

Experiencing quality - the patient's perspective

Mike Hart

Principal Lecturer, Department of Public Policy and Managerial Studies
De Montfort University, Leicester

Introduction

The National Health Service has been concerned with issues of 'quality' since its inception and these concerns have intensified with the requirements of *The Patient's Charter* and the various types of audit (medical, clinical) to which staff are subject. The introduction into the NHS of an internal market in which purchasers (either GP's or commissioning groups) buy services, typically from hospitals, has further raised the salience of the 'quality' dimension. Purchasers increasingly are concerned not only with the total quantum of care purchased but also with some measures (usually statistical) which stipulate that the quality of care provided meets certain minimum standards. However, the measurement of what is a quality service is typically left for the purchaser to specify or for the provider to supply. Such measures may include a target for outpatient referral times, for example. A recent initiative is for hospitals to undergo a rigorous process of accreditation which can then be used as evidence to purchasers that block contracts for services should not be placed elsewhere. However, accreditation may be seen more as a public accountability tool than an overall indicator of quality. Evidence from countries such as the US, Canada and Australia which have long had accreditation systems shows that there is no clear linkage to patients defined as consumers achieving redress for service failures (Hunter, 1995).

Statistical measures of outpatient quality

Long periods of time waiting to be seen whilst attending an outpatient clinic have long been defined as a source of concern (Cartwright and Windsor, 1992) and was an issue specifically addressed in *The Patient's Charter* (1991). The most recent edition - *The Patient's Charter and You* (1995) - stated that 'when you go to an outpatient clinic you can **expect** to be given a specific appointment time and to be seen within 30 minutes of that time'.

Dramatic improvements appear to have been effected since the time of the authoritative survey by Cartwright and Windsor which showed that only 45% patients had experienced a wait of less than thirty minutes. The latest national figures showed a figure of 88% for January-March 1995 and 90% for January-March, 1996 (NHS Executive, 1995;1996). This 'headline' figure is the one most likely to be quoted as an indication of quality within the clinic itself. Comparable figures indicating the amount of time spent waiting to obtain an outpatient appointment are less easy to interpret. The 1995-96 Performance Guide gives a global figure for each NHS Trust indicating the percentage of outpatients seen within 13 weeks covering 'All specialties' but a comparable figure was not published in the 1994-1995 edition. The diligent researcher would need to look at the data for each specialty and then calculate the weighted average of them all in order to assess the differences in performance of each Trust (rather than the specialties within it) between the relevant years.

As the figures for waiting times within clinics appear to show that one of the prominent sources of dissatisfaction has been removed, is it then a safe inference that the quality of the experience of those attending outpatient clinics has risen as a consequence? It is at this point that the purely statistical approach to the measurement of quality appears to break down. It is theoretically possible both that quality is increasing (because sources of dissatisfaction have been removed) and also that quality is decreasing (as patients are processed with less individual care and attention to ensure that the 'quality' guideline that all patients be seen within 30 minutes is met). As Gaster (1995) trenchantly observes:

'The main weakness of the quantitative data method is that of the 'measurable driving out the non-measurable: only those aspects of a service that can be counted are measured' (Gaster, 1995, p.111)

Asking the patients

It has been said that the importance of consulting consumers is now accepted in the health service (Williamson, 1995). However, particularly with the introduction of the 'managed market' into healthcare provision, it is also claimed that the providers of healthcare have not traditionally been accountable to the users of healthcare - the patients - who have little information and few rights of redress. Baggott identifies the emergence of the 'supermarket' model which focuses mainly on customer relations, performance targets and better information for patients (Baggott, 1994).

The traditional literature of TQM did not draw a sharp distinction between 'purchaser' and 'consumer' - indeed, Deming often uses the terms interchangeably (Deming, 1986). In the case of public services and particularly in the case of healthcare, it is necessary to draw a sharp distinction between these roles as those who purchase healthcare (fund-holding GP's, DHA in their health commissioning role, private insurance companies) are evidently not the same as those who 'consume' the healthcare. The 'purchaser' and the 'consumer' only coincide in those rare cases when individuals are purchasing healthcare for themselves or their family on an open market out of their own resources. More typically, a 'purchaser' attempting to maximise the greatest good of the greatest number may decide not to spend scarce funds on cases with a very poor prognosis, thereby alienating one set of consumer(s) and their carers in order to satisfy other 'consumers' who feel they are equally deserving of support. Such debates over rationing of healthcare, highlighted in the 'Child B' case, indicate that some of the conventional formulations of TQM may need theoretical refinement before they can be applied uncritically to healthcare.

