 'mean' in terms of the subjective reality of the patient who experienced it?

Chapter 1: Introduction to the study

Despite the significant growth of patient satisfaction research over the last twenty years, a large number of studies have been subjected to a substantial degree of criticism, particularly relating to methodological and conceptual issues (e.g. Avis et al, 1997; Williams et al, 1998a; McIver & Meredith, 1998; Staniszevska & Ahmed, 1999; Baker, 2001). One of these is the lack of consensus regarding the nature and definition of patient satisfaction (Avis et al, 1997; Baker, 1997). Little attention has been given to understanding and elucidating the actual meaning of the term 'patient satisfaction.' As I pointed out in the preface to this study, there is an inherent and largely underlying assumption in the literature that patient satisfaction requires neither further clarification nor discussion (McIver & Meredith, 1998; Wilde et al, 1999). Furthermore, there is the uncritical acceptance that its 'essence' can be apprehended by purely quantitative methods, such as the patient satisfaction survey approach which has tended to dominate the satisfaction literature (Bowling, 1997; Staniszevska & Ahmed, 1999). Although it is evident that some quantitative surveys may incorporate multiple items that probe satisfaction with different aspects of healthcare (for example, Ware's Patient Satisfaction Questionnaire 1983), it remains unclear as to whether these measures adequately cover all the relevant aspects of satisfaction (Eriksen, 1995). Additionally, several authors (Coyle 1999a; Avis et al, 1997) have cast doubt on whether such an approach is able to accommodate the potential reported range of feelings, values and experiences deemed necessary for understanding the meaning of satisfaction. Indeed, Avis et al (1997) have questioned whether

quantitative methods are in fact only reflecting purely superficial views of patient satisfaction rather than gauging more meaningful and precise views of patients.

Thus one may question whether the quantitative approach is fundamentally flawed and misguided in its basic assumptions regarding the 'objective' measurability of satisfaction.

This study challenges such an assumption and takes a diametrically opposed, post-positivistic qualitative stance. Its primary aim is to explore, in an overtly phenomenological sense, subjective understandings regarding the meaning of satisfaction. A secondary aim is to evaluate the extent to which the methodological approach undertaken, (i.e. interpretative phenomenological analysis), is successful in eliciting these subjective meanings of satisfaction. By addressing these aims, the study will hopefully open up an alternative positioning, one which will not only be relevant to current healthcare settings, but also one which will identify new ways of understanding patient satisfaction. It will also be both practically and theoretically relevant, by contributing to the existing knowledge on patient satisfaction and by questioning the universally accepted or 'taken for granted' notions regarding the subject.

The study in context

The study was conducted within the context of a randomised controlled trial of telemedicine in dermatology (RCT) which was funded by the NHS R&D Health Technology Assessment Programme, a four-year project (commencing in 1998 and completed in 2002 (Bowns et al, in press). The aim of this project was to compare traditional outpatient consultation with the application of telemedicine

in order to obtain a specialist dermatological opinion. Telemedicine is broadly defined as ‘ the use of telecommunications technologies to provide medical information and services. The defining aspect of telemedicine is the use of electronic signals to transfer information from one site to another.’ (Perednia & Allen, 1995). There are various applications of telemedicine, the simplest being the telephone and facsimile. The application used within this trial was asynchronous or ‘store and forward’ telemedicine. Asynchronous telemedicine transmits still text and high resolution digital images to a health practitioner, who is able to look the images or text (in this case skin problems), in a similar way that one would look through e-mail, and return a message (in this case a diagnosis and management) to the referrer.

The objectives of the trial were to assess clinical equivalence of the accuracy of diagnosis between a traditional and telemedicine consultation, and undertake an economic analysis and compare patients’ and professionals’ opinions. This trial was conducted between a locality group of eight General Practices in Sheffield and a single teaching hospital in Sheffield that provided the local dermatology referral service. It comprised of new (referred with a new problem or not seen by the hospital dermatologist in the preceding 12 months), consenting adults (aged 16 and over) judged by the general practitioner to require a conventional outpatient consultation with an NHS hospital consultant dermatologist.

There were two reasons for patient exclusion from the study. Firstly, the nature of the dermatological problem. This related to anatomical sites e.g. genital lesions, a strong perception that palpation of the skin was crucial to diagnosis and

management, or the possibility that physical treatment was needed immediately. Other reasons for exclusion, unrelated to the skin problem, were mental illness or handicap, language barriers, patients who wished to consult privately, or patients who refused to consent. Patients were randomised by their GP into two groups which received a traditional specialist dermatological opinion through (a) a traditional outpatient consultation (the control group) or (b) an asynchronous telemedicine consultation (the telemedicine group).

As part of the trial, all patients were asked to complete a patient satisfaction questionnaire, and it was at this point that patients were invited to take part in the interviews carried out as part of this current study. Ethical approval for the trial was gained from the Local Research Ethics Committee.

The following chapter sets the scene for this study and provides an overview of the relevant literature on patient satisfaction.

Chapter 2: Overview of the patient satisfaction literature

Introduction

The following chapter aims to provide the background to this study and presents an overview of the current patient satisfaction literature outlining the historical development of the concept of patient satisfaction. It focuses specifically upon conceptual issues surrounding patient satisfaction and critically evaluates some of the problems and limitations within this area. In order to illustrate some of the difficulties in interpreting patient satisfaction studies, literature from patient satisfaction studies specifically carried out within telemedicine have been used. The concluding section draws together the findings from the review which subsequently provides a rationale and framework for this study.

Searching the literature

The literature was drawn from a variety of disciplines which included psychology, medicine, health services research, nursing, and sociology. It limited the search to include previous reviews of patient satisfaction, and papers that focused specifically upon conceptual issues of patient satisfaction research. In order to illustrate some of these issues, examples taken from the patient satisfaction in telemedicine literature are provided. The majority of papers identified emanated from either the United Kingdom or the USA. The following electronic databases were searched: MEDLINE 1966-2001, Social Science

Citation Index 1981-2001, Embase 1988-2001, CINAHL 1982-2001, PsycINFO 1967-2001, Telemedicine Information Exchange database 1995-2001 and The Cochrane Library 2001 Issue 3.

Use of terms

Before proceeding with the review clarification of the terms used within the study are provided. The term 'patient' is defined as 'people who are currently using or waiting for health services' (Barker et al, 1999: 80). However, there is no widely accepted definition of this term and there is an ongoing debate surrounding the appropriateness of particular terms to describe particular groups of people (see Blaxter, 1995; Consumers in NHS Research, 2000). Bastian (1994) concurs that:

There is no universal agreement about the words meant to specify the people who use, or are meant to be served by, health care...the debate is fuelled by the fact that this is not just an argument about words, but about the ways of seeing and portraying people and their relationships with the health care system. (Bastian, 1994: 8)

Given the awareness of such debates the term 'patient' was used interchangeably with 'user' and 'consumer.' The term 'satisfaction' was also found to be used interchangeably with terms such as 'views' 'opinions' 'attitudes' 'perceptions' and 'experiences.' However, because of the volume of review articles retrieved the search was limited to searching the term 'satisfaction' only.

Eliciting user views of health care

Patient satisfaction is one area falling under the broader umbrella group of ‘user views.’ Therefore, it is useful to identify the development of user views research before focussing down more specifically upon patient satisfaction.

Over the past thirty years, there has been a proliferation of interest among academic researchers, policy makers and health service professionals in incorporating the views of patients when formulating, monitoring and improving health policies, practices, and services (Sitzia & Wood, 1998a). Indeed successive UK Governments have continued to stress the importance of being responsive to the needs and views of the public and service users and it has become a major theme underpinning Health Policy in the UK today (NHS Management Inquiry 1983 ‘The Griffith Report’(DoH,1983); Working for Patients (DoH,1989); The Patient’s Charter, (DoH, 1991); NHS Management Executive’s Guidance Local Voices (NHSME, 1992); ‘The New NHS: Modern Dependable (NHS E, 1997); A First Class Service: Quality in the New NHS’ (DoH, 1998); Patient and Public Involvement in the NHS, (DoH, 1999). More recently, the NHS Plan has placed increasing emphasis on the importance of the quality of patient experience and responding to patients’ views of services. This document outlined the vision of a patient-centred NHS that would ‘offer a personalised service’ (DoH,2000:17) thereby giving patients and citizens a greater say within the NHS. Throughout this particular document the importance of eliciting (and responding) to patient views is continuously emphasized:

Patients are the most important people in the health service...The NHS has to be shaped around the convenience and concerns of patients...Patients must have more say in their own treatment and more influence over the way the NHS works. (DoH, 2000:88)

Although a variety of approaches have been employed in order to elicit patients' views of health care (see Beverley et al, 2001), the most frequently used means to eliciting user views has been through patient satisfaction surveys (Avis et al, 1995; Staniszewska & Ahmed, 1999; Coyle, 1999b). Indeed, Objective II of the Department of Health Public Service Agreement, as part of the NHS Plan, continues to emphasise the role of surveys in health care; it unequivocally aims to 'secure year-on-year improvements in patient satisfaction, including standards of cleanliness and food, as measured by independently audited local services.' (DoH, 2000:143)

The Historical Context of Patient Satisfaction

Studies of patient satisfaction with health care originated in the USA in the 1950s where survey research was the method of choice (Batchelor et al, 1994).

Throughout the next decade, several studies were carried out within the UK (Cartwright, 1964; 1967), however, it was not until later, the early 1980s, that patient satisfaction research began to gather momentum within the UK (Barnes, 1994). Since that time patient satisfaction surveys have gained widespread recognition as a measure of quality within the British National Health Service (Donabedian, 1966, 1992; Fitzpatrick, 1984; Williams et al, 1998b; Newsome & Wright, 1999; Crow et al, in press). Increasingly, trials of new interventions

include patient satisfaction as an important outcome measure (Sixma et al, 1998; O'Connell et al, 1999; Kelson, 1999; Baker, 2001), and patient satisfaction has also been related to issues such as patient health behaviour (Ware et al, 1978a; 1983; Pascoe, 1983; Rees Lewis, 1994), utilisation of care, continuity with the same provider and compliance (Larsen & Rootman, 1976; Ho et al, 1994; Fitzpatrick, 1984,1991;) and with therapeutic outcomes and health status (Rees Lewis, 1994). Patients are also more likely to follow medical advice and treatment instructions if they are satisfied (Hall et al, 1988), and perhaps unsurprisingly, dissatisfied patients are more likely to complain (Swan, 1992) and participate in negative word-of-mouth practices (Sirdeshmukh et al, 1991).

In addition to the factors outlined, over the past twenty years there has been a general shift towards a more consumerist ethos within the UK (Barnes, 1994; Bowling, 1997; Dougall, 2000). This emphasis on market ideology has helped to create a view, in government at least, that recipients of health services (as consumers) deserve the same level of choice, value for money and satisfaction as consumers within a business-focused setting (Merkouris et al, 1999; Dougall, 2000; Crow et al, in press; Boote et al, in press). Within such a consumerist model, health agencies seek information and guidance from their consumers through market –style surveys in order to improve their efficiency, economy and effectiveness. The patient becomes a consumer with legitimate rights and expectations (Barker et al, 1999). The publication of the 1983 NHS Management 'Griffiths Report' (DoH, 1983), which required health managers to carry out market research on patients views, was greatly influenced by such models.

Government Policy documents such as 'The Patients' Charter' (DoH, 1991) and the NHS Management Executive's Guidance document Local Voices (NHSME, 1992) can also be viewed as significant milestones in the development of patient satisfaction research. More recently, the NHS Plan, has laid out its vision to 'modernize, deepen and broaden the way that patient views are represented.' (DoH, 2000:93). Objective II of the Department of Health Public Service Agreement, as part of this plan has set out to 'secure year-on-year improvements in patient satisfaction' (DoH,2000:143), thus placing central importance on eliciting patient satisfaction.

Conceptual issues of patient satisfaction

Despite the number of studies on patient satisfaction, relatively few studies have attempted to define the term 'satisfaction' (Mahon,1996; Sitzia & Wood,1998a; McIver & Meredith 1998; Wilde et al,1999; Merkouris et al, 1999; Crow et al, in press). Indeed, as I have previously mentioned, there appears to be a universally accepted or 'taken for granted' notion of patient satisfaction. It is a concept that is frequently discussed as if it were unitary a single measure viewed as being adequate. The *meaning* of satisfaction itself is either disregarded or rarely asked:

It is rare to find the concept of patient satisfaction defined and there has been little clarification of what the term means either to researchers who employ it or respondents who respond to it (Locker & Dunt, 1978:283).

Fifteen years on from this quotation, McIver (1994) made the observation that little progress has been made in clarifying the concept. Indeed, this remains the case today.

Sitzia and Wood (1997) in their review of the 100 papers published in the field of patient satisfaction problematise this issue:

The lack of attention to the meaning of the construct 'patient satisfaction' has been the greatest single flaw in patient satisfaction research (Sitzia & Wood, 1997:1832).

Formulating a definition of patient satisfaction

The term satisfaction comes from the Latin *satis*, meaning 'enough'; dictionary definitions of satisfaction present the concept of satisfaction as the need to meet needs and wants. The Oxford English Dictionary defines satisfaction in the following manner;

Satisfaction (n): thing that satisfies desire or gratifies feeling. **Satisfactory (a):** satisfying expectations or needs; leaving no room for complaint; adequate

Satisfy (v): fulfil expectations or desires, be adequate; content, please adequately fulfil or deal with expectation; giving what is required.

Crow et al (in press) raise two points about these dictionary definitions. Firstly, feeling satisfied with a service does not necessarily mean that the patient is

overly pleased about it, rather than an adequate or acceptable standard has been achieved. Secondly, in such definitions satisfaction is viewed as being related to individuals' expectations, needs or desires.

Satisfaction and expectations

A number of authors have placed *expectation* as central to understanding and determining satisfaction. This is based upon the 'expectations disconfirmation model' of satisfaction (Swan, 1992). This model focuses on whether perceived performance is viewed as falling below, equals or exceeds prior expectations. For example, as perceived performance increases relative to expectations (*positive disconfirmation*) satisfaction increases. However, when performance falls short of expectations dissatisfaction occurs (*negative disconfirmation*). Thus, the higher one's expectations, the greater the likelihood of negative disconfirmation (or dissatisfaction) due to the increasing inability of performance to match expectations. Such an approach is viewed as an attitude, or a feeling, determined by a patient's cognitive belief, or their perceptions and affective evaluations of health care attributes (Linder-Pelz, 1982). Thus, taking this approach satisfaction has been defined as a 'summary psychological state resulting when emotion surrounding disconfirmed expectations is coupled with the subject's prior feelings about the experience under consideration.' (Oliver, 1980:462). Such an approach has underpinned and been supported in a number of studies on satisfaction (Abramowitz et al, 1987; Linder-Pelz, 1982; Williams, 1994; Stimson and Webb, 1975; Larsen & Routman, 1976; Locker & Dunt, 1978; Fitzpatrick & Hopkins, 1983; Donabedian, 1992; Kravitz, 1996). However, some studies have reported conceptual difficulties with the approach. For example,

several studies have reported that patients' expectations have only an indirect effect on levels of satisfaction, and that patients report being satisfied even when their expectations have not been met (Linder-Pelz, 1982; Brody et al, 1989).

Additionally, other studies have suggested that patients' expectations of using services are not fixed until their episode of care is completed (Fitzpatrick & Hopkins, 1983).

Some authors have been more tentative in suggesting a relationship between satisfaction and expectation. Whilst they acknowledge a relationship, it has been suggested as being complex (Linder-Pelz, 1982; Ware et al, 1983; Pascoe, 1983; Haas, 1999; Crow et al, in press). For example, Linder-Pelz (1982) reported expectations accounted for only 8% of the variance in satisfaction and suggested that the patients' background beliefs played a more significant role in determining their satisfaction with care than their perceptions of care received. This author proposed five social-psychological variables as probable determinants of satisfaction: -

- occurrences- the individuals perception of an event that occurred.
- value-evaluation-the individuals views of an attribute, or an aspect of health care encounter, in terms of it being either good or bad.
- expectations- the individuals beliefs about the probability of certain attributes being associated with an event, and the perceived probable outcome of that association.

- interpersonal comparisons- the individual's rating of the health care encounter in comparison with all such encounters known to or experienced by him/her.
- entitlement- the individual's belief that s/he has proper, accepted grounds for seeking or claiming a particular outcome.

Critical factors influencing satisfaction

A number of studies have attempted to explain the concept of satisfaction by identifying critical factors, which make up satisfaction. Such factors are based on reviews of the available literature, which then form the basis for the development of instruments to measure satisfaction (Crow et al, in press).

For example, Ware and his colleagues (Ware et al, 1983; Ware & Hays, 1988; Davies & Ware, 1991) developed a taxonomy of satisfaction which was the result of a content analysis of items included in published patient satisfaction questionnaires and patient responses to open-ended questions posed to identify satisfaction. The analysis resulted in the identification of eight dimensions thought to determine satisfaction. These were:

1. accessibility and availability of services and providers
2. choice and continuity
3. communication
4. financial arrangements
5. interpersonal aspects of care

6. outcomes of care
7. technical quality of care
8. time spent with physicians.

Such dimensions were later developed into an instrument to measure satisfaction which then conceptualised satisfaction as being a 'rating or evaluation of health care services or health care providers (Ware et al, 1983). Pascoe (1983) provided a similar definition and defined satisfaction as, 'the health care recipients' reaction to salient aspects of the context, process and result of their experience to a subjective standard' (Pascoe, 1983: 189). Such definitions, Edwards and Staniszewska (2000) argue, hint at the personal nature of patients' own responses to healthcare.

A review of satisfaction studies undertaken from 1957 to 1974 (Risser, 1975) reported four components of satisfaction: cost and convenience, providers' personal qualities and the nature of the interpersonal relationship, and the providers' professional competence and perceived quality of care received. In a later review, Rubin (1990) listed six important components of satisfaction: nursing care, medical care, communication, ward management, ward environment and discharge procedures.

A meta analysis of 230 UK surveys on patient satisfaction undertaken in 1989 (Dixon and Carr-Hill, 1989) identified ten attributes which were most frequently used to measure patient satisfaction. These included the overall quality of care,

technical competence, outcome, facilities, humanness, continuity of care, access, informativeness, cost, bureaucracy and attention to psychosocial problems.

More recently, a systematic review of patient satisfaction (Crow et al, in press) outlined three broad areas that were most frequently associated with satisfaction. These being (1) the characteristics of the health provider (such as personality, knowledge, technical skills, caring approach) (Ware et al, 1983; Pascoe, 1983; Fitzpatrick, 1984; Rubin, 1990; Sitzia & Wood, 1998a; Crow et al, in press), (2) the features of the patient-practitioner relationship (such as information exchange, patient involvement, shared decision making, patient centred approach) (Korsch et al, 1968; Abramowitz et al, 1987; Dixon and Carr-Hill, 1989; Rubin, 1990; Hall & Dorman, 1990; Bruster et al, 1994; Ong et al, 1995; Charles et al, 1997; Williams et al, 1998a; Williams et al, 1998b; Salmon et al, 1999; Rivadeneyra et al, 2000; Mead & Bower, 2000) and, (3) factors relating to the structure and setting of the health care delivery (such as accessibility, waiting and choice) (Sitzia & Wood, 1998a; Crow et al, in press; Steven et al, 1999; Coyle & Williams, 2000).

In summary, a number of factors have been postulated as being important factors that underlie patient satisfaction. However, this does not advance our understanding of the concept itself.

Personal characteristics as determinants of satisfaction

A number of determinants relating to the personal characteristics of the patient was identified within the literature. These personal characteristics included age, ethnicity, health status, gender, socio-economic and psychological status.

Age

Several authors (Fitzpatrick, 1991; Hall & Dorman, 1990; Locker & Dunt, 1978; Pascoe, 1983; Cornwell, 1989; Hopton et al, 1993; Kolodinsky, 1995; Cohen, 1996; Gross et al 1998; Steven et al 1999) have reported that older patients tend to report being more satisfied than younger patients. This was also evidenced in a recent systematic review of patient satisfaction (Crow et al, in press).

Additionally Ross et al (1995) found that the older, less well educated and in poorer health more likely to be highly acquiescent (i.e. the tendency to agree with statements regardless of content). Hall & Dorman (1990) found that doctors' social behaviours and technical competence were deemed to be the most significant in actually predicting older patient's satisfaction.

Ethnicity

There are few studies which concentrate on ethnicity and satisfaction, and in fact, little is known as to whether ethnicity is a relevant factor in satisfaction research. Instead, studies have tended to focus upon ethnic minorities and psychiatric services. Callan and Littlewood (1998) found ethnicity to be an insignificant factor when predicting satisfaction with psychiatric patients. Another study

(Auslander et al, 1997) reported that mothers who reported greater perceptions of racism and family stress were significantly less satisfied with their children's medical care than those from less stressful environments.

Health status

The relationship between health status and patient satisfaction has also appeared to be a significant factor in predicting patient satisfaction (Cleary & McNeil, 1988; Hall & Dorman, 1990; Gross et al, 1998). Patients with poorer health status are more likely to be dissatisfied than those with better health status (Linn & Greenfield, 1982; Hall & Dorman, 1990; Rubin 1990; Cohen 1996; Patrick et al 1983). Although a recent systematic review of the patient satisfaction literature confirmed these findings, current knowledge about how health status affects satisfaction is inadequate.

Gender

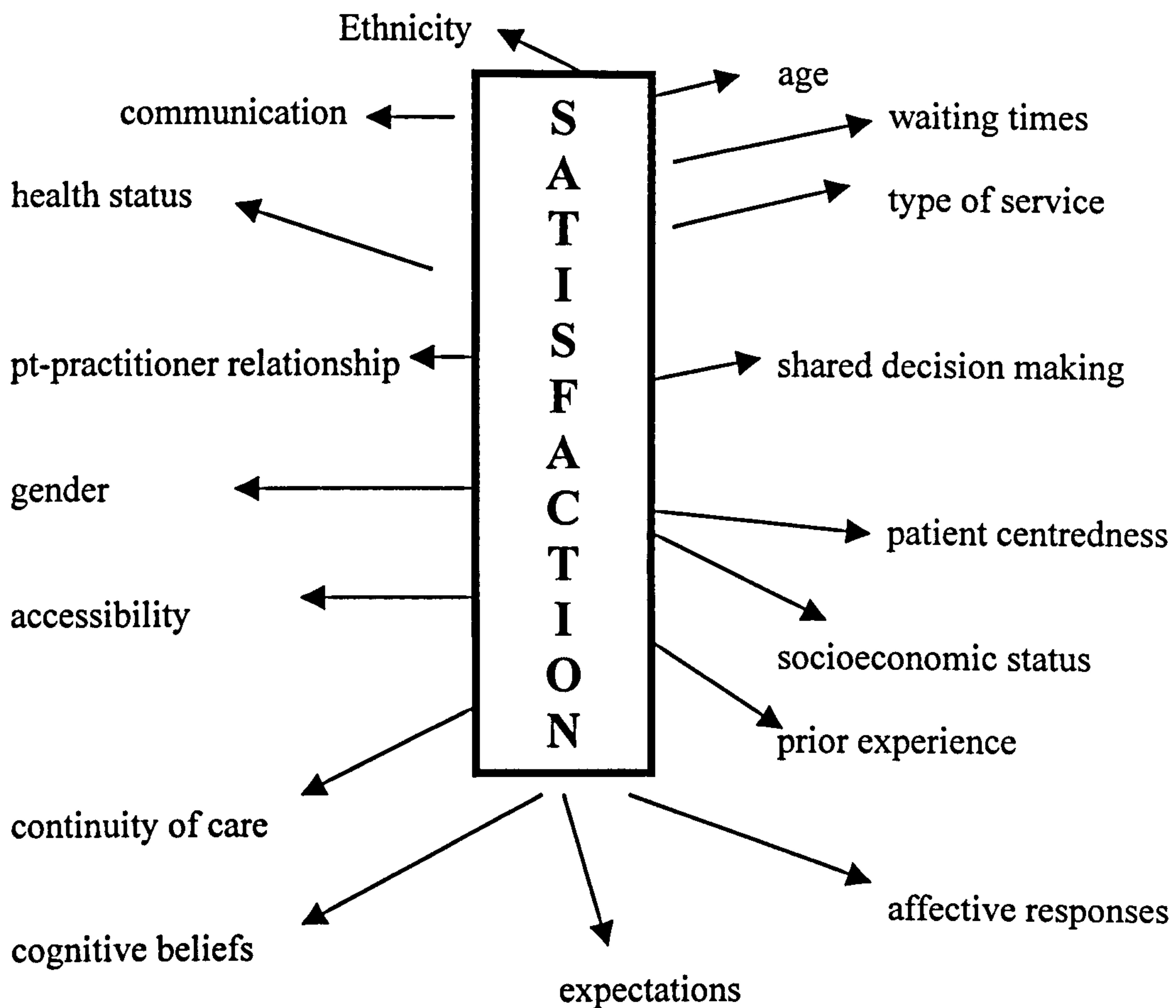
As with ethnicity and health status, the relationship between gender and patient satisfaction is difficult to interpret. Some studies have found gender to be influential in predicting satisfaction levels, with female patients tending to be more satisfied than their male counterparts (Pascoe, 1983; Williams & Calnan, 1991a; Fox & Storms, 1981). However others (Mangelsdorff, 1979; Khayat & Salter 1994) have reported men as being significantly more likely to be satisfied than women. Yet other studies have found no correlation between gender and satisfaction (Hopton et al, 1993; Kenny, 1995; Hall & Dorman, 1990).

Socio-economic status

In their study of general practice patients, Khayat and Salter (1994) found that higher social classes were significantly more satisfied than patients of lower social classes. Cohen (1996) noted that social class was associated with feeling patronised or ignored by doctors. Educational achievement has also been identified as a characteristic of satisfaction, the trend being that greater satisfaction is associated with lower levels of education (Hall & Dorman, 1990; Schutz et al, 1994). However, Kolodinsky (1995) indicated that decreased income was associated with increased satisfaction. Thus, any findings about the relationship between socio-economic status and satisfaction remain inconclusive.

From the above, it can be suggested that satisfaction has been linked to a number of factors . This is illustrated in Figure 1. However, although such findings may be useful in order to predict patient satisfaction, it offers no useful way forward in understanding the subjective *meaning* of the concept itself.

Figure 1: Overview of some of the factors linked to patient satisfaction



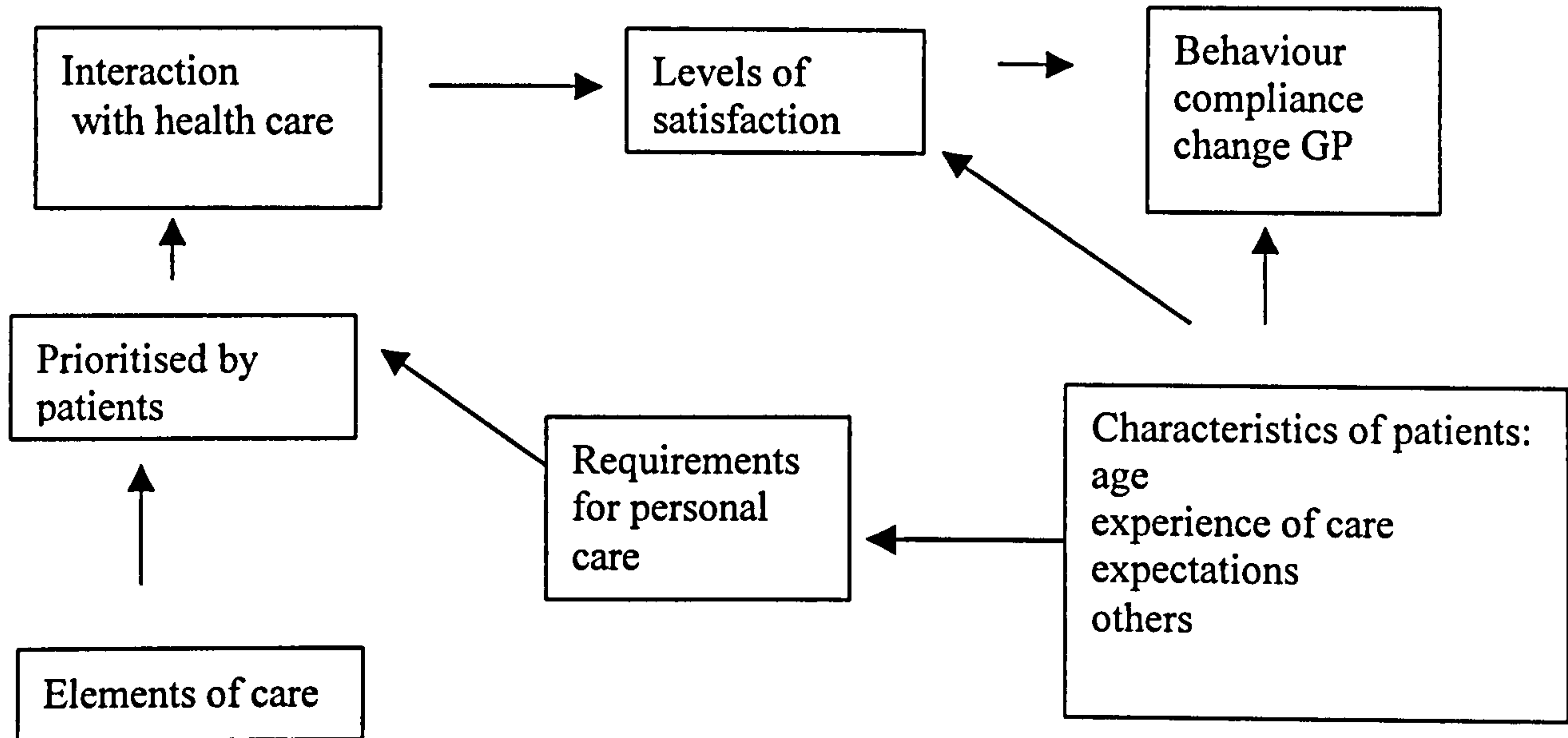
Patient satisfaction as multi-dimensional

Some studies have suggested that there is, in fact, no single model or comparison process with which to fully explain all patient satisfaction; rather the concept of satisfaction includes multiple *processes* and standards of comparison such as beliefs, expectations and experiences (Erevelles & Leavitt, 1992; Cleary & McNeil, 1988; Mahon, 1996). This multifaceted approach to understanding satisfaction attempts to incorporate as many possible influences on satisfaction and provides a framework for exploring interactions between variables. Through

these interactions it is suggested that further understanding of the factors affecting satisfaction might be gained (Crow et al, in press). For example, Baker (1997) developed what he terms a 'pragmatic' model of satisfaction (see Figure 2). The model is pragmatic since it links together available evidence about patient satisfaction without recourse to more general social or psychological theories of behaviour, other than to define satisfaction as an attitude. Baker defines 'attitude' as an evaluative judgment (or reaction to care received) and, as with other attitudes, it is learned from experience. An attitude, Baker suggests, is relatively enduring in comparison to emotional states and exerts some influence on behaviour.

Bakers' model regards satisfaction as multi-dimensional, with different elements of care causing differences in satisfaction. For example, a patient may be satisfied with one element of care but dissatisfied with another. Thus the measure of overall satisfaction will be a summary of the competing evaluations of the patient and may not be sensitive to differences in levels of satisfaction with individual elements of care. Furthermore, in different settings, different elements of care may be more or less important. The model suggests that patient characteristics may in fact influence the patient's attitudes to care, and also the importance they assign to different elements of care; patient characteristics may influence the priorities they assign to different elements of care, and their attitude or level of satisfaction following an interaction with the health care system. Furthermore, this pragmatic model proposes that satisfaction can influence a patient's future behaviour, such as their compliance with advice or whether they change doctors.

Figure 2: Baker's pragmatic model of patient satisfaction



As indicated previously, while these models attempt to develop an understanding the complexity of satisfaction by exploring how variables relate to satisfaction, the meaning of satisfaction is not illuminated. Thus, the theoretical foundations on which the concept of satisfaction and its measurement are based are arguably disregarded (Sitia & Wood, 1997).

Problems and limitations with the satisfaction research literature

Most patient satisfaction surveys have tended to typically report high-undifferentiated levels of patient satisfaction, with very few expressing dissatisfaction (Locker & Dunt, 1978; Abramowitz et al, 1987; Wilkin et al, 1992; Hopton et al, 1993). Hall and Dornan's (1990) meta-analysis of satisfaction found average satisfaction levels to be 76% across more than 200 studies, and Fitzpatrick (1991) identified that at least 80% of respondents express

satisfaction for any given question. This figure increases to over 90% in general practices (Khayat & Salter, 1994). Indeed, within patient satisfaction studies in telemedicine, 80%-100% of patients across studies indicate they are satisfied with telemedicine (Williams et al, 2000). Typically, satisfaction ratings are reported, as 'patients with at least a high school education were 100% satisfied with telemedicine' or 'patients who received a medical consultation were 100% satisfied with Telemedicine' (Chae et al, 2001).

However, how meaningful and useful is this information? Are we to take it that the service was perfect? In the above study there is no discussion as to why such high levels of satisfaction had been reported. This is typical of many of the satisfaction studies that have been undertaken in telemedicine. Such consistently reported high satisfaction levels are of little use when directions of improvement in care or management are sought or when attempting to detect small but potentially important differences in satisfaction (Hudak & Wright, 2000). Indeed, such surveys fail to address what it was patients liked or disliked about a service and why. Hence the underlying reasons for dissatisfaction or satisfaction remain unclear.

Thus it may be argued that such high satisfaction levels are actually only reflecting purely superficial views of patient satisfaction rather than gauging more meaningful and precise views of patients (Avis et al, 1997). Additionally, the limited variability in such results raises questions about the validity of this method to survey patient opinion (Carr-Hill, 1992). Other authors (Wensing et al, 1994; Carr -Hill, 1992; William & Calnan, 1991b; Bruster et al, 1994) have

highlighted how the types of question and scales used can also affect the degree of satisfaction or dissatisfaction expressed by patients, a finding which is rarely discussed in papers reporting satisfaction. Consistently high satisfaction levels has also been explained in terms of the tendency for patients to report greater satisfaction than s/he actually feels, because s/he believes positive comments are more acceptable. In other words, a 'social desirability response bias.' Strong attachment too, or loyalty towards the NHS has often been cited as an alternative explanation (Sirdeshmukh et al, 1991). Additionally, patients are also aware of their dependency on the service and may, as a result, be reluctant to say the wrong thing or complain for fear of unfavourable treatment in the future (Raphael, 1969; Owens & Batchelor, 1996). They may also feel gratitude for receiving care and treatment (Sheppard, 1994; Sitzia & Wood, 1998a) and fear being labelled a nuisance, a neurotic or unpopular (Mulcahy & Tritter, 1998). Finally, acquiescence bias the 'tendency to agree with statements of opinion regardless of content' (Ware, 1978) is a problem in satisfaction research; for example in Ware's study (1978), 40-60% of respondents manifested some degree of acquiescence with 2-10% demonstrating noteworthy tendencies.

Measuring patient satisfaction

Satisfaction (and user views more generally) in health care has been characterised by a range of different approaches and methods (Sitzia & Wood, 1997; Duff & Lamping, 2000; Chan, 2000; Barker et al, 1999; Beverely et al, 2001; Crow et al, in press), but it remains the case that the predominant method in patient satisfaction studies is the quantitative, structured standardised patient satisfaction survey approach (McIver & Meredith, 1998; Bowling, 1997;

Merkouris et al, 1999). These have tended to be one-off management driven self-completion patient satisfaction questionnaires (Avis et al, 1995). An analysis of 195 papers published in 1994 (Sitzia, 1999) found that, with few exceptions study instruments demonstrated little evidence of reliability or validity. Moreover, the authors reported, that study authors exhibited a poor understanding of the importance of these properties in the assessment of satisfaction. Taking one area, patient satisfaction studies in telemedicine, such problems are demonstrated. Most of these studies used survey approaches to measure satisfaction. These surveys having being developed by the authors themselves for the purpose of the study. Additionally, in most cases, there is no discussion raised about the validity and standardization of measures used (May et al, 2000).

It is evident that few studies have incorporated a qualitative element to their work. Williams et al (2000) found that of the 65 studies included in their review of satisfaction studies in telemedicine only 17% (n= 10) incorporated at least some qualitative element. Similarly, another recent review (Mair & Whitten, 2000) identified 32 studies (published between 1966 and 1998), of which twenty-six studies used simple survey instruments, one was a randomised controlled trial, five did not specify the exact methods and only one used qualitative methods.

Commentary

Arguably, the predominance of such surveys implies that some ‘objective’ measurement of the term can be applied; such measures reduce satisfaction into component parts and as a result negate individual subjective experience.

Furthermore, it is questionable whether all domains pertinent and meaningful to each respondent are included within a patient satisfaction survey (Bowling, 1997). Neither is there any discussion whether such surveys are able to accommodate the range of feelings, values and experiences of patients (Coyle 1997,1999a; Avis et al, 1997). Edwards and Staniszewska (2000) go much further proposing that it is unlikely that such surveys are providing us even with ‘a reasonable reflection of users’ experiences of health care.’[418], and argue that such methods are:

to some extent reductionist, working with implicit assumptions that we know what we want to measure, and that we are able to measure it. (Edwards & Staniszewska, 2000:418)

The positivistic approach of many of the patient satisfaction surveys, assumes that the inquirer unquestioningly implies the most relevant variables/factors and how they can be measured. In an epistemologically sense this contrasts with a qualitative methodology which allows respondents more freedom to express subjective personal opinions and viewpoints (Bowling, 1997).

Williams et al (1998a) argue that:

If the underlying policy purpose of satisfaction surveys is to provide patients with a voice in the assessment and continuing development of services then it is not adequate to utilise satisfaction survey results. Effort must be put into designing methods of accessing patients' experiences of service and the meaning and value they attach to them, whether these are positive or negative and whether they can be improved. (Williams et al, 1998a: 1358)

Williams (1994) argues that 'patients have a complex set of beliefs about satisfaction that are not easily embodied in descriptive statistics,' and, 'the reductionism necessitated by a quantitative survey may result in diverse opinions being collapsed into a single category of users all of whom expressed satisfaction.' [514]

To further complicate this matter, several qualitative studies have reported the incongruity between patient responses when standardised patient satisfaction measures have been used to elicit health experiences compared with findings elicited from in-depth interviews (for example, Raftery & Zarb, 1990; Bruster et al, 1994; Williams et al, 1998a; Dougall et al, 2000). Such studies identify that although high levels of satisfaction were being expressed on standardised patient satisfaction surveys, in-depth interviews were indicating negative experiences and perceptions that were not being reflected on the questionnaires. On the basis of this, Dougall et al (2000) argued that standardised patient satisfaction measures alone are inadequate indicators of patients' experiences in health care.

A further difficulty with the measurement of patient satisfaction, regardless of which approach is taken, is that satisfaction is usually measured at the end of a treatment, and dissatisfied patients are more likely to withdraw from the treatment before completion (Hudak & Wright, 2000); as a result they are underrepresented in a sample of respondents. This bias towards representation of individuals who have completed treatment in studies may yield high satisfaction scores that can be misleading.

Many patient satisfaction studies also fail to discuss issues relating to response rates, non responders, accuracy of patient recall and positive response bias (Cartwright, 1964; Locker & Dunt, 1978; French, 1981; Sitzia & Wood 1998b). Again, taking patient satisfaction studies in telemedicine as an example, a recent review (Mair & Whitten, 2000) reported that response rates were generally low in telemedicine studies and that patient selection criteria were frequently not specified. Similarly, another review (Williams et al, 2000) reported that of the sixty five telemedicine patient satisfaction studies reviewed, non response rates ranged from 0% to as high as 65% with the average being around 24%. Thus, it is unclear whether responders to questionnaires differed in any way to the non-responders. One is left to guess as to whether non-responders were more or less satisfied than the responders. Such methodological problems, question the generalisability of the findings, and leave any firm conclusions about the acceptability and satisfaction of telemedicine to patients in question (Collins et al, 2000b; Mair & Whitten, 2000; Williams et al, 2000). May et al (2000), in their summing up of patient satisfaction in telemedicine, conclude that:

Telemedicine has focused on patient and professional 'satisfaction' as a quantifiable index...satisfaction and 'acceptability' are complex phenomena that need to be considered in the context of the particular clinical and psychosocial ecologies in which they are apprehended and expressed. (May et al, 2000:20)

Therefore it is apparent from this review of the literature that, although studies of satisfaction frequently suggest high satisfaction levels, there is substantial evidence of both conceptual and methodological problems with patient satisfaction research. As a result, firm conclusions about satisfaction cannot be reached.

Conclusion

This chapter has provided an overview of the current literature in patient satisfaction research and has focused specifically upon the conceptual issues of patient satisfaction. It has highlighted several approaches which have attempted to explain the factors underlying satisfaction with health care (ranging from studies that investigate how factors co-vary, to more detailed theoretical models that attempt to explain the relationship between variables). However, such approaches have not advanced an understanding of the concept of satisfaction itself and the heavy reliance upon quantitative approaches has supporting the view that satisfaction is an 'objective' and measurable concept. There exists an inherent essentialist stance in the literature which regards satisfaction as a common construct (Bowling, 1997; McIver & Meredith, 1998; Wilde et al, 1999). However, to date, it is evident that there is no one clear, unambiguous

definition or explanation of patient satisfaction, with a remaining lack of consensus within the research literature (Mahon, 1996; Bowling, 1997; Sitzia & Wood, 1997; Williams et al, 1998a; Newsome & Wright, 1999). Crow et al (in press) conclude that:

A complete definitive conceptualization of satisfaction with health care remains to be established, and [that] our understanding of the process by which a user becomes satisfied or dissatisfied is incomplete. (Crow et al, in press)

To reiterate Linder-Pelz, we need 'to understand the concept of satisfaction before we can really explain why certain factors cause it and others are caused by it. (Linder-Pelz,1982:584). Avoiding this issue has arguably impeded measurement efforts, and raises issues in any interpretation of patient satisfaction results (Avis et al, 1997; Baker, 1997).

Thus, in order to tilt the balance away from the predominantly quantitative stance embedded in most of the studies and to 'give priority to the patient's agenda, rather than to medicalised definitions of satisfaction' (Mair et al, 2000:36), this study adopts a phenomenological approach to explore the ways in which patients describe the concept of 'satisfaction.' The theoretical and philosophical underpinnings of this approach will be discussed in the following chapter.

Chapter 3: Formulating an Appropriate Methodological Framework

Introduction

As I indicated in the previous chapter, many studies on patient satisfaction remain problematic due to the elusive and inadequately defined concept of 'satisfaction'; they have either tended to disregard, or have rarely asked, patients for their subjective understandings of satisfaction. In other words, this concept has been accepted uncritically. I argue that in order to gain a fuller and more 'human' insight into patients' understandings of satisfaction, it is essential to adopt a phenomenological mode of inquiry, an approach which works towards exploration of the 'participant's view of the world' (Smith, 1996:264) and rejects the view that all perceive the same underlying reality (Hinchliff, 2001). This chapter outlines the theoretical underpinnings of the study, followed by a description of the method of data analysis used.

The suitability of a qualitative approach

A dominant approach to understanding the social sciences has been 'the scientific method.' The principle of this approach emphasizes universal laws of cause and effect based on an explanatory framework which assumes a realist ontology; that is, that reality consists of a world of objectively defined facts.' (Henwood & Pigeon, 1992: 98). Such an objectivist, realist, positivistic and 'received' view of the world has dominated the physical and social sciences for the past four hundred years (Guba & Lincoln, 1994). Within satisfaction research

the predominant method of enquiry has been through the adoption of such an approach, embodied in attempts to measure and predict satisfaction by working with a subset of variables.

This study is primarily concerned with pursuing *subjective* meaning and understanding rather than establishing abstract universal laws. Thus, as Henwood and Pigeon point out, in order not to ‘overwrite internal structured subjectivities with an a priori systems of meaning’ (Henwood & Pigeon, 1994:227), a qualitative approach was viewed as being particularly appropriate, since the study aimed to explore meanings from an individual view point. Such an approach was seen to offer an alternative and valuable means to further understanding subjective experiences of patient satisfaction.

In a recent review of the literature relating to qualitative research methods, Murphy et al (1998) suggest five features characteristic of qualitative research.

These include:

1. Adopting the perspective of the people being studied in order to understand the meanings that inform their behaviours.
2. A description of the setting: challenges routine, but unexamined assumptions about familiar settings.
3. An emphasis upon understanding the phenomenon of interest holistically, seeking to study phenomena in context.
4. An emphasis on the process and dynamic nature of social life.
5. Flexibility of design that actively allows hypothesis generation and

discovery.

These are particularly pertinent to the aims set out in this study. Qualitative methods viewing people as reflective social beings who interpret the world they inhabit and who attach meanings to their actions and experiences (Marshall et al, 1996). Nicolson and Anderson (2001) further assert that qualitative approaches identify:

Contradictions and complexities in the way individuals not only perceive things, but go on to explain them (Nicolson & Anderson, 2001: 553-554).

It is an approach to research which is generally concerned with ‘the quality and texture of experience rather than with the identification of cause-effect variables’ (Willig, 2001:9). Schwandt (1994) suggest that the qualitative method allow a richer understanding of ‘the complex world of lived experience from the point of view of those who live it’ [118]. Yardley (2001) indicates that such an approach is particularly useful in the realm of healthcare research:

With respect to our basic understanding of the experience of health and illness, qualitative methods are generally best suited for inquiring into subjective meanings and their socio-cultural context. (Yardley, 2001:8)

The illusion of objectivity

To reiterate, the predominant philosophical stance underlying much, if not most, of the current literature on satisfaction, is ‘scientific’; that is, it claims a

positivistic objectivity. But, in their critique of the conventional 'wisdom' of science, Guba and Lincoln (1994) suggest that a positivistic approach is not only 'context stripping', (i.e. it removes variables from those particular contexts which gives it social meaning), but also, in its drive for hypothesis testing, distances itself from 'meaning' either in an individual or social context.

With the aim of this study to 'understand participants' perspectives of phenomena in terms of experienced meanings,' (Elliott et al, 1999:216) (that is, their perspective on received healthcare in terms of satisfaction) it is inevitable, perhaps, that a qualitative, subjective approach to enquiry may place generalisable, 'objective truth' on the back burner. Nonetheless, with such an approach there is the opportunity to develop deeper theoretical understandings of important psychological phenomena (Elliott, et al, 1999:22) as well as assessing the utility of existing models. In an epistemological sense then, qualitative research aims:

To understand and represent the experiences and actions of people as they encounter, engage, and live through situations. In qualitative research, the researcher attempts to develop understandings of the phenomena under study, based as much as possible on the perspective of those being studied. (Elliott et al, 1999:216)

In moving away from the objectivist/positivist research stance dominating the satisfaction literature, there is a corresponding need to address and implement appropriate research paradigms (Schwartz & Ogilvy, 1979), which in turn require it to be set within a broader philosophical context.

A theoretical framework-the phenomenological approach

This study is phenomenological in that it is concerned with the individual's account of reality rather than an objective reality itself (Smith, 1996). Such an approach works towards exploration of 'the participant's view of the world and to understand and integrate, as far as is possible, an 'insiders perspective' of the phenomenon under study' (Smith, 1996:264). It rejects the scientific view that all perceive the same underlying reality and emphasises subjective meaning as being the primary reality (Hinchliff, 2001).

Phenomenology as a philosophical tradition was first introduced by Edmund Husserl (Husserl, 1970), and was extended by Albert Schutz (1977), Merleau-Ponty (1962) and Giorgi (1985) who subsequently established phenomenology as a major philosophical and social science perspective (Patton, 1990).

Phenomenological study is concerned with description; description of the experience or the '*lifeworld*' of those being studied, rather than a pure account of that experience in terms of scientific 'objective reality'. The life-world is defined as 'the world as it is encountered in everyday life and given in direct and immediate experiences, independent of and prior to explanations (Kvale, 1996:54). It is primarily a philosophical perspective, concerned with meaning, so, as Creswell (1998) points out, 'for the phenomenologist, an *a priori* decision is made that he or she will examine the meaning of experiences for individuals.'

[45]. Ashworth (2001) describes such a perspective as:

The description of the essential characteristics of the various forms of experience, and of experience as such. It becomes plain, in

addressing a phenomenon, that it is always found within a network of associated meanings and can never be totally abstracted from its world. (Ashworth, 2001:1)

An important methodological characteristic of phenomenology for the ‘transcendental’ Husserlian phenomenologist (1970), is that of *epoche*, or ‘bracketing’ (Giorgi, 1997). This requires the researcher to put to one side assumptions regarding the focus of study with ‘the resolve to set aside theories, research presuppositions, ready-made interpretations etc, in order to reveal engaged, lived experience’ (Ashworth, 2001:2). Significantly, such an approach dispenses with the notion that the lived experience under study is one that can be explained in terms of scientific causal relations, variables, causes and effects. As a result, in undertaking ‘*epoche*’, the researcher can only be concerned with *description* of a participant’s life-world. This being contradictory to the idea of reflexive qualitative research, and subsequently, the stance discussed and taken in the latter parts of this study (see the end of chapter 5 and chapter 6).

For the Heideggerian phenomenologist (Heidegger, 1962) the subjectivity of the participant is not bracketed (Giorgi, 1997) and in the interview situation, meanings are viewed as intersubjective. Experiences are relayed through verbal communication, and there is the assumption that others perceive the world similarly to ourselves (Ashworth, 1997a). Lived experience is what one does in the world, where one is ‘thrown’ into the world of objective things. Since one is, as Perttula (1996) points out, what one does in the world, ‘a phenomenological reduction to one’s own private experience is impossible’ [1]. Pure description of an experience is therefore impossible since, as Heidegger states, ‘when

something within-the-world is encountered as such, the thing in question already has an involvement which is disclosed in our understanding of the world, and this involvement is one which gets laid out by the interpretation' (Heidegger, 1962:190). Similarly, Ashworth argues that interpretation depends on 'standpoint' (2001: 4), and this interpretation is naturally related to the researcher, and the research project itself.

It may well then be the case that all 'descriptions' of experience involve interpretation. Langan (2000) suggests that, 'however intensely, however 'objectively' we present the experience of the thing to be described, the describing itself is interpretative' [2]. If this is the case, then the most appropriate methodology for this particular study of patient satisfaction, would be one which, as Ashworth points out, 'achieves its findings through a hermeneutic process that purposively develops an understanding of the participants' accounts which goes beyond the overt meaning of the accounts' (Ashworth, 2001:4). This understanding may be arrived at through implementing *interpretative phenomenological analysis*.

Interpretative phenomenological analysis

Interpretative phenomenological analysis (IPA) is a recently developed methodological tool and is used in order to understand individuals' experience (Smith, 1996); it is increasingly being used as a qualitative method particularly within health psychology research (Willig, 2001). The decision to use IPA as opposed to other qualitative approaches (such as grounded theory or discourse analysis) was based on the nature of the research problem. As the main aim of

the study was to explore *individual* meanings of satisfaction, IPA was viewed as being the most appropriate tool to meet this aim. Although the grounded theory method was also viewed as being a useful approach to understanding patient experience (Charmaz, 1990), it is an approach rooted in sociology, developed to study basic *social* processes, rather than *individual* participants' psychological worlds (Willig, 2001). Discourse analysis (Potter & Wetherell, 1987) in contrast, regard verbal reports as behaviours in their own right therefore 'it is not viewed as necessary to go beyond the verbal statement to seek relationships to other behaviours to underlying cognitions and to attempt to do so proves problematical (Smith, 1996:263). IPA is an approach which aims to bridge the opposed views of discourse analysis (which regards verbal reports as behaviours in their own right), and social cognitive views (which view verbal reports as accurately reflecting underlying cognitions). An IPA analysis does consider that there is a relationship between underlying cognitions and verbal reports, although also shares a commitment with discourse analysis a commitment to the importance of language (Smith et al, 1999).

Although IPA is phenomenological, in that it explores individuals' personal perspectives of an event or a state, it considers that one cannot do this directly or completely, and in a Heideggerian sense, assumes dependency upon a researcher's own conceptions in making sense, or interpreting that individual's experiences. This analytic approach aims, as Jarman et al (1997) point out, 'to capture our concern with exploring individual participant's perspectives, whilst also recognising the research exercise as a dynamic process, to some extent guided by the interests and concerns of the investigator' [141]. Central is the

researcher's own interpretation of meanings which are elicited within the analysis of each participant's interview-narrative. Interpretative phenomenological analysis aims 'to explore the participant's view of the world and to understand and integrate, as far as is possible, an 'insiders perspective' of the phenomenon under study' (Smith, 1996:264). It assumes, in a health care scenario, a 'belief in and concern with, the chain of connection between account, cognition and physical state' (Smith, 1996:265), which can be arrived at through interpretation of participant's narratives in the form of semi-structured interviews. In contrast to traditional phenomenology, IPA recognises that what the individual thinks is not necessarily transparently available from the narrative; central to IPA is the researcher's interpretation of meanings elicited within the analysis: its methodology involves the researcher looking for initial themes and connections in narratives and then moving to a 'higher-ordering' of themes which bring the data together in meaningful ways.

The use of interviews in qualitative research

In-depth semi-structured interviews were chosen as the most appropriate method of data collection for this study. Such a method reflects the phenomenological approach adopted and allows the exploration of what Kvale terms, 'people's understanding of the meaning in their lived world, describing their experiences and self-understanding, and clarifying and elaborating their own perspective on their lived world' (Kvale, 1996:105). It is a method of data collection that is both compatible with the phenomenological position and the method of data analysis (interpretative phenomenology) adopted. A number of authors (e.g. Banister et al, 1994; Murphy et al, 1998) have also supported the view that the in-depth

interview is particularly suited where issues, contradictions and complexities of subjective views and experiences can be explored. In a semi-structured interview the participant is encouraged to speak freely and openly, within a carefully constructed interview guide, one that allows the researcher to redefine the topic under investigation (Willig, 2001).

Summary

Thus, to conclude, I suggest that a qualitative phenomenological methodological approach is needed in order to understand the ways in which patients describe and understand the term 'satisfaction.' IPA is presented as an appropriate methodological tool in order to elicit such meaning. The following chapter describes the methods of data collection and analysis predicated on such an approach.

Chapter 4-Methodology

Introduction

The aim of this chapter is to describe the methods used for the study. It describes the practicalities of recruitment and sampling, ethical considerations and the interview process. The analytic procedure of the method of data analysis (interpretative phenomenological analysis) is thereafter outlined, and following this, a worked example of the approach is presented.

Sampling and recruitment

Participants were recruited onto the wider trial by their GPs and had to fulfil the following inclusion criteria:

- a. They had to have been referred with a new problem or not seen by the hospital dermatologist in the preceding 12 months
- b. They had to be aged 16 years or over
- c. They were judged by the general practitioner to require a conventional outpatient consultation with a National Health Service hospital consultant dermatologist.

There were three reasons for exclusion onto the main study.

1. The nature of the dermatological problem. Exclusion related to anatomical sites (e.g. genital lesions), a strong perception that palpation of the skin was crucial to diagnosis and management, or the possibility that physical treatment was needed immediately.
2. Mental illness or handicap, language barriers unrelated to the skin problem,
3. People who wished to consult a specialist dermatologist privately

The process of establishing initial contact with participants was relatively straightforward. All participants were contacted through their involvement with the wider randomised controlled trial. As part of this trial, all participants were asked to complete a patient satisfaction questionnaire. At the end of this questionnaire, a section was added which explained this study and asked participants whether they would be willing to be contacted to discuss being interviewed about their recent experiences of the healthcare they had received (Appendix 2). The overall response rate to the questionnaire was 72.7% (n=128). Of these 56.2% (n=72) patients stated their willingness to be interviewed. Fifty six patients (43.8%) declined to be interviewed. As recruitment onto the wider trial was slow, a decision was taken to interview the first patients who agreed to take part in the interview. The interviews were continued until 'saturation' was reached. By convention, this is defined as being when a series of additional interviews adds little to what has already been learned (Rubin & Rubin, 1995). Therefore when no further insightful information was being gained from the

participants the data collection period ended. Thirty participants were interviewed in total. They represented 12 men (7 from the telemedicine group, 5 from the control group) and 18 women (13 from the telemedicine group, 5 from the control group) Their ages ranged from 16 to 82 years. Twenty-eight participants classed themselves as 'white' European, one as Afro-Caribbean and one as Asian. The participants interviewed were recruited from all the eight participating GP Practices, although the Practice where access was negotiated first represented 34% (n=11) per cent of all the participants interviewed. The participants presented to their GPs with a range of dermatological problems. These were grouped under three broad headings, which included rashes (itchy/painful or tender (16), gradual/sudden hair loss (2), lesion(s) growing/bleeding or painful (12). Details of individual participants are illustrated in Table 1. It is important to recognise at this stage, that the group of participants interviewed were not all-inclusive and representative of all groups. Rather they were selected in order to further understand the concept of satisfaction, to gain new insights and to develop the current knowledge in this field of satisfaction.

TABLE 1: INDIVIDUAL PARTICIPANT CHARACTERISTICS

Participant	Gender	Age	GP Practice	Patient Group	Skin Problem
1	man	64	1	telemedicine	rash
2	man	67	1	telemedicine	rash
3	woman	82	2	control	lesion
4	woman	54	3	control	rash
5	woman	39	1	telemedicine	lesion
6	woman	35	3	telemedicine	hair loss
7	woman	33	4	telemedicine	lesion
8	woman	45	2	control	lesion

9	man	61	4	control	lesion
10	man	29	1	control	rash
11	woman	36	4	telemedicine	rash
12	woman	81	1	telemedicine	lesion
13	woman	32	4	telemedicine	rash
14	man	44	2	control	lesion
15	woman	41	1	telemedicine	rash
16	man	31	5	telemedicine	rash
17	man	72	4	control	lesion
18	woman	45	6	control	lesion
19	man	64	2	telemedicine	lesion
20	woman	39	5	telemedicine	hair loss
21	woman	37	1	telemedicine	rash
22	woman	56	8	telemedicine	rash
23	woman	52	1	control	rash
24	man	45	1	telemedicine	lesion
25	woman	40	4	telemedicine	rash
26	man	59	1	telemedicine	lesion
27	woman	58	7	telemedicine	rash
28	man	18	6	control	rash
29	woman	16	1	telemedicine	rash
30	man	38	3	telemedicine	rash

Ethical considerations

Prior to the start of the study, ethical approval was obtained from the Local Medical Research Ethics committee. Participants were fully informed about the research before the interview began. Each interview began with a brief description of the study, its aims and objectives, and allowed time for the participants to raise any concerns or questions. Participants were also asked if they had objections to the interviews being tape-recorded: none objected. They

were also reminded that they were under no obligation to disclose anything with which they felt uncomfortable, and also that the tape recorder could be turned off at any point. Participants were asked to read through and sign an interview consent form (Appendix 4). This comprised of a brief statement that the research had been explained to the participant, that they were willing to take part in the interview and were aware that the interview data would be used for research purposes only. Participants were also informed that they were free to withdraw from participation in the study at any time without giving any reason, or without fear that it would affect any future care that they had. The participants were also assured that the interview data would be treated confidentially and that they would not be identified within the study or within any verbatim quotations used to illustrate emergent themes. A summary of findings resulting from the interviews was forwarded to all participants at the end of the study.

The pilot study

In December, 2001, pilot interviews were conducted with two participants. The aim of these interviews was to gauge how various aspects of the interview had been experienced. Feedback was also elicited on the perceived length of the interview, the wording of the questions and any difficulties that were experienced whilst completing it. Feedback from both participants was positive and the interviews appeared to be well received. Both participants felt that the consent form was too formal and as a result, the wording was altered and it was shortened. Data from these interviews was subsequently included in the final analysis.

The interview guide

The data collection period took six months to complete (January-July, 2001). Interviews were conducted, in most cases, within one month of the individual's telemedicine or traditional face-to face-consultation. In line with the phenomenological approach an interview guide was constructed (Appendix 3). This incorporated a small number of open-ended and non directive questions (Willig, 2001). In order to meet the aims of the wider trial (to elicit patient confidences and preferences for treatment) and the aims of this study (to explore subjective meanings of satisfaction), an interview guide was developed which incorporated both areas of exploration. The interview began by asking participants to describe their recent health care experiences. Responses to this were then followed up as a result of specific issues raised. For example, where a participant stated that the doctor had not taken them seriously, this was followed up with the question, in what way did the doctor not take you seriously? Can you describe what happened that made you feel like this? This maintained the conversational flow enabling the participants to tell their own stories in their own words. The interview thereafter progressed to discussing aspects specific to the wider trial. These included issues relating future health care preferences and confidence with diagnosis. The concept of satisfaction was explored during all phases of the interview. For example, when participants talked about their experiences this frequently included an evaluative aspect, for example, whether an experience had been good or bad, this was thereafter followed up with an exploration of satisfaction. Participants were asked in each interview to describe what the concept of satisfaction actually meant to them. They were also asked to reflect on the patient satisfaction questionnaire they completed as part of the

wider trial, and asked whether there was any differences between the concepts 'satisfied' and 'very satisfied. When all topics had been covered within the interview, participants were asked if there was anything else that they considered important that had not been covered in the course of the interview, and this often took the form of the participant recapping and expanding on the issues covered during the earlier part of the interview. The interview ended with contact details being exchanged in case they wished to discuss further the interview or any other aspects relating to the study. This offer was not taken up by participants. A follow up letter was sent to all participants thanking them for their time and participation in the interviews. It also reminded them that they could contact me at any point if they had any issues or concerns relating to the interview. The interviews varied in length, ranging from between thirty minutes and two hours. Summary notes of each interview were made immediately following each interview and prior to verbatim transcription(an example of an interview transcript is provided in Appendix 5). Self-reflective notes were also made (extract provided in Appendix 6). These referred to any issues that had emerged during the data collection period and these are discussed in chapter 7 of this study.

Data analysis

The data obtained through the semi-structured interviews was analysed using interpretative phenomenological analysis (IPA) (Smith, 1996).The following section will discuss this approach in detail.

Implementing interpretative phenomenological analysis

The aim of this approach is to represent as closely as possible the subjective experiences of participants, and the meanings that such experiences hold for them. In order to keep as near to the participants' accounts and in order not to deny multiple experiences and perceptions, the analysis of the interview data is guided by a phenomenological approach, namely, interpretative phenomenological analysis (Smith, 1996). The theoretical underpinnings of this approach having already been outlined in chapter 3 of this study. The aim of this approach is to represent as closely as possible the *subjective* experiences of participants, and the *meanings* that such experiences hold for them, in an idiographic mode of inquiry (Smith et al, 1995). The approach operates through working up from individual case studies to a more generalised schema, rather than in a nomothetic sense, where claims are made about individual cases from the analysis of a large-scale aggregation of data. It is concerned with exploring individual perspectives, while recognising the research exercise as a dynamic process, one which is guided to some extent by the interests and concerns of the investigator (Jarman et al, 1997).

The analytical stages of IPA outlined by Smith (1996) acted as a useful guide to the analysis. These steps were not applied rigidly, and as outlined in Smith's paper (1996), 'it is likely that you will find yourself adapting the method to your own particular way of working' [220]. The adaptations made will be clearly outlined in the forthcoming chapters. Within this study, each transcript was read a number of times and mapped out, initially in a basic way in order to familiarise

and orientate myself to the data. Initial thoughts, possible codes and anything interesting or significant about what the participant was saying was noted on the left side of the margin. Working through these more closely, the right margin was then used to document emerging themes that captured the essential quality of what was found in the text. At this point I went back through the transcript to see if there were any ways in which these initial themes could be grouped together (subordinate theme). I went back through the transcript to ensure that each theme was represented. In order to demonstrate how the themes emerged, a worked example of one part of a participant account is provided in Table 2.

TABLE 2: DATA ANALYSIS: A WORKED EXAMPLE

Initial coding	Interview 10: Participant description of satisfaction	Emerging themes
<ul style="list-style-type: none"> -Gives a negative example rather than positive -Dismissive -Use of metaphor -meet personal needs- reassurance - wants to know -trying to understand actions of doctor comparison perception good/bad doctor- interpersonal 	<p><i>I think one that's more personal [a consultation]. Treating you more as a person than as a patient.</i></p> <p>What type of thing would that be, when you say they treat you as a person?</p> <p><i>I don't know. It's a difficult question.</i></p> <p>What types of things would he or she do that you'd think I liked that?</p> <p><i>Well I could probably point out how you probably wouldn't want to be treated, is when you go in, he just says well what's wrong with you, has a quick look, right use this and give you a prescription and you're out, you're on a conveyor belt as such. If they maybe gave you a little bit of reassurance and just give you an insight into what you'd got and maybe allay any concerns before you ask what the concerns are then it just maybe reassures you, let's you know what their talking about to an extent, and when you go in maybe a smiling face. I mean I know people have hard days or whatever but it's a job where they are dealing with the public, so they shouldn't let that affect them. I mean you can realise the constraints on them, that there is a waiting room full of people who all want to see them and there are only so many hours in the day as such.</i></p> <p>So how would the good doctor manage that?</p> <p><i>He'd still probably only have the same amount of time with you but he'd be able to put more across to you, you know just be abit more into relations as such.</i></p>	<ul style="list-style-type: none"> individualised care uncertainty need for explanations trying to make sense/ understand importance of interpersonal skills

<p>skills -seeing expert -focus on waiting wants to know -needs answers</p> <p>-shortcoming of consultation- need to 'delve' to get answers -awareness of poor IP skills</p>	<p>So what about at the hospital? <i>Well I know I jumped the queue in using this, and I think that took maybe eight or ten weeks for that which is pretty quick. The initial waiting list would have been nine months, so that wasn't too bad, at least I knew I was going to see somebody who was basically at the top of the tree, in their specified area of expertise, so I knew basically the person I was going to see, that there was nobody really above them as such, so I knew I was going to get a definitive answer when I went. The actual consultation itself, was pretty fast track, I think fifteen minutes delay on the first one and an hour late for the second one. The actual consultation, the first one, I did have to delve I thought to get the answers I wanted. If I'd have just sat quiet I would have basically just received a prescription. Again that's probably the consultants actual interpersonal skills, which may be different to the second consultant who was, although it was a lot shorter, and basically he knew he was just there to give a diagnosis, although he did come across, I mean if it'd been the other way around the first one would have given me a response without me having to ask.</i></p>	<p>need for explanations/ answers</p> <p>Perceived inadequacies of health professional</p>
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The above stages were carried out with all thirty transcripts. In order to identify shared themes, commonalities between, and individualities within, transcripts were recorded, a process similar to the *constant comparison* method of grounded theory (Strauss & Corbin, 1990). As new themes emerged in subsequent transcripts, these were analysed against earlier transcripts. These emerging subordinate themes were then integrated 'in order to identify shared themes which captured the essence of the participants experiences' (Willig, 2001:61). Additionally, because participants described satisfaction in different ways, I found it useful to see all descriptions of satisfaction together, and copied and pasted these descriptions onto one document. By mapping these individual descriptions, the multi-faceted nature of satisfaction became more evident (see Chapter 5, Table 3)

Finally, re-reading the original transcripts a number of times allowed immersion in the data and ensured that interpretations were grounded fully in what the participants were saying.

Summary

This chapter has provided an overview of the methods of data collection and analysis adopted to undertake this study. The following two chapters present the main findings of this study.

Chapter 5: Findings One: towards a more sophisticated understanding of patient satisfaction

Introduction

One of the aims of this study was to explore in a phenomenological sense, the *meaning* of patient satisfaction from the perspective of participants who were part of a wider randomised controlled trial of telemedicine in dermatology. This chapter presents the findings from the semi-structured interviews conducted with thirty participants as part of this study. In order to keep as near to the participants' 'lifeworld' as possible and not subsume multiple experiences and perceptions of satisfaction, this chapter presents an initial *descriptive* analysis of the participants' accounts (Husserl, 1970). This intends to reflect the 'chain of connection between account, cognition and physical state' (Smith 1996:261). Bearing in mind, the Husserlian notion of *epoche*, or 'bracketing,' (Giorgi, 1997) an attempt has been made to put to one side assumptions regarding the focus of study with 'the resolve to set aside theories, research presuppositions, ready-made interpretations etc, in order to reveal engaged, lived experience.' (Ashworth, 2001:2). A more interpretative analysis will be laid out in the following chapter.

Stage one: Descriptive analysis

Although phenomenology is concerned with the 'lifeworld' of the individual, this does not discount the possibilities of reaching intersubjective agreement in

phenomenological analysis (Ashworth 1997b; Hinchcliff, 2001). From the analysis of the interview transcripts, six superordinate themes were identified which described and exemplified the participants intersubjective descriptions of satisfaction. Some of these themes invariably overlapped. These themes were:

1. receiving a diagnosis, treatment and cure
2. receiving information and explanations
3. doctor/patient communication/ characteristics
4. being taken seriously
5. receiving individualised person care
6. being seen quickly/minimal waiting

Additionally, the data identified significant differences in participants' descriptions between being 'satisfied' and 'very satisfied' with healthcare. Three themes emerged which differentiated these concepts. These were:

1. mode/manner of treatment received
2. sense of incomplete care and management
3. adequacy of management

The presentations of these themes are illustrated with extracts from the verbal accounts of participants that were chosen for their pertinence to the themes and for being especially representative of all the participant accounts. In order to contextualise the quotations, the participants' gender, age and group are provided. Furthermore, the use of such extracts provides the opportunity for the

reader to appraise the data and the authors understanding and use of the data (Elliot, 1999).

Use of the term satisfaction

The term 'satisfaction' was not a term that was spontaneously used by participants in order to describe their experiences. Rather they articulated their experiences in terms of care being either 'good' or 'bad.' Therefore, the following themes emerged as a result of a direct question which asked participants to describe their own understanding and meaning of 'satisfaction' within the health care context.

Superordinate theme 1: Diagnosis, treatment and cure

The first theme to emerge that was significant in participant's descriptions of satisfaction was their perception that they had received a diagnosis, treatment and cure (or symptom relief). Participants consulted their GP because they either felt uncertain about their symptoms (i.e. a mole) or they wanted symptom relief (i.e. itching). They wanted to know what was wrong and what treatment was required. Ultimately, they wanted a resolution of their problem. Therefore participants had an expectation that they would receive a diagnosis, and treatment, which would result in health improvement, including relief of symptoms or a complete cure:

Well I'll tell you I'm right pleased about the improvement. It's ever so good the treatment that the consultant gave me is ever so good and I'm right pleased about it. Yeah, I'm telling you sitting down

here, but my foot was a big concern to me, all of a sudden my foot just started breaking up in sores just splitting out and getting harder I can't walk on it. I were right worried about it, ever so worried, made me right worried. (Interview 4: woman, age 54, control group)

The consultant obviously looked at it, diagnosed it and sent me away with a cream which has got rid of it which is exactly what I was hoping for. (Interview 11: woman, age 36, telemedicine group)

For the following participant, the process of receiving a diagnosis, being given treatment, resulting in a successful outcome had led him to describe his overall satisfaction with the care and management he had received in the following way:

Well its end result luv int it? It's the same as this thing on me leg, if it goes and its done with then I'm quite happy. I'm satisfied. You know it lived up to my expectations. They told me what it were and they're removed it and everything's ok. (Interview 14: man, age 44, control group)

In contrast, the outcome of treatment, a cure, was the most significant factor in determining satisfaction for the following participant:

I mean obviously the way you're treated still has an effect on how satisfied you feel, but however you're treated if, at the end of the day your problem is solved then you do feel more satisfied than you would in the other circumstances.' (Interview 23: woman, age 52, control group)

Some participants expressed dissatisfaction with their management, and in these cases the consultant had not given any clear diagnosis and treatment, or there had been clear disagreement of diagnosis, resulting in frustration. For example:

I have seen truthfully four doctors. There is nothing wrong with doctors at all but not one of them would commit themselves to say what it was. What I've had up here is excellent, except I've got this disagreement, normal doctors couldn't diagnose one case of eczema between them, you know this is it, so that's all I've got to say.

(Interview 1: man, age 64, telemedicine group)

Within these descriptions the importance of being physically examined by the GP and consultant was evident, and resulted in participants feeling as though they had received a thorough consultation. This is illustrated by the following participants' account:

The first consultant was very thorough. Sometimes I used to feel as though some of em you know [pause] but that doctor was very thorough. I went into this cubicle right and stripped off and he looked at em and this rash, everything, he really did you know, and that was his diagnosis and I thought that were good. I did really think that were good. (Interview 17: man, age 72, control group)

For several participants the thorough consultation meant that integral to being physically being examined was being asked questions about their complaint:

He was very thorough. He explained the situation when he went in, took me into another room and looked at the skin complaint and asked me an awful lot of questions.' (Interview 22: woman, age 56, telemedicine group)

The two-way process of the doctor asking questions and having questions answered was also an important facet of being satisfied with a thorough consultation. This is illustrated in the following extract:

They looked at me foot, and I ask him questions about it, he would answer me about it, and I were satisfied about that. You never had anything from your treatment that could have been done in any other way, different. He could answer me questions and explain things to me and I were quite satisfied with that. (Interview 4: woman, age 54, control group)

He was very thorough. He explained the situation. He looked at the skin complaint and asked me an awful lot of questions. They moved the skin about, they really examined it which is really what I'd gone for and which I wanted them to do. (Interview 23: woman, age 52, control group)

On the other hand, several participants expressed their dissatisfaction with not having a physical examination:

It just seemed to me, how can you decide what to do with a person just by looking. He didn't even touch me to see if it were a lump or a cyst you know. (Interview 18: woman, age 45, control group)

The following participant hints at the multi-faceted nature of satisfaction in her account of her healthcare experience, with her feeling as though the doctor was interested in what she was saying as well as receiving a physical examination:

Well you feel that they are interested in it what you are saying and the thing itself, you know they examined it well and, which all the doctors that I've seen did. (Interview 3: woman, age 82, control group)

The physical examination and interpretation of symptoms was important to the participants. This was one facet of what was perceived to be a thorough consultation and which resulted in participants feeling reassured. For most participants the importance of receiving a diagnosis, treatment and cure in an environment where they had been managed quickly was the main descriptor of satisfaction. However, for other participants, receiving a diagnosis, treatment and cure was secondary to other factors, such as receiving information and explanations, being taken seriously and good communication (between the doctor and participant). These will now be discussed.