Patients may be seen either as a mass of isolated, competing individuals each of whom seeks satisfaction in the market for healthcare (illustrated by the position of the apostrophe in *The Patient's Charter*) or as a member of wider collectivities such as pressure groups. Williamson (1995) has argued that it is possible to distinguish three categories of consumer in healthcare: *Patients* and their carers, *Consumer Groups* (e.g. community groups, self-help groups) and *Consumerists* (those consumers whose understanding of patients' interests and concerns is wider and more abstract than that of any single consumer group). It should then be possible, Williamson argues, for managers of healthcare to incorporate the viewpoint of the 'consumer' more appropriately into healthcare provision. For example, the reorientation of maternity care exemplified in *Changing Childbirth* was given a considerable impetus by the incorporation of 'ordinary' women's views.

One way to take account of the patient perspective is to administer a patient satisfaction questionnaire. This is particularly common after treatment as an in-patient. However, some commentators express a degree of cynicism that such surveys represent anything other than a management desire to pay lip-service to patient consultation. As Carr-Hills's (1992) study indicated, the questions asked often reflect 'producer-led' rather than 'consumer-led' concerns, patients are not asked to comment upon aspects of clinical practice and the methodological treatment of such items as non-response rates leaves a lot to be desired. As Carr-Hill observes

'Once the fieldwork is over, there is a considerable temptation to forget what are confidently described as respondents' views are only their replies to questions devised by the researcher and not necessarily the patients' own views and priorities'
(Carr-Hill, 1992, p.245)

Although it may be argued that the majority of patient satisfaction surveys have tended to reflect the interests and the agenda of the *producers* of healthcare, this is not inevitably the case. Hart (1996a), for example, has argued that patients could be consulted in focus groups and in a variety of non-structured ways so that the questions that are of importance to patients themselves be included in any further surveys of patient opinion. It is also possible that local people can be involved to help provide the items for questionnaires. It may well be a surprise to policy makers and managers if issues that figure largely in their own agenda (of which waiting times in clinics is a prime example) are not reflected in the world views of their patients when they are encouraged to express their opinions freely. Indeed, health authorities are now encouraged to pay attention to 'local voices' and to become 'champions of the people' (NHSME,1992) but this has usually been interpreted as the monitoring of opinion through market research techniques rather than full public consultation and participation.

An ethnographic approach to patient monitoring

It is evident that the approaches to quality already outlined (i.e. the *statistical* approach and the *provider-led* approach) may have shortcomings if we are to use them as overall indicators of the quality of a service. This does not mean, however, that they can be ignored altogether. Although patients may well have strongly held views concerning the quality of the treatment they are receiving, as consumers that are not always in the best position to determine that quality. It is possible that acceding to the wishes of one group of patients may lead to the withdrawal of services from other groups who are less articulate or in a position of power to defend their interests. It has been argued that the philosophy of consumerism within the public services may serve to further empower those who are vociferous and/or well organised at the expense of those who are not. Therefore providers who are concerned to ensure equity of access to the services they provide may, on occasion, have to deny further benefits to such powerful groups (e.g. white, middle class groups) if the consequence of acceding to their wishes would be to deny treatment to others.

An ethnographic approach to the measurement of quality seeks to complement existing measures of quality and not to replace them. An ethnographic approach is one in which the researcher attempts to sample the 'world-as-experienced' by the participants. In the case of an outpatient clinic, one would want to discern, without prejudging, those aspects of a clinic that may be a source of dissatisfaction to patients without assuming, *a priori*, that time spent waiting for the consultation is necessarily one of such issues. It is often forgotten that, as

Meredith (1993) reminds us, patients often arrive in an outpatient clinic after long and exhausting journeys and in an anxious frame of mind and may not therefore fully appreciate all that is said to them by the consultant when discussing their case with them.

Much survey work involving patients will tend to be sociographic in that it seeks to paint a statistical picture rather than to construct and test analytical hypotheses as such. It may be that tests of significance are possible (e.g. to establish if there are gender differences in the pattern of responses within a sample) but the aim of the research is fundamentally to advance the state of knowledge about the groups themselves rather than the extension of social theory.

Ethnographic research, on the other hand, may be seen as part of the scientific process of induction rather than deduction. Conventional survey work seeks to establish generalisations from sample groups in such a way that it is possible to make statistical inferences (subject to confidence intervals) about the statistical populations from which they are drawn. However, the questions that are asked of the data are those which have been demonstrated by similar surveys in the past, usually with the aim of producing a statistic (satisfaction rate, attendance rate) which can then be used to monitor and evaluate the service under examination. Ethnographic investigations, however, seek to determine *which* questions may subsequently be investigated by the more well known statistical techniques. The ethnographer seeks to establish the 'who', 'what', 'where' 'why' and 'how' questions which are present in any social setting. To the ethnographer in a medical setting, it is important to establish through observation and questioning what each of the participants is bringing into a 'social transaction'. For example, it is possible that a patient presents with urgent symptoms and is seeking a rapid diagnosis of what is defined as a 'problem', followed by a 'solution' in the form of some type of therapeutic intervention. The medical staff may perceive their role in a different way in that diagnosis only follows a fuller examination of 'what is the problem' and they may initially be concerned with a range of diagnostic procedures which would tend to 'rule out' certain possibilities and increase the likelihood of others. The ethnographer would seek to establish what are the background expectations that both clinical staff and patient bring to a social transaction and the consequences if they were to fail to match with other. One potential hypothesis would therefore be that dissatisfaction is seen as a potential consequence of a mismatch of expectations between clinical staff and their patients.