Superordinate theme 2: Receiving information and explanations

The second theme to emerge that was significant in participants' descriptions of satisfaction was the need for them to be able to explain their symptoms and concerns whilst at the same time discuss treatment with a doctor and, hopefully, receive an explanation. For example, after what was obviously a frustrating consultation for the following participant, it became clear, how for this participant, the consultation could have been managed differently:

I think I would now know to go in with more questions and I wouldn't worry about keeping a ten-minute appointment. I think I'd be a bit bolshier. Not rude, I don't mean that but I'd be quite, right I'm going

in now and I'm going to ask him why what and when. I'm sorry if it gets to half past two and I'm due next door then tough. (Interview 18: woman, age 45, control group)

She expressed the simple expectation that:

You just want to know about your body really don't you. (ibid)

Such retrospective self reflection was evident in many of the accounts. Additionally, participants concerns and anxieties were evident. This being apparent in their 'needing to know' everything about their problem. Participants wanted clinical certainty with definitive answers and a confirmed diagnosis:

I just felt as if somebody was going to be concerned if you see what I mean so I was happy that they hadn't just turned round and said 'we don't know what it is, there's nothing you can do,' because I had blood tests, swabs again at the doctors which were inconclusive and that inconclusiveness is always abit of a worry. (Interview 21: woman, age 37, telemedicine group)

In this 'exchange of information' context, participants expressed their satisfaction when the doctor spent time with them, provided information and explanations about their condition and subsequent management:

He really did take his time explaining what were going to happen, to such an extent that I actually went in, he saw another patient and then said sit outside which were great I thought for him to take that amount of care. (Interview 27: woman, age 58, telemedicine group)

I were very pleased with what they did and time they took, spent with it you know, explained everything, it were really good really you know. (Interview 24: man, age 45, telemedicine group)

Conversely, insufficient information and explanations resulted in uncertainty and was not viewed favourably by participants. When uncertainty about their condition or treatment arose within the consultation this was almost always followed by anxiety and resulted in an overt need for reassurance and guidance:

Well I'd just like to know that they know what's happening and what treatment is necessary to clear it up. (Interview 12: woman, age 81, telemedicine group)

The consultant could have suggested what I could have done to make my skin better ...and they didn't suggest much that could help me so I was back to square one with my own GP...they [the consultants] didn't give me any other information that I didn't already know.'
(Interview 28: man, age 18, control group)

He didn't tell me enough. Because then I was in such a state I didn't ask enough. But I felt I was being shunted. We don't want to waste people's time by asking what you think are stupid questions even though they niggle you. (Interview 18: woman, age 45, control group)

These participants were left with an uncertainty about how they should manage their skin problem, and what they could do to improve their symptoms. This reduced their feelings of personal control and resulted in feelings of disempowerment.

Additionally, several participants were dissatisfied with the way in which information and explanations had been given by the doctor. More specifically, being given a diagnosis over the telephone:

He phoned me at work and gave me the results at work. It was noisy and it was busy and I'm trying to talk to this doctor on the phone and he said that, you know, it was alright, but I didn't seem to have the time to sort of sit and discuss the results with him. (Interview 5: woman, age 39, telemedicine group)

This was an unsatisfactory way for her to acquire information:

I could have done with going and seeing him. I just didn't feel over the phone I got enough information, I couldn't concentrate, I couldn't concentrate on what he was saying and you know so, yeah fair enough he'd had problems getting in touch with me you know because I was in and out all the time. (ibid)

At a later stage in the interview the participant reflects on the pressures the doctor may be encountering, and proposes a more suitable and effective mode of transferring information:

So I suppose that to him was quite an easy way of giving the results and getting them passed on, but I do feel if I had got an appointment, if he had written to me or rang me and said we've got your results come in and see me then that would have been better. (ibid)

In contrast, several participants were, in fact, satisfied with being given the results over the telephone. This was viewed as being more convenient than having to go and see the doctor in person:

Yeah, well because otherwise you've either got to take more time off work or you've got to fuff around and try and get an appointment and be fit in you know, yeah I mean, it's much easier because then you either know. (Interview 7: woman: age 33, telemedicine group)

I rang him. It just seemed easier to give him a ring. I'd much rather phone the GP actually. They're very accommodating. I mean he's done me repeat prescriptions just by giving him a ring and having a chat. (Interview 11: woman, age 36, telemedicine group)

Superordinate theme 3: Doctor-patient communication/characteristics

The communication between the patient and the doctor or consultant was an important descriptor of satisfaction. Participants expected the health professional to behave in a particular manner or style; they used terms such as the 'good', or the 'nice', doctor to describe one who was perceived as being friendly, open and honest, showed concern, was empathetic, introduced themselves and treated the participant as a person rather than a number. These approaches enabled participants to feel comfortable or 'put at ease' within the consultation which resulted in their being more likely to feel able discuss their problems as well as ask more questions about the diagnosis and treatment offered.

The following participant was 'put at ease' simply because the doctor had been honest, had listened and possessed a 'bedside manner':

I will say that doctor [] I would say was very good, because she openly admitted that she didn't really know what it was. So that's fair enough...I mean doctor [] was very good she listened to my problem and everything like that and the doctor at the hospital, or the consultant at the hospital was absolutely excellent...You know I mean, straight away, he straight away puts you at ease. He's got the what you call it bedside manner I think. (Interview 1: man, age 64, telemedicine group)

Despite what seems at first sight to be an overtly global critical stance by participants, they frequently and honestly acknowledged their own shortcomings, for example:

I am inclined to freeze and forget everything what I intend to say. It depends how easy they are too talk too. I sense when people aren't easy to talk to, and I'm inclined to go into a bit of a shell. Like he asked me what tablets I took and it just went absolutely blank. I felt a right fool. (Interview 3: woman, age 82, control group)

This participant was frustrated with the inadequate degree of communication and went onto describe how important it was for the doctor to put her at ease within the consultation. If this was not the case:

You come away saying half what you wanted to say and you walk out and think I ought to have said so and so. (Interview 3: woman, age 82, control group)

Thus, the doctor's manner was seen to either help or hinder the participant's ability to be able to effectively interact with the doctor. Poor communication

within the consultation frequently resulted in the participants feeling as though it was because the doctor was not taking them seriously. Participants would present in the interviews visual scenarios or ‘cameos’ of unsatisfactory consultations which were experienced as both awkward and depersonalising:

The consultant was very...didn't communicate with me, he was above me intellectually and everything. With his manner, his dress, how he was. He was not a right approachable, 'hands on' doctor. His bedside manner left a lot to be desired which to me [pause] I found it embarrassing and difficult to talk to. Four people in room, him across desk, I made a joke about it in end because I was embarrassed. Not intimidating but uncomfortable. (Interview 14: man, age 44, control group)

Here, in the space of six lines, the participant has described their examination, in terms of:

- a perceived status and disempowerment: *'he was above me intellectually and everything.'*
- impersonality: *'he was not a right approachable hands on doctor.'*
- an awkward environment: *'Four people in room, him across desk, I made a joke about it in end because I was embarrassed. Not intimidating but uncomfortable. (ibid)*

Similarly, for the following participant, the knowledge and competence of the consultant was not sufficient; they needed to feel as though the consultant was taking the situation seriously and understood the participant's own perspective of their condition. As a result they give a perceptive account of their consultation:

I was disappointed that they seemed flippant about the condition. I felt they had not taken it seriously. I just think a more down to earth approach with people really his body language and appearance was a cut above the patients and although they've got the knowledge they don't always provide a service . It's a mixture and I don't always think you get that' I didn't feel as though they were concerned or understood how I felt, or they didn't feel it important. I know it wasn't their fault as there's nothing they can do if there's no treatment , but neither of them took it seriously and really as I say I really came out really quite down. (Interview 24: man, age 45, control group)

So the above extract shows how although the participant accepted that there may be no treatment, the main cause of dissatisfaction was the fact that '*neither of them took it seriously.*' This participant describes his experience in terms of his 'feelings', which reflects the affective aspect of satisfaction.

In the following extract, the participant describes with a considerable sense of recall, the awkwardness which existed in the consultation, due to, in their mind, the off hand manner of the doctor. This participant acknowledged the intelligence and expertise of the consultant, but this melted into insignificance in terms of the affective expectation of the consultant, that they wanted to be treated as a person rather than as an object.

She describes her first impressions:

Well I found that very disconcerting. I mean I got in there and he didn't introduce himself. (Interview 23: woman, age 52, control group)

Then the stance of the consultant:

He didn't introduce anybody else that was in the room and he just looked down and started writing and ask me the odd question but never looked at me to the point at which I was trying to say something and show him what I meant. (Interview 23: woman, age 52, control group)

This prompts the participant to be proactive within the consultation itself:

But he just wasn't paying any attention so I just stopped in mid sentence and he suddenly realised I'd stopped and sort of said ' Oh, Oh' and he did change his manner slightly after that. (ibid)

But the glimmer of hope that the participant has in being taken seriously is lost in the failure of communication:

He was more attentive after that and he did seem to be talking directly to me for a short time but most of the time I felt throughout the consultation he wasn't talking to me. (ibid)

Another participant echoed this approach by a consultant:

It felt like it was dismissive; perhaps that's just me. I think it's just [pause] it's the way they are flicking through things. I mean they often try and talk down to you. You know, because I know what's going on and kind of you don't. You know he sat there looking at my notes and sort of, and you're kind of sat there and then its right ok yes I'm ready to look at the female. (Interview 7: woman, age 33, telemedicine group)

Like many other participants, this participant acknowledged and understood the skill of the consultant:

I didn't have any doubt that he knew what he was talking about and I'm sure he's a very knowledgeable dermatologist.(ibid)

But did so with reservations:

His manner during the consultation was very off putting and you didn't feel, it wasn't easy to sort of ask questions.(ibid)

Once again it is the participant who is proactive in eliciting information regarding their condition, asking for the medical terminology to be placed in layperson's terms:

Then when he told me what was wrong he gave me this technical term and then I had to say well what does that mean? (Interview 7: woman, age 33, telemedicine group)

These extracts suggest that perceived inequality and status differential are operating within the interaction between the participant and the consultant. These

are manifesting themselves in the form of the consultant's non-verbal behaviours, body language, lack of introductions and the use of technical language. Participants tended to adopt a passive stance in their interactions with doctors, and particularly with consultants. They frequently gave accounts that signalled their need and desire to be part of, or an active participant within, the consultation process. The difference in status that was apparent in the words and phrases and effectively diminished their ability to feel part of the clinical encounter. This led to their feeling frustrated because they had been dismissed and not taken seriously. Additionally, frustrations were increased when the doctor used language that the participant didn't understand, where there were lack of introductions and poor usage of body language such as not looking up when the participant entered the room. Such behaviours were also interpreted as the doctor not taking them seriously and thus that they were being 'fobbed off', this increasing their sense of being disempowered within the consultation.

In a number of extracts, the participants placed the consultation in the context of their own normal day-to-day personal interaction with others. Again the affective nature of satisfaction emerges through the use of a simile to describe the interaction:

I mean if you're meeting someone for the first time and you look up smile and say you know and I'm who ever you know, I'm doctor whoever and this is whoever else is in the room then you know you feel kind of included and you feel like a person rather than just a sort of next body through the door (Interview 23:woman, age 52, control group)

Thus it is clear that patients not only value a consultation that is comprehensible, but also verbalise the vital importance of initial introductions and active participation by the consultant, within the consultation. First impressions appear to direct how the participant is likely to feel and act throughout the consultation.

Again, the perceived inequality and disempowerment within the relationship between the participant and the doctor was evident in a number of transcripts:

I think the majority of people seem to be frightened of doctors I don't know why. I see them everyday so I see them more as humans.
(Interview 9: man, age 61, control)

The following extract explores this issue in more detail:

With the GP I think it's easier because they're more like on your level, but with the consultants, I mean you go in and you feel abit taken aback you know what I mean, but then when he were talking and that, he introduced himself, he shook your hand and that you know, he were very nice, so it made you feel abit more at your ease so you could actually talk to them, because sometimes as I say you are in awe of them aren't you and you sort of sit there like a little school girl you know what I mean? You get all these questions mulling about in yer head and then you don't actually say. He were alright, you could ask your questions and that, and he actually asked me at end is there anything you want to know. (Interview 8: woman, age 45, control group)

For this participant, her own sense of status, i.e. *'like a little school girl'* who is *'in awe'*, who is, *'taken aback'* by the consultant, highlights the importance of the simple act of shaking hands. By this everyday human act, the consultant was perceived as being affirming and subsequently enabled the participant to communicate *'all these questions mulling about'* in her head.

Another example of the importance of the doctors' manner is illustrated below. The dismissive and devaluing nature of the consultation resulted in the following participant feeling dissatisfied with the consultation:

Well I thought the consultant was very very pompous. I went in and he were just reading through notes and then he says and you are, and I said my name, and he said I think I already know that. Then he said you are on this telemedicine study and I said yes and he said I suppose you're here about that thing on your face and thought how pompous and arrogant he was. I think there's definitely was a barrier there. (Interview 20: woman, age 39, telemedicine group)

In a similar tone, the following participant was pleased that:

They tried to make you feel comfortable, right comfortable. I don't want to go to a doctor and then I come out the surgery and I say oh my god I'm not comfortable seeing that that GP. I have to go and find another one. It has never happened to me (Interview 4: woman, age 54, control group)

Terms such as *'arrogant'* *'aloof'* or *'dismissive'* were used to describe interpersonal styles that participants disliked. These styles resulted in a feeling of as though they had little control over the interaction and subsequently their care

and management. It pervaded their self of worth and within the interaction with the consequence that they felt unable to discuss their concerns or ask any questions. One participant forcibly illustrates this point:

He was incredibly arrogant and almost intimidating in his mocking of why are you here. I'd been referred. I'm not a medical person. At the end of the day I can dismiss that, that's just arrogance. But you aren't in a position to discuss with him in those circumstances.
(Interview 13: woman, age 32, telemedicine group)

This very negative interaction led the participant to reflect upon her own status in the doctor-patient interaction:

One day I'll get assertive enough to put this in place. I've already decided that being in a consultation, for yourself, whilst they're trying to train other members of staff, is actually quite debilitating in terms of what you actually get out of that consultation because they're focusing on training others.(ibid)

She then further reflected upon her sense of self, acknowledging herself as a person who also, like the consultant, had little personal time:

One day I'll get assertive enough to actually say I don't want that, I'm here, I've got limited time already, I've had to wait six months for this appointment. Had I been more with it and less rushed I think, and feeling less intimidated by the guy's personality, I think I might have said that. But he was incredibly, incredibly intimidating.(ibid)

At this point, it can already be seen that through the process of the research interview, this participant moved from an initial, tentative description of the consultant as 'almost intimidating' to one where he is being 'incredibly, incredibly intimidating,' thus refining and constructing through the interview, the meaning of that particular experience.

The power differential described above evidenced itself in several ways, for example, use of language that the participant didn't understand. Again there was evidence of the lack of introductions by the doctor and poor use of body language, such as not looking up when the participant entered the room. Such behaviours were interpreted as the consultant not taking the participants seriously (being 'fobbed off') and resulted in the participant feeling disempowered within the consultation.

In many of these perceptive accounts, I observed an honest self-appraisal by the participant (i.e. 'I'm not a medical person,' 'had I been more with it,' 'perhaps that's just me', 'I forget everything I intended to say,') occurring before a cameo or 'snapshot' of their particular consultation experience. Thus, in the light of what should be a human interaction based on equality, they acknowledge their own human, inter-relational and intellectual shortcomings and in doing so, clearly point to serious problems with such interactions.

It is evident then, that participants wanted to be able to give a full account of their experiences, with the doctor listening and providing adequate information and explanations; participants who were reluctant to spontaneously ask questions

appreciated a doctor offering them the chance to ask questions. This two-way communication was a reassuring factor that helped to reduce their anxieties. Time set aside to do this was also appreciated. The manner of the doctor was also important to most participants (friendly, approachable, listening). They wanted to be put at ease and made to feel comfortable. Problems with the doctor-patient interaction impacted upon effective information exchange, which in turn was likely to impact on what information was given to the doctor

Superordinate theme 4: Being taken seriously

The fourth theme to emerge from the transcripts of the interviews was the importance of participants feeling as though they were being taken seriously. Although, participants constructed their own idiosyncratic descriptions of being taken seriously, their accounts encompassed two subordinate themes, that of, 1) not feeling 'fobbed off', and 2) doctors 'doing their personal best.'

- Subordinate theme 1: Not feeling 'fobbed off'

Looking at the following participant's account of a satisfactory consultation, it might be said that being taken seriously is the participants awareness and acknowledgement by the doctor that their condition is being taken seriously:

You know like even if it's like trivial to them and it isn't to you they don't like fob you off and say well there's nothing I can do or you

know or there's nothing seriously wrong why are you troubling us?

(Interview 27: woman, age 58, telemedicine group)

Other participants used similar language when speaking of being taken seriously.

For example:

There's no fobbing you off. They'll sit down and speak to you, discuss things and things like that. I mean there's no just 'here you are go next door and get a prescription.' (Interview 12: woman, age 81, telemedicine group)

So, not feeling 'fobbed off' then, could mean for some a form of 'connectedness' with the doctor's attention, and thoroughness of examination.

Feeling as though you are being taken seriously, which I think a lot of them don't. As long as I get a thorough consultation and somebody seems to be taking me seriously instead of just go home and if it's no better in six months come back. I'm quite forgiving about most things, once I've got in there, as long as I feel as though I'm been taken seriously and has been thorough and they have looked properly then that's fine and I'm quite satisfied. (Interview 5: woman, age 39, telemedicine group)

Here, there is an affective response where the participant uses expressive and personal language to communicate their satisfaction. Again, multiple aspects of care were deemed essential in order to ensure a satisfactory outcome to the consultation (i.e. thoroughness, being taken seriously, being looked at 'properly'). Some participants described instances where they had felt the

consultant had not listened to them and had too readily 'dismissed' them or 'fobbed' them off.

But he were so quick to dismiss it, just ignore those sort of symptoms. Just to give a quick prescription and try that sort of thing. (Interview 14: man, age 44, control group)

For one participant, being taken seriously meant that the doctor had not only listened him to, but that her own views and perspectives of her condition was perceived as being valued by the doctor:

I've had a condition taken seriously, that I've been listened too, that I felt able to articulate how it was making me feel and have that taken seriously. (Interview 25: woman, age 40, telemedicine group)

There was a positive outcome for this participant thereafter since he had been:

Given some advice on how to treat it and prevent it recurring.
(Interview 25: woman, age 40, telemedicine group)

So, being taken seriously for this participant indicated a degree of empowerment. He did not have to rely fully upon the doctor, but could, as a result, take on personal responsibility for his own health.

- Subordinate theme 2: Doing their personal best

Participants frequently described feeling as though they were being taken seriously in terms of doctor having done all s/he could to make them better or improve their condition:

Well I think they've done as much as they can do for you at that particular time, and I mean to know that they'll say 'well come back and see me again' and following it up, that to me is satisfaction.

(Interview 12: woman, age 81, telemedicine group)

However, although participants expressed a desire for a positive outcome; i.e. they wanted their skin problem to 'go way' or be cured, the perception that the doctor was 'doing his/her best' in order to fulfil the aim of 'cure' was an important feature in the participants accounts of what being satisfied meant to them. The following extract highlights this:

I suppose really that all the way along I felt that they were taking an interest and doing what they could to sort out my problem and they were terribly sympathetic and did everything they could to make that stop. That's all you can ask really isn't it, that they listen and do what they can to make it go away. (Interview 11: woman, age 36, telemedicine group)

Whereas for another participant a positive outcome meant that they had been referred:

That someone had taken some action you know to get an appointment somewhere else, so you'd gone to your GP and they'd said I don't know but we'll refer you onto somebody else. For that bit of the case

you're satisfied because they're done what they could do. (Interview 6: woman, age 35, telemedicine group)

In some cases, it seemed that this issue of the doctor perceived to be doing their 'personal best', was just as important as actually curing the patient's condition:

To be satisfied is that they have done their personal best to achieve the aim of finding the cure or treatment for the condition. (Interview 10: man, age 29, control group)

However, for some participants the manner of the consultant was of little significance and although they may have drawn attention to the interpersonal manner of the doctor, they described feeling satisfied with the consultation. For example, the following participant drew attention to the impersonal manner of the consultant but, regardless of this, they still felt satisfied with the consultation since the consultant was 'methodical,' that is, the methodical skills of the doctor was viewed as being a prime descriptor of satisfaction:

He did seem a little bit distant, but he were very methodical well it's one of them things, I mean different people react different. I was happy with it actually, you know, no messing about, no, he just stuck to his job and did it as far as I'm concerned. He explained it as he went along and I was quite satisfied you know. As far as I'm concerned I went there and he did his job and he did it efficiently. (Interview 2: man, age 67, telemedicine group)

When prompting this participant about what he meant by the doctor doing his job 'efficiently', he described it in terms of having his condition 'explained in detail',

being asked 'relevant questions', having 'no questions to ask' and the doctor having not only looked at his foot but also, 'the rest of me.'

It is evident then, that the interpersonal and communication skills of the doctor affected participants' reactions to their overall consultation and their resultant appraisal of satisfaction. Satisfaction was most likely to occur when the doctor dealt with the participants' concerns, when the doctors manner, both verbally and non verbally, communicated warmth and interest and concern about the participants who, as a result, felt as though they were being taken seriously.

Superordinate theme 5: Receiving Individualised Care

The fourth superordinate theme to emerge was the importance of receiving individualised care. This encompassed three subordinate themes, where the doctor/consultant was a) listening to the participant b) taking time with the participant and, c) personalised care.

- Subordinate theme 1: Listening

For many of the participants, their satisfaction with healthcare was bound up with their experience of the doctor listening carefully to their expressions of needs and being seen as being interested in them. Like other participants, the following participant acknowledged the fact that doctors are often busy, and this fact highlighted her appreciation of their 'listening' and competent approach:

You like them to take an interest in you don't you. I know they see hundreds of people a week but you like to feel as though you're going into the doctor and they know you. They know what they're talking about and they're listening to you. (Interview 6: woman, age 35, telemedicine group).

In addition to the interpersonal aspects of the consultation the above participant, as with other participants, also required the doctor to be competent, 'to know what they're talking about', in order to feel satisfied with the outcome of their care.

Other participants linked listening skills with two other components in a successful consultation. For example, satisfaction as:

A positive experience that you go along and you feel that you've been listened to you've had your questions answered and your problem solved and offered some treatment. (Interview 24: man, age 45, telemedicine group)

In a similar manner, other participants also expected answers from the doctor.

The following extract illustrates this:

My main concern when I go to doctors is I have to have doctors who will listen to me and be prepared to sit a few minutes while I talk and tell him what's wrong, cos some on 'em aren't like that. You know that's one of my main concerns. You know if I've got a problem and I'm going to the doctors I want someone to talk to, or listen, but he did. (Interview 9: man, age 61, control group)

This desire for active participation within the consultation was often apparent. The participants wanted to tell their story to the doctor while the doctor gave them time and listened to them.

Listening skills require sensitivity and attentiveness to an individual's need. It was clear that participants appreciated opportunities within the consultation to discuss their problems with the doctor and explore ways in which the problem was making them feel. However, in several accounts, a lack of attention to the individual needs of the participants was evident. The following extract gives an illuminating, if somewhat slightly humorous, account of the doctor being pre-occupied with other issues:

You don't want to walk into doctors and them be like some of 'em are like writing stuff down and then they'll look up and say 'how are we today'? and you know they're not bothered because they are finishing off what other patients notes and what have you, and you can be sat there two minutes and they are still writing until they look up and say what's up with you. (Interview 6: woman, age 35, telemedicine group)

This quote encapsulates the inadequate communication skills of the doctor in the consultation scenario. A scenario where eye contact is not established, in essence denying any acknowledgement of them as a person in their own right. In this case, the participant felt that the lack of attention, the lack of interest, went hand in hand with a patronising attitude.

She then sums up the issue of satisfaction:

It's to do with personal attitude to you. To see they are listening to you and taking what you say and they're not sort of poo pooing what you say and taking the trouble to look properly and telling you properly afterwards what the implications are you know, what you have got and whether its significant or not. (ibid)

The above description again draws attention to the subjective and multi-faceted nature of satisfaction. Indeed. For the above participant, five separate factors were identified as essential to this participant in order to feel satisfied with the outcome of the consulting process:

1. listening
2. a non-dismissive attitude
3. physical examination
4. diagnosis
5. adequate feedback: implications and significance

The opportunities to discuss healthcare problems was appreciated by participants and resulted in them having more confidence in the doctor as part of the process:

What it is I think is they're so nice and that you seem to have confidence in em you know what I mean...you can go and talk to em and you know they're very nice and they'll listen, and if you've got other problems besides what I've got like now, they're very reassuring you know I think that's what it is. (Interview 27: woman, age 58, telemedicine group)

Again, we see in the short space of the account, a participant exploring their own general notion of the doctor and what constitutes satisfaction in terms of the consultation, moving from a general description of the doctor being 'nice' to a more specific, thought out appraisal of him/her being 'very reassuring.'

- Subordinate theme 2: Taking time

Effective listening by a doctor requires a degree of time to be spent within the consultation; the perception of not feeling rushed and being given adequate time within the consultation was appreciated by participants. The following participant, who had already indicated that she was well aware of the demands upon doctors, made repeated reference to this point:

You don't want to walk in and like here's your prescription and see you whenever. Most of them down there, they will take time. It's like I were in all that time and he weren't rushing. He weren't rushing me and saying oh come on this that and the other. He were like taking his time and you know like, taking an interest. (Interview 6: woman, age 35, telemedicine group)

This extra time within the consultation often resulted in the participants feeling more comfortable within the interaction. The following extract illustrates this point:

He was really good I mean he put a double appointment aside so we didn't have to rush or anything. I felt very comfortable. (Interview 22: woman, age 56, telemedicine group)

Conversely, some participants indicated their dissatisfaction with this aspect of the consultation. They felt as though they had been rushed through their consultation an issue more apparent within the hospital consultation rather than with the GP consultation. For several participants, this resulted in their feeling as though they had not received a thorough consultation, and had subsequently been left with unanswered questions and concerns about their condition:

I would have thought they would have taken time to look at my case. If he'd [the consultant] spent more time he would have got more of an idea of what types of treatment if they had took time to know what was wrong with me. (Interview 28: man, age 18, control group)

For other participants, the perceived lack of time within the consultation resulted in their not feeling able to take an active role within the consultative process:

I felt as though I couldn't question him this morning. If I say it took me longer to walk into room than it did for him to do what he had to do. (Interview 24: man, age 45, telemedicine group)

- Subordinate theme 3: Personalised care

It was apparent that participants needed to feel recognised and to feel as though they were receiving individualised care. This resulted in them feeling 'special' within the encounter and enabled them to feel more confident to become active within the consultative process. It also resulted in them feeling as though the doctor was interested in them. This is illustrated in the following extract:

It means ever such a lot to me. And when I go to the GP and he said I'll refer you to the hospital but I'll give you this leaflet to read first and see what you think about it, well you can say that your GP's interested in your health, you know what I mean. He is interested.

(Interview 4: woman, age 54, control group)

However, again, what is interesting is the participants' acknowledgement of the demands upon the medical profession, and the tendency to make allowances:

I think like this I think you can't expect when they're seeing five hundred whatever patients a day to get excellent number one first class cover. (Interview 18: woman, age 45, control group)

This feeling of receiving individualised care was evident in a number of participant descriptions of satisfaction.

Well if I say I'm satisfied with something I think they've done as much as they can do for you at that particular time, and I mean to know that they'll say 'well come back and see me again' and, 'following it up', that to me is satisfaction, to know that, you know I'm not just a number if you know what I mean. (Interview 12: woman, age 81, telemedicine group)

Other participants similarly echo this lack of individualised care:

I think they've got to be more personal. I think they tend to treat you just as a patient rather than a person.' (Interview 10: man, age 29, control group)

Participants frequently described their feelings of depersonalisation, by using a variety of similes and metaphors:

You expect to be treated like a person not a piece of bread that's passing through you understand what I'm saying. (Interview 18: woman, age 45, control group)

She uses a scene from a television advertisement to further illuminate her point:

Like there used to be an advert on with these babies on a conveyor belt and its that sort of thing [pause] unfortunately you're a number. You're a loaf of bread coming on and off and it's a shame. (ibid)

Another participant uses the image of the assembly line:

I could probably point out how you probably wouldn't want to be treated, is when you go in, he just says 'well what's wrong with you', has a quick look, 'right use this' and gives you a prescription and you're out, you're on a conveyor belt as such. (Interview 24: man, age 45, telemedicine group)

In order to make sense of their experience, participants tended to reflect upon, and make appraisals of the consultation within the research interview. This often highlighted the multifaceted nature of satisfaction. For example, the following participant defines satisfaction:

If they maybe gave you a little bit of reassurance_and just give you an insight into what you'd got and maybe allay any concerns before you ask what the concerns are then it just maybe reassures you, let's you know

what they're talking about to an extent, and when you go in maybe a smiling face. (Interview 10:man, age 29, control group)

The above extract identifies five factors that appear to be important to the participant when defining satisfaction. These being:

1. reassurance
2. diagnosis
3. information about condition
4. competence of doctor
5. interpersonal manner of doctor

The participant qualifies and validates the account by acknowledging the demands on the doctors which might have explained the doctors behaviour:.

I mean I know people have hard days or whatever but it's a job where they are dealing with the public, so they shouldn't let that affect them. I mean you can realise the constraints on them, that there is a waiting room full of people who all want to see them and there are only so many hours in the day as such. (Interview 10:man, age 29, control group)

The following participant, like others, uses similes, to enhance his appreciation of non-objectification in the consultation. Furthermore, he demonstrates the complexity of satisfaction, by again, revealing the multi-dimensional nature of the concept:

Well if I were satisfied its going to my GP getting a diagnosis whatever it is and being treated quick and successfully and being treated really like a person. I mean treated like as if you're not like just something like a photograph on somebody's computer and it doesn't belong to you sort of thing. If you're treated like a person.
(Interview 30: male, age 38, telemedicine group)

So for the above participant satisfaction is described in terms of:

1. receiving a diagnosis
2. quick treatment
3. effective treatment
4. individualised care
5. interpersonal manner of the doctor

Finally, in the participants attempts to describe expectational failings in a person-to-person interaction, it is clear that participants creatively interpreted their experiences through a variety of similes and metaphors. For example that they felt like a 'piece of bread', 'conveyor belt', 'a number' and more bleakly as 'a photograph on somebody's computer.' I would suggest at this early point that such emerging subjective experiences could not have been elicited without the use of in-depth questioning, through qualitative interviews.

Superordinate theme 6: Seen quickly/minimal waiting

The fifth theme to emerge was that of waiting time. The importance of minimal waiting time was evident in many accounts, with participants keen to be seen and treated by the doctor as quickly as possible.

I suppose from a basic level right from the beginning I mean I'd like to be seen at a reasonable time, without having to wait. (Interview 5: woman, age 39, telemedicine group)

No waiting for treatment. It's the waiting that I think gets to everyone.' (Interview 28: man, age 18, control group)

Some participants chose to describe the importance of waiting times in terms of dissatisfaction rather than satisfaction. For example:

One of the things that would make you dissatisfied would be the fact if you had to wait a long time either to see the consultant or the doctor but I never did it was only a short wait you know. I think that's very satisfactory. (Interview 25: woman, age 40, telemedicine group)

Minimal waiting time resulted in lessening participants' anxiety and resulted in satisfaction with this aspect of care.

Well I'm satisfied that I got seen to by the doctor and he gave me treatment, and I were satisfied because I didn't have to wait very long to go to the hospital you know... It worries you, you know. I

can't explain to you. It worries you when you don't get seen to straightaway you know. (Interview 17: man, age 72, control group)

Participants from the telemedicine group liked the speedy diagnosis and treatment that telemedicine offered them, and appreciated not having to wait for an appointment to see the consultant at the hospital.

You felt that straightaway something was being done about it, you know you'd gone through the GP, he doesn't know but he knows a man who will. So you've left knowing it's on it's way, then probably getting a diagnosis without having to go back to the GP and, you know, having to take more time off. (Interview 7: woman, age 33, telemedicine group)

The GP was getting an answer quickly and so rather than just sitting and waiting for someone to write to me in three weeks time or whatever, and because I was ringing the GP for the results and the GP was having the results e-mailed to him, so it made everybody much more accessible for me. (Interview 11: woman, age 36, telemedicine group)

In addition although telemedicine participants had to visit the hospital for a follow up appointment [as part of the trial], they liked the idea of being managed through telemedicine, and not having to travel and wait at the hospital.

It saves quite a lot of time for a lot of people doesn't it? It saves time. It also saves sitting and waiting at the hospital like I did when I went to see the consultant. It saves queuing everywhere doesn't it? I mean if the GP can give you a prescription that you need then fair enough. It saves

journeys to the hospital. (Interview 12: woman, age 81, telemedicine group)

However, although the lack of travelling was viewed as desirable to participants, receiving an equivalent diagnosis and treatment was foremost in the mind of participants. This is illustrated in the following extract.

Well for me I can go to the surgery, its only 5 minutes and, if I'm getting the treatment, I'd rather do that than you know, go and sit in the hospital for 3 or 4 hours, half a day like as long as I'm getting the treatment, you know the same treatment as I would get. (Interview 2: man, age 67, telemedicine group)

Several participants, however, described their dissatisfaction with not receiving any treatment whilst waiting for the appointment at the hospital. The following extract highlights this point:

I've still not got the results from the hospital. I'm still waiting. The receptionist rang me on Monday and said that she'd been in touch with the secretary there, and they said they'd passed these notes back to somewhere else, and this secretary was on holiday and they still didn't know whether I'd get them this week or next week so I'm still waiting. I don't know what to do. In the meantime no-one's prescribing anything. I mean if they can e-mail photographs why can't they e-mail the results. (Interview 12: woman, age 81, telemedicine group)

Additionally, several other participants explained how the waiting for results had affected their overall satisfaction with the experience.

I was supposed to go back to him for the results. However he was on holiday so the second appointment with the GP didn't happen. This is where it's fallen apart I think in terms of how things went. (Interview 13: woman, age 32, telemedicine group)

These participants were clearly annoyed at having to follow up their results:

I had to ring the surgery 3 or 4 times to get the results [of telemedicine] to begin treatment. It was a long time before I saw the doctor again, you know for any treatment but if it had been set up right I'd probably have waited a week. (Interview 30: man, age 38, telemedicine group)

The surgery could have said we've got it back come and see us. They sort of took the photographs then sort of left it. If they'd said right we'll take the photographs, we'll get one diagnosis back and we'll give you an idea. (Interview 24: man, age 45, telemedicine)

Almost half of the participants who had received the traditional consultation at the hospital felt that they had waited too long for the hospital appointment (the maximum waiting time was 12 weeks from going to the initial GP visit to seeing the consultant at the hospital).

Well it's a long time to wait. It is a long time to wait to see a consultant. I know what they say about it improving and whatever but it's still a long time. I mean if you're ill you want to be seen straight away don't you. Let's face it you do. (Interview 17: man, age 72, control group)

I thought I would have been seen quicker as on the trial but I had to wait a full 12 weeks. (Interview 8: woman, age 45, control group)

I think all I can say is the waiting time, that was long, that could have been better, yeah, it could be a lot lot better. (Interview 4: woman, age 54, control group)

The following participant describes the own disruption to her life at having to get to the hospital, as well as how the whole experience of waiting was similar to being in a 'cattle market':

The hassle of getting to the Hallamshire and the parking which is a pain and having to sort out child care and then having to queue. I mean you know it was just a complete fuff and all due respect to the hospital but the waiting, the cattle market kind of nature of out-patient clinics so no it was all of that, it's too clinical. Whereas the GP surgery is local, it's accessible, it's familiar, it's all of those things. (Interview 25: woman, age 40, telemedicine group)

However, this didn't affect the overall satisfaction for several participants, because they had been given explanations as to why they were waiting for long periods, thus justifying their wait.

The lady receptionist said to me well I'm really sorry there has been a major accident so the doctors have had to go off, but as soon as they all come back I will notify them that you are next in the queue. But then that was explained to me. (Interview 1: man, age 64, telemedicine group)

Participants also expressed their satisfaction at how quickly they had been seen once they had arrived at the hospital for their follow up consultation; they had expected to have to wait for much longer and expressed positive surprise at how quickly the process had taken:

I couldn't believe to be honest when I got there that there was no waiting. Basically my appointment was at 11 o'clock and I was in town by half past and my niece couldn't believe it either because I rung her from the hospital. Yeah, so that were really good. (Interview 20: woman, age 39, telemedicine group)

When I go there it's three or four hours usually so I mean this time when I was in and out by quarter to four I thought it was marvellous. It was very good. (interview 3: woman, age 82, control group)

However, several participants were clearly dissatisfied with this aspect of the consultation.

What I was thinking is there might be too much patients for one consultant. Why take so long? You know what I mean? If they could have a few more consultants for more patients, for less patients I think things would be a lot better, it would be a lot lot better. (Interview 4: woman, age 54, control group)

Participants expressed their annoyance at having to wait in two different areas within the hospital before actually been called through to see the consultant.

I mean you sit in the open waiting room for like ages and you think 'right sorted' and you go round the corner and there's another

flaming queue, you knows, chairs before you go in, and that's just soul destroying that is. (Interview 7: woman, age 33, telemedicine group)

The findings reveal how participants described satisfaction in personal and idiosyncratic ways. By looking at four examples in tabular form (Table 3) the multi-faceted and complex nature of satisfaction begins to emerge.