The traditional literature which is replete with examples of 'doctor-patient interaction' is strangely silent when it comes to a more systematic understanding of the role of nurses, receptionists and the other paramedical professions in the organisation of 'clinic life'. What the ethnographer seeks to observe is 'what is going on around here' or more specifically 'what is it that makes for a *good* clinic on any one day or a *bad* clinic'. Evidently, there are certain environmental variables (such as the location of the clinic in the hospital, the time of day, the time of year) which may be regarded as relatively fixed.. To this, we need the add the organisational variables, such as appointment times (have patients been given very standardised appointment times or are they 'de facto' seen on a first-come, first served basis?). Then we would seek to establish the deployment of staff on the day in question (were all the medical staff detailed for that day present and on-time?). Finally, an ethnographic study seeks to establish the 'chemistry' of the interactions between the various participants. Evidently, each person may be seen as the bearer of particular roles and statuses which will impinge upon the transaction - for example, younger patients may live in a more time-oriented culture in which 'time is money' in contrast to the way in which time is experienced by, say, a person of retirement age.

Ethnographic work may be conceptualised as less ‘hard-edged’ than those approaches which appear to be closer to the scientific ideal in that they generate a mass of statistical data. For this reason, the randomised controlled trial is often held to be the ‘gold standard’ to which scientific work should aspire whilst ethnographic work is often less well understood and less likely to be published in that it does not arrive at ‘firm conclusions’. However, the ethnographic examination of outpatient clinics may provide much a much firmer foundation for improving the quality of patient experience than greater statistical refinement could ever do. When the issue of a waiting time assumed such a salience in *The Patient’s Charter*, most hospitals were urged to achieve a standard in which 80% of patients were seen within 30 minutes. Given that samples of waiting times do not follow a normal distribution, this figure will imply an average waiting time of about 12 minutes (see Hart, 1996b, for some empirical data on this point). Establishing a drive to ensure that 90% (or even 100%) patients are seen within 30 minutes may well generate extra ‘stars’ in the officially published indices of quality, but only result in the reduction of 1 or 2 minutes in waiting time. It is highly unlikely that waiting in outpatient clinics is so irksome that a reduction in waiting times of 1-2 minutes is likely to result in perceptions that the quality of the clinics has improved! In this scenario, it is quite likely that policy makers need to be supplied with much more sensitive indicators as to the quality of the patient experience *which can only come from ethnographic research*.

Patient expectations and patient satisfaction

Many studies of patient satisfaction appear to conceptualise satisfaction in such a way that satisfaction is likely to be high if patients’ expectations have been met. However, this implies that *expectations* should be conceptualised as a simple independent variable whereas, as Thompson and Suñol (1995) point out it is possible to define expectations in four different ways: *ideal* (preferred outcomes), *predicted* (anticipated outcomes), *normative* (outcomes that ‘should’ occur) and *unformed* (users are unable or unwilling to express expectations.)

It is also possible, in the health services context, that expectations are ‘epiphenomenal’ in that they arise in the course of interaction with clinical staff rather than being pre-formed beforehand. The provision of healthcare has particular distinctive features that means that the approaches used to evaluate other type of service goods (e.g. the disjunction between expected and perceived levels of service that characterise approaches such as SERVQUAL) may not be appropriate. For example, health care episodes typically form a trajectory starting with initial consultations with a GP and then leading to further referral, courses of treatment and resolution of some type. Expectations at each stage are unlikely to be fixed or even ‘free-floating’ but to be a function of the trajectory itself and the individual’s own social, biological and health statuses. It is also salient to point out that patients differ from other consumers in that they may be seen as the producers of their own health care status as well as acting of consumers of healthcare services. Thompson and Suñol call for more in-depth interpretative studies of the ways in which expectations are both conceptualised and articulated by patients and clients. Ethnographic techniques and other forms of qualitative analysis including narrative analysis are needed here in order to throw more light on the nature of expectations before further quantitative studies are undertaken.

Conclusion

The statistical measures which have purported to act as global indicators of quality in the arena of outpatient clinics are too crude an instrument to be allowed to stand on their own.

There is an urgent need for such crude and producer-defined measures of quality to be complemented by measures which more fully reflect patient expectations and experiences of a service. The traditional patient satisfaction survey does not really allow the patients to 'speak for themselves'. Therefore there is a pressing need to develop tools of analysis to investigate quality-as-experienced but using the tools of naturalistic rather than positivistic social science.

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