TABLE 3: INDIVIDUAL DESCRIPTIONS OF SATISFACTION

Participant Statement	Meaning of Satisfaction
<p><i>From a basic level right from the beginning I mean I'd like to be seen at a reasonable time, without having to wait. Kept waiting for goodness knows how long that annoys me. As long as I get a thorough consultation and they have looked properly and somebody seems to be taking me seriously instead of just go home and if its no better in six months come back then that's fine and I'm quite satisfied. (Participant 1)</i></p>	<p>Satisfaction=minimal waiting thorough consultation, examination, taken seriously</p>
<p><i>That what you've gone for you've got treatment for, and you're satisfied with the treatment they've prescribed you, and you like them to take an interest in you don't you. I know they see hundreds of people a week but you like to feel as though you're going into the doctor and they know you. They know what they're talking about and they're listening to you. (Participant 2)</i></p>	<p>Satisfaction=received treatment own perception of treatment prescribed interest taken doctor listening, individualised care doctor competent</p>

<p><i>That they've met my requirements. You know what I've actually gone for; you know they've told me what I wanted to know. Being treated properly and they've told me exactly what will happen, and that's what you want to know, what's going to happen, explain things to you.</i></p> <p>(Participant 3)</p>	<p>Satisfaction=treatment congruent with own perceptions, information, received explanations</p>
<p><i>That I've had a condition taken seriously, that I've been listened too, that I felt able to articulate how it was making me feel and have that taken seriously and to have, to be given some advice on how to treat it and prevent it recurring.</i></p> <p>(Participant 4)</p>	<p>Satisfaction=taken seriously, doctor listening, concerns met, advice</p>

The continuum of patient satisfaction – from satisfied to very satisfied

From analysis of the data it was evident that participants felt that there was difference between being 'satisfied' as opposed to being 'very satisfied' with healthcare received. While for some participants, being satisfied with health care was described in terms of care being adequate or average, for others it meant that there were aspects of health care that could be improved, or that something was missing and that optimal care was not achieved. In other words, care and management had been 'acceptable' or 'sufficient' but not 'outstanding.' In contrast, being very satisfied with particular aspects of health care was described in ways that suggested that the service was not only more than adequate, but ranged from 'better than

average' to 'outstanding' that is, optimal care had been provided. These differences were described using a wide variety of words, metaphors and similes throughout the interviews that helped to particularise differences (Table 4).

TABLE 4: TERMS USED TO DESCRIBE THE CONTINUUM OF PATIENT SATISFACTION

<i>Satisfied</i>	<i>Very satisfied</i>
Alright	Outstanding
OK	Brilliant
some way to go before perfect	Great
Just happy-still along way to go	Spot on
run of the mill	Better than average
Not going overboard about it	Good as opposed to alright
Not ecstatic but not pulling it down	New idea
middle of the road	Very confident
Always element that can be improved	Problem sorted
or changed	Perfect
If one thing missing	Someone putting in more effort
If doubtful	no niggles
Managed up to a point	
Still concerns	
A bit niffed about something	
In that I'm 90 or 99% maybe sure	
given best treatment	

Three themes emerged which were significant in delineating the continuum from 'satisfied' to 'very satisfied.' These were:

1. The mode/manner of treatment received e.g. 'the way you've been treated.'
2. The sense of incomplete care and management e.g. 'if I'm left with some niggles' or 'something missing.'
3. Adequacy of management e.g. 'good enough but room for improvement.'

Superordinate theme 1: Mode/manner of treatment received.

Participants frequently described being 'very satisfied' as comprising of more than one component. For example, participants felt satisfied with their care when they had not only received a thorough consultation, but had also received treatment that had resulted in their condition improving or being 'cured'.

Participants described the way in which this care had been given as being an important factor in determining whether they were likely to feel 'satisfied' or 'very satisfied' with their experience.

Well I think it's to do with the way you've been treated when you're there as well as being managed and having your treatment.

(Interview 30: man, age 38, telemedicine group)

Several participants described being 'satisfied' as meaning that their problems had been managed or 'treated,' but in order to feel 'very satisfied' with their health care experience, although the treatment was perceived to be the same, there was a sense that staff had made an 'extra effort.' Extra effort seeming to mean a caring and individualised approach.

The following participant's account is quoted at some length because it is both typical and pertinent to many of the participant accounts of being satisfied or very satisfied in terms of the way in which their care was managed:

Well satisfied is just that it's the system you know just as it goes along. You know ordinary run of the mill system. You go and its neither here nor there you know. You go and they say right take these tablets and come back next week or something you know that's just an example, I mean that's just being satisfied you know you've been treated. Very satisfied is when there seems to be that bit of extra effort put in and makes you feel that they do really care or the system is set up for you. It's not just a production line sort of thing. Just satisfied is just going to the doctor or hospital and being treated as a thousand. I know it's difficult for them because they've got that many. But if you go and you're made to feel that the system is set up for you and that you know you've been treated alright. You know being treated and this system is set up for you rather than 'next please' you know that's satisfied. If you go and they say 'right see you next week,' but if you go and they do the same treatment but it's handled in a different way you're very satisfied to me. You know I know it's difficult because they're busy but some give that little bit and some don't. It feels better. (Interview 20: woman, age 39, telemedicine group)

The importance of the interpersonal skills of the doctor in distinguishing being 'satisfied' as opposed to 'very satisfied' are illuminated in the following extracts:

I guess it's how you've been dealt with isn't it, because very satisfied, I mean my view of satisfied is I've come away with a result so the only difference is probably how you were dealt with because you've

come out with the same result. (Interview 7: woman, age 33, telemedicine group)

To make it very satisfied to me would have been a more welcoming atmosphere you know not so many people in the room for what you consider to be quite an embarrassing complaint. As I said I was a bit jokey about it because that's how I coped with it. It was a big issue to me. So I was dissatisfied that they didn't take it quite seriously I'm not dying am I? I've not got a serious illness. So I felt a bit belittled about that, using their time up for something they considered trivial really. (Interview 24: man, age 45, telemedicine group)

From the above examples, the value of using interviews to elicit perceptions of satisfaction is evident. This rich data would arguably not have been elicited through a more conventional tick box patient satisfaction questionnaire. By way of example, the following Table (Table 5) illustrates the range of ways in which participants described being either 'satisfied' or 'very satisfied' with their care.

TABLE 5 COMPARISON OF THE TERMS USED TO DESCRIBE THE CONTINUUM OF PATIENT SATISFACTION

	treatment	description of system	implications
satisfied	similar	<i>'run of the mill'</i> <i>'neither here nor there'</i> <i>'production line'</i> <i>'one of a thousand'</i> <i>'next please'</i>	ordinary impersonal non- individualistic care
very satisfied	similar	<i>'made to feel system set up for you'</i> <i>'handled in a</i>	personal individualistic care extra effort

		<i>different way'</i> <i>'some give that little</i> <i>bit extra'</i>	
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Superordinate theme 2: Sense of incomplete treatment

Participants used words such as 'adequate' 'acceptable' and 'okay' to describe their feelings of being 'satisfied' with the health care they had received. However, they spoke of it with a sense that there was still an indefinable something 'incomplete' or 'missing' from the care and management.

That it had been managed up to a point but I'd still got some concerns, or there's still some way to go before it's perfect.
(Interview 17: man, age 72, control group)

Well I think if I'm very satisfied then I've come home feeling good. I've not got any little niggles you know, I can come home and I'm not niggled about anything. I think being satisfied I'm probably a little bit niffed about something. (Interview 22: woman, age 56, telemedicine group)

As this particular interview progresses the participant becomes more specific about what the 'niggle' might actually be, and comes to realise that the doctor had not spent adequate time with her:

Well it's hard to just put me finger on it exactly. If I go and I see a GP right, and I don't think they've fully had time with me then, but they've seen to me so I come home satisfied, but I'm not very satisfied. (Interview 22: woman, age 56, telemedicine group)

This was also echoed in other extracts. Feeling 'very satisfied' meant that participants were left feeling as though nothing had been missed and that all their questions had been addressed:

Well say my GP didn't tell me say how long I'd have to wait for an appointment, I'd have probably only put satisfied because I'd have felt he'd have missed something out. If they're had been one little detail that I'd have come home and thought well, because after I'd been to see him you obviously have questions in your mind don't you? But if there was one question that I had a doubt about then I wouldn't have put very satisfied, but I didn't. (Interview 29: woman, age 16, telemedicine group)

Again, the importance of having no outstanding or unresolved issues on completion of the health care encounter distinguished the differences between being 'satisfied' and 'very satisfied.'

Well I think the very satisfied would mean that there was nothing else that you could really ask. You know everything that you wanted to know was answered fully whereas satisfied would probably be that there was a few areas. You know you were quite happy with how everything went but there were a few areas that you weren't so happy about. You know if there's just a couple of minor things that they couldn't answer. (Interview 22: woman, age 56, telemedicine group)

Several participants described 'very satisfied' in terms of feeling mentally contented. For example:

When you're very satisfied you walk away you know and you think they were really really good and then sometimes you think well I don't know I just don't feel...I feel alright about it but I'm not content about it. I think when your really content in your mind then I'm highly satisfied. (Interview 28: man, age 18, control group)

Superordinate theme 3: Adequacy of care and management

Unlike the previous participants, for whom the differential between being 'satisfied' and 'very satisfied' was defined in terms of 'something missing' from the health care experience, the following participants were very precise in their definition of being 'very satisfied; it was the experience of management and care being 'outstanding.

Well it just depends whether that I think the person or people that treated me was outstanding in my own mind. New ideas of how I could have helped myself, and treatment like my GP never tried on me. I'd have thought he'd have given me better ideas on how to overcome it or what to do to help myself. Then I would have said I'd have been very satisfied because I'd got new ideas in my brain that I could help myself. (Interview 1: male, age 64, telemedicine group)

Conversely, being 'satisfied' was described in terms of care and management being 'adequate', 'acceptable' or 'sufficient' but that there were areas that could have been improved in order to have made them feel 'very satisfied' with their health care experience. The following data extracts illuminates this point:

I tend not to put very satisfied unless I've really thought it was brilliant, it was great, unless it was, you know absolutely spot on. (Interview 16: man, age 31, telemedicine group)

I think if you just tick satisfied, and I always think well that's it, it's done you know, it's alright. But I think when you're very satisfied I think you've had the satisfaction of knowing that somebody is taking time out and you're going to get to know what is going off, and I were very satisfied with everything they asked me and what they told me. Whereas satisfied to me is you just go and they do it .I mean I were very satisfied. I thought it were brilliant you know. (Interview 27: woman, age 58, telemedicine group)

Participants used terms such as 'middle of the road' or 'run of the mill' to describe their sense of adequacy of care and management when describing satisfaction.

I mean I'm not exactly ecstatic about it and I'm certainly not pulling it down. It's the middle of the road. It's right. It's good. It's ok you know. (Interview 17: man, age 72, control group)

Conversely, 'very satisfied' being only achieved when participants perceived the service they were receiving as being 'better than average.' So for example, the following participant demonstrates how receiving a prompt appointment made her feel as though the system was better than 'run of the mill':

I thought it were good as opposed to being alright you know, satisfied. You know satisfied is you know that's ok. But I thought it were very good so I'm very satisfied. Well satisfied is kind of, it's abit like 'run of the mill' isn't it type of thing, but I thought the whole

system were abit better than that. I thought it were sort of better than average you know what I mean. I thought it were better than that. I'd come back from holiday and my appointment had already come so yeah. (Interview 20: woman, age 39, telemedicine group)

For several participants, feeling confident with aspects of their health care was an important issue when deciding whether they were satisfied or very satisfied with their care. The following participant reported that although she was satisfied with her care and management, she 'didn't feel totally confident' implying that if she had have done, then this would have resulted in her feeling very satisfied:

Things like being confident that the consultant had given the GP enough information for them to pass the information back to me second-hand and I didn't feel totally confident that it had because of the nature of the communication that came back to me. (Interview 25: woman, age 40, telemedicine group)

This feeling of confidence was echoed on other participant accounts:

Well very satisfied is that you are absolutely totally confident in what they've done. Satisfied is just happy with what you've done but there is still along way to go, and good is just that it is at the back of your mind still. (Interview 15: woman, age 41, telemedicine group)

Negative case analysis

As suggested by a number of authors (Henwood & Pidgeon, 1992; Mason, 1996; Murphy et al, 1998; Elliott et al, 1999), one of the ways in which to assess the quality of qualitative research is to search for data that is inconsistent with

emerging themes. Although integration of such data has been incorporated within the descriptive analysis, here, more specific accounts of negative-discrepant cases are presented (Silverman, 2000). Despite most participants describing differences in being either 'satisfied' or very satisfied' with health care, several outliers emerged which capture the diverse views of the participants in this study. For example, three of the participants felt that there was no difference between the two terms.

Well not really I don't think there is to be honest I don't know. I mean you're either satisfied or your not aren't you. I mean you can't be half satisfied. (Interview 2, man, age 67, telemedicine group)

Well I think in my case you couldn't take it that there was much difference at all between satisfied and very satisfied. You know I think they're so near to each other that you cant expect to see any difference. (Interview 18: woman, age 45, control group)

Another participant also highlighted the arbitrary nature of responses to satisfaction questionnaires:

I think its fairly arbitrary actually. I always find it quite difficult doing those kind of questionnaires you know where it lies. I mean I try to do it as well as I could but it does feel a bit arbitrary at the end of the day. (Interview 12: woman, age 81, telemedicine group)

Additionally, although several participants perceived that there was a difference between the two terms, they felt unable to make a judgement within the research

interview because they had received care that was new to them and they felt that they had no 'benchmark' or past experience to draw upon.

Just because it's new. You know because it's a new thing. Like I wouldn't put I'm not dissatisfied with it because as I say it's new. I'm very satisfied with it but not to the extent I'd go overboard about it because it's new you know what I mean. If it had been going about what a couple of year I would be very satisfied but it might just like all go pear shaped. (Interview 6: woman, age 35, telemedicine group)

The unfamiliarity of what 'normal practice' was, again resulted in a reluctance to suggest any possible differences between the terms.

It was the unknown as in I'm quite happy to do this because I think it's important to do things like this. I don't know what would be expected if you see what I mean. So I couldn't say I was very dissatisfied with anything because I don't know if that would be the normal practice if you see what I mean. I mean I hadn't got a benchmark to work with to actually say this is what should have happened. I don't know normal practice, so I didn't want to be totally dissatisfied with anything because I didn't know whether that was the norm or not. (Interview 21: woman, age 37, telemedicine group)

Finally, one participant felt unable to assess the skills and competence of the consultant because he didn't have the expertise to know whether the diagnosis and treatment given was the right one. This resulted in the participant feeling satisfied as opposed to very satisfied.

I would be very satisfied with something if I knew what very satisfied was. Again I'm not on the same level as the consultant as regards his field so I can't judge his response to my complaint or whatever. I can't judge him saying yeah it's this and this. If I knew he was right then I would be very satisfied because he'd probably say exactly what I knew, if I knew he was 100%, so yeah, I'm satisfied in that I'm 90 or 99% maybe sure that he's given me the best available treatment. (Interview 10:man, age 29, control group)

Conclusion

While it is clear that participants held a variety of views, this descriptive analysis identified six themes that emerged as being significant in participants' descriptions of satisfaction. These were:

1. receiving a diagnosis, treatment and cure
2. receiving information and explanations
3. importance of doctor-patient communication/characteristics
4. the perception that their condition had been taken seriously
5. receiving individualised patient care
6. minimal waiting for an appointment and treatment.

The descriptions identify the importance of receiving a diagnosis, treatment and cure, of being provided with information and explanations, and of minimal waiting time for an appointment and treatment. The findings also highlight the importance of good communication and receiving individualised care in an environment where participants are given optimal care and are treated in a way

that they feel as though they are being taken seriously. Additionally, previous studies have failed to address the continuum of patient satisfaction. These findings suggest that there are differences between the states of being 'satisfied' as opposed to 'very satisfied' with health care. These were expressed in terms of a) the manner of treatment received, b) the sense of completeness of care and c) the adequacy of management of care. These were differentiated by the overarching importance of receiving individualised, patient-centred care. For example, whereas being *satisfied* indicated the minimal standard or adequacy of care and management, being *very satisfied* pointed towards the participants need and appreciation of care which was experienced being tailored to the individual.

While the aim of this chapter has been to provide a broadly *descriptive* phenomenological analysis of the transcription of the participant interviews, it represents only the first stage in an attempt to fully implement an interpretative phenomenological procedure. A more specific focus on individual cases with a phenomenologically *interpretative* analytical lens may capture of 'the way in which the world presents itself in an immediate (unmediated way)' (Willig, 2001:65).

A reflexive approach

Heidegger (1962) questioned the human ability to observe objects separated from the world of objects, since, as Draucker points out 'we are beings inseparable from an already existing world' (Draucker, 1990:361). Draucker further states that the Heideggerian activity of 'being-in-the world' means that 'humans are always living hermeneutically, finding significance and meanings in their world' (ibid). In this phenomenological 'arena' we are arguably, as researchers, also inseparable from the so-called 'objects' of our study, and the

understanding we aspire involves, as Todres and Wheeler point out, ‘a self-reflective thematizing on the world of meanings that are present in our human engagements and relationships. We thus always find ourselves in the middle of complex situations about which we may have existing provisional assumptions. Such assumptions may be revised in the process of experience and reflection’ (Todres & Wheeler 2000:4). This is a potentially problematic issue in that it brings the researcher’s subjective interpretation to the fore. However, as Nicolson points out:

What is important is not ‘eliminating’ the subjective interest in the research, but being able to recognise its existence and identify the part that this interest and commitment plays in the relationship between the researcher, the respondents and the data. (Nicolson, in press)

Furthermore she concludes that ‘the processes involved in in-depth interviews are not (and can never be) neutral, objective and unbiased acts’ (ibid).

Denzin (1989) supports this view by stating that every researcher brings their own pre-conceptions into the research arena; thus, with the phenomenological aim of exploring the participant’s ‘world’ there is a need for the researcher to acknowledge their own assumptions and belief systems. As Smith points out:

While one attempts to get close to the participant’s personal world, one cannot do this directly or completely. Access is both dependent on, and complicated by, the researcher’s own conceptions which are required in order to make sense of that other personal world through a process of interpretative activity.’ (Smith, 1996: 264)

Accepting that the research process is itself socially constructed, and accepting that by flying in the face of classical notions of scientific objectivity, the researcher should acknowledge that ‘ the personal is always present’ (Henwood & Pidgeon, 1992:105); the research process itself becomes socially constructed with the researcher included in the body of research. This is viewed as an integral part of the process at each stage of the research. As Todres & Wheeler point out, ‘there can be no non-positional understanding of anything, understanding is always situated and never absolute’ (Todres & Wheeler, 2000: 4). The importance of researcher-reflexivity and subjectivity in the interpretation of the data is viewed here as being important in elucidating important insights into the meaning of satisfaction.

No human being can step outside of her or his humanity and view the world from no position at all, which is what the idea of objectivity suggests. The task of researchers therefore becomes to acknowledge and even work with their own intrinsic involvement in the research process and in the results that are produced. Researchers must view the research as necessarily a co-production between themselves and the people they are researching. (Burr 1995:160)

In aiming for accuracy, quality and ‘goodness’ of this kind of research, Henwood & Pidgeon (1992) suggest that the progress of a study and its evaluation by others can be helped through implementing a reflexive approach (see also Cooper & Stevenson, 1998). In such an approach, the researcher reflects upon their own process of research, acknowledging their own biases, as well as the impossibility of total objectivity. Nicolson (1998) goes further in suggesting that it is essential not only to ‘acknowledge, but to explore one’s personal action as a

researcher in order to understand the research process and to recognise problems and anxieties which are related to this task' (Nicolson, 1998:73). Thus, in reflexive analysis the researcher is 'aware of experiencing a world and moves back and forth in a kind of dialectic between experience and awareness' (Finlay, 2002, 533)

Banister et al (1994) suggests that reflexivity requires the simple methodological understanding that one works 'conjointly *with* participants rather than *on* them', and continues, 'an acceptance of the need for reflexivity is intrinsically a denial of the doctrine that scientists think, while their subjects are mechanical and determined' [148]. This author suggests that, 'reflexivity is perhaps the most distinctive feature of qualitative research' [149], and states that reflexivity 'is about acknowledging who you are, your individuality as a researcher and how your personal interests and values influence the process of research from initial idea to outcome. It reveals rather than conceals, the level of personal involvement and engagement.' (Banister et al, 1994: 150). A reflexive approach expects that the participant and the researcher become involved in a jointly constructed case through a dynamic interactive process of 'iteration, analysis, critique, reiteration, reanalysis' (Schwandt, 1994: 129). This process may take place as a form of dialogue, as Mulkay (1985) suggests:

By abandoning the analyst's usual assumption of interpretative privilege, one could enlist the participants help in revealing one's own textuality, while at the same time digging more deeply into their interpretative capacities and your own. (Mulkay, 1985:76)

Some authors have highlighted the inherent difficulties associated with a rigorous implementation of the reflexive stance (e.g.Gough & McFadden, 2001; Finlay, 2002) where the researcher's position can 'become unduly privileged, blocking out the participant's voice' (Finlay, 2002: 541), and there is the presumption of self-critical awareness on the behalf of the researcher (who is placed within a postmodern context which regards the self as socially constructed and therefore fluid) Indeed, as Gough & McFadden (2001) point out, in adopting a reflexive approach ' Can we be sure that we know what prompts us to choose a particular research project, to ask certain questions, to respond in specific ways? To accomplish such an onerous task, would require a 'superhuman self-consciousness'(68). The authors point out the danger that reflexivity could 'slide into self-referential analysis' (69);.Gadlin & Ingle (1975) suggest that this danger can be avoided through implementing a 'constant awareness of the researcher's ' relationship to and with his subject matter and awareness of his own role with respect to his inquiry'

There is the hope then, that in this study, a reflexive approach will, as Steier (1991) somewhat obtusely points out, 'allow ourselves to hear what our subjects are telling us, not by imposing our categories on them, but by trying to see how our categories may not fit' [7-8]. If a researcher is actively involved in interpretative research, it requires their acknowledgement of an interactive relationship between the researcher and the researched (Elliott et al, 1999; Chamberlain, 2001).

Thus adopting the position that all research has some element of a personal component, the notion of pure objectivity and impartiality may not only be a myth but also misguided. Health research interests and activities are viewed as human activities, situated in the world, and as a result, from a reflective viewpoint are inextricably tied up with the interests, values and life experiences of the researcher. Therefore, in order to engage more intensely and in greater depth with the process of research into patient satisfaction there is an unashamed thread of reflexivity woven throughout the fabric of this study (Henwood & Pidgeon, 1992; Banister, 1994; Nicolson, 1998). This is set within the process of making transparent not only my own theoretical and methodological orientations but also my ongoing perceptions of the research process.

As a result much of this study is written as a first person account. More specifically, this transparency led me to introduce in the preface to this study, my own experiences, background and research interests that have played a significant role in shaping the direction of the research. A personal and reflective account of some of the issues experienced during the course of this study are also discussed in chapter 7. The following chapter, therefore, looks at individual accounts in greater interpretative depth.

Chapter 6: Findings Two: interpreting patients' descriptions of satisfaction

Introduction

The data analysis carried out with the thirty interviews (outlined in the previous chapter) generated good descriptive data concerning participants perspectives on satisfaction. When the themes are cross-validated, these descriptions provide a valuable depth and context. However, as I indicated in chapter 2, a purely phenomenologically descriptive (or Husserlian) mode of analysis of the participant interviews may not be possible, since any description of experience (whether one' own or that of others) is unlikely to be entirely free from some degree of interpretation.

It was evident through the initial analysis that a straightforward reduction to common superordinate themes does not take into account instances of self-contradictory comments, or idiosyncratic ways of speaking by a person. These ways of speaking, which arguably cannot be given justice with a broad analytical base often contained 'repetition, explanation, justification, vernacular terms, implicit and explicit assumptions and unusual phrases' (Flowers et al,1999:487). As a result subtle inflections of meaning were in danger of being lost in the analytical process of coding large swathes of transcribed interview data.

Attempts to overcome this difficulty is to be seen in more recent IPA based studies which have reduced the number of participants (for example, Osborn & Smith (1998) [with 9 transcripts]; Baillie et al (2000) [8 transcripts]; Jarman et al

(1997) [5 transcripts]; Smith (1996) [1 transcript]. See also Collins & Nicolson, (2002) for further discussion.

Thus, in order to counteract the danger of depersonalising and diluting highly individual participants accounts and experiences, it is important to examine a small number of purposively selected interviews through a quasi case-study format. That is, to examine those accounts which most succinctly reflect the previously identified significant themes derived from the large body of transcripts. The intention being to maintain a rich and holistic view of the participants' life-world. The claim of IPA is that it enables the researcher to engage more intensely and in greater depth with the data (which here is encapsulated in the interaction between the respondent -and their experience of health care - and the researcher.) This more intense engagement with the data, this 'involvement' with the thing in question, which in a Heideggerian sense 'gets laid out by the interpretation' becomes a more contextually interpretative account (see Collins & Nicolson, 2002).

There is here, therefore, a second stage of IPA with four participants which will then 'funnel down' onto one participant. This aims to:

Explore the data in depth to identify the processes that underlie the discussions in the interviews, and from consideration of these, detect the meaning attributed to the content of the discussions by the respondents. This in turn leads to the development of a conceptual framework for explaining key aspects of the experience. (Nicolson & Anderson, 2001:556).

Thus it is a detection process, one of trial and error perhaps, but one that potentially lends more important insights than one which more systematically attempts objectivity in interpretation.

Interpretative analysis of four individual accounts

The following section, therefore, examines interpretatively individual accounts derived from four separate interviews. These accounts were selected in order to provide an idiographic perspective, where the concern was 'with the particular rather than the general' (Willig, 2001:70). As mentioned above, the transcripts of these four participants' accounts were seen to reflect most comprehensively the themes which arose from the main body of interviews with the aim of generating new insights and knowledge.

1. Participant One (interview 25)

The following interview was carried out with a woman, aged 40, who presented to the GP with an itchy rash. She was interviewed 3 days following her follow up consultation at the hospital. On a patient satisfaction questionnaire, completed as part of the wider trial, this participant reported that she had both been satisfied with the care she had received and the way it had been managed. She reported being neither satisfied nor dissatisfied that her skin problem had been addressed

This participant begins by describing at length the background to her particular condition. Thirty lines of text are given over to a detailed account of the various stages of diagnosis.

After the 30-40 lines of historical account /cameo/background the participant states her anxiety about her skin problem and her need to know why *'something so severe could come up with no reason and go away as quick. That is really what I wanted to know.'*

The participant did in fact feel *'100% confident with the diagnosis'* but not with the treatments since she *'wanted an explanation.'* Thus despite a very reasoned and intelligent account of her problem, and a complete faith in the competency of the doctor and her subsequent diagnosis, she keenly *'wanted to know.'* This need to know is reiterated in the next sentence with an added emphasis; *'what I really wanted to know was why did I get it, how can I stop getting it again?'* So there is an issue of communication here, where the lack of knowledge on the behalf of the patient creates significant anxiety and in fact, she acknowledges herself that her problem may well be stress-related.

For this participant, communication in the form of a letter would have been satisfactory, but not in, what seemed to have been, an *'off-hand manner'* in the form of a telephone call *'oh, we've got confirmation of what we thought anyway.'* This participant then assumes the role of consultant to her problem and offers an example of the letter she would have hoped to receive: *'a letter that said it was palma plant postulosis. It's a form of psoriasis. On the basis of what you have told me about the patient, it's likely it's genetic in some form.'* The degree of self-awareness this participant brings to the interview is significant; she is fully aware that her lifestyle where she has to *'juggle family and a demanding*

job ' is almost certainly creating stress (*'something going on inside me that was making this worse.* '). What she really wanted was to know something concrete and factual, rather than circumstantial i.e. that it is a genetic disorder.

This is the issue which leads the participant to say that she would prefer to see her GP instead of the consultant since, *' your GP knows you, so is looking at you in a holistic way and they know the general stresses and strains you're under and your medical history so that's important in terms of preconceptions about you.'*

This certainly seems an important element in this particular account; the background knowledge of her GP, which the consultant does not possess, is essential, a fact reflected by the significant proportion of the interview she has given to a sequential, accurate and detailed account of her condition.

However, it is not only the fact that the GP has a 'holistic' knowledge, but the structural difficulties included in a hospital consultation which were compounding her preference for a GP diagnosis (*visiting* the hospital involves *'sorting out child-care'* *'parking'* *'having to queue'*). The impersonal nature of the hospital setting which was described as, *'the cattle-market kind of nature of out-patient clinic, it was all of that, it's too clinical'*, also influenced her future preferences.

Despite this negativity, the participant was very positive about the communication between herself (*'assertive and articulate'*) and the consultant (*He was lovely. He didn't dismiss acupuncture*). This she described as being *'really important'*. The positive manner continues at this point in the interview,

mainly in terms of communication-based issues; *'the communication between him and myself was good.'*

A clear, emerging theme running through this participant's transcript is the central importance of communication. This was viewed in terms of the consultant not being dismissive, the doctor who had a holistic knowledge of her condition (as well as her history) and who could, as a result, communicate effectively. This is a critical point; this participant does not require effective communication only to put her mind at rest, but rather to act as a form of empowerment: *'I suppose it's like preventative medicine. It's about saying this is really what we think you ought to do, so it's information about helping a patient to take a bit of control to stop something happening again.'* At this point in the interview, one observes a strange blurring of roles between patient and doctor; indeed, the strong need for information by this participant leads her to admit that *'I always feel that I have to push that. I'm the one who has to ask that question'* (i.e. how to treat the condition and stop it recurring).

However, it is only at the close of the interview that the participant gives a deeper insight into the relationship between her skin problem and her inner self. There was a recognition that *'it was obviously something that was going on inside me that was making this worse.'* Indeed, the use of creams that the doctor had recommended wasn't dealing successfully with the problem and *'it was really scary.'* Her panic and obvious deep anxiety about what was visually happening to her body leads her to express this panic in the interview several times in succession: *'I'd think what is it that's going on in my body? There was*

something really scary about it, and again, *'it just felt like this was happening in spite of everything I'm doing to stop it happening, so it was scary.* For this participant, one who sees herself as *' articulate and assertive'* and who is able to quite naturally reverse the roles of doctor and patient in terms of communication-based issues, being in a situation where she felt out of control consequently meant she attached a high degree of importance to informative communication over and above all other issues.

2. Participant Two (interview 5)

The following interview was carried out with a woman, aged 39, who presented to the GP with a mole. She was interviewed 7 days following her follow up consultation at the hospital. On a patient satisfaction questionnaire, completed as part of the wider trial, this participant reported being satisfied with the care she had received, the way her problem had been managed and satisfied that her skin problem had been addressed.

In introducing her condition, this participant describes a mole that keeps swelling up. In what may be termed an off-hand, downbeat manner, she discusses how *'It doesn't bother me.'* Her visit to the GP was merely a *'check that it was alright, just a check.'* But this is perceived by the participant as only part of what could be a bigger problem, that is *'I've got other lumps and bumps, I mean I think it's hormonal.'* The teledermatology consultation, although being positive in focusing specifically upon her mole, left her with a feeling that the consultation was not complete, and that there may have been related issues to address. She talks about this initially in a quite guarded manner, giving very little away about

the 'bigger picture' which was troubling her: *'it didn't really give a lot of room for any, it was specifically for this mole, so I couldn't even say about, well I could say, but it was very much for this specific thing you know, not as a whole.'*

The appointment system set up for this particular consultation had left her feeling equally frustrated – *'the receptionists didn't seem to know or understand what I was going on about.'* The fact that the doctor was ringing her at work where she couldn't communicate effectively or in private – and concluding that a return to the GP practice to discuss the results may well have been more satisfactory. The frustration was compounded since the diagnosis had *'come early'* and with no explanation except over the phone, at her noisy and busy workplace (*'I couldn't concentrate, I couldn't concentrate on what he was saying'*). She was thereafter left hanging and wondering: *'it was left to me, it was left up to the patient, if you like, to decide what to do about it.'*

This situation was set in complete contrast to her GP practice where despite an 'absolutely packed' waiting room, she could say that: *'I never feel that I'm being rushed or you know, I feel as though he's very thorough and he's spending the time.'* Communication was not a problem since she perceived that she was *'being taken seriously'* by her doctor, and that he took time over her appointment. She was not afraid to make a list in writing to discuss issues troubling her: *'if there are little things that are worrying me, I tend to save everything up now.'* As if to underscore this point she repeats: *'I try and make a list you know, I'll try and write it down.'* It is the issue of good communication with a doctor who takes her condition seriously, which leads her to admit that, in the context of a teledermatological consultation, she would *'probably want to see somebody face*

to face. ' This represented a need for human intervention, and to be able to express feelings of wanting to have an expert speak to her face to face, to alleviate not just her condition but her significant anxieties: *'I just needed somebody to say, you know it's nothing to worry about.'*

In reflecting later on in the interview about how the system could improve she again says: *'I did expect him on the phone to say we've got your results, nothing to worry about.'* Like other participants describing their experiences, this participant places herself in the role of the doctor, providing a convincing and perceptive snapshot of what would have constituted a satisfactory outcome: *'I did expect him on the phone to say, we've got your results, nothing too worry about, and we'll discuss it, you know if you've got any worries.'* For this participant *'that would have been great.'*

Despite her initial downbeat approach to her condition, she reports elsewhere that, *'I've had moles and things removed and I'm quite blasé about it really,'* this participant is quite clear about what satisfaction means. It is only at the end of the interview that she is prepared to abandon this throwaway approach to her own health and admit that: *'As long as I get a thorough consultation and somebody seems to be taking me seriously, as long as I feel as though I'm being taken seriously and [the consultation] has been thorough, and they have looked properly then that's fine and I'm quite satisfied.'*

At this stage she begins to reflect upon how she might have acted differently in the consultation situation. She admits that *'I think I'm not terribly aggressive but*

I'm not positive enough when I go to see the doctors a lot of the time'. She proposes that this may be a common dynamic in the doctor/patient transaction, 'you are sort of in awe of them a little bit aren't you?' The only answer for this participant is that patients have to be more proactive in order to avoid the following situation that she rather comically describes in these terms: 'I mean he [the GP] was quite into the computer. He was all into computers, but his bedside manner was atrocious. I'd rather not even go to the doctors than go and see him.'

Thus, in order to avoid such situations and to actually receive more information, as with the previous participant, she viewed patients as having to, *'be a lot more positive, and you would have to question, and you would have to push a bit more maybe.'* For this participant, the doctor's communication and manner of approach are seen to be of major importance. She summed this up in the following statement at the close of the interview: *'They end up doing a technically correct job but it's the wrong thing for that person because they've not done the communication or the consultation properly.'*

3. Participant Three (interview 7)

The following interview was carried out with a woman, aged 33 who presented the GP with an inflamed lesion on her eye. She was interviewed 5 weeks after receiving her follow up consultation at the hospital. On a patient satisfaction questionnaire, administered as part of the wider trial, she reported being both very satisfied with the care she had received and the way she had been managed

and was neither satisfied nor dissatisfied that her skin problem had been addressed.

This substantial interview (75 minutes), like the previous two, illustrates the way in which a patient is able to use an interview situation to reflect upon, reappraise and contextualise their healthcare experience.

Unlike the previous two participants, this participant initially adopted a fairly low-key or modest self-appraisal of her problem: *'I'd got this funny thing in my eye which was the dermatology thing. I don't know whether I would have gone for that one thing.'* Nonetheless, she acknowledged at an early point in the interview that it was quite worrying, since *'it was obviously not, it was not like spots, it didn't go away, it was obviously there, and getting, you know, not getting any better.'*

However, the participant herself initiates a secondary concern within the interview about her high blood pressure. The fact that this was not the central factor in the interview may explain her very tentative approach in opening up the topic: *'I always end up with, you know, I always seem to end up with, I also happen to have high blood pressure.'* However, the following section of the interview reveals why she is so cautious in discussing this problem. The participant is patently not confident with the expertise of the medical profession, and she is afraid that she will not be taken seriously:

They don't really know why, and so it's like 'oh well, it's just one of those things and you're going to have to take these tablets' kind of thing, so you're used to that. I mean, they don't really know. I mean although medicine knows a lot. They don't really know a fat lot do they?

There is, at this juncture, a sense of resignation that her problem is not serious enough to bother others about, *and 'as long as it's nothing like, horrible, I think that's your concern isn't it?'* However, the worries and anxieties are still there, and she continues, *'When you get something, you think what is it? Is it just one of those things or is it something I should be worried about?'*

The interview continues with the participant describing her experiences at the hospital, mainly in structural terms such as waiting times, and the 'dismissive' attitudes by the staff. The need to be able to talk about her condition is evident, and the off-hand manner of the consultant is contrasted with the openness of her GP: *'since there's a rapport there you'll sit and you'll talk about it, and that might be the thing that's really worrying you'*, whereas with the consultant, *'It's a bit different. It just doesn't feel like that. It doesn't feel like they're particularly bothered about it. It was almost like it was a bit of a nuisance.'* A little later in the interview the importance of being taken seriously by her GP compensates for structural issues such as being kept waiting: *'sometimes you know they run late, but it's like you don't mind so much because when you go in you feel like someone's sitting and listening to you.'* This is, in fact, an essential component of satisfaction for this participant, who again underscores the importance of

being known and understood as a person in her own right, rather than a depersonalised patient with a condition. With her GP practice she feels, *'they know a bit about who I am and what I do'*, but, *'in the hospital, I mean it's in one door, out that door you know, nothing.'* The participants expectations of healthcare are conflated with not being depersonalised together with receiving a informative diagnosis and treatment: *'You want someone to say, yeah, you're right, you know we need to do x,y, or z, or no, it's ok it will go away.'*

It was only half an hour into the interview that the participant begins to reflect upon her own role in the healthcare process, admitting (possibly in a resignatory fashion once again) that *'I don't expect them to know everything. They don't know everything.'* Instead, she shifts the burden of responsibility onto herself: *'it's responsibility, it's taking responsibility for your own actions and responsibility for your own life isn't it?'* This reflective stage then triggers off more information on what really seems to be concerning her; indeed, it is not primarily her dermatological problem, but rather her high blood pressure, that was hinted at in such a tentative way at the opening of the interview, that is worrying her. Now, approximately thirty minutes on, the patient abandons the *laissez-faire* attitude and adopts a more urgent and anxious tone: *'I've got a problem with circulation in my hands. I mean it's just getting worse. It's ridiculous. Now I'm starting to get numbness in my hands, I mean, what do I do now?'* This expression of deep concern (once again, not for dermatological matters) continues for two pages of the interview transcript, and she begins to ask me (the researcher) more questions, *'Next winter I'll be a bit more worried, you know, is it the drugs? Or isn't it? I mean, I know that I've got bad circulation,*

now is it the drugs making it worse? That's what I want to know'. The interview account continues with the participant describing herself as in a position where she is casting around for possible sources of information on her condition since she: a) does not wish to experience being '*talked down to*' again by the consultant and; b) she is unsure about the severity of her condition and is afraid of '*troubling*' the profession. Her account becomes more animated and disjointed:

I mean this Raynards or whatever it is, now all I need to know is, is it just that or are these drugs making it worse? Now if I could just go and see somebody. I mean I almost don't need a consultation. I mean if there was somewhere you could look up which says 'yes this is a known side effect of these drugs.' I mean I think that's where the trouble is, a lot of people's concerns of things are. I mean when can I go back to the GP and say 'right, this bloke said this', and 'can we try what other drugs we've got then, that will keep my blood pressure under control that might not have these side effect.' A load of people have these kind of, you know, it's almost silly little things that other people are worried about, that you just need somewhere to go or someone to talk to.

In identifying herself with '*a lot of peoples' concerns*' and '*a load of people*', and '*other people*', she is identifying herself with others, in a sense of despair and frustration that her condition had not been taken seriously. This frustration reaches a climax of criticism where she projects this frustration onto the consultants and the healthcare system generally:

That's when the consultants get frustrated and hacked off presumably because they've seen loads of what to them is stupid, poxy things that don't

matter because they're not great big, juicy whatever.

This frustration, where her questions are either ignored or displaced, are powerfully expressed in the comment, *'you just need somewhere to go or someone to talk to'*, moulds and shapes her definition of satisfaction. The manner of the consultation is secondary, *'I don't expect the manner of the consultant to be particularly great, so I almost wouldn't judge them on that. I probably just go in wanting an answer from them.'* It is the lack of information which becomes almost as incapacitating as her condition, *'you don't know whether it's anything serious, and chances are it's something reasonably insignificant'*, and this leaves her to resign herself to say that, *'I suspect I'll come out and I'll probably have to put up with it.'*

It is evident then, that over the course of the interview, this participant has not only been describing, and accounting her healthcare experiences, but also working through very personal issues, which encompass having her condition taken seriously, being able to communicate her anxieties to professionals, together with uncertainty over the seriousness of her skin condition and her high blood pressure. The effectiveness of the interview in eliciting a contextualised, phenomenological understanding of the participant can be summarised in her penultimate, unprompted comment: *'I'm quite surprised you know, when you go back and think about things, it's quite funny how things are deep in you, deep in your mind.'*

It is possible to clearly observe in the three of the interviews, that participants move from a general descriptive account of their condition and their particular

healthcare experiences, to a more thoughtful, evaluative and reflective account; this was a common pattern across most of the interviews. However, it is important to point out that there were instances where this pattern was less clear and participants did not always give their personal interpretations of events and initial reading seemed to offer less fruitful data. In a qualitative research study, it is important to present an alternative that is inconsistent with emerging analysis as a method to assess the comprehensiveness and quality of the qualitative analysis presented (Henwood & Pidgeon, 1992; Murphy et al, 1998; Elliott et al, 1999).

4. Participant Four (interview 6)

The interview took place with a woman, age 35 who was interviewed 4 weeks following her consultation at the hospital. She presented to her GP with an itchy scalp, hair loss and bald patches on head. On a patient satisfaction questionnaire completed as part of the wider trial she reported both being very satisfied with the care she had received and that her problem had been addressed, and satisfied with the way her skin problem had been managed.

In this particular interview, the participant begins with a matter-of-fact, pragmatic stance, and continues in this manner through to the close of the interview. Questions were answered either very curtly. For example:

KC: What about the way it has been managed?

PT: That telemedicine?

KC: *Yes*

PT: *That were brilliant*

KC: *Because?*

PT: *It were quick*

KC: *Right, and that's the most important thing?*

PT: *Yeah.*

Or 'bounced back' to the interviewer:

KC: *The way in which your skin condition has been managed – did you have any input into that?*

PT: *Well I just go and they're the doctors aren't they? You do what you're told don't you?*

And:

KC: *What about if you knew you weren't going up to the hospital and the consultant was purely going to diagnose you from these pictures?*

PT: *Well, that's the point of that telemedicine isn't it?*

Therefore, with such modes of response there is the difficulty of eliciting any meaningful understanding of the participant's life-world. However, halfway through the interview, when probed for her own definition of 'patient

satisfaction', this participant abandons the clipped, questioning stance, and becomes more verbose. Despite the participant's rather cynical view of a consultation as, *' Well I just go and they're the doctor aren't they? You do as you're told, don't you?,'* it is clear that this is a 'front', since in the space of eight lines of following transcript, the participant expresses a clear need to be treated as an individual in her own right: *' Yeah, and you like them to take an interest in you don't you? I know they see hundreds of people a week but you like to feel as though you're going to the doctor and they know you.'* They know what they're talking about and they're listening to you.'

The participant uses the words or phrases such as 'like to feel', 'taking an interest', to underscore her expectations. In a withering account of what has obviously been a consultation experience the participant describes the opposite of a productive patient/professional interaction:

...and you know they're not bothered because they are finishing off other patients notes and what have you, and you can be sat there two minutes and they are still writing until they look up and say what's up with you?

Interestingly, this rather laconic participant describes a typical, or cameo consultation, which she considers would be more appropriate (or more human): *'You want to walk in, sit there, 'Hello, right, what can I do for you?'* The return, after this section in the interview, to clipped phrases, and simple one-word answers, only serves to highlight the very importance the participant attaches to the consultant taking a genuine interest in her.

I had mentioned earlier that, throughout reading, re-reading, description and interpretation of the complete interview transcripts, it became increasingly evident that in the process of establishing themes between participant accounts, there was the danger of diluting rich, idiosyncratic and personal accounts, as well as sidelining the sequential aspect of these accounts.

I have briefly discussed the manner in which the semi-structured interview (rather than the questionnaire) can uncover a process of reflection and re-evaluation by the participant, as can be seen in the four participants' accounts above. I also suggest that by viewing the accounts sequentially, and recognising the emergent nature of the data over time, it is possible to make further sense of the data (irrespective of the apparent lack of disclosure by the final participant).

Interpretive analysis of an individual account (interview 11)

Todres and Wheeler (2000) argue that the 'life-world' of a participant is 'always more complex than anything we can say about it: the lived world is greater than the known' [3]. They go on to assert that the 'task of phenomenology is to *clarify* the world.' [3] The existential perspective of Heideggerian phenomenology (1962) considers that the understanding of our participants cannot occur in isolation from their world. Thus in order to engage more intensely and in greater depth with the process of research and the interaction between the participant, researcher and the experience of health care, and in order to move from a descriptive thematic analysis to a more contextually interpretative reading of an individual case (Smith, 1995; Smith et al, 1999), a 'time-based' analysis of an

individual account was undertaken. Thus, unlike the procedures of IPA which cluster and aggregate themes within texts with no regard to their positioning within the *actual* interview, Todres and Wheeler (2000) point out the need for less mechanistic or formulaic approaches where ‘ descriptions of phenomena, as text, are open to multiple readings and interpretations, depending on personal perspective and historical context. The task of the researcher in this regard is to find a viable mode of interaction with the text’[4].

The following account succinctly reflects the previously identified themes derived from the thirty interviews; it represents an interview carried out with a 36 year old woman who presented the GP with an itchy rash, who was recruited to the telemedicine group. She was interviewed 6 days following her consultation at the hospital and reported being very satisfied with the care she received and the way her problem had been managed. She was satisfied that her problem had been addressed via the patient satisfaction questionnaire administered as part of the wider trial. Extracts from the account are laid out in table format (Table 6) which establishes a framework within which other accounts can be located. Column 1 provides a sequential mapping of the interview as it proceeds, whilst Column 2 provides an interpretation of the participant account.

TABLE 6: WORKED EXAMPLE: ONE PARTICIPANT ACCOUNT

Column 1		Column 2
Page No	Sequential extracts from participant account	Interpretation
	The interview opened with the participant describing the background to her skin condition.	
1	<i>she didn't even look at it, didn't even look.</i> <i>She didn't look at it from my point of view</i>	Dissatisfaction with the doctor's approach and manner is apparent.

		She sums up the failings of the first GP
3	<i>I'm not dissatisfied with it because as I say it's new</i>	Reluctance to express any overt dissatisfaction, pragmatically distancing herself from the overall project
4	<i>I'm very satisfied with it but not to the extent I'd go overboard about it because it's new you know what I mean?</i>	Objective stance leads to a degree of caution
4	<i>If it had been going about a couple of years I would be very satisfied, but it might just like go all pear-shaped.</i>	The cautious approach continues despite her constant distress at losing her hair
5	<i>Put me mind at rest and treatment. Just reassurance.</i>	Expresses for the first time her real needs and expectations in the management of her skin condition.
6	<i>I know doctors have got a hard job But, They are just not interested.</i>	The emotional, psychological desire for reassurance that her skin condition was at least treatable, triggers a discussion of the issue of this condition being taken seriously, with the dilemma of continuing with her pragmatic approach or not. There is a conflict of needs with expectations
6	<i>I know they see hundreds of people a week, but you like to feel as though they know you I know everybody has bad days but you know they're not bothered I didn't like how she, but as I say it might have been a bad day I don't know</i>	This oscillation between wanting to be taken seriously but 'accepting the fate' of the long waiting time, or the demands upon the practitioner is apparent
6	<i>Someone has taken notice It were just like a weight off me</i>	Expression of relief and surprise when on visiting an alternative GP

	<i>shoulders...I thought thank god for that.</i>	she feels she has been taken seriously
As the interview progresses, the participant moves from a guarded, almost defensive quasi-pragmatic stance, to one where she gradually discloses more personal and intimate feelings. This initial guardedness may well be due to her identification of the health policy researcher carrying out the interview, with those others in the profession, the GP's and the consultants, whom she clearly sees as being in a more powerful situation than herself.		
7	<i>They make you feel daft. You look up to them don't you? Like you do what they tell you sort of thing.</i> <i>Well they know what they're doing don't they? They're more educated.</i>	It becomes increasingly evident that reluctance to express opinions or expectations of her treatment, is not merely based upon diffidence, shyness or a reluctance to waste these professionals time, but on a preconceived status differential
7	<i>They're more educated. Like you do what they tell you sort of thing, and no, I wouldn't have turned round and said owt [sic] to her</i>	The status differential results in her feeling cautious about asking for an more in-depth examination by the first [dismissive] doctor
8	<i>The appointment were a waste of time, and she wasted me a week.</i>	Participant makes an overall evaluation of the appointment with her first GP
It is at this point within the interview, where the probing becomes more insistent, that the participant begins to acquire confidence in her own on-going appraisal of her experience, and her own developing construction of 'satisfaction.'		
9	<i>Yeah and like you like them to take an interest in you don't you?</i>	The language becomes more animated and questioning
9	<i>I know they see hundred of people a week but you like to feel as though you're going in to the doctor and they know yer. They know what they're talking about and they're listening to you. You don't want to walk in and like 'here's your prescription and see you', whatever. Most of them down</i>	Participant expectations begin to emerge. Despite a preliminary accepting comment, she talks in terms of meaningful, two-way communication in an environment where time is not a driving issue, and where the fact that 'they're more

	<i>there will take time. It's like I were in there all that time and he weren't rushing. He weren't rushing me and saying 'oh come on this and that and the other'. He were like taking his time and you know like, taking an interest</i>	educated' is regarded in positive, non-threatening terms
10	<i>I think on looking back how you put it now, I should have put I was very satisfied with the treatment because looking back I am very satisfied with it.</i>	Through the process of the interview, the participant now discovers an element of self-reflectivity and reformulates her original evaluations
10	<i>what you've gone for you've got treatment for, and you're satisfied with the treatment they've prescribed you.</i>	<u>First in road into defining satisfaction.</u>
12	<i>and like you like them to take an interest in you don't you. I know they see hundreds of people a week but you like to feel as though you're going into the doctor and they know yer. You don't want to walk in and like here's your prescription and see you whenever. Most of them down there, they will take time. It's like I were in all that time and he weren't rushing. He were taking his time and you know like, taking an interest.'</i>	As the interview progresses, the participant <u>refines the meaning of satisfaction</u> The self-reflective appraisal of satisfaction continues- 'satisfaction' is embedded in the concept of a different doctor taking time with the patient.

So as can be seen from this mapping of the interview/account over time, the participant was actively and reflectively, *constructing*, her own, very personal definition of satisfaction. Despite being initially dissatisfied with the perceived dismissive manner of the first doctor, this participant concludes that she was in fact satisfied with her experience since she had eventually been taken seriously

(by another doctor) and her problem thereafter had been dealt with quickly and effectively (cured) which had significantly reduced her anxiety. The gradual metamorphosis from being dissatisfied at the very opening of the interview, to satisfied at the close, clearly indicates how an individual account of satisfaction emerges, and is refined over time. This is illustrated in the extract provided below.

KC: The satisfaction questionnaire you filled in suggests that you were satisfied with most aspects of the consultations and management of your skin condition. Would you say that accurately reflects how you feel?

PT: Yeah. It were all very good yeah. They explained everything to me, what it was all about and asked me if I'd agree to do it. It were very good all the way down the line. I were really satisfied.

KC: So for you then satisfaction means...

PT: It was handled in the best possible way I thought, to my satisfaction, which means a lot you know. I wasn't told like some of them, we are going to do this, you know, it were handled very well and to my satisfaction, and I were quite satisfied with all the procedures and the way it were handled.

KC: and when you say it was very good all the way down the line, what sort of things made your experience good?

PT: My main concern is having doctors who will listen to me and be prepared to sit a few minutes while I talk and tell them what's wrong, cos some on 'em aren't like that. You know that's one of my main concerns. You know if I've got a problem and I'm going to the doctors I want someone to talk too, or listen, but they did.

As the interview progresses the fluidity of satisfaction becomes apparent.

KC: So you felt a little confused with all the information they were telling you?

PT: Yeah, that could have been explained a lot better but I think they were in a rush. They kept moving us about.. I mean I went to another department and they did exactly the same. In fact I thought they just made a mess of it actually. I was waiting for over an hour. They put you in a room, they sit you in this room and

then keep taking groups of you out. They cleared the room three times and I were still sat there. Anyway I eventually got round there, I got two appointments one at quarter past two and one at quarter to three and I think they looked at them wrong and mistook me for the quarter to three one and forgot about the quarter past two one. The first appointment was the quarter past two, I eventually got in at quarter past three to see the first one, I were an hour late and hadn't even seen the second one. I mean so I suppose everything wasn't all that great. That could have been a lot better, it really could. It didn't annoy me, but when he said if you don't mind waiting I'll do it, and I said oh that'll be fine like. I went out I got sat in a corridor, so I think someone should have said well his clinic finishes at five o'clock like and you come back at five o'clock but they left me sitting there for about an hour and a half.

KC: So you were sat in this corridor for an hour and a half.

PT: It didn't seem that long, maybe an hour and ten minutes. Looking back now it could have been better.(interview 9: man, age 61, control group)

The above extract demonstrates how over the course of the interview, through interaction with the researcher, the participant actively reflects and re-evaluates his experience and sense of satisfaction.. The fluidity of experience was a typical feature of many of the participant accounts.

Summary

If, as Clandinnin & Connelly (1994) suggest 'our principal interest as researchers is ' the growth and transformation in the life stories,' [418] then examining the sequential and unfolding nature of a typical interview above illustrates the way in which individuals' descriptions of satisfaction emerge and are refined over time; it emphasizes as Stake points out, 'episodes of nuance, the sequentially of happenings and in context, the wholeness of the individual' (Stake, 1995: xii).

In a typical interview the following process was observed over time:

- 1) The participant firstly gave a biographical context to their experience
- 2) They then moved onto a cameo or snapshot of their consultation with the doctor
- 3) They then described and evaluated their experiences.
- 4) Finally, the participant self-reflectively constructed their own definition of satisfaction.

So, whether at a broader level (chapter 5) or at a closer, more narrowed interpretative level reported here, each participant offered an idiosyncratic account of their own perception and conceptualisation of their health care experience. The rich use of metaphors and similes offering a deeper level of insight into the nature of satisfaction. Furthermore, by providing the responses to the satisfaction questionnaire (administered as part of the wider trial), the incongruity between responses from the questionnaires compared to what participants subsequently accounted in the interview, support the findings of other qualitative studies (for example, Raftery & Zarb, 1990; Bruster et al, 1994; Williams et al, 1998a; Dougall et al, 2000). Although high levels of satisfaction were being expressed through the standardised patient satisfaction surveys, the interviews revealed more negative and complex experiences and perceptions which arguably would not have emerged if the interviews have not taken place.

The issues raised here within the four individual accounts, and with the single sequential interpretative analysis, will be discussed in greater detail in the

following chapter, together with the related issue of methodological appropriateness.

Chapter 7: Discussion

Introduction

The primary aim of this study was to achieve a phenomenological understanding of the ways in which dermatology patients described and constructed satisfaction through the medium of the interview. A secondary aim was to evaluate the extent by which the methodological approach of the study was successful in eliciting such subjective meanings of satisfaction. In this chapter, I want firstly to discuss the findings that have resulted from this study in relation to the current patient satisfaction literature, and secondly, to critically reflect upon the appropriateness of the research methodology used.

Relating the findings

In the opening chapter, I argued that, in most studies to date, there has been the assumption of a universally understood definition of satisfaction, with an unstated implication that there is no need for further clarification of meaning. That is, patients are either satisfied or not satisfied. In response to this, the aim of this study was not to produce a definitive definition of what constitutes 'patient satisfaction', but rather to explore in a phenomenological sense, the ways in which individual patients describe and construct their own experiences of what it is to be satisfied with their healthcare. I do not suggest that the data gathered by

any other means (i.e. quantitative surveys) is, by implication, null and void. Nor do I claim that the qualitative stance of this study obviates the need for such surveys (see for example, McDowell & Maclean, 1998; Weinholtz et al, 1995; Pope & Mays, 1995) However, what I do argue is that there has been an over-reliance on quantitative methods which have aimed to test theories and models of satisfaction rather than attempting to explore the meaning of satisfaction from the *patient's* perspective.

This study then has assumed an anti-essentialist perspective (which necessarily incorporates the broad range of human values, feelings, experiences and emotions encapsulated in what is termed 'user views'). There follows a corresponding expectation that, unlike the aim of large-scale 'scientific' patient satisfaction surveys (such as Annandale & Hunt, 1998 with 985 patients and Pichert et al, 1998 with 12,000 patients) with their overt (or covert) drive for hypothesis testing, the findings from this study would not necessarily be generalisable. But, as I have pointed out, there was the opportunity to develop a deeper and more informed phenomenological understanding of patient satisfaction, rather than purely negate existing quantitative studies. In the course of reaching this aim, there was also the opportunity to evaluate the extent to which the methodological strategies used were successful, a point to be discussed further in this chapter.

User views and patient satisfaction

Earlier in the study, I had indicated that health authorities, primary care groups, Trusts and general practices are becoming increasingly reliant upon eliciting user views for the purpose of formulating and implementing health policy and practice. Historically, the most common method of achieving this aim has been via measuring patient satisfaction through the use of standardised patient satisfaction surveys. Similarly, I had also highlighted that some authors are becoming increasingly sceptical about the reliability of such surveys, since they may not offer even a 'reasonable reflection of users' experiences of health care' (Edwards & Staniszewska, 2000). To achieve such a 'reasonable reflection' I had suggested that there is the need, as Linder-Pelz points out: 'to understand the concept of satisfaction before we can really explain why certain factors cause it and others are caused by it' (Linder-Pelz, 1982:584).

Mair has suggested that a definitive conceptualisation of satisfaction with health care may necessitate the development and use of, 'research techniques which give priority to the patient's agenda, rather than to medicalised definitions of satisfaction' (Mair et al, 2000:36), and this has been attempted in this particular study. Nonetheless, on the basis of quantitative studies, various conceptual models for patient satisfaction have been proposed, which were described in detail in the literature review.

Quantitative variables or phenomenological meaning?

Willig (2001) points out that qualitative researchers do not tend to work with variables, rather they are interested in 'the meanings attributed to events by the

research participants' [Willig, 2001:22]. Thus, I have aimed to explore individual participant's descriptions of satisfaction regardless of patient characteristics variables such as age, ethnicity, health status, gender, socio-economic status, and psychological status. In this respect, the themes identified from the descriptive data in chapter 5 (the need for diagnosis, treatment and cure, individualised care, minimal waiting times, information and explanations, communication/ interpersonal skills of the health care provider and the need to be taken seriously) as determinants of patient satisfaction are already well established in the current patient satisfaction literature (Fitzpatrick, 1984; Cleary & McNeil, 1988; Coyle & Williams, 2000; Williams et al, 1998a). The 'need to know and understand' was apparent throughout the interviews. Participants wanted to be diagnosed and treated for their condition as quickly as possible, to know that the treatment they were given would alleviate their symptoms and cure their condition. Participants felt satisfied when doctors attempted to understand their experiences. They appreciated time to discuss their thoughts and feelings with the doctor asking questions to encourage the patient's explanation of their symptoms.

This type of interaction is characteristic of the patient-centred approach (Rivadeneyra et al, 2000), one which has been previously linked to patient satisfaction (Kinnersley et al, 1999). Here, doctors employ active listening skills in order to encourage patients to express their agendas, attempting to understand patients' points of view and expectations, and working with patients to find common ground regarding management (Stevenson et al, 2000). A number of scales have been developed to measure the patient-centred approach (see review by Mead & Bower, 2000) and such scales have included aspects which were

identified as descriptors of satisfaction within this study (Grol, 1990; de Monchy et al, 1988).

In a number of transcripts, there was a sense that participants felt disempowered within the clinical setting. Participants perceived that they had little control within the health care setting which resulted in their difficulty in 'having a voice' within the clinical encounter. This resulted in expressions of having been dismissed within the consultation and not being taken seriously. Additionally, frustrations were increased when the doctor used language that the participant didn't understand, where there were lack of introductions and poor usage of body language (i.e. not looking up when the participant entered the room). Such behaviours resulted in the participants adopting a passive and dependent role within medical consultation. Such behaviours are already well established in literature relating to therapeutic encounters (Charles, Gafni & Whelan, 1997; Britten et al, 2000). Indeed, Coyle (1999a) in her qualitative study exploring the meaning of dissatisfaction with health care identified dehumanisation, disempowerment and devaluation are the three recurring themes in participants accounts of dissatisfaction.

In contrast, participants wished to be actively involved and participate in their care and management; they wanted sharing of information, to reach a consensus and agreement through discussion about preferred treatment. In other words, they wanted some form of shared decision-making between themselves and the doctor (Charles, Gafni & Whelan, 1997).

Treatment outcome is frequently overlooked in patient satisfaction research (Rees Lewis, 1994), however, participants in this study identified the need for diagnosis, treatment and cure as being an important descriptor of patient satisfaction. Indeed Fitzpatrick (1984) stated that a major concern for patients was not the extent to which they were satisfied but for some resolution to their problem, and to a certain extent this was also reflected in this data; some participants did express satisfaction simply because their condition had improved -the communication and interactional aspect of care and management was less significant to them than receiving a diagnosis and treatment. However, other participants described feeling satisfied when there was no evident health improvement. For these participants, receiving a thorough consultation in an environment where they were able to give a full account of their experiences, with the doctor listening and providing adequate information and explanations was a factor which helped to reduce participants anxieties and positively influenced their resultant appraisal of satisfaction.

The complexity of satisfaction

In this phenomenological process of exploring individuals descriptions of satisfaction, rather than the imposition of quantitatively applied variables, this study has revealed the complexity in arriving at a definitive notion of patient satisfaction. Many of the identified themes involved in the process of understanding are already well established in the current patient satisfaction literature (Fitzpatrick, 1984; Coyle & Williams, 2000; Williams et al, 1998a). However, this study further highlights the complexity of eliciting any definitive

notion of satisfaction *across* accounts, and raises two particularly important issues:

- which themes are necessary elements of satisfaction?
- which themes/attributes could be absent, or ‘traded off’, in order for the participant to remain satisfied?

For example, some participants reported that they would be satisfied if only one of the identified themes had been present i.e. an improvement in their skin problem. However, the other identified themes (i.e. communication and the interactional aspect of care) were not important to them as predictors of satisfaction. For other participants receiving a thorough consultation in an environment where they were able to give a full account of their experiences, with the doctor listening and providing adequate information and explanations, was a more important factor in their appraisal of satisfaction than receiving a diagnosis and cure. Such a finding provides support for the benefits of applying both a health service attributes model (Crow et al, in press) and a multi-dimensional construct model (for example, Ware, 1978; Ware & Davies, 1991) of patient satisfaction. In these models, the characteristics of the provider (personality, knowledge, technical skills, caring), the features of the patient–doctor relationship (information-exchange and patient involvement), and factors relating to the setting of delivery of health care (accessibility and choice) were all descriptors of satisfaction. However, it should be pointed out that the physical environment dimension (for example the comfort of the waiting rooms or

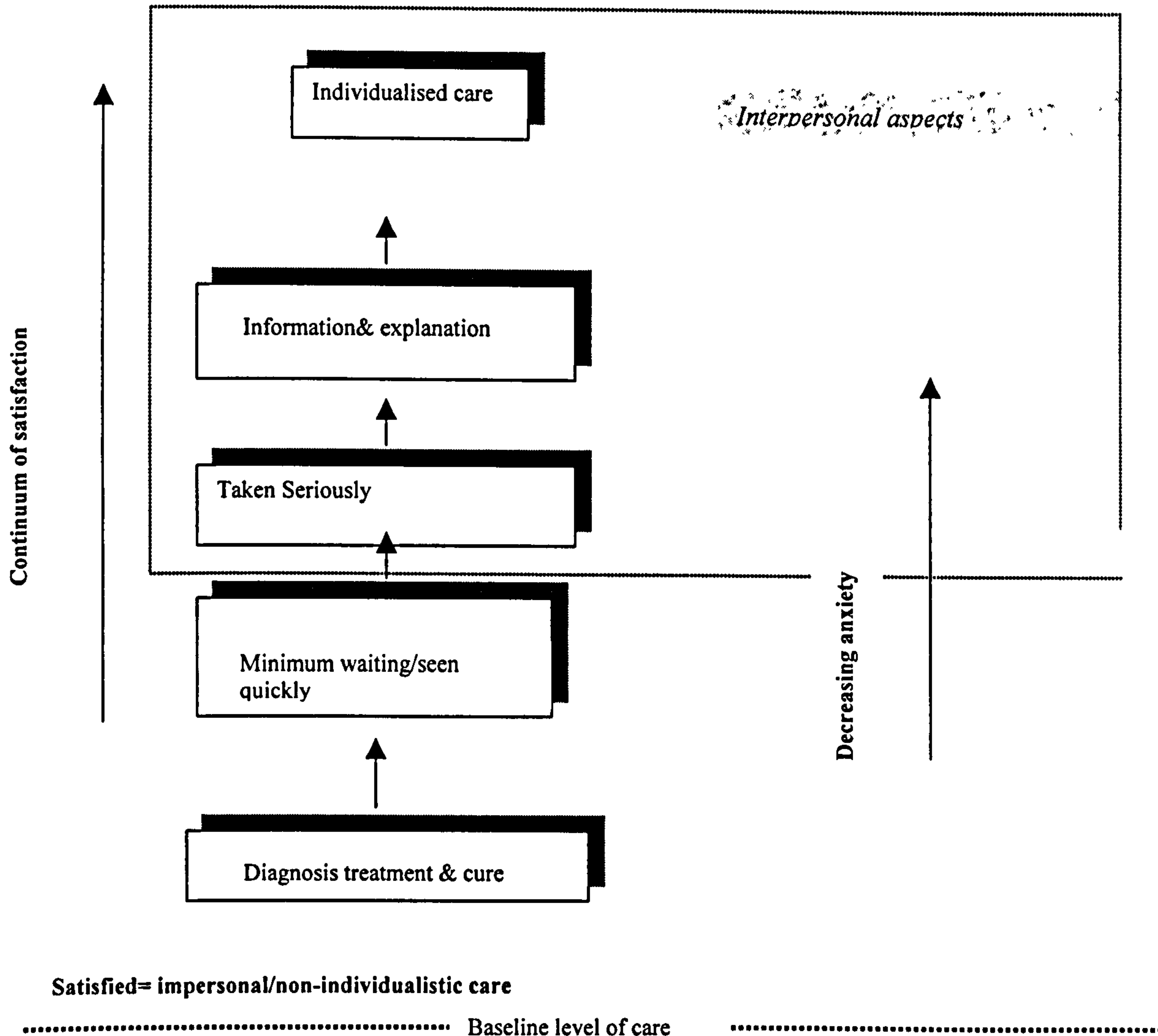
parking) and the financial dimension described in the multi dimensional model did not emerge as significant, in this study.

The continuum of satisfaction

A significant finding from this study was that participants described being satisfied as opposed to very satisfied in very different ways. I had indicated in chapter 3 of this study, that many studies of patient satisfaction have tended to be survey based (Bowling, 1997; McIver & Meredith, 1998; Merkouris et al, 1999), and within such surveys, the coding categories ‘satisfied’ and ‘very satisfied’ are frequently collapsed/merged into one category during the process of statistical analysis in order to make the data analysis statistically valid. Thus, a typical result might be presented as: ‘96% of patients reported being satisfied/very satisfied with their care.’ However, the findings from this study would suggest that there are critical differences between the two constructs ‘satisfied’ and ‘very satisfied’. As Crow et al (in press) have stated, the Oxford English dictionary defines satisfaction in terms of care being *adequate* or *acceptable*, and this was indeed the case in this study. However, being ‘very satisfied’ was expressed in terms of care being more than adequate or acceptable – it was described in terms of care being ‘outstanding’ or ‘excellent.’ Despite the observation that satisfaction was seen to be idiosyncratic and flexibly constructed by participants, this finding that there was a distinction between ‘satisfied’ and ‘very satisfied’ emerged across accounts. This can be illustrated in graphical form (see Figure 3 below).

Figure 3: The continuum of patient satisfaction

Very satisfied= personal/individualistic care



From the diagram it can be seen that baseline, adequacy of care was commensurate with feeling satisfied, (impersonal, non-individualistic care) and this ran in a continuum to feeling very satisfied (personal, individualistic care). On this continuum, the baseline of diagnosis, treatment and cure, was common to most participants. For some of these participants, satisfaction with healthcare

would stay at this point in the continuum. For others, a reduction in their anxiety would be achieved by being seen quickly. The pathway towards the end of the continuum corresponding to 'very satisfied' meant not only diagnosis treatment and cure, and/or minimal waiting time, but a move into the area illustrated in the schema above, (dotted-line box) that is, the arena of *interpersonal aspects*, which could only be implemented through the use of appropriate interpersonal skills by the healthcare professional (i.e. 'being taken seriously' and/or 'taking an interest').

Participants' sequential construction of satisfaction

It was clear from the findings here that patient satisfaction is a construct underpinned by a range of values, beliefs, attitudes and experiences.

Furthermore, it is 'fluid'; it is not a pre formulated, static concept, but (as observed in the process of the interview scenario) is defined, redefined and re-evaluated by participants over the course of the interview.

Throughout the process of data collection and analysis, it became increasingly apparent that the intricate subjective, personal and contextual nature of satisfaction was being presented sequentially over time. This was observed in a typical manner:

1. Participants initially tended to make tentative biographical appraisals of their experience
2. They provide scenarios or cameos of good and poor practice, often seeing the health professional in unreachable, high-status terms

3. Participants suggest that their own behaviour was 'normal' (suggesting 'real-world' alternatives/re-interpretations) as opposed to the professional's behaviour
4. Towards the end of the interview they begin to reflect upon their experiences
5. Patients attempt to look at the situation from the perspective of the professional (i.e. 'I know they're busy')
6. They re-define their initial appraisals and refine their definition of what it means to be satisfied.

In other words, the meaning of satisfaction emerged over the period of the interview. This may be molded by the format of the interview schedule, however, it is clear that the participants themselves were frequently guiding the direction taken within the interviews. A similar kind of framework was identified by Baruch (1981) where, in the context of parents' stories of encounters with the health professions, he spoke of 'analysing the construction of their talk.' Baruch postulates a strikingly similar framework (condensed here):

1. Story-tellers locate themselves in worlds occupied by lay-people; they appeal to features of an everyday world.
2. They locate the health professionals in a world quite distinct from that occupied by lay people.
3. They appeal to features of their world and show that they have acted reasonably, given the situations described in their stories

4. Members of the medical world are often shown to have acted incompetently according to the standards of their world
5. Story-tellers acknowledge the reasonableness of the medical world according to its standards and rules, but unreasonable in the context of their everyday world. (Baruch, 1981: 282)

Thus, through the process of the interviews, participants gave an idiographic/sequential account (deriving from their phenomenological 'life-world') of their conceptualization and perception of patient satisfaction and it became clear that satisfaction was a construct underpinned by a multifarious range of values, beliefs, attitudes and experiences.

The observation of this sequential structure has implications for assessing the appropriateness of utilising IPA, which I will now discuss.

The usefulness of interpretative phenomenological analysis

I have stated earlier that IPA is a methodological strategy which enables the researcher, 'to explore the participant's view of the world and to understand and integrate, as far as possible, an 'insiders perspective' of the phenomenon under study' (Smith, 1996: 264). IPA proved a coherent means of developing an initial stage of analysis and drawing attention to individual subjective meanings.

However, in the lengthy process of data collection and analysis, it became increasingly clear that the primary aim of eliciting the 'insider's perspective' of

the meaning of patient satisfaction was not adequately addressed through the process of eliciting super-, and sub-ordinate themes, since each interview presented a sequential, *self-related* schema through which satisfaction was processually defined or constructed.

The claim of IPA to gain insight into *individual* experiences, through what it describes as ‘an idiographic approach to analysis which begins with ‘particular examples (and) slowly working up to more general categorisation or theory’ (Smith et al, 1999: 220) was problematic. It may be said that the methodological procedures of IPA essentially place an interview outside of any real-time context; the non-linear, clustering of themes between cases used in IPA ignores the evidence of a time-based, process of thematic development and refinement of meanings, made by participants, over the course of an interview. This location with the participant through a Heideggerian process of understanding their contextualised ‘life-world’, is not truly possible with the ‘horizontal’ of IPA, which seeks to locate and cross-compare themes and categories across accounts with scant regard for the individualistic, idiosyncratic unfolding of meaning. Such an unfolding of meaning by the participant may be said to present itself in a ‘*vertical*’ manner. Thus I would argue that the contextualised, sequential unfolding within a single interview is at risk of being neglected using IPA. If, as Gelven (1989) asserts, through analysis we wish to transform the ‘vague language of everyday existence into the understandable and explicit language of ontology without destroying the way in which those meanings manifest themselves to us in our everyday lives’ [793], then it is essential to acknowledge

sequentiality; or as Clandinnin & Connelly (1994) describe as the: 'growth and transformation in the life-stories' of participants' [418].

Furthermore, in the process of disaggregating and subsequently unitising the data and identifying themes across accounts, potentially rich and personal accounts of individuals (which in the interview scenario lasted up to one and a half hours) were at risk of getting lost, or at the very least diluted and decontextualised . This is significant since the claim of IPA is that it maintains the importance of the *individual* within the analytical process. On reading and immersion in the transcripts of the interviews it was clear that the instances of self-contradictory comments, as well as idiosyncratic ways of speaking, could not be given justice within a large analytical base. Indeed, some IPA-based studies themselves have clearly demonstrated a need to focus the analytical lens down onto a smaller number of participants/transcriptions. For example, Smith (1996) [1 transcript]; Jarman et al, (1997) [5 transcripts]; Osborn & Smith (1998) [9 transcripts]; Baillie et al (2000) [7 transcripts]; Smith et al, (2002) [5 transcripts]; Robson (2002) [1 transcript]. (e.g. Osborn & Smith (1998) [9 transcripts]; Jarman, Smith & Walsh, (1997) [5 transcripts], Smith (1996) [1 transcript]).

Context based IPA

The strength of the phenomenological approach is that it emphasises the richness and complexity of an individual's lived experience and privileges agency.

Indeed, Willig (2001) in her critique of IPA, points out that while it is able to

'generate detailed, rich descriptions of participants' experiences of situations and events, such research does not tend to further our understanding of *why* such experiences take place and *why* there may be differences between individuals' phenomenological representations. That is, 'phenomenological research describes and documents the lived experience of participants but does not attempt to explain it' [64]. Thus, what participants described ('appearances') only reflects the ontological assumption that there is no discrimination between what constitutes self, and what constitutes the outside 'world'.

This particular issue was highlighted when, outside of the framework of this study, in the wider trial (*The Randomised Control Trial of Telemedicine in Dermatology*-Bowns et al, in press), it was necessary to interview the consultants who had been managing the participants in this study. In this context it became very apparent that the descriptions and accounts of the participants were being set in a broader perspective, and as a result a paradigmatic shift of understanding from *perception* to *explanation* was set in motion. Thus, for example, one participant's perception of a consultant was that the healthcare professional did not spend a great deal of time in the consultation, 'fobbing them off'. But, seen from the perspective of the consultant, after interview, such a perception could be explained by the following transcript:

I think that the pressure on time with seeing large numbers of patients is a continual problem and also the number of additional activities which one is being expected to do apart from seeing patients seem to be more things all the time. Teaching, administration, there seem to be more and more committees and discussion groups that one is needed to be involved in to some extent

and fitting all these things in to the schedule is difficult and then it comes to the point of having not enough time really to think about and deal with patients with difficult problems. (Consultant)

In other words, the consultant himself was acutely aware that due to administrative pressures he may well be running the danger of ‘fobbing off’ patients. Thus, through this paradigmatic shift the issue at hand became a matter of structural issues than with communication deficiencies, an aspect which would almost certainly not have been identified through purely interpretative phenomenological analysis.

In a different scenario, participants spoke of satisfaction in terms of receiving some form of treatment. But, a different perspective of understanding arose when the consultant explained problems with inadequate treatments and his role-dilemma:

Now with some skin conditions the treatment is obvious and straightforward. Many of the things I deal with is head problems/scalps, and treatment is not very good, there is not a lot available and your management is actually talking to the patient and in a way I regard that perhaps as my major, that’s in a large way the role of a specialist, so when that part of your job just goes, just disappears you feel as though your not doing your job. (Consultant)

In the shift in emphasis from phenomenological understanding in terms of the patient’s perspective/voice, (i.e. the patient’s ‘lived behaviour’ (Giorgi, 1985) to an explanation of *why* events are as they are, it is clear that there are, once more implications for the *sole* use of IPA as a methodological tool.

A possible way forward to gain insight and understanding patient satisfaction might be through drawing on social constructionist theory (e.g. Gergen, 2001). Both social constructionism and phenomenology are similar in that they both share a commitment to examining the lived experience of individuals, and in doing so, focus on the meaning of the discourse, text or narrative under investigation. They both offer a radical critique of the positivist, empiricist assumptions on which psychology is based. They also both share a distrust of methodologies, which are grounded in notions of 'objective reality. (Cosgrove, 2000). However, social constructionist research aims to analyse power relations that impact upon the ways in which individuals live their lives (Burr, 1997). This requires an acknowledgement of 'the crucial influence of social environment, history, cultural background, and structures of power on the way people think and talk about their actions and experiences' (Ciclitira & Weaver, 2002:181). Whereas Husserl (1970) and Heidegger (1962) were critical of the effect of culture and tradition and rather advocated that phenomena should be described as free as possible from cultural contexts (Husserl, 1970). For the social constructionist, 'meaning is not believed to reside in the research participant's head, nor in the narrative accounts of her experience' (Cosgrove, 2000:257). Similarly, the researcher cannot, by virtue of switching from a quantitative to a qualitative approach, uncover an experience or identity that 'exists' inside the subject (that is, that exists pre-discursively)' (ibid). Social constructionism in contrast to phenomenology holds that knowledge is constructed out of human engagement with objects that are already in the world rather than meaning being discovered or created anew by each person (Crotty,

1998). Meaning is viewed as residing in words themselves and direct access to an individual's experience is viewed as being impossible. Therefore, a transcript is useful in order to understand the ways in which individuals talk about experience within a particular context rather than the experience itself (Willig, 2001) The social constructionist seeks to challenge rather than describe reality, however, Cosgrove (2000) argues that 'perhaps phenomenology needs the political awareness (that is, the attunement to power dynamics) of social constructionism so that it does not lapse into a naïve humanism' [259].

Conversely, the strength of phenomenology is that it 'emphasises the importance of the individual's lived world and the interpersonal realm in the constitution of identity; it stresses the importance of the structural unity of experience, body and environment' [258]. Thus, while it is acknowledged that in a Heideggerian sense IPA may well provide 'an in-depth understanding of both the idiosyncratic and culturally constructed aspects of a person's being-in-the-world' (Shaw, 2001:49), this must be recognised as only 'one side of the coin.'

A broader understanding of patient satisfaction may well be achieved through a methodology which I would postulate as *contextual interpretative phenomenological analysis* that is, an implementation of Cosgrove's *rapprochement* of phenomenology and social constructionism. This latter perspective acknowledges the validity of different experiences and realities, but views these realities as being able to co-exist. Such a methodology would take on board the constructionist paradigm which sees the lived world 'in the form of multiple mental constructions, socially and experimentally based, local and specific, dependent for their form and content on the persons who hold them'

(Guba, 1990:17). These constructions of the world are: not more or less 'true' in the absolute sense, but simply more or less informed and/or sophisticated (Guba & Lincoln, 1994:111) and are created through the dynamic process of human interaction; that is, they are socially constructed. Thus,

1. any understanding of satisfaction must not assume some 'essential' notion of satisfaction; it is a product of social processes and interactions which may occur between patient and the provider of healthcare,
2. patient satisfaction must be viewed within socially/culturally specific settings where the variables are not stripped from particular contexts
3. since language is regarded as part of a social process/interaction, the individual patient's explanations of the world are of critical phenomenological importance.

This social constructionist approach has been criticised on the grounds of its relativist ontology; it might be said that no one account of an observed phenomenon has precedence over another, and each is simply one of many interpretations. Cooper and Stevenson (1998) when describing the polarity between positivistic and constructionist research approaches, suggest a compromise of post-positivism which accepts a real world 'out there' but accepts that a true representation of reality can only be partial due to the limits of human cognisance. Schwandt (1994) reiterates this point in that, 'one can reasonably hold that concepts and ideas are invented (rather than discovered) yet maintain that these inventions correspond to something in the real world' [126].

This means therefore, that patients construct their own descriptions of satisfaction, which may be elicited through reflexive interaction with the researcher. This point can be summed up by quoting Charmaz (1990) in her study of chronic illness:

Chronically ill people, like almost everyone, experience their constructions as reality; their constructions are neither convenient fabrications nor idiosyncratic inventions. Rather, ill peoples' constructions reflect their understandings of their experiences as well as the diverse situations in which they have them. (Charmaz, 1990: 1161)

It is therefore suggested that integrating these approaches offers the potential to gain a fuller and more integrated understanding of patient satisfaction. Although phenomenology has been useful in understanding patients experiences, a critique of it is that it does not further our understanding of why such experiences take place and why there may be differences between individuals' phenomenological representations (Willig, 2001). Thus embedding patient satisfaction within a social context might be a useful means to answering differences questions that go beyond and explain individual descriptions.

Reflections: the reflexive account

As discussed in chapter 3, the progress of the study and its evaluation by others can be helped through implementing a reflexive approach (see also Cooper & Stevenson, 1998), one which is summed up by Gadlin and Ingle (1975) as being the 'psychologist's awareness of his relationship to, and with, his subject matter

and the awareness of his own role in respect to his inquiry'[1008]. Here in this study, I have reflected on my role and status as a researcher and the impact this may have had on the participants; I wish to preface this reflection with a comment by Sword (1999):

Although some would criticise the subjectivity that is inherent in interpretive work, no research is free of the biases, assumptions, and personality of the researcher. We cannot separate self from those activities on which we are intimately involved. I believe that disclosure of how one is inherently enmeshed in the research enhances the legitimacy of findings and new insights.(Sword, 1999: 277)

In the interviews, with the tape-recorder switched off an informal discussion often took place, which seemed, in most cases, to be a natural wind down to the whole process. However, at times, topics explored during the interviews prompted some participants to discuss experiences unrelated to the topic under exploration. The challenge of multiple roles within the interview situation became apparent; Cartwright & Limandri (1997) have discussed at length, the multidimensional relationship that is likely to develop between the researcher and participant during an interview. At the outset there had been the decision taken to present myself as a researcher, rather than former nurse turned researcher. Although I acknowledged, in adopting this stance, that different accounts may have emerged if I had presented myself as the former nurse, I anticipated that if participants had been aware of my professional background some might shift the focus of the interview to health related questions rather than the original focus of the interviews (Murphy et al, 1998).

Additionally, I felt that participants might have been less likely to be critical when speaking about their care and experiences. I also made the conscious decision that if any participant asked me about past experiences, I would answer as honestly and truthfully as I could. However, very soon into the research situation, I began to question these initial intentions, and, on several occasions I felt as though, within my role as researcher, some conflict of interests was apparent. As a former 'health care professional', there was a desire to advise against some of the health practices that participants were undertaking.

Participants would also ask for my opinions regarding their treatment and management. In such instances, I encouraged the participants to talk about their feelings and concerns whilst I listened. However, I refrained from giving any direct clinical advice. Instead I suggested that perhaps they could go back to their GP in order to discuss aspects of care that I was unfamiliar with. By drawing upon one interview the complexity of the roles played within the interview situation is illustrated.

One participant gave an unsolicited and very personal account of an ongoing problem she was encountering. This was, in fact, not directly related to the study, but as a result she became extremely upset. Initially, my role was that of researcher, to discuss issues with the participant relating to the care she had received; but these issues then had brought up upsetting emotions about her own son. Part of me wanted to move her back to the interview schedule but the other half saw an individual that needed support and compassion. As Nicolson (2002) argues, the value the participants 'letting off steam' and 'unburdening themselves of certain anxieties' demonstrates the integral part the researcher has in the

research process. Coyle & Wright (1996) suggest that it is ethically questionable for researchers to address sensitive issues without being able to deal with the resultant distress. They suggest a useful way to address this problem is to foster basic counselling attributes and skills within the situation. On this occasion the counselling skills that I had developed during my nursing career were helpful, allowing the participant to talk at length about her feelings whilst I listened, accepted and genuinely empathised. I suggested she might visit her GP to discuss specific concerns relating to her sons care. After I left the participant in the morning, I contacted her again in the afternoon from the University to see how she was feeling. She was apologetic for being so upset and thanked me for listening to her. She said she felt 'a weight had been taken from her shoulders.' Again I suggested that she might return to her GP to discuss some of the issues raised earlier that morning. This felt like a more comfortable ending to our meeting.

This interview had been particularly insightful for me. It had engaged me in critical self-evaluation regarding my own position in the research process and the role of interviewing as a therapeutic process (see Coyle & Wright, 1996; Rickard, 1998). It had questioned my role as researcher, as nurse, as professional, as counsellor. On reflection I think my initial view, that I would adopt a particular role within the interview situation, was naïve. Different circumstances brought out different facets of my 'self' and differing roles emerged throughout the process (see Cartwright & Limandri, 1997).

Reflections: researcher-participant issues

What I describe in my research is in no way existent apart from my involvement in it – it is not ‘out there.’ (Steedman,1977: 3)

As discussed by Burgess (1984) the relationship between researcher and those who are researched is crucial within the interview encounter. Coyle & Wright (1996) have suggested that it is doubtful that a truly equal relationship between researchers and participants is possible. However they suggest that it is possible ‘to ensure that both the researchers and respondents can derive benefit from the interview process’[432]. Thus, in order to facilitate the interview and put the participants at ease, I was keen to present myself as a friendly, open and trustworthy researcher. However, despite this, the relationship felt ‘official’ and I had been placed in the role of being a professional with all the power. On these occasions there was a sense that participants were keen to say ‘the right thing’ rather than describing their own experiences and revealing their ‘lifeworld.’ On two occasions I also felt as though I had failed to engage with the participant in any meaningful way- the interviews felt superficial and stilted. These participants seemed unsure about what to expect from the interaction and appeared unwilling to engage in a form of in-depth dialogue. Here, despite interview prompts and encouragement, responses took the form of yes/no replies. This raised questions about how to get data from the less articulate and more reticent participants.

In recent years a number of authors have paid particular attention to the effects of researcher characteristics on the interview process (Murphy et al, 1998). Burgess (1984) discussed factors such as age, social status, race and ethnicity that create an immediate impression of the researcher and may influence the data obtained within the interview. Such differences may have impeded in-depth dialogue and, in retrospect, had there been more self-disclosure by myself more information may have been elicited. As the participants themselves had no real vested interest in the research area, and to some extent, the boundaries of exploration had already been set up by myself prior to the interview, some 'free' expression by the participant may have been attenuated. Banister et al (1994) take the viewpoint that it is not possible to achieve complete mutuality and equality because:

It is the researcher who is firmly positioned by participants as knowledgeable, who sets the process in motion, who decides on the initial research issue, which frameworks to use, which prospective participants to contact and what happens with the final product. In the final analysis it is the researcher's version of reality that is given public visibility (Banister et al, 1994: 155).

Thus, in order to minimise potential inequalities, I was careful to facilitate an environment that was both comfortable and non-threatening. The initial ten minutes of the interaction were often spent trying to establish some form of rapport by engaging in 'friendly but not over sociable conversation (Burgess, 1984:101). Within the interview itself, participants were encouraged to tell their stories in their own words, and without using the schedule in a formalised and structured way (Lee, 1993). The intention being to facilitate an interaction where

participants felt as though they were in control and so enable them to voice what they considered to be the most important issues for them.

Reflections: approaches to data analysis

The problem of method of data analysis was paramount, as there was a constant concern that I would not do justice to the participants' accounts within any analysis. Essentially, as a 'novice' *qualitative* researcher I was keen to find a particular method and follow it through, but as time progressed, my theoretical position began to emerge and develop (see Chapter 3), and the method of data analysis emerged as a natural progression from this.

The process of transcribing and analysing the data was far more time consuming than I had been originally envisaged. Working with, and developing the analysis was not only mentally challenging but on many occasions was disheartening. My hesitancy at moving the data from a purely descriptive account to a more rigorous and interpretative account was a major hurdle in this study. It was a time when I felt my learning curve was particularly steep. I found it invaluable sharing extracts from the interview data with an experienced qualitative researcher. This process served three purposes. Firstly, although I felt sufficiently immersed in the data, I felt my interpretations were too 'common sensical.' However, it was pointed out that these interpretations might not seem so obvious to someone who was not similarly emerged or familiar with the data, thus it acted as a springboard for new emerging interpretations and ideas. Secondly, at a personal level, it increased my own confidence in qualitatively analysing and

interpreting the data. It was also reassuring to know that the difficulties I was experiencing were common to qualitative researchers. Finally, it was reassuring that another researcher identified similar themes and this led to me to write with more assurance and confidence, and, as a result, the initial interpretative uncertainty became less problematical.

Summary

There continues to be debate about how best to evaluate the quality of qualitative research and there is a corresponding absence of agreed criteriology (Patton, 1990; Murphy et al, 1998). However, Elliott (Elliott et al, 1999) has attempted to synthesise some of the key aspects. These include owning ones perspective, situating the sample, grounding the examples, providing credibility checks, coherence, accomplishing general versus specific research tasks and resonating with readers. So, it is hoped that this study has 'resonated' with readers; that it has 'represented accurately the subject matter and has expanded their appreciation and understanding of it' (Elliott et al, 1999: 228). However, it is still important to raise some issues relating to limitations within this study:

Firstly, it is important to recognise that the group of participants interviewed were not all-inclusive and representative of all patient groups. The purpose of the study has not been to establish representativeness or generalisability, but rather to reflect 'the diversity within a given population' (Barbour, 2001:1115) and to generate new insights and understanding into the concept of satisfaction.

However, the study was intended as an exploratory piece of work, and it would

be useful to establish and compare the findings across different health care settings and patient groups.

Secondly, by providing basic descriptive data about the participants who took part in this study (i.e. age, gender, trial group and skin condition), an attempt has been made to contextualise the findings, although the relevance and importance of these factors have not been discussed here. Although I would concur with Barbour (Barbour, 2001), that this study does not use the qualitative dataset to its fullest (i.e. to explore in a more 'broad' sense individual descriptions of satisfaction before linking such differences to characteristics of participants), the intention is to act as a stepping-stone for possible future research areas.

Thirdly, this study has identified how satisfaction changed over the process of the interview. This being the case, it would be valuable to interview participants at different points during their care and management. For example, when they first visit their GP, prior seeing the consultant at the hospital, immediately following the consultation, one week later and perhaps three months later. In other words, a longitudinal study of a smaller group of participants exploring the ways in which satisfaction changes over time. This methodology would enable meanings elicited during the interviews to be contextually located with a comparison of patients' accounts at various stages of their care and management.

In the following and final chapter I wish to draw together the key points raised by this study of the meaning of patient satisfaction in terms of methodology and findings.

Chapter 8: Conclusion

The main aim of this chapter is to draw together the key findings from the study in order to address the original research aims presented in chapter 1. The original aims were:

1. To explore, in an overtly phenomenological sense, subjective descriptions of the meaning of satisfaction.
2. To evaluate the extent to which the methodological approach undertaken (interpretative phenomenological analysis) was successful in eliciting these subjective meanings.

The Meaning of Patient Satisfaction

Meaning comes not from seeing or even observation alone, for there is no 'alone' of this sort. Neither is meaning lying around in nature waiting to be scooped up by the sense; rather it is constructed.

'Constructed' in this context, means produced in acts of interpretation. (Steedman,1997:5)

Throughout the course of this study I have attempted to indicate that the meaning of satisfaction is not derived via imposed criteria from the researcher, but is described and constructed by the participants themselves. It is these participants descriptions of satisfaction which have been central to this thesis, descriptions understood through the use of phenomenological analytical methods. I now wish

to conclude the study by drawing together the key findings relating to the ways in which these dermatology patients described what it meant to be satisfied with their healthcare, and evaluate the extent to which the methodological approach used was successful in eliciting such subjective meanings.

The descriptive findings from this study support previously undertaken work in the area. Descriptions of the meaning of satisfaction across accounts illustrated the importance of diagnosis treatment and cure, good communication, being taken seriously, minimal waiting times, receiving information and explanations and the need for individualised care.

It is evident from the data that satisfaction is a complex construct that is underpinned by a range of experiences. Furthermore, it is a fluid construct; it is not pre-formulated, static or global, but is defined, redefined and re-evaluated by participants through the interview process. A significant finding was that participants were observed to be defining and redefining their own meaning of satisfaction in a sequential manner, an issue which is missing from the current patient satisfaction literature. The evidence that patients' descriptions of satisfaction emerged over time, and underwent re-formulation in the space of a one hour interview, has implications for providers who wish to elicit patient satisfaction within short time constraints, through such means as bedside electronic questionnaires as indicated in the NHS Plan (DoH, 2000). If participants in this study were seen to be reflexively and creatively constructing descriptions of satisfaction with their received care within the short time frame of an interview, then it is fully conceivable that further refinement and reappraisal

may well occur over longer periods of time. For example, a patient having just received treatment may 'soon after the event' articulate frustration and disappointment with the manner of the healthcare professional, and suggest that good interpersonal skills constitute their fundamental idea of 'satisfaction.' However, after a more significant period of time of reflection, that same patient may well realise that interpersonal skills are in fact, seen within their broader life-picture and be less significant than having been treated successfully.

A further new and significant finding arising from the research was the identification of a 'continuum' of satisfaction, that is, the identification of differences along a continuum from being 'satisfied' as opposed to 'very satisfied.' While for some participants, being satisfied with health care was described in terms of care being adequate or average, for others it meant that there were aspects that could be improved, or that something was missing and that optimal care was not achieved. In other words, care and management had been acceptable or sufficient but not outstanding. By way of contrast, being very satisfied with particular aspects of health care meant that the service was not only more than adequate, but ranged from 'better than average' to 'outstanding' that is, optimal care had been provided.

This observation of a 'continuum of satisfaction' -again missing from the related literature- has specific and important implications for future policy initiatives and directives. For example, the NHS documentation, 'The NHS Plan; a plan for investment, a plan for reform' (2000) states that 'most people in Britain support the NHS and are broadly satisfied with its overall performance.' [24] The

evidence from this study would question such a statement; for example, what do we mean by 'broadly satisfied'? Are we to take it that health care is 'adequate' or 'acceptable' or is it 'outstanding' or 'excellent'? Such statements as 'broadly satisfied' mask areas where improvement is needed; by acknowledging potential differences between being 'satisfied' as opposed to 'very satisfied' would be one useful means to enable purchasers and providers of health care to understand where future health care could be improved.

It may be fair to say that with limited resources the NHS aims to improve the health of the nation by providing an adequate standard of care for the majority rather than excellent care for the individual. However, the position taken in this study suggests that the NHS should aim to achieve optimum or excellent standards of care for the majority, even though this may be construed as idealistic. Given that the key criticism of patient satisfaction surveys with their reported high levels of patient satisfaction with little variation between studies, the findings here may offer a different slant upon the way satisfaction surveys are reported. I would suggest that *distinguishing*, rather than *collapsing*, the two categories 'satisfied' and 'very satisfied' permits a more informed understanding and insight into patient experiences of health services. The concept 'very satisfied' may itself be a standard or new measure which audit and evaluation could aim for.

These new findings – a) the sequentiality of construction of meanings (derived through a 'vertical' approach to interpretation rather than the 'horizontal' of IPA techniques) and b) the continuum of satisfaction – indicate quite clearly that

within patient satisfaction research there is a need for a critical reassessment of methodologies. Had IPA been used as rigorously as its proponents suggest, then it is certain that such findings would have been missed, since, as I have stated, IPA does not take into account the process of an interview where a participant might alter or amend their viewpoints during the course of interaction with the researcher.

As a result, although the phenomenological approach is useful at the initial stage of data analysis, there is a clear and unambiguous requirement to locate this same data, through what I would term, *contextualised interpretative phenomenology*. This reflects Cosgrove's (2000) suggestion of a *rapprochement* of social constructionist approaches with phenomenological methods (which themselves would take into account verticality and sequentiality of meaning construction);this could potentially address and challenge outstanding and important issues such as power relations and socially and culturally specificity. I contend that patient satisfaction needs to integrate both approaches. This integration would maintain the focus on the individual and personal dimension of satisfaction, but would also account for the social embeddedness of satisfaction, thereby representing a more critical and challenging approach to the understanding of patient satisfaction.

Does patient satisfaction research have a future?

In conclusion, through the aim of according 'credibility and legitimacy to the subjective experience of health and illness'(Nicolson, in press), this study has highlighted a serious gap in current methods of eliciting patient satisfaction. It

has demonstrated the need for a critical approach, challenging the mainstream traditional acceptance of, and reliance upon, quantification in order to understand health and illness from the patient's viewpoint. The study has argued that, for patient satisfaction concepts to be valid at all, clarity is needed (a point also commented on by, for example, Eriksen, 1995; Avis et al, 1997; Baker, 1997; Coyle & Healy 1998; McIver & Meredith, 1998; Staniszewska & Ahmed, 1999; Baker, 2001; Wilde et al, 1999).

However, one may conjecture that the concept of satisfaction is unlikely ever to be 'clarified'; participants were observed to define and re-define their descriptions through the course of interviews and multifaceted definitions of satisfaction emerged within and across these accounts. There was no evidence to suggest that there exists a generalized, absolute notion of what constitutes satisfaction. Indeed, and perhaps curiously, use of the word 'satisfaction' was, in the main, not spontaneously initiated by participants. Rather, they articulated their experiences in terms of what they found 'good' or 'bad' about their care and management; indeed, it was necessary to provide them with frequent prompts in order to elicit data regarding satisfaction with health care.

On the basis of this I would argue whether 'global' or 'objective' definitions are useful or meaningful in the search to understand and clarify the concept of satisfaction. In the context of ongoing attempts by other researchers to systematise and categorise the mercurial notion of patient satisfaction, McIver, (1993 cited in Batchelor et al, 1994) suggested, ten years prior to this study, that it may well be time to abandon the search for a definition. This may be an

extreme measure (although I pointed out earlier that within this study participants did indeed evaluate their experiences in terms of what was either ‘good’ or ‘bad’ rather than spontaneously articulating whether they were ‘satisfied’ or ‘dissatisfied’). Instead, I would contend that eliciting the views of patients’ experience rather than satisfaction, with a constant sensitivity to, and critical appraisal of, existing methodologies used to establish patients’ views, may offer a broader and more meaningful way of understanding healthcare.

A less radical approach, in order to engage more productively with current health policy and contribute further to current issues in patient satisfaction research, would be some form of committed methodological symbiosis of phenomenology and social constructionism. A study cast in this form could maintain the importance of phenomenological insight into patients’ worlds, at the same time observing these worlds within their social and cultural contexts. Such a stance would enable a *contextual* exploration of ‘the participant’s view of the world and to understand and integrate, as far as is possible, an ‘insiders perspective’ of the phenomenon under study’ (Smith, 1996:264) and is a suggested area for future research.

In conclusion, I wish to refer back to the comment by Stake (1995) made at the opening of this thesis:

The function of research is not necessarily to map and conquer the world but to sophisticate the beholding of it. (Stake, 1995:43)

It is reasonable (and realistic) to accept that this study has neither conclusively

mapped or finally conquered the elusive world of patient satisfaction. However, it does offer a new view across the landscape of patients' healthcare experiences, with significant findings, and methodological strategies which will hopefully, as Stake suggests, accord a more sophisticated beholding of such experiences.

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Appendices

Appendix 1: Copies of Publications arising from this study

Please see following;

Patient satisfaction in telemedicine

K. Collins, P. Nicolson and I. Bowns

Recent improvements in technology and telecommunications have resulted in renewed interest in telemedicine [1]. The UK's National Health Service (NHS) Executive has recently published an 'Information for Health' strategy which states that 'telemedicine and telecare will undoubtedly come to the fore as a way of providing services in the future. They have a key role to play in the Government's plans to modernize the NHS' [2]. Within the current climate, the future success of telemedicine will depend on patient and provider acceptance of such technologies. It is, therefore, imperative that the views and experiences of the users and providers of healthcare services are sought to enable problems to be resolved and issues addressed before telemedicine is fully implemented: 'Information about the patients' experiences can be an important lever for change, both highlighting where, and what sort of quality improvements are needed' [3].

This paper provides an overview of telemedicine and patient satisfaction and considers the satisfaction studies to date. It finally discusses some of the problems in assessing patient satisfaction within telemedicine and how future studies may be improved in light of the findings. It is based upon work that is presently being carried out at the School of Health and Related Research (SchARR) at the University of Sheffield as part of a Randomized Controlled Trial of telemedicine in dermatology, funded by the NHS Executive Research and Development Programme.

INTRODUCTION

Telemedicine has been defined in a number of different ways: '[It] can be broadly defined as the use of telecommunications technologies to provide medical information and services. The defining aspect of telemedicine is the use of electronic signals to transfer information from one site to another' [4].

A narrower definition of telemedicine is given by Preston, Brown and Hartley [5] as: 'Telecommunication that connects a patient and a healthcare provider through live two-way audio, two way video transmission across distances and that permits effective diagnosis, treatment and other healthcare activities' [5].

It is important to realize, however, that telemedicine definitions vary enormously. For example, the two definitions cited above differ in a number of respects. The Perednia and Allen definition [4] is significantly wider in scope and would include telecommunications in health service management and education. The second definition is quite restrictive, excluding not only management and education, but also any clinical use that does not directly involve the patient in synchronous telecommunication. This seems to exclude asynchronous telemedicine in dermatology, radiology and pathology.

There are various applications of telemedicine, the simplest being the telephone and facsimile. More commonly associated with telemedicine is asynchronous or 'store and forward' telemedicine and synchronous or interactive television (IATV). Asynchronous telemedicine transmits still text and high-resolution digital images to a practitioner, who is able to look at the images or text, in a similar way that one would look through email, and return a message: for example, a diagnosis or management to the referrer. This mode of transmission has been used increasingly in areas such as radiology, histology and dermatology. Synchronous or interactive television (IATV) allows a real-time teleconsultation between the patient and practitioner. Interactive systems transmit real-time two way images over which consultations take place. This has developed most rapidly in non-clinical uses such as administrative and educational activities, orthopaedics, emergency/disaster medicine, dermatology and psychiatry [6].

Telemedicine projects date back to the 1950s [7] [8] [9] [10]. During the 1970s and 1980s, however, although telemedicine projects were successful, there was very little progression [11]. This was primarily because of inadequate technology, poor telecommunications, high transmission costs and limited physician acceptance [12] [13]. Historically, telemedicine focused on providing healthcare to geographically remote or rural areas where there were few specialist doctors to provide care. Recent improvements in technology and telecommunications have, however, resulted in telemedicine being introduced and implemented in a variety of healthcare settings such as remote diagnosis and consultation, home monitoring, prison medical services and continuing medical education, involving clinical specialities such as radiology, dermatology, pathology, psychiatry, surgery, ultrasound, cardiology, minor injuries and medical education [1]. It has also been suggested that telemedicine will, in the future, become integral to all areas of healthcare [14].

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IS PATIENT SATISFACTION IMPORTANT?

Within the changing climate of the UK National Health Service (NHS), the role of the patient has changed and user satisfaction has increased in importance [2] [15] [16].

From satisfaction studies we are able to understand more about patients' experience of healthcare, promote co-operation with that care and increase compliance with treatment [17]. They also help the health professionals to identify problems in healthcare and evaluate that care [18], to understand the patient-doctor communication process and predict patient health-related behaviour [19] [20] [21] and to predict patient utilization of care, continuity with the same provider and compliance [22] [23] [24].

As part of a National Performance Framework [2] [3], the Government has recently introduced a National Survey of Patient and User Experience of the National Health Service. This new policy agenda aims to ensure that the experiences of users and carers become central to the work of the NHS. The survey is to be carried out annually at health authority level to determine patients' and carers' perceptions of services. This includes the responsiveness to individual needs and preferences, the skill of service providers, continuity of service provision, patient involvement, information and choice, waiting and accessibility, the physical environment and the organization and courtesy of administrative arrangements.

Specific to telemedicine, patient satisfaction is an important aspect to consider as: 'Patient and healthcare professionals' perceptions, satisfaction and future needs with telemedicine may be important in future acceptance and adoption of telemedicine... Successful telemedicine applications may depend on patient and clinician acceptance' [25].

WHAT DO WE MEAN BY SATISFACTION?

The concept of satisfaction is complex. Some authors have attempted to relate satisfaction to their perception of the outcome of care and the extent to which it meets their expectations [25] [24]. Pascoe [20] addressed this relationship, exploring expectations, values and satisfaction, and defined patient satisfaction as: 'the healthcare recipients' reaction to salient

aspects of the context, process and result of their experience' [20].

This theory indicates that dissatisfaction occurs when there is a gross discrepancy between experience and expectation, or where a negative standard exists. Ware [27] attempted to make a distinction between objective satisfaction, such as waiting times, and satisfaction ratings; such as personal preferences, expectations and realities of the care received. Other models have concentrated on areas of dissatisfaction rather than satisfaction [28] [29] [30].

Other models have also related satisfaction to human cognition [31]. The Linder-Pelz Model [32] is one of the few psychological theory building models in patient satisfaction research. This views satisfaction as being an expression of an attitude, and it approaches a definition of patient satisfaction through content analysis of satisfaction studies. It views satisfaction as: 'the individual's positive evaluations of distinct dimensions of health care' [32].

However, Fitzpatrick [18] puts forward an alternative view and argues that there are three models of satisfaction, each strongly associated with one determinant. The first model – 'the need for the familiar' – argues that socially created expectations are the primary determinant of the degree of satisfaction; the second model, 'the goals of help-seeking', proposes that the major concern for patients is not satisfaction but some resolution of their health problems, while the third model, 'the importance of emotional needs', stresses that most medical problems involve an emotional experience, and patients are therefore only able to judge satisfaction by observing affective behaviour and communication skills.

APPROACHES TO MEASURING PATIENT SATISFACTION

There are numerous patient satisfaction measures and many have heavily relied on quantitative measures, such as questionnaires. These have included scales such as Likert scales, Guttman scales, semantic-differential scales, visual analogue scales, behaviour intention measures and willingness to pay measures. Measures such as the Patient Satisfaction Questionnaire [19] [27], the Scale for the Measurement of Satisfaction with Medical Care [33], the Evaluation Ranking Scale [34], the Client Satisfaction Questionnaire [35], the Medical Interview Satisfaction Scale [36], SERVQUAL [37], the Patient Satisfaction

Scale [38], the Linder-Pelz Model [32], the Critical Incident Technique [39], the MacKeigan and Larson questionnaire [40] and the Satisfaction Questionnaire [41] have all developed as part of the traditional quantitative research tradition.

Increasingly, however, the importance and relevance of qualitative methods such as in-depth interviews, focus groups and observation has been acknowledged to understand the attitudes, behaviour and experience of the users and personnel of the health services [42] [43] [44] [45] [46] [47] [48].

SATISFACTION STUDIES SPECIFIC TO TELEMEDICINE

To date there have been very few telemedicine studies specific to patient satisfaction. Early reviews and evaluations compared primarily synchronous 'real-time' telemedicine with traditional face-to-face consultation and found that the users of telemedicine were for the most part satisfied [49] [50] [51]. More recently, studies have also indicated that patients appear to be satisfied with 'real-time' telemedicine encounters [51] [52] [53] [54] [55] [56] [57]. Other studies have similarly reported that patients are satisfied with the telemedicine encounter but indicated that they would prefer to see a specialist in person [58] [59] [60]. In one of these studies [58], this preference was related to which physician they saw. Female patients were also more likely to be self-conscious during the televideo consultation, and touch was reported to be an important part of a consultation. Lowitt *et al.* [60] also found that younger patients were more willing to accept the new technology. However, Whitten, Mair and Collins [61] found that elderly patients were satisfied with home telenursing and that the technology itself was not important to them. A larger study using real-time teledermatology consultations found patients to be universally satisfied with the technical aspects and the personal experiences of the teledermatology consultation. Eighty-five per cent felt comfortable using the video link, and 88% of them felt that a teleconsultation could save time. They also found the telemedicine consultation to be as acceptable as the conventional dermatology consultation [62]. Jones *et al.* [62] reported patients' mixed feelings towards teledermatology consultations. They reported that almost a third of patients felt that the telemedicine setting was not as easy as the traditional clinic setting, with a further third of patients reporting that the encounter was as

easy as the traditional setting and that they found no difficulties in using it at all.

PROBLEMS WITH THE SATISFACTION LITERATURE IN TELEMEDICINE

Within satisfaction studies in general, there is a lack of agreement as to what 'patient satisfaction' actually means [26] [64]. This is highlighted in the satisfaction studies specific to telemedicine where there is little or no attempt to explain what is meant by patient satisfaction, nor a discussion of factors such as non-response rates, poor patient recall and positive response bias, all of which are crucial in any patient satisfaction evaluation [65] [66] [26] [67]. Furthermore:

When a study omits identifying concepts or theories, the study loses viability for further use. This accounts for the many 'stand alone' studies on patient satisfaction, none of which tell us what we really need to know [68].

Patients tend to express high levels of satisfaction, with very few expressing dissatisfaction [26] [69] [64]. This may be partly as a result of their reluctance to say the wrong thing or complain for fear of unfavourable treatment in the future [70], or because of the fact that some patients tend to agree with statements of opinion regardless of content, that is, the acquiescent response set [71]. However, little attention has been paid to these issues in the satisfaction telemedicine data despite claims that patients are generally satisfied with the telemedicine experience.

With few exceptions [62], telemedicine satisfaction studies to date have all tended to be small, anecdotal, exploratory or feasibility studies that have lacked good quality rigorous evaluative data [4] [72] [73] [74] [75] [76] [77] [78] [79]. 'To date, the appeal of telemedicine remains largely intuitive and based mostly on logical speculation and anecdotal evidence' [80]. Furthermore, the studies have failed to discuss the rationale for inclusion or exclusion of particular items within questionnaires, thus the reliability and validity of these studies may be in question.

There has also been concern about the independence of studies [25]:

Further research on user and provider satisfaction is required as pilot studies so far contain small number of subjects, lack serial follow-up, and include potential bias associated with researchers evaluating their own programmes' [81].

These highlighted problems have resulted in poor external validity, reliability and generalizability of the patient satisfaction telemedicine studies to date.

There is a need for further studies in patient satisfaction within telemedicine [82], as there are many shortcomings in the research to date. Future studies need to take a more rigorous approach in measuring patient satisfaction; they should incorporate a detailed account and rationale of their methods, and draw on the relevant literature concerning the issues surrounding patient satisfaction research. It is also crucial that increased sample sizes are used so that results become more reliable in detecting real differences between patient groups, and that inappropriate conclusions are not drawn. There is also a need for more qualitative approaches to measuring satisfaction within telemedicine studies to gain a more in-depth understanding of the experiences and perceptions of telemedicine [45] [46] [47] [48].

CONCLUSION

To date there are few rigorous patient satisfaction studies in telemedicine, and if telemedicine is to become an accepted part of healthcare systems, it is crucial that the experiences and perceptions of its users and providers are sought, with future satisfaction studies becoming an integral part of telemedicine research [58] [81] [82].

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▶ General practitioners' perceptions of store-and-forward teledermatology

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Summary

We studied the views of 26 general practitioners (GPs) towards store-and-forward teledermatology before its introduction into their practices. A postal questionnaire was developed using Likert-type questions with respondents able to explain their answers in free text. Questions related to the GPs' knowledge, perceptions and expectations of teledermatology, as well as their attitudes towards being part of a research trial. Most of the GPs had limited prior knowledge of teledermatology. They perceived its role to relate to quicker access to specialist opinions, decreased referrals, increased convenience for patients, diagnosis, and education and teaching. There was an overwhelming view that any system needed to be quick, easy to use, efficient and reliable. Concerns were expressed about being part of the clinical trial, using new technology and an increased workload. The future of teledermatology was thought to depend on the clinical adequacy of the system.

Introduction

Studies relating to the acceptance of telemedicine, and more specifically teledermatology, have tended to focus on patient satisfaction¹⁻⁷. Few studies have reported physicians' perceptions of telemedicine. Doctors have universal but superficial knowledge of telemedicine, an appreciation of the value of technology, but low usage of the telemedicine services available to them^{8,9}. Medical students also felt telemedicine would become very important in the future^{10,11}.

Studies to date have tended to focus on the physicians' actual experience of using asynchronous or realtime telemedicine. An early study⁵ found that the major benefit reported by physicians using telemedicine was improved access to health-care. The unreliability of equipment and the time required for telemedicine consultation were the two main problems. A more recent study¹² found satisfaction to be high among four dermatologists who had been engaged in live teledermatology consultations with patients. They were satisfied with the interpersonal aspects of both the face-to-face and video-visits,

although face-to-face examinations were preferred. For all face-to-face examinations and 81% of video-examinations, the doctors were also satisfied with their ability to examine the patients' skin. The most frequent problems were the on-screen icons that partially obstructed the view of the patient, certain anatomical locations (lower legs, feet, genitals and scalp) being difficult to examine, inability to touch the skin and difficulties with fine focus in some cases. The GPs liked the rapid opinion and the opportunity to initiate action quickly for their patients. They also appreciated the teaching aspect of the consultation and being able to discuss various treatment options. Another study¹³ also reported satisfaction among 43 GPs using telemedicine in 10 different specialties between an outpatient department and six general practices.

There appear to be no reported studies of the views of GPs towards teledermatology *before* its introduction into their practices.

Methods

A randomized controlled trial of telemedicine in dermatology was being planned. In advance of the trial, a postal questionnaire was sent to GPs from seven practices in Sheffield that had agreed to take part in it.

Accepted 20 August 1999

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Table 2 General practitioners' views of teledermatology

	Yes		No		Unsure	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Do you think that teledermatology will make things better for you as a GP?	8	31	0	0	18	69
Do you feel that teledermatology will improve patient and/or health care?	13	50	0	0	13	50
Have you any concerns relating to costs?	6	23	14	54	6	23
Have you any concerns relating to the doctor-patient relationship?	3	12	19	73	4	15
Have you any concerns relating to the image of doctors?	3	12	17	65	6	23
Have you any concerns relating to ethical problems?	3	12	18	69	5	19
Have you any concerns relating to patient and professional privacy/confidentiality?	6	23	17	65	3	12
Have you any concerns relating to medical liability?	6	23	16	62	4	15
Do you feel that teledermatology will influence developments in the future?	15	58	0	0	11	42
Do you have any fears about using the teledermatology system?	12	46	12	46	2	7

patient care than those with low expectations (Kendall's tau = -0.44, *P* = 0.005).

Only one in four of the respondents (27%, *n* = 7; 95% CI 9-45%) felt confident or very confident about the diagnosis and management of care through the teledermatology system. Most felt that they were unsure (69%, *n* = 18; 95% CI 47-85%). Only one respondent (4%) did not feel confident.

Seventy per cent (*n* = 18; 95% CI 47-85%) said that they were very or fairly enthusiastic about being part of the teledermatology study. Twenty-seven per cent (*n* = 7; 95% CI 9-45%) felt that they were not sure and only one respondent (4%) was not enthusiastic at all. Male respondents appeared to be more enthusiastic than the female respondents (*P* = 0.05).

Approximately half of the respondents (54%, *n* = 14; 95% CI 31-72%) expressed some concern about taking part in the research trial. Of those who expressed concern, 39% (*n* = 5) also reported having concerns relating to professional and patient confidentiality, medical liability (31%, *n* = 4), ethical issues (27%, *n* = 3), cost concerns (38%, *n* = 3), the image of doctors (30%, *n* = 3) or concerns relating to the doctor-patient relationship (25%, *n* = 3).

Seven themes emerged from the qualitative data. These related to:

- (1) the future of teledermatology;
- (2) the perceived effects of teledermatology;
- (3) the perceived desirable features of the teledermatology system;
- (4) the perceived problems with implementing the system;
- (5) concerns relating to medical, ethical and legal issues;
- (6) the role of teledermatology;
- (7) concerns about being part of the research trial.

Discussion

Owing to the small sample size, it is difficult to generalize from the findings of the present study. The GPs had already agreed to take part in the research trial when they completed the questionnaire, so that the sample may not have been representative of GPs in general. There is also the potential for response bias—the non-responders may have been indifferent to the introduction of teledermatology into their practices and we have no information about the non-responders in this study.

The qualitative data from the open-ended questions provided information about some of the subjective perceptions and concerns of the GPs about teledermatology and its introduction into their practices. The GPs perceived their knowledge of teledermatology to be limited. Similar findings have been reported elsewhere^{3,9,10}. Despite this, these GPs expressed clear views about what they viewed as the role of teledermatology. There was a perception that teledermatology in general practices would result in quicker diagnosis and treatment, decreased referral rates and improved medical education and training. There was an overwhelming view that a telemedicine system needed to be quick, easy to use, efficient and reliable.

Almost half of the GPs expressed concerns about being part of a teledermatology research trial. There were fears of increased workload, time commitment and consultation time. There were also concerns about the quality of images transmitted and the reliability of the equipment, as well as about the security of the system, patient confidentiality and medical liability.

Despite many of the GPs not knowing what to expect of teledermatology in their practices, none of them expressed the view that it would not improve patient care. However, only one in four of the GPs felt

confident about diagnosis and management using teledermatology. This may be related to the GPs' limited knowledge of teledermatology and its applications. The implication is that teledermatology may be less likely to be introduced and accepted into practices if GPs do not feel confident about its potential to diagnose and manage skin problems effectively. It may therefore be necessary to provide education and training to GPs to increase their knowledge and awareness of new techniques such as telemedicine.

The present study suggested that GPs are cautious about the introduction of teledermatology into their practices. It also suggests that confidence with management and diagnosis through teledermatology may increase as GPs become more knowledgeable about the application. The findings have implications for teledermatology in the National Health Service. Managers need to be aware of and address some of these concerns if teledermatology is to 'have a key role to play in the Government's plans to modernise the NHS'^{16,17}.

Acknowledgements: The research trial of telemedicine in dermatology is funded by the NHS R&D Health Technology Assessment Programme, but the views expressed are those of the researchers. We thank the GPs participating in the trial, especially those who completed the questionnaire as part of the study.

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The Meaning of 'Satisfaction' for People with Dermatological Problems: Re-assessing Approaches to Qualitative Health Psychology Research

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Journal of Health Psychology
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London, Thousand Oaks and New Delhi.
[1359-1053(200209)7:5]
Vol 7(5) 615-629; 026681

Abstract

A qualitative study was undertaken to explore descriptions of satisfaction with health care, with 30 dermatology patients. The relevance and usefulness of the approach chosen to analyse the data-interpretative phenomenological analysis (IPA) was also retrospectively evaluated. The findings suggest that 'satisfaction' is a complex and fluid construct, which is defined, redefined and re-evaluated by participants throughout the interview process. IPA was useful in guiding the analysis. However, in order to build upon this approach, it is suggested that more attention be paid to the sequential nature of an individual account/interview, which might lead to a more informed understanding of the meaning of patient satisfaction.

Keywords

data analysis, patient satisfaction, qualitative methodologies

Introduction

IN THE UK, approximately 15 per cent of general practice consultations are for dermatological problems, with 4 per cent of these patients being referred to a consultant dermatologist (RCGP, 1995). In order to improve access to such services telemedicine has been proposed (DoH, 1998). However, to date, little is known about the clinical effectiveness and satisfaction with such technologies (Collins, Nicolson, & Bowns, 2000; Mair & Whitten, 2000).

The concepts of 'patient satisfaction'¹ and 'dissatisfaction' have been long established as important predictors of health-related behaviour for people with a variety of medical conditions (Pascoe, 1983; Ware, 1978; Ware, Snyder, Wright, & Davies, 1983). Such behaviour includes changing doctors, seeking second opinions and compliance with medical advice and treatment (Annandale & Hunt, 1998; Fitzpatrick, 1984, 1991; Ho, Herzberg Stegall, & Wan, 1994; Larsen & Rootman, 1976). People with ill health are more likely to follow medical advice and treatment instructions if they are satisfied with their care (Hall, Roter, & Katz, 1988). Perhaps unsurprisingly, dissatisfied patients are more likely to complain (Swan, 1992) and participate in negative word-of-mouth practices (Sirdeshmukh, Pathak, Kucukarlan, Segal, Kier, & Aversa, 1991). A study of dissatisfaction episodes by Annandale and Hunt (1998) found that of 985 respondents, 307 reported disagreement episodes with doctors; 22 per cent took no action at all in response to their felt disagreement while the remaining 78 per cent acted in a number of ways. This included seeking a second opinion, verbally challenging (or questioning) the doctor, stopping prescribed treatment or medication, making repeated visits to the same doctor or eventually leaving and changing doctors. This suggests that disagreement and/or dissatisfaction with medical intervention and advice leads to different behaviours and thus might have different meanings for different people.

Despite the growth of patient satisfaction research over the last 20 years, such studies have been subjected to criticism, particularly on the basis of methodological and conceptual issues (Avis, Bond, & Arthur, 1997; Baker, 2001;

McIver & Meredith, 1998; Staniszewska & Ahmed, 1999; Williams, Coyle, & Healy, 1998). One of these concerns being the lack of consensus regarding the nature and definition of patient satisfaction (Avis & Bond, 1997; Baker, 1997).

Measuring satisfaction in health care, therefore, is problematic. It has been characterized by a range of different methods (Sitzia & Wood, 1997), but the predominant approach has been quantitative, using for example, the structured non-standardized patient satisfaction survey (McIver & Meredith, 1998; Merkouris, Ifantopoulos, Lanara, & Lemonidou, 1999). Despite the refinement of these surveys over the last 10 years, several authors still cast doubt on whether quantitative research alone is able to accommodate the potential reported range of feelings, values and experiences deemed necessary for understanding the meaning of satisfaction (Avis et al., 1997; Coyle, 1999; Coyle & Williams, 2000). Edwards and Staniszewska go further in saying that it is unlikely that such surveys are providing us with even 'a reasonable reflection of users' experiences of health care' (2000). Although some quantitative surveys may incorporate multiple items that probe satisfaction with different aspects of health care (for example, Ware's Patient Satisfaction Questionnaire 1983), it remains unclear as to whether these measures adequately cover all relevant aspects of satisfaction. Avis, Bond and Arthur (1997) have questioned whether these methods are in fact reflecting purely superficial views of patient satisfaction rather than gauging more meaningful and precise views of patients.

Increasing emphasis on the value of using qualitative methods to elicit perceptions of health care has emerged over the last five years (Britten, Stevenson, Barry, Barber, & Bradley, 2000; Dixon & Carr-Hill, 1989; Dougall, 2000; Edwards & Staniszewska, 2000; Fulop & Allen, 2000; Poulton, 1998; Salmon, Peters, & Stanley, 1999; Williams et al., 1998). Williams et al. argue that:

If the underlying policy purpose of satisfaction surveys is to provide patients with a voice in the assessment and continuing development of services then it is not adequate to utilise satisfaction survey results. Effort must be put into designing methods of

accessing patients' experiences of service and the meaning and value they attach to them, whether these are positive or negative and whether they can be improved. (1998, p. 1358)

But, methodological problems with patient satisfaction research remain and the concept of 'satisfaction' remains elusive and inadequately defined (Collins et al., 2000). Little attention has been paid to understanding and elucidating the actual *meaning* of the term 'patient satisfaction' and there remains a lack of consensus about how best to define and conceptualize it. There is an inherent and largely underlying assumption in the literature that satisfaction is a common construct, with a universally understood meaning of the term which requires neither further clarification nor discussion (McIver & Meredith, 1998; Wilde Larsson & Larsson, 1999) and its 'essence' can be apprehended by purely quantitative or quasi-qualitative methods. This article attempts to address this issue through an evaluation of a qualitative methodological approach.

Design and methods

Aims

The aims of this article are:

- to explore the subjective meaning of satisfaction for dermatology patients; and
- to identify the extent to which interpretative phenomenological analysis (IPA) was a useful method to elicit these meanings.

This study was conducted within the context of a randomized controlled trial of telemedicine in dermatology (RCT) funded by the NHS R&D Health Technology Assessment Programme. The trial was conducted between the locality group of eight General Practices in Sheffield and a single teaching hospital in Sheffield which provided the local dermatology referral service. The qualitative study had the explicit aim of exploring participants' understanding of 'satisfaction' following consultation under two conditions. Participants in this study were randomized into two groups who received a traditional specialist dermatological opinion through either: (a) a traditional out-patient consultation (the control group); or (b) an asynchronous telemedicine consultation (the telemedicine group). The data from both groups are presented below.

Sampling and recruitment

All participants were asked to complete a patient satisfaction questionnaire. This included a section which asked participants to indicate whether they would be willing to be contacted for subsequent interview. The response rate to date (the study is ongoing) of the questionnaire was 72.7 per cent ($n = 128$). Of these 56.2 per cent ($n = 72$) patients stated their willingness to be interviewed. Fifty-six patients (43.8%) declined to be interviewed.

Participants were originally recruited onto the trial by their GPs and had to fulfil the following inclusion criteria:

1. They had to have been referred with a *new* problem or not seen by the hospital dermatologist in the preceding 12 months.
2. They had to be aged 16 years or over.
3. They were judged by the General Practitioner to require a conventional out-patient consultation with a National Health Service hospital consultant dermatologist.

There were three reasons for exclusion from the main study:

1. The nature of the dermatological problem. This related to anatomical sites (e.g. genital lesions), a strong perception that palpation of the skin was crucial to diagnosis and management, or the possibility that physical treatment was needed immediately.
2. Mental illness or handicap, language barriers unrelated to the skin problem.
3. People who wished to consult a specialist dermatologist privately.

In order to understand further the concept of satisfaction, the first 30 participants who had agreed to be part of the wider trial and to be interviewed subsequently were included in the sample. They comprised 12 men (six from the telemedicine group, six from the control group) and 18 women (13 from the telemedicine group, five from the control group). The age of participants ranged from 16 years to 82 years. Each participant presented to their GPs with a range of dermatological problems. These were grouped under three broad headings, which included rashes (either painful/itchy/tender) ($n = 16$), gradual/sudden hair loss ($n = 2$), lesion(s) growing/bleeding or painful ($n = 12$).

In-depth, semi-structured interviews were

chosen as the most appropriate tool for eliciting data in this study, since they allowed the researcher to access subjective meaning and 'permit exploration of issues that may be too complex to investigate through quantitative means' (Banister, Burman, Parker, Taylor, & Tindall, 1994). Such interviews enable the exploration of individual constructions of the meaning of satisfaction.

Ethical considerations

Prior to the start of the study, ethical approval to undertake the interviews was obtained from the Local Medical Research Ethics committee. Each interview began with a brief description of the study, its aims and objectives, and an opportunity was given for the participants to ask questions. Participants were asked whether they had objections to the interviews being tape-recorded: none objected. They were also reminded that they were under no obligation to disclose anything with which they felt uncomfortable, and also that the tape recorder could be turned off at any point. Participants were asked to read through and sign an interview consent form, which comprised a brief statement stating that the research had been explained to the participant, that they were willing to take part in the interview and were aware that the interview data would be used for research purposes only. This was signed and dated by both the researcher and the participant.

The interview guide²

Interviews were conducted, where possible, within one month of the individual's recent telemedicine or traditional face-to-face consultation. Each interview began by asking participants to describe their recent experiences of the care they had received. Responses to this were then followed up as a result of specific issues raised. This maintained the conversational flow, enabling the participants to tell their accounts in their own words. Topics centring around future health care preferences, confidence with their diagnosis and issues relating specifically to the meaning of satisfaction were explored subsequently. When all topics had been covered within the interview, participants were asked if there was anything else they considered important that had not been covered in the course of the interview. This often took the

form of the participant recapping and expanding on the issues covered during the earlier part of the interview. The interview ended with contact details being exchanged in case the participant wished to discuss further the interview or any other aspects relating to the study. None of which did this.

The interviews varied in length, ranging from between 30 minutes and two hours. Summary notes of each interview were made immediately following each interview and prior to verbatim transcription. Self-reflective notes were also kept by the researcher, which referred to any issues emerging during this data collection period which were considered relevant to understanding the meaning of satisfaction, the data analysis and/or the interview process.³

Data analysis

The data obtained through the semi-structured interviews were analysed using interpretative phenomenological analysis (IPA) (Smith, 1996). The aim of this approach is to represent as closely as possible the subjective experiences of participants, and the meanings that such experiences hold for them.

Implementing interpretative phenomenological analysis

Although IPA is phenomenological in that it aims to explore individuals' personal perspectives of an event or a state, proponents of this approach take the view that one cannot do this, directly or completely, and in an Heideggerian sense, assumes dependency upon a researcher's own conceptions in making sense of, or interpreting, an individual's experiences. The aim of this analytic approach therefore, as Jarman, Smith and Walsh point out is, 'to capture our concern with exploring individual participant's perspectives, whilst also recognising the research exercise as a dynamic process, to some extent guided by the interests and concerns of the investigator' (1997, p. 141). Central to IPA therefore is the researcher's own interpretation of meanings elicited within the analysis of each participant's interview-narrative. IPA aims 'to explore the participant's view of the world and to understand and integrate, as far as possible, an "insider's perspective" of the phenomenon under study' (Smith, 1996, p. 264). In a health care scenario it also assumes a 'belief in and

concern with, the chain of connection between account, cognition and physical state' (Smith, 1996, p. 265), which can be elicited through interpretation of participant's narrative via semi-structured interviews.

In the process of eliciting participants' experiences, and in line with the analytical framework of IPA (Smith, 1996), each transcript was read a number of times and mapped out, initially in a basic way according to the process described by Smith (1996) to familiarize and orientate the researcher with the data. Anything considered to be related to previous literature and theoretical models of patient satisfaction was noted on the left side of the text margin. The right margin was then used to document emerging themes (subordinate themes). Commonalities between, and individualities within, cases were recorded, a process similar to the *constant comparison* method of grounded theory (Strauss & Corbin, 1990). Adopting this process, new themes emerging in subsequent interviews were tested against earlier transcripts. These were then modified and identified as the superordinate theme.

Finally, re-reading of the original transcripts a number of times allowed immersion in the data to ensure that interpretations were grounded fully in what the participants were saying. The first three interview transcripts were then analysed by the second researcher in order to check the initial coding categories made by the first researcher.

Findings

From analysis of the interviews using IPA, five themes emerged when participants described the meaning of satisfaction. These were:

1. receiving a diagnosis, treatment and cure;
2. receiving information and explanations;
3. the need for participants to feel as though they were being taken seriously;
4. the need for individualized personal care; and
5. the importance of minimal waiting for an appointment and treatment.

For the purpose of this article, these themes will be briefly summarized. The presentation of these themes is illustrated below with verbatim extracts from the accounts of participants chosen for their pertinence to the themes, and

for being especially representative of all the participant accounts. As the aim of the article is to explore the meaning of patient satisfaction, it is necessary to first identify the key aspects which participants described as important when considering satisfaction, before moving onto the links and any relationships between them. Thus, as this study is primarily concerned with participants' own descriptions of satisfaction, at a first level of analysis a phenomenologically descriptive account is presented in order to remain as near as possible to participants' own 'voice'. This procedure identifies themes and describes subjective perceptions of participants, before moving onto interpretative phenomenological analysis (IPA).

Theme 1: Diagnosis, treatment and cure

The first theme to emerge from participants' descriptions of satisfaction was the perception that they had received a diagnosis, treatment and cure (or symptom relief). Participants consulted their GP because they either felt uncertain about their symptoms (i.e. a mole) or they wanted symptom relief (i.e. itching). They wanted to know what was wrong and what treatment was required. Ultimately, they wanted a resolution of their problem: to receive a diagnosis, and treatment which would result in health improvement: 'The consultant obviously looked at it, diagnosed it and sent me away with a cream which has got rid of it which is exactly what I was hoping for' (interview 11: woman, age 36, telemedicine group).

Theme 2: Exchange of information

The second theme to emerge was the importance of receiving information and explanations. Participants wanted to be able to explain their symptoms and concerns while at the same time receive an explanation and discuss treatment with a doctor. In this context of 'exchange of information', participants expressed their satisfaction with time spent with them providing information and explanations about their condition and its subsequent management. Insufficient information and explanation resulted in uncertainty and was not viewed favourably by participants. When uncertainty about their condition or treatment arose within the consultation

this was almost always followed by anxiety and an overt need for reassurance and guidance: 'You never had anything from your treatment that could have been done in any other way, different. He could answer me questions and explain things to me and I were quite satisfied with that' (interview 4: woman, age 54, control group).

Theme 3: Being taken seriously

A third theme to emerge was that of participants feeling that they had been taken seriously. Although, participants constructed their own meanings of being taken seriously. It might be said that being taken seriously is the awareness and acknowledgement by the participants that their condition was not being belittled. Participants used similar language when speaking of being taken seriously, so not being 'fobbed off' then, could mean for some of the participants some form of connectedness between the doctor's attentiveness, and thoroughness of examination:

You know like even if it's like trivial to them and it isn't to you they don't like fob you off and say well there's nothing I can do or you know or there's nothing seriously wrong why are you troubling us. (interview 27: woman, age 58, telemedicine group)

Participants frequently described feeling as though they were being taken seriously in terms of the doctor having done all s/he could to make them better or improve their condition. Although participants expressed the desire for a positive outcome, i.e. they wanted their skin problem to 'go way' or be cured, the perception that the doctor was 'doing his/her best' in order to fulfil this aim of 'cure' was an important feature in the participants' accounts of satisfaction. In some cases, it seemed that this was just as important as actually curing their condition. However, for others, this was of little significance. Although some drew attention to the impersonal manner of the consultant, they described feeling satisfied with the consultation since the thoroughness of the consultant was perceived to be more important than their interpersonal skills:

Well I think they've done as much as they can do for you at that particular time, and I mean to know that they'll say 'well come back and

see me again' and following it up, that to me is satisfaction. (interview 12: woman, age 81, telemedicine group)

It is evident then, that the interpersonal skills of the doctor affected participants' reactions to their overall consultation and their resultant appraisal of satisfaction. Satisfaction was most likely to occur when the doctor dealt with the participants' concerns, when the doctor's manner, both verbally and non-verbally, communicated warmth and interest and concern about the participant who, as a result, felt as though they had been taken seriously.

Theme 4: Receiving individualized personal care

The fourth theme to emerge from the interviews was the importance of receiving individualized care. Participants appreciated feeling as though they were receiving individualized care, which in turn made them feel as though the doctor was interested in them and that they were 'special'. This enabled them to feel more confident within the consultative process and become an active participant within the interaction. Participants frequently conveyed this creatively by describing and interpreting their experiences using a variety of similes and metaphors. For example, in order to illuminate their feelings of depersonalization within the consultation, participants compared themselves to 'a piece of bread', 'conveyor belt', 'a number' and quite bleakly as 'a photograph on somebody's computer'.

The doctor taking time and listening indicated to the participants that they were important as individuals in their own right. Participants tended to acknowledge the various demands upon the medical profession, and made allowances for their perception that they had not received 'excellent number one first class cover':

I mean I know people have hard days or whatever but it's a job where they are dealing with the public, so they shouldn't let that affect them. I mean you can realize the constraints on them, that there is a waiting room full of people who all want to see them and there are only so many hours in the day as such. (interview 10: man, age 29, control group)

It means ever such a lot to me when you can say that your GP's interested in your health.

you know what I mean. He is interested.
(interview 4: woman, age 54, control group)

The theme of individualized care also encapsulated two other elements:

1. Listening to the patient.
2. Taking time with the patient.

Listening to the patient For many of the participants, satisfaction with health care was bound up with the notion of their doctor listening carefully to their expressions of needs:

You like them to take an interest in you don't you? I know they see hundreds of people a week but you like to feel as though you're going into the doctor and they know you. They know what they're talking about and they're listening to you. (interview 6: woman, age 35, telemedicine group)

However, the desire for active participation within the consultation was apparent. Participants wanted to tell their story while the doctor gave them time and listened. Listening skills require sensitivity and attentiveness to an individual's need, but as illustrated in the following extract this was not always the case. Participants appreciated opportunities within the consultation to discuss their problem with the doctor and explore ways in which the problem was making them feel; this resulted in them having more confidence in the doctor as part of the process. The following participant gives an illuminating, if somewhat slightly humorous, account of the doctor being preoccupied with other issues:

You don't want to walk into doctors and them be like some of 'em are like writing stuff down and then they'll look up and say 'how are we today'? and you know they're not bothered because they are finishing off what other patients notes and what have you, and you can be sat there two minutes and they are still writing until they look up and say what's up with you. (interview 6: woman, age 35, telemedicine group)

Taking time with the patient Effective listening requires a degree of time to be spent within the consultation: the perception of not feeling rushed and being given adequate time within the

consultation was appreciated by participants. When participants felt as though they had been rushed through their consultation dissatisfaction was often expressed. There was the feeling that they had not received a thorough consultation, and they were left with unanswered questions and concerns regarding their condition. The lack of time given resulted in the following participant not feeling able to be an active participant within the consultative process:

I think I would now know to go in with more questions and I wouldn't worry about keeping a ten minute appointment. I think I'd be a bit bolshier. Not rude, I don't mean that but I'd be quite, right I'm going in now and I'm going to ask him why what and when. I'm sorry if it gets to half past two and I'm due next door then tough. (interview 18: woman, age 45, control group)

Theme 5: Seen quickly/minimal waiting

The fifth theme to emerge from the participants' accounts was that of waiting time. The importance of minimal waiting time was evident in many accounts, with participants keen to be seen and treated by the doctor as quickly as possible. This lessened their anxiety and resulted in their describing their satisfaction with this aspect of care:

Well I'm satisfied that I got seen to by the doctor and he gave me treatment, and I were satisfied because I didn't have to wait very long to go to the hospital you know ... It worries you, you know. I can't explain to you. It worries you when you don't get seen to straight away you know. (interview 17: man, age 72, control group)

Participants described being satisfied in terms of not waiting for too long for an appointment to be seen either by their GP or by the consultant at the hospital: 'No waiting for treatment. It's the waiting that I think gets to everyone' (interview 38: woman, age 72, telemedicine group).

Individual descriptions of the meaning of satisfaction

The themes identified above give an overview of important aspects of health care which

relate to patient satisfaction over the 30 interviews. While this provides us with a generalized pattern of satisfaction, what became apparent when asking participants specifically to describe their own subjective perception of the meaning of satisfaction, was that some of the five identified themes above had greater weighting than others. It also seems necessary, in order to counteract the danger of depersonalizing participants' accounts of their experiences, to counteract a potential watering-down of participants' accounts, and maintain a rich, holistic view of these highly individual accounts, to examine a small number of purposively selected interviews in a quasi-case study format, i.e. those which most succinctly reflect the previously identified and significant themes derived from the large body of transcripts (as suggested by Smith, 1996). This was undertaken within the study. However for the

purposes of this article, only the individual verbatim descriptions of four participants are provided (see Figure 1). It can be seen that each participant described satisfaction in personal and idiosyncratic ways, thus demonstrating the multifaceted and complex nature of satisfaction.

Interpretive analysis of an individual account

From the findings of the analysis carried out above with the 30 interviews, good descriptive data concerning participants' perspectives on satisfaction with their health care were elicited. However, an interpretive qualitative analysis of in-depth data enables the researcher to engage more intensely and in greater depth with the process of research and the interaction between the participant, researcher and the experience of health care. This approach can be potentially

<i>Participant statement</i>	<i>Meaning of Satisfaction</i>
'From a basic level right from the beginning I mean I'd like to be seen at a reasonable . . . without having to wait . . . kept waiting for goodness knows how long that annoys me. As long as I get a thorough consultation and they have looked properly and somebody seems to be taking me seriously instead of just go home and if it's no better in six months come back then that's fine and I'm quite satisfied.' (Participant 1)	Satisfaction = minimal waiting thorough consultation, examination taken seriously
'That what you've gone for you've got treatment for, and you're satisfied with the treatment they've prescribed you, and you like them to take an interest in you don't you. I know they see hundreds of people a week but you like to feel as though you're going into the doctor and they know you. They know what they're talking about and they're listening to you.' (Participant 2)	Satisfaction = received treatment own perception of treatment prescribed interest taken doctor listening individualized care doctor competent
'That they've met my requirements. You know what I've actually gone for, you know they've told me what I wanted to know. Being treated properly and they've told me exactly what will happen, and that's what you want to know, what's going to happen, explain things to you.' (Participant 3)	Satisfaction = treatment congruent with own perceptions information received explanations
'That I've had a condition taken seriously, that I've been listened to, that I felt able to articulate how it was making me feel and have that taken seriously and to have, to be given some advice on how to treat it and prevent it recurring.' (Participant 4)	Satisfaction = taken seriously doctor listening concerns met advice

Figure 1. Participants' meaning of satisfaction.

problematic in that it brings the researcher's subjective interpretation to the fore. However the importance of researcher-reflexivity and subjectivity in the interpretation of the data is that it provides important insights into the meaning of satisfaction.

Thus the second stage of IPA analysis conducted here aims to:

explore the data in depth to identify the processes that underlie the discussions in the interviews, and from consideration of these, detect the meaning attributed to the content of the discussions by the respondents. This in turn leads to the development of a conceptual framework for explaining key aspects of the experience. (Nicolson & Anderson, 2001)

Thus it is a detection process, one of trial and error perhaps, but one which potentially lends more important insights than one which more systematically attempts objectivity in interpretation.

Analysis of an individual account was undertaken in order to move from a descriptive thematic analysis to a more contextually interpretative reading of an individual case (Smith, 1995; Smith, Jarman, & Osborn, 1999). This account was selected as one which succinctly reflected the previously identified themes derived from the 30 interviews and thus enables comparison. The selected interview was carried out with a woman, aged 36, that had had an acute dermatological condition. The account is summarized in table format to establish a framework within which other accounts can be located (see Table 1).

So as the interview/account proceeds over time, the participant actively and reflectively, *constructs* her own, very personal definition of satisfaction. Despite being initially dissatisfied with the perceived dismissive manner of the first doctor, this participant concluded that she was in fact satisfied with her experience because she had eventually been taken seriously (by another doctor) and her problem thereafter had been dealt with quickly and effectively (cured) which had significantly reduced her anxiety. The gradual metamorphosis from being dissatisfied at the very opening of the interview, to satisfied at the close, clearly indicates how an individual account of satisfaction emerges, and is refined

over time. This sequencing was a typical feature of an individual's account.

Discussion

In the introduction to this article we pointed out that in most studies to date, there has been the assumption of the existence of some universally understood definition of satisfaction, with an unstated implication that there is no need for further clarification of meaning. Patients are perceived to be either satisfied or not satisfied. In response to this we suggested that the aim of the study was not to produce a definitive definition of what constitutes 'patient satisfaction', but rather to explore in a phenomenological sense, the ways in which individual patients describe and construct their own experiences of what it is to be satisfied with their health care. We do not imply therefore that the data gathered by any other means (i.e. quantitative surveys) is, by implication, null and void. Nor do we claim that the qualitative stance of this study obviates the need for such surveys (see, for example, McDowell & MacLean, 1998; Pope & Mays, 1995; Weinholtz, Kacer, & Rocklin, 1995). Rather, the aim was to explore the meaning of satisfaction from the *patient's* perspective, in order to add depth and detail—in a subjective sense—to existing data.

The descriptive account provided within this article identified five themes across accounts. These themes are already well established in the current patient satisfaction literature (Coyle & Williams, 2000; Fitzpatrick, 1984; Williams et al., 1998). However, this study further points out the complexity of eliciting any definitive notion of satisfaction across accounts, and raises the important issue regarding which themes are necessary elements of satisfaction and which themes could be absent (or 'traded off') in order for the participant to remain satisfied. For example, some participants reported that they would be satisfied if only one of the identified themes had been present, i.e. an improvement in their skin problem. However, the other identified themes (i.e. communication and the interactional aspect of care) were not important to them as predictors of satisfaction. For other participants receiving a thorough consultation in an environment where they were able to give a full account of their experiences, with the doctor

Table 1. Selected interview

Page no.	Participant account	Author interpretation
	The interview opened with the participant describing the background to her skin condition.	
1	'she didn't even look at it, didn't even look' 'She didn't look at it from my point of view'	Dissatisfaction with the doctor's approach and manner is apparent. She sums up the failings of the first GP
3	'I'm not dissatisfied with it because as I say it's new'	Reluctance to express any overt dissatisfaction, pragmatically distancing herself from the overall project
4	'I'm very satisfied with it but not to the extent I'd go overboard about it because it's new you know what I mean?'	Objective stance leads to a degree of caution
4	'If it had been going about a couple of years I would be very satisfied, but it might just like go all pear-shaped'	The cautious approach continues despite her constant distress at losing her hair
5	'Put me mind at rest and treatment. Just reassurance'	Expresses for the first time her real needs and expectations in the management of her skin condition.
6	'I know doctors have got a hard job' But, 'They are just not interested'	The emotional, psychological desire for reassurance that her skin condition was at least treatable, triggers a discussion of the issue of this condition being taken seriously, with the dilemma of continuing with her pragmatic approach or not. There is a conflict of needs with expectations
6	'I know they see hundreds of people a week, but you like to feel as though they know you I know everybody has bad days, but you know they're not bothered' 'I didn't like how she . . . but as I say it might have been a bad day I don't know'	This oscillation between wanting to be taken seriously but 'accepting the fate' of the long waiting time, or the demands upon the practitioner is apparent
6	'someone has taken notice' 'It were just like a weight off me shoulders. I thought thank god for that'	Expression of relief and surprise when on visiting an alternative GP she felt she had been taken seriously
	As the interview progresses, the participant moves from a guarded, almost defensive quasi-pragmatic stance, to one where she gradually discloses more personal and intimate feelings. This initial guardedness may well have been due to her identification of the health policy researcher carrying out the interview, with those others in the profession, the GP's and the consultants, whom she clearly sees as being in a more powerful situation than herself.	
7	'They make you feel daft. You look up to them don't you? Like you do what they tell you sort of thing' 'Well they know what they're doing don't they? They're more educated'	It became evident that reluctance to express opinions or expectations of her treatment, was not merely based upon diffidence, shyness or a reluctance to waste these professionals time, but on a preconceived status differential
7	'They're more educated. Like you do what they tell you sort of thing, and no, I wouldn't have turned round and said owt [sic] to her'	The status differential resulting in her feeling cautious about asking for an more in-depth examination by the first (dismissive) doctor
8	'The appointment were a waste of time, and she wasted me a week'	Participant makes an overall evaluation of the appointment with her first GP
	It is at this point within the interview, where the probing becomes more insistent, that the participant begins to acquire confidence in her own on-going appraisal of her experience, and her own developing construction of 'satisfaction.'	

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Table 1. Selected interview

Page no.	Participant account	Author interpretation
9	'Yeah and like you like them to take an interest in you don't you?'	The language becomes more animated and questioning
9	'I know they see hundred of people a week but you like to feel as though you're going in to the doctor and they know yer. They know what they're talking about and they're listening to you. You don't want to walk in and like here's your prescription and see you, whatever. Most of them down there will take time. It's like I were in there all that time and he weren't rushing. He weren't rushing me and saying oh come on this and that and the other. He were like taking his time and you know like, taking an interest'	Participant expectations begin to emerge. Despite a preliminary accepting comment, she talks in terms of meaningful, two-way communication in an environment where time is not a driving issue, and where the fact that 'they're more educated' is regarded in positive, non-threatening terms
10	'I think on looking back how you put it now, I should have put I was very satisfied with the treatment because looking back I am very satisfied with it'	Through the process of the interview, the participant now discovers an element of self-reflectivity and reformulates her original evaluations
10	'what you've gone for you've got treatment for and you're satisfied with the treatment they've prescribed you'	<i>First in-road into defining satisfaction</i>
12	'and like you like them to take an interest in you don't you. I know they see hundreds of people a week but you like to feel as though you're going into the doctor and they know yer. You don't want to walk in and like here's your prescription and see you whenever. Most of them down there, they will take time. It's like I were in all that time and he weren't rushing . . . He were taking his time and you know like, taking an interest'	As interview progresses, the participant <i>refines the meaning of satisfaction</i> . The self-reflective appraisal of satisfaction continues—satisfaction being embodied in the concept of a different doctor taking time with the patient

listening and providing adequate information and explanations, was a more important factor in their appraisal of satisfaction than receiving a diagnosis and cure.

In these accounts participants wanted to give an account of their history to their doctor, with the doctor listening and providing adequate information and explanations about their symptoms. The 'need to know and understand' was apparent throughout the interviews. Participants wanted to be diagnosed and treated for their condition as quickly as possible, to know that the treatment they were given would alleviate their symptoms and cure their condition. Participants felt satisfied when doctors attempted to understand their experiences. They appreciated time to discuss their thoughts and feelings with the doctor asking questions to encourage the patient's explanation of their symptoms. This type of

interaction is characteristic of a patient-centred approach (Rivadeneyra, Elderkin-Thompson, Cohen Silver, & Waitzkin, 2000). Here, doctors employ active listening skills in order to encourage patients to express their agendas, attempting to understand patients' points of view and expectations, and working with patients to find common ground regarding management (Stevenson, Barry, Britten, Barber, & Bradley, 2000). A number of scales have been developed to measure the patient-centred approach (see review by Mead & Bower, 2000) and such scales have included aspects which were identified as descriptors of satisfaction within this study: for example, the importance of patients being taken seriously, patient involvement in decisions, providing information to patients, equality in the doctor-patient relationship and sharing decisions (deMonchy, Richardson, Brown, &

Harden, 1988; Grol, de Maeseneer, Whitfield, & Mokkink, 1990). Such a patient-centred approach has been previously linked to patient satisfaction (Kinnersley, Stott, Peters, & Harvey, 1999).

In a number of transcripts, a perceived inequality and power differential within the relationship between the participant and doctor was evident. The apparent 'powerlessness' of the participants pervaded their sense of being in control, and resulted in their difficulty in 'having a voice' within the clinical encounter. It resulted from their perceptions of being dismissed within the consultation and not being taken seriously. Additionally, frustrations were increased when the doctor used language that the participant did not understand, where there were lack of introductions and poor usage of body language (i.e. not looking up when the participant entered the room). Such behaviours were also interpreted as the doctor not valuing their views and resulted in participants feeling as though they were not being taken seriously. As a result participants felt disempowered within the consultation. This passive and dependent role within medical consultations is already well established in literature relating to therapeutic encounters (Britten et al., 2000; Charles, Gafni, & Whelan, 1997). In contrast, participants wished to be actively involved and participate in their care and management: they wanted sharing of information, to reach a consensus and agreement through discussion about preferred treatment. In other words, they wanted some form of shared decision-making between themselves and the doctor (Charles et al., 1997).

A further finding from this study suggests that satisfaction cannot be viewed in essentialist terms. The qualitative stance of this study reinforces the view that it is 'fluid'; it is not a pre-formulated, static concept, but (as observed in the process of the interview scenario) is defined, redefined and re-evaluated by participants over time. In a typical interview the following was observed over time: participants gave a biographical context to their experience (justification for help-seeking behaviour). They then moved on to give a cameo or snapshot of the consultation with the doctor (describing what was said and what occurred within the consultation), moving on to describe and evaluate their experiences (in terms of the good and bad

aspects) in terms of their own preconceptions of the 'good' consultation or the 'good' doctor. By examining the sequential nature of a typical interview, the ways in which participants' constructions of satisfaction emerge and are refined over time are captured. This approach, as Stake points out, emphasizes 'episodes of nuance, the sequentiality of happenings and in context, the wholeness of the individual' (1995, p. xii).

Each participant gave an 'idiosyncratic' account of their conceptualization and perception of patient satisfaction, underpinned by a range of values, beliefs, attitudes and experiences. As a result, it is questionable whether any global 'model' of satisfaction can be meaningfully applied.

Reflections on using the IPA approach

A phenomenological research stance attempts to 'uncover and describe the essence of "being" as represented by the informant's language and behaviour in in-depth interviews' and this 'uncovering', emerges 'from the analyst's engagement with the data in the form of the participant's account' (Osborn & Smith, 1998). It is evident that in any one reading and re-reading of a transcribed account, which 'aims to get close to the participant's personal world' (Smith et al., 1999) there may well be identification of self-contradictory comments, as well as idiosyncratic ways of speaking by one person, which cannot be given justice with a large analytical base. These ways of speaking might include 'repetition, explanation, justification, vernacular terms, implicit and explicit assumptions, unusual phrases, or indeed personally resonant accounts' (Flowers, Hart, & Marriott, 1999), and this was the case in this study. IPA is not intended to analyse large data sets (e.g. Jarman et al., 1997 (five transcripts); Osborn & Smith, 1998 (nine transcripts); Smith, 1996 (one transcript)), as potentially subtle inflections of meaning may be lost in the analytical process of coding large swathes of transcribed interview data. In order to represent an IPA approach, there was an emerging need in this study to funnel down from a broadly descriptive analysis of 30 interviews, through to four accounts, and ultimately one interpretative account.

Within this article, we have indicated that to

counter the overtly positivistic, quantitative approaches of much of the current literature, a phenomenological perspective was essential, one which could be achieved through the implementation of interpretative phenomenological analysis. The authors also found the analytic methods proposed by Smith et al. (1999) to be helpful in guiding the data, and in highlighting convergences and divergences within and across cases. However, we would argue that in undertaking in-depth 'interpretative engagement with the respondent's text', there was a sense that data were also becoming diluted by this disaggregation and unitization of the data, and it is questionable whether IPA in its search for connections, similarities or divergences across cases misses a potentially richer seam of data, that of a contextualized, unfolding and sequential account within a single interview, which in this case, might lead to a more informed understanding of patient satisfaction. These rich personal accounts of individuals (which in this study lasted up to one-and-a-half hours) were in danger of becoming 'lost' and decontextualized. Furthermore, it is questionable whether, or to what extent the approach is different from a rigorous thematic analysis (Mason, 1996) as used within psychology and other related disciplines.

Conclusion

It is evident from the data that satisfaction is a complex construct that is underpinned by a range of experiences. Furthermore, it is a fluid construct; it is not preformulated, static or global, but is defined, redefined and re-evaluated by participants through the interview process. Indeed, the interviews enabled the participants to 'find their own voice'. Participants' constructions of the meaning of satisfaction were presented and re-presented over time.

IPA was a useful approach to guide the analysis of data in this study. However, in order to build upon the approach, it is suggested that more attention be paid to the sequential nature of an individual account/interview. IPA does not appear to take apart the process over the interview where participants can change, alter or amend their viewpoints during the course of interaction with the researcher. Such attention

may well lead to a more informed and meaningful understanding of the phenomena under study, in this case, patient satisfaction.

Appendix 1: The interview guide

- Participants' descriptions of recent experiences of having their skin problem managed.
- Confidence with diagnosis, treatment and outcome of care.
- Future preferences.
- Satisfaction-meaning, differences between being satisfied and very satisfied.

Notes

1. The term 'patient' is used in this article when referring to the concept 'patient satisfaction', a common and meaningful phrase in health services research. It is also used occasionally to describe the role the respondent is taking. Otherwise we use the terms 'participant' or 'respondent'.
2. Appended.
3. This article focuses on the meaning of satisfaction only.

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Appendix 2: Invitation for Interview

As researchers, we are interested in knowing more about your experiences and perceptions of the way in which your skin problem has been managed. We are intending to interview a selection of patients, in order to understand more about these experiences. We would therefore like to know of your willingness, if selected, to be contacted by telephone to discuss further being interviewed about your recent experiences. The interview would take about an hour and would take place at a location convenient to you. You would be under no obligation to agree to be interviewed, and if you did agree you would be free to withdraw at any time without giving any reason for withdrawing, and without it affecting your future medical care. The information would be collected exclusively for research purposes and treated as completely confidential, with only the researchers having access to it. No individuals would be identified in any of the reported data and no information would be passed on to your GP or consultant.

Please could you tick the appropriate box.

I would be willing to be contacted by telephone to discuss being interviewed on my opinions about the way in which my skin problem has been managed

My telephone number is

I would **not** be willing to be contacted by telephone to discuss being interviewed on my opinions about the way in which my skin problem has been managed

Please put the completed questionnaire into the attached envelope and hand it into the reception staff before leaving. If, for whatever reason, you are unable to complete it at the hospital clinic please complete and return it to us as soon as possible in the freepost envelope provided.

Thank you for taking time to complete this questionnaire.

Appendix 3: Interview Guide Used with Participants

Thank participants for their participation in the research.

Introduce the scope and purposes of the research project, and my role

Acknowledge participants are free not to answer any questions, or to stop interview at any time.

Consent form to be explained and signed

Interview Prompts

Can you start off by describing your recent health care experiences (for your skin problem).

Introduce issues around satisfaction-Can you describe what the term satisfaction actually means to you? Are there any differences for you between being satisfied as opposed to very satisfied with healthcare?

What was your overall perception/feeling about receiving a traditional GP consultation or telemedicine consultation? (what was good about it/what could have been better)

Thinking about your overall care, how confident do you feel about your treatment and management

Encourage participants to discuss and elaborate on factors affecting their confidence

Thinking about your future preferences, do you think you would prefer to be managed through telemedicine again, or through the more traditional referral route (and seeing the consultant face to face)?

Could you describe and elaborate on their stated preferences (i.e. factors influencing preferences)?

Any other comments

Do you have any other general or specific comments about your experiences.

Is there anything that we haven't touched upon that you feel is important and that you would like discuss

Ending

Thank participants for their time and cooperation with the study.

Ask them if they would like to receive a summary of the main findings of the study

Inform participants they can contact me if they have any further thoughts or ideas which they would like to contribute, or if they have any concerns or worries regarding the study. Ensure participants have my contact details

Appendix 4: Participant Consent Form (Telemedicine in Dermatology Study)

I agree to participate in this study. It was explained to me that all material would be treated as confidential and anonymous.

I understand that involvement in the research would involve taking part in a research interview. I understood that research interviews would be audio tape recorded and transcribed. I was under no obligation to take part in the study, and I understood that if I wish to withdraw from the research at any time, I would be free to do so. Audiotapes will be destroyed when the research project

I understood that all research data would be treated as confidential and kept in a secure place; and that confidentiality and anonymity are maintained by any person who has access to the data, including the researcher, the transcriber and the research supervisor, who are bound by conditions of confidentiality.

I am writing for all research data gathered from myself to be reported in all publications which are based on this research, where all such data reported is treated as anonymous and confidential.

Participants name: print-

Participants signature-

Date:

Researchers name:

Researcher's signature:

Appendix 5: Example of an Interview Transcript

Interview: 7

Pt ID:24

Interview Date: 04/02/01

Length of interview: 65minutes

Transcribed: 10/02/01

KC	OK. Could we possibly start with you telling me a little bit about your most recent experience of using the health services. If you could describe what actually happened from beginning to end that would be really helpful. .
PT	Well I usually kind of go to the GP with a collection of things so I'd got this funny thing in my eye which was the dermatology thing, so I'd got two or three things that I needed to go and see about. I don't know whether I would have gone for that one thing although it was quite annoying and it hadn't gone down for ages so I went and sort of went through the other ones, mentioned that, and he wasn't sure what that was and then he mentioned that he'd got this trial on so.
KC	So then...
PT	So then he just took photos of it. It was all just horribly inflamed and weepy down here.[pt points to eye]
KC	So when he took the pictures how accurately do you think it reflected your complaint at that time?
PT	Well it was just about the same as it had been for like a week or two, it was obviously not, it was not like spots it didn't go away, it was obviously there and getting, you know, not getting any better so I went to the GP and he said he'd got this trial on and would you mind taking part, and then he explained that eventually you get a thing through from the Hallamshire to actually go up to see the consultant.
KC	So what happened next?
PT	Well he said to call back, I forget now when they would have had the photos back because what he did was send them off and then they got a phone call and then they called me back, whether it was a week or a few days later I can't remember now.
KC	And did you do that?
PT	Yeah. I tried then we just kept missing each other for ages and then in the end he left a message on my answer machine phone and that was fine because we just kept missing each other, so that was fine for me as you know it was easier. It was probably easier him doing that than me trying to get hold of him.
KC	And was that preferable to actually going into the surgery and discussing the results?
PT	Yeah, well because otherwise you've either got to take more time off work or you've got to faff around and try and get an appointment and be fit in you know, yeah I mean, it's much easier because then you either know. You know I was pleased with it all. I mean even if it's...you know for me it was alright because, well it was a bit inconclusive but it was kind of like there was nothing, it doesn't look like anything major to worry about. I mean if he'd left a message saying please could you make an appointment you

KC	know, then you'd know that you'd have to go for an appointment, but it was, it's alright don't worry about it.
PT	So is that what made it ok, that you actually got your results on the answer machine that basically in your mind it wasn't perceived as anything serious?
KC	Yeah. Yeah.
PT	OK. You also said that it was a bit inconclusive, how did you feel about that? Did that worry you at all?
KC	No because I always end up with...you know...I always seem to end up with...I also happen to have high blood pressure and they don't really know why and so it's like oh well it's just one of those things and you're going to have to take these tablets kind of thing, so you're kind of used to that. I mean they don't really know. I mean although medicine knows a lot, they don't really know a lot do they about lots of things so as long as it's nothing like horrible, I think that's your concern isn't it, when you get something you think what is it, is it just one of those things or is it something I should be worried about.
PT	OK. Yes I can understand that.. So thereafter, after you had had the results at the surgery, what happened next? Could you tell me a little a bit about that? Well I actually work at the childrens [hospital] you know so I cheat a bit because what I do is always phone up on the internal line and say how long's the wait? How far behind are you? Because it seems to work better on the internal than on the external, and they never tell you the truth because you know, I don't even set off now until the time of the appointment at the earliest actually, and you go across there and you're still waiting twenty minutes. I mean it's only five minutes walk across and I forget how long I waited now, but I've never waited less than twenty minutes even if I've set off, and I'll have been late when I arrived, and then you speak to them, and they say oh no they're running on time, on schedule and stuff and they're not. I mean I don't mind if they say they're behind, I don't have a problem with that, I just want to know, especially for me because it's so easy for me to get across. I can get there whatever they say get across there, but if they're just be honest then I don't fuff around wasting my time that I could be doing other stuff for, and then you go in and, I don't know they're always a bit dismissive. You know you feel like you're a bit...you know...I mean it was like oh I'm just here I'm just checking, but it didn't seem that he was that interested in the trial kind of thing. It was almost like oh they'd got this thing going on, but we need to do it. Like I'm here now kind of thing and checking up on it, which I know is kind of what they're doing but it felt like it was dismissive, perhaps that's just me.
KC	No, that's important. I'm interested when you say you felt like it was dismissive. What do you think makes it dismissive?
PT	I don't know, I think it's just...it's the way they are flicking through things.
KC	I mean they often try and talk down to you.
PT	In what way?
	Well you know, because I know what's going on and kind of you don't. But then, I mean the trouble is I suppose I'm a bit coloured by normal working life, but you know he sat there looking at my notes and sort of, and you're kind of sat there and then it's right ok yes I'm ready to look at the female. It's just that, it's not at all like when you go and see the GP where you sit down, I mean the GP sort of sitting and I run through my two or three things, but

	they tend to listen just in case there is anything else, I can then say well this was bothering me, but since there's a rapport there, you'll sit and you'll talk about it, and that might be the thing that's really worrying you. Whereas it's a different...it just doesn't feel like that, it doesn't feel like they're particularly bothered about...it was almost like it was abit of a nuisance, Or maybe it was because oh well no it's alright because there's nothing to particularly worry about.
KC	
PT	But to you it nevertheless made you feel as though you were being dismissed?
KC	Yeah. I mean it might have cleared up abit by the time I went to see him so you know, that could have been frustrating for him as well, but then he started talking saying well you've had alopecia and you've had this that and the other and they thought it might be this, and you have had, it's in your notes. I had to think, and eventually I sort of remember having a bald spot on my head when I was little, but he could have given me a clue like well thirty years ago or twenty five years ago didn't you have something like that. I mean he's got the notes, he knows what the dates are. I just found that very annoying. I said no I haven't because I was thinking I did have to go to the dermatologist at the Hallamshire the year before because I had a lump on my face and they took that off, and I was thinking is it that you know. No, no, no you've had it, it says in your notes, your GP has found it in your notes, and either he hadn't got the information that said it was twenty odd years ago, in which case he should have had that, or he could have told me, because I was trying to go back to all my hospital visits or my GP visits over the last ten or fifteen years not twenty odd. It was like 'oh it's nothing'.
PT	That must have felt really horrible.
KC	Yeah it was.
PT	So was there an agreement between the two consultants?.
KC	Yeah about what it was.
PT	So did you feel reassured by that?
KC	Yeah. I mean I think he thought it was just...it was either kind of a spot or something that had got inflamed and then had just not got better really.
PT	So what happened next?
KC	Well that was it really.
PT	Right.Thank you. That's really helpful. So looking back was there anything that you could say stood out as being particularly good throughout it all?
KC	Well I think with the GP it was fine because they tend not to...and sometimes you know they run late there, but it's almost like you don't mind so much because when you go in you feel like someone's sitting and listening to you so there's a trade-off isn't there, and I don't mind waiting ten or fifteen minutes, I mean it's never like ages, but you know, twenty minutes it's fine. I mean it's fine if you can get through all the thing that you wanted to talk about. I think often, I mean it might just be because you're just so hacked off being held up by the time you get to the Hallamshire that you're not in a brilliant frame of mind anyway, and you've probably got crosser about waiting and then they're abit harrassed because they know the clinics running late so I didn't feel particularly...but maybe I wasn't particularly bothered because I fairly happy with what I'd been told already, so I probably didn't press or was..but I think I probably would have done if I was bothered about something, but probably in this instance I
PT	

<p>KC PT</p>	<p>wasn't particularly bothered but I don't know what it would have been like if I had been. I'd have probably made a point and asked, but I could see I was reasonably confident to do that but I could see other people who weren't.</p>
<p>PT</p>	<p>What would have made it better do you thing? Well they're either trying to put through an unrealistic amount of people through the clinics, so the size of the clinics are too high, so they need more consultants to meet the size of the clinics. I mean I don't know what the optimum size is, but I think truthfulness would help for starters. Yes I mean ok it's running two hours late. I mean you could almost go down town and do your shopping and come back if they told you it was two hours. I mean</p>
<p>KC PT</p>	<p>it's the sit in that room, I mean do you know the dermatology one? No, no I don't.</p>
<p>KC PT</p>	<p>I mean you sit in the open waiting room for like ages and you think right sorted and you go round the corner and there's another flaming queue, you knows, chairs before you go in, and that's just soul destroying that is. That sounds really awful.</p>
<p>KC</p>	<p>Yeah, and they'd read my notes wrong as well because it's oh sit down here, and I thought that was funny because I don't think it's that clinic, and it's because I'd been a year before about this thing on me face, they'd just got my notes wrong. I mean I thought I wasn't under that persons clinic so I mean again, it's late isn't it, it's late in the day, they're fed up because it's towards the end of the clinic, but you know abit more attention may be needed. it's just ridiculous. It just annoys me and everybody. Because I mean if you turned up there and they'd said right it's running...I mean they're not going to reduce clinic times because of all the pressure they're got on waiting lists but I mean they must get loads of complaints because people just get hacked off or fed up.</p>
<p>PT KC</p>	<p>Yeah. I can understand that. If you were now in the real world and it wasn't a trial condition and you'd have had your skin condition managed entirely from the GP surgery with recommended treatment and management throught the telemedicine system, but without seeing the consultant, and thus as you've just said, the annoyance of waiting at the Hallamshire, how do you think you would feel?</p>
<p>PT KC</p>	<p>Fine. Yeah.</p>
<p>PT</p>	<p>So what would things would you consider that would make it fine? I think...going back one when I had this thing on my face the previous year, if I'd had a photo back said it still said yes you still need to come because it was a lump that just appeared on me face, then they'd probably just said yes you need to come. I don't know if I'd have been annoyed if I'd have missed</p>
<p>PT KC</p>	<p>a week or two of joining on the queue, because I was quite distressed about that because it was on me face and leaking and you know, so I'd have wanted to know that...you know it would have been fine sending the photo off but I would have wanted to know that almost like...because I'd have thought in my head, yeah you can take a photo that's fine but something needs to be done about this because it's obviously something that needs to be sorted out, so I would have wanted to know that I'd be getting in the queue somewhere to be seen by someone who could do something about it, because it clearly needed to be removed or something. I mean I suppose with this the only thing they could have done would have been a cream thing</p>
<p>PT</p>	<p>would have been a cream thing</p>

	<p>or something like that, so if they'd have come back and said oh yes it's some kind of alopecia type of thing what you need to do is take a load of cream, for that, or you'd need to try and work out what it is if it's some irritation or something, you know presumably you could get a big list of things saying stop trying this or...and try and work out what it is, so for the kind of treatment that's going to be a cream or a potential allergy thing that'd be fine, but if it's something where you think, where you're like, no somebody needs to cut this lump out of me face and stitch it up, I mean in my case it turned out to be nothing, however, it's a big lump on your face and you don't want a big lump on your face, and so I'd have kicked up a fuss if he didn't cut it off, so I would have wanted to know I was getting in the queue to actually get it seen?</p>
KC	<p>Yeah, so it probably differs depending on what you think it is.</p>
	<p>Yeah. Right. Again that's useful. And what about the time factor? Is that important ? For example if you were given two scenario's, one being that you actually could see a consultant say within four weeks or you could have this type of consultation, this telemedicine consultation, and the consultant sends his diagnosis and suggested management to your GP surgery within say two weeks, what do you think your preference would be then?</p>
PT	<p>I'd be happy with the diagnosis within two weeks. I mean it doesn't really matter what you go to the Hallamshire for you're stuck there for hours you know. I mean for what I had this for, the photographic system was fine, it's just added stress and hassle and an afternoon.</p>
KC	<p>So for you it's absolutely fine, unless there was something that you perceived it to be something that really needed sorting out, and then you'd prefer to be on the list to see someone at the Hallmashire?</p>
PT	<p>Yeah, but I think the GPs can probably pick that up can't they. I mean they were very good when I had this other thing on my face. They were very good. I mean I don't know what they thought it was, whether they thought it's probably nothing, but clearly seeing I was upset about it, and straight away it was I'll write you a letter this afternoon to refer you to the Hallamshire. Now if they can do that kind of management of individuals they can filter people to appropriate sources.</p>
KC	<p>So how important in that case is having trust in your GP?</p>
PT	<p>That's interesting because the surgery where I am has been great you know, really really good to me. I mean I've had GPs in the past and in other surgeries where I 've not had so much faith in them.</p>
KC	<p>So what is it that gives you faith or trust in a practice or in a GP?</p>
PT	<p>I think it's time isn't it. I think it's time. I mean because I've been backwards and forwards abit because I've had this high blood pressure and I've been right hacked off with it because I do tons of exercise and have never smoked and all that kind of jazz, but because I've sat and I've talked this through with this, and there's a few people there who do quite abit of exercise I mean I'm not quite sure about the drugs I'm taking I think it's probably alright because it's quite a low dose but I'm not quite sure whether that's the right drug for exercise but they're quite willing to sit and debate and you know kind of talk about it, and they'll get their books out and sit and work it out so.</p>
KC	<p>So is it about being involved in it?</p>
PT	<p>Yeah that and they'll have a look what you should be doing and what</p>

KC	<p>shouldn't be doing. So I feel they know abit about who I am and what I do, so then when I go in for something, you know they kind of know that you're probably coming in because you're concerned about something and you need to do something, it's not that you're just going in with a cold kind of thing. I don't even mind repeating it all and running through it all again with a different doctor at that surgery if I've not seen them before, because you kind of feel that they're all kind of the same so they'd all have that kind of approach. I mean it's just got quite a nice feel to it. Whereas you go into the Hallamshire, and I mean it's in one door, out that door you know, nothing, so if there was something else. I mean it's difficult because if there's something else bothering you, and it's not to do with that well they can't do a fat lot because they'll only refer you onto someone else's clinic or something anyway. I mean I don't know, they do tend to refer a lot I suppose.</p>
PT	<p>That's so helpful. I think, if you don't mind, that links up very well to what you think your main expectations when you go to see your GP or a consultant at the hospital?</p>
KC	<p>Well, really that if it's anything major that they'll tell me about it and they'll do something about it. I mean you're concerned. There's something that wasn't there before and your concern is, well hang on I've waited abit and it's not gone away so do I need to go and see somebody about it. is it something that's going to go away or not, so you're starting to get abit concerned, so you want someone to say, yeah you're right, you know we need to do x y or z, or no it's ok it will go away, you know reassure you that it will go away.</p>
PT	<p>So for you then your main expectation is that you get treated?</p>
KC	<p>Yeah. Yeah. That's it.</p>
PT	<p>Would you say in this context would you consider yourself to have high or low expectations about the management of your skin problem?</p>
KC	<p>I don't expect them to know everything. They don't know everything. There's tons of stuff that happens that no-ones got a clue about and maybe I guess if you thought you're a doctor and you should know everything about medicine then...it depends where you're coming to it. I mean I often knacker myself in because I don't get enough sleep, but there's no point going to the doctor and saying oh but I feel really tired you know, I'm worn out and I've got no energy. That'll be because you've had five hours sleep for the past two weeks you know. But it's responsibility, it's taking responsibility for your own actions and responsibility for your own life isn't it. Some people go you know and it's somebody else's fault, therefore it doesn't matter if the cars bust or the supermarkets out of bread and it's the girl at the check outs fault, it'll be someone's fault. It's not yours for going at eleven o'clock at night. I mean people go to the doctors on and off for everything and they expect, you know tablets that will make it alright. And if I've gone I've gone because it's something that I'm concerned about. I mean I've got a classic one at the moment where I'm at the Hallamshire again of waiting. I've got a problem with circulation in my hands and wondering whether it's a side effect of the blood pressure tablets. I mean it's just getting worse. It's ridiculous. Right I'll refer you, get a letter through from the Hallamshire, I mean I don't know two months ago now. Loads and loads of referrals to that clinic we'll write to you when we've got an</p>
PT	

	<p>appointment, so I haven't heard anything. Now it's starting to get..I mean now I'm starting to get numbness in my hands, I mean what do I do now? Do I try and follow it at the Hallamshire, but can't remember because it's so long I ditched it. To phone them up and say what's happening, or do I go and bother my doctor again, but it's actually not my doctors fault. The doctors done what he said he was going to do. Now I trust my GP when he says this bloke has an interest in that kind of thing, but where do you go now. I mean I'm starting to get worried again because it's coming up to winter and it's been quite bad in the summer so I'm going to have to go back to my GP, or I'm going to have to phone them up, but that's stupid because I've been through that route. It's a waste.</p>
KC	<p>Yeah, I can see where you're coming from, the GPs done what he can do</p>
PT	<p>and..</p>
	<p>But what's the alternative?He's probably trying to run his clinics better and not have so many patients but then there needs to be more information on the letter so it says right we're taking an active stance not to have three hours delays...now I don't mind if somebody tells me that, and currently we're looking at booking in patients in September. I know what they're doing, they're fudging the waiting lists. You know by not giving me an appointment you're not coming on the back end and therefore...I mean I</p>
KC	<p>know that because of where I work.</p>
PT	<p>But that doesn't help you.</p>
	<p>No it really doesn't . I mean they did say something about I don't know six weeks before they'd contact me again, but that's been and gone ages ago. It's just like, they kind of oh well if they don't contact us back again. I mean in the great scheme of things they don't bother me too much now but what's going to happen is next winter I'll be abit more worried, you know is it the drugs or is it...I mean I know I've got bad circulation, now is it the drugs making it worse. That's what I want to know. If it is can we try something else. But it's that type of thing that frustrates you. It's just more information isn't it. It's abit more honest truthful information about what's going on. Now I don't know because that might be fine for somebody else but I object to being talked down too, and that did make me feel like I'd been talked down too. So it completely undermines the stuff the GPs done.</p>
KC	<p>It'sound really frustrating</p>
PT	<p>Yeah. Well that's it. I mean and that's another annoying thing you know,</p>
	<p>and I think that's what a lot of people have, is these silly little things that you know...I mean this Raynards or whatever it is, now all I need to know is, is it just that or are these drugs making it worse. Now if I could just go and see somebody. I mean I'm tossing out whether to go to one of those walk-in centres or something like that, because again that's not far away but you almost...I mean I almost don't need a consultation. I mean if there was somewhere you could look up which says yes this is a known side effect or these drugs or...I mean I think that's where the trouble is, a lot of people's concerns of things are...I mean then I can go back to the GPs and say right, this bloke said this, can we try...what other drugs have we got then that will keep my blood pressure under control that might not have these side effects, but a load of people have these kind of you know, it's almost silly little things that other people are worried about, that you just need somewhere to go or someone to talk to, because you don't necessarily need this big</p>

<p>KC PT</p>	<p>formal..and that's when kind of the consultants get frustrated and hacked off presumably because they've seen loads of for what to them is stupid poxy things that don't matter because they're not great big juicy whatever. I mean NHS Direct are no good because they won't know because if it's into drugs and stuff I'm not sure that they'd...because it's nurses doing it, and nurses don't usually do that. You know they can't dispense stuff can they, so I can see really see what you're saying I really can.</p>
<p>KC PT</p>	<p>Yeah, but it's that kind of...I mean the dermatology scene, it 's that kind of frustration when you just want to see them for five minutes. I want them to say look it's been there for a few weeks, there's something not quite right, the GP doesn't know, fine, he's not expected to know everything because he's a GP, he's not a specialist in a particular area, so all I want to do is just go and see somebody, so they can say right don't worry about that it'll go away, and I'd have thought that's what most people want, right the GP doesn't know, he needs to refer it to an expert, a specialist, but it might only be a five minute thing.</p>
<p>KC PT</p>	<p>And something that you've got to wait months for. Yeah. Yeah, and then you get stressed out about waiting. I mean the one that specialises in blood pressure probably knows straight off that it's a side effect to this, but you know it's crazy. Then I know I'll waste an hour and a half when I get there.</p>
<p>KC PT</p>	<p>Yes I can really identify with what you're saying I really can. So taking all your experience into account were there any aspects that you particularly liked</p>
<p>KC PT</p>	<p>Oh Yeah, I mean straight away you felt like something was being done about it. Like the GPs didn't know, take these photo's and then it's going to somebody who will be able to sort out what it is. So you felt that straight away something was being done about it, you know you'd gone through the GP doesn't know but he knows a man who will. So you've left knowing it's on it's way. Not that you've got to have a letter written and then you'd get another letter back saying come to us in four weeks or six weeks or whatever. Then probably getting a diagnosis without having to go back to the GP and you know having to take more time off.</p>
<p>KC PT</p>	<p>Ok, conversely, was there anything that you didn't like? I know you've already mentioned the waiting time. Yes. Not from the GPs end at all really. No I mean the GP end was fine. I was satisfied with that. I mean it felt alittle bit dismissive and stuff at the Hallamshire but then.</p>
<p>KC PT</p>	<p>When you say you were satisfied with the GP end , could I ask you to describe for me , what you actually mean when you say you are satisfied with the health care you received. What does satisfaction actually mean to you?</p>
<p>KC</p>	<p>Yeah, sure. For me it would be that I'd got no outstanding issues that I wanted resolving. That somebody had taken some action you know to get you an appointment somewhere else or something, so you'd gone to your GP and they'd said I don't know but we'll refer you onto somebody else, for that bit of the case you're satisfied because they've done what they could do. Like if you'd gone with a problem and the GP had gone come back in six weeks and see if it's got any better I wouldn't be very satisfied because I would have gone being concerned about this, so going back in six weeks is</p>

	<p>not going to make any difference. I mean he could have said right no there's nothing to worry about, it will take six weeks to go away but it will go away, then that's different, you're satisfied then because you've been told that there's nothing to worry about and you can't do anything about getting it to go away any quicker, it will go away, but it's the come back in six weeks and we'll see if things are any difference. Or I don't even like the oh well we don't really think it's anything but if you get a problem then come back again. I don't like that either, because does that mean I've got to take some more time off coming to see you or you know. I also think the manner of your GP is also important because you feel you know like you're closer to them so you've probably...if you didn't feel as though you could talk about all the things you wanted to your GP then you might be dissatisfied with the service you're getting, because you didn't feel you could talk about everything. I don't expect the manner of the consultant to be particularly great so I almost wouldn't judge them on that. I probably just go in wanting an answer from them. Having said that though when I went up this time they were really good, so I thought oh great because I don't expect that from them. I'd expect it more from the GP side, but I think that's to do with the kind of rapport and that kind of thing.</p>
KC	<p>Right. Right. That's really helpful. It also interests me whether there is any difference between being satisfied or very satisfied with healthcare experiences....</p>
PT	<p>For me its all to do with confidence in expressing your opinions isn't it I think. I mean a lot of people are happy to stick in the middle and they don't want to be kind of out of a crowd and stuff you know. I think satisfied is when you've got an answer to your questions. I guess it's how you've been dealt with isn't it, because very satisfied..I mean my view of satisfied is I've come away with a result so the only difference is probably how you were dealt with because you've come out with the same result as been very satisfied, so it must be the way it has all been handled.</p>
KC	<p>That's interesting.</p>
PT	<p>But saying I'm dissatisfied is a different matter. You see if I was really hacked off and couldn't get anywhere else, I'd probably pay and go somewhere. I'd probably try and go back to the GP, but in the end if I was really fed up you know there's the Westfield thing round here so I'd go and pay.</p>
KC	<p>Why would that be?</p>
PT	<p>I mean with the consultant I think it would be very difficult to say you're dissatisfied. . I mean I'd find that quite hard I think. I mean I'm pretty hacked off about my hands and stuff and probably what I should do is phone them up and say right what's going on here because it's ridiculous. And you're not quite sure and you're a little bit worried that it's just a silly think that they're just going to think don't be so stupid everybody's got that you know that kind of thing, or whether it's something I should be worried about. So because you're unsure about where you're starting from because you know you're not happy but you don't know whether it's anything serious, and chances are it's something reasonably insignificant because most skin things often are. So for me it's about doubt, because it's got worse over the last few years how am I going to get that across, and I suspect I'll come out and I'll probably have to put up with it, and because I feel that's</p>

KC	<p>what he's probably going to say I'm not prepared to go out on a limb and go no you've got to do something about this. I mnea if you've got a lump or something and you'd be like no this is a big lump, this needs sorting and you'd be much more sure of your ground work, your footing, to say you know I'm not going out of here until I see somebody, and if you make a big scene they'll sort it won't they? Whereas if you're not sure of where you're starting from, and then your going to make a big scene because you're worried about, and they say it's nothing. I mean that's what puts you at a disadvantage to complain or to make your feelings known.</p>
PT	<p>I know exactly what you're saying I think. So to the future. How would you feel about being managed in this way again?</p>
KC	<p>Fine I think.</p>
PT	<p>Would you?</p>
	<p>Yeah. I wouldn't have any problem with it other than what we've said at the beginning where if you think it's just going to be one of those things where it's a creamy thing then that's fine. If you think somebody needs to chop something then not.</p>
KC	<p>OK. Is there anything else that you think is important that we haven't</p>
PT	<p>touched upon?</p>
	<p>No I'm quite surprised you know when you go back and think about things it's quite funny how things are deep in you, deep in your mind and how</p>
KC	<p>much I've got to say.</p>
PT	<p>Yes thank you for sharing all of that. I really has been interesting as well as</p>
	<p>helpful.</p>
	<p>No thank you. I've really enjoyed going over it again. Its surprising how</p>
	<p>much you forget. Thank you for listening.</p>
	<p>Close of interview. Tape recorder switched off.</p>

Appendix 6: Extract from Reflexive Journal

June 2nd 2001

Participant Two – Interview 25

My previous interview had left me with feelings of powerlessness; as an ex-nurse I had identified with this patient's anxieties and panic '*what is it that's going on in my body?*' '*I felt like this was happening in spite of everything I'm doing to stop it happening – it was scary*'. My natural reaction was to begin to empathise, and to express this in terms of identifying with her frustration at her having to demand answers from her consultant. Why are these professionals incapable of everyday human communication skills? I would ask myself.

So, how much do I enter into the interview process? Do I maintain my interview schedule or go off tangent and attempt to explore new and uncharted areas and get the participant to disclose more? I felt guilty that I was unable, in an immediate sense, to effect change for this person – if they had been under my care, I would have made sure that communication was clear and effective, and tried to put her mind at ease. Of course, as a researcher, visiting her home, and being grateful for anything she might offer, I was not in such a position.

This, I reflected, is the dilemma of interpretative phenomenological research – we are not looking for explanations, or even placing the participant's experience within any social or cultural context; it is only descriptions and constructions which we deal with in this research methodology, rather than any form of explanation. I am beginning to feel that there are limitations here, since I recognize in myself a frustration with research which seems to have no identifiable benefit for the patient. I am beginning to explore readings in social constructionism. I am reading Carla Willig's (2001) comments in this area at the moment; she says 'phenomenological research describes and documents the lived experience of participants but does not attempt to explain it' (64). I reflect whether I am content to assume this epistemological stance.

8th June 2001

I have been considering again the status of reflexivity within the research process. This is very new and unusual for me since the majority of all research I have been involved in to date has been overtly quantitative – oddly, although I consider myself as able to connect with others thoughts and emotions, my research experience has for ten years precluded this, and I struggle with bringing the ‘personal’ into a study. It seems less ‘scientific’ and more open to a variety of interpretations. Willig again has been useful in this respect: She says that ‘What matters to IPA is how participants *experience* the situation or event. It does not ask whether participants’ accounts of what happened to them may be ‘true’ or ‘false’ or to what extent their perception of an event corresponds to external reality.

But I continue to struggle with this – my most recent interviewee was worrying whether the drugs she was taking was making her condition worse. In a phenomenological sense, I have to forgo my own need to place this participant within a particular context (where she is quite clearly not receiving adequate explanations, a situation which could be addressed), and focus instead upon her descriptions and constructions of anxiety. What do I say when she despairingly says to me that ‘ you just need somewhere to go or someone to talk to’? Do I really consider that in a relativistic sense there are multiple interpretations of such as statement?

I am acknowledging as honestly as possible my own stance within this project, and my own presuppositions . Frank (1997) suggests that ‘the challenge is not to eliminate ‘bias’ but to be more neutral, to use it as a focus for more intense insight’ (89). I hope that I can bring this to my interviews and analysis